Joined Up Care Derbyshire

INTEGRATED CARE PARTNERSHIP
07 February 2024

ITEM 06

Report sponsor: Kate Brown, Director of Joint Commissioning and Community Development, Derby and Derbyshire Integrated Care Board (ICB)

Report authors: Kate Brown, Dr Ian Lawrence, Hannah Leaton, Angela Wright, Jo Warburton, Louise Swain

Age Well/ Die Well - Update

Purpose

1.1 Age Well / Die Well is the third of the three strands of the Integrated Care Strategy and a Key Area of Focus.

1.2 The purpose of this report is to provide background, share the significant progress and the future ambition for the range of improvement work addressing this priority.

1.3 A further purpose is to raise awareness of the key issues that may enable or limit the pace of improvement.

Recommendations

2.1 To acknowledge the body of work and progress to-date.

2.2 To reinforce the ambitions around integrated, multi-partnership strength based approaches and for members to identify further opportunities to promote and embed those within their organisations and spheres of influence.

2.3 To note the opportunity for a flagship partnership strategic commitment in the form of an accelerated community transformation programme to drive delivery of the age well and die well ambition.

Reasons

3.1 To ensure delivery of the Integrated Care Strategy.

Supporting information

Background

4.1 The Integrated Care Partnership (ICP) published the Derby and Derbyshire Integrated Care Strategy 2023 in June. It sets out how Local Authority, NHS, Healthwatch, and voluntary, community and social enterprise (VCSE) sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system-level health and care challenges.

4.2 Prior to development of the Strategy the Joined Up Care Derbyshire system had agreed statements to describe the experience, through life stages, if the population was living in good health. The ambition is that citizens thrive and stay fit, safe and secure into older age. They maintain independence and actively participate in society. They have a personalised, comfortable, and supported end of life.

4.3 The Strategy agreed three Key Areas of Focus (KAOF) chosen to test in detail our strategic aims and ambitions for integrated care in response to population health and care needs. The scope incorporates improvement in prevention, early intervention and service delivery outcomes.

4.4 For age well and die well the following key area of focus was agreed

- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

4.5 Clearly significant work addressing the needs of older people and those at the end of life was underway ahead of the strategy, and indeed the KAOF builds on a track record of success.

4.6 This paper aims to set out for the Integrated Care Partnership Board;

- high level needs of older people
- The approach taken to driving and embedding improvement
- High level achievements so far
- Planned next steps and opportunities, and
- Implications for ICP members.

Need

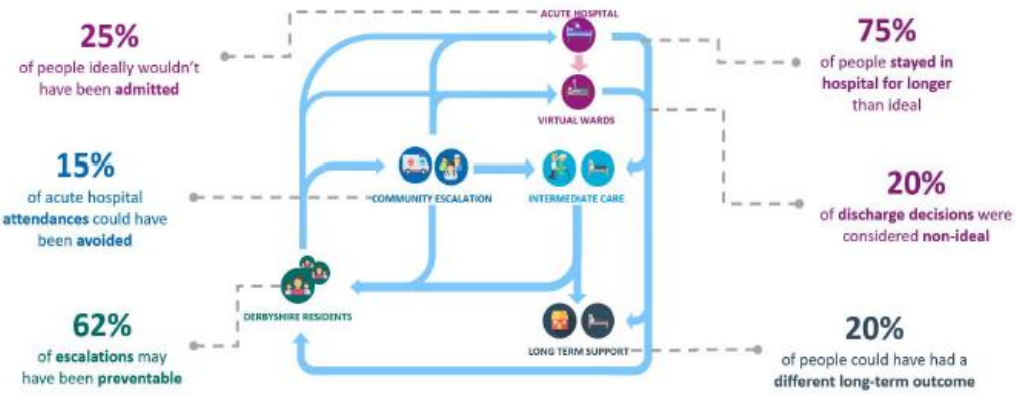
4.7 We need to be driven by, and continually refresh our understanding of the data and the insights from the population, in terms of need.

4.8 People in England can now expect to live for longer than ever before – but these extra years of life are not always spent in good health, with many people developing conditions that reduce their independence and quality of life. The health and care sector has a key role to play in helping older people manage these long-term conditions, making sure they receive the right kind of support to help them live as well as possible.

4.9 The NHS Long Term Plan (January 2019) set out a vision to give people greater control over the care they receive, with more care and support being offered in or close to people's homes, rather than in hospital. The national Ageing Well programme is concerned with how the population is looked after in the community. There is no age criteria although the vast majority of community resources are used to care for and support the moderate and severely frail population, of which there are approximately 30,000 in Derby and Derbyshire. The moderately and severely frail population in the ICS had approximately 96,600 hospital bed days (in 2019-20) – the equivalent of about 10 wards. This figure is only predicted to increase in the future.

4.10 The Integrated Place Executive (which has representatives from NHS organisations, local authorities and the voluntary sector) commissioned work to understand our improvement opportunities. The process included analysis of more than 5million data points and over 180 staff participated in workshops and activities which reviewed more than 200 resident cases.

4.11 For our priority cohort of older people with the most complex needs the high level findings identified the following issues within our current system:



4.12 This position is reinforced by the insights that feedback, surveys and engagement with the population tell us. Recently the VCSE Alliance held a session to discuss the Age Well theme with organisations that work with and represent older people. They have shared valuable feedback with key messages included emphasising the need to take a holistic view on care for older people. Also, recognition that statutory health and care services are often a very small part of what contributed to well-being. They also noted that provision can feel very siloed and concern was expressed that the clear preferences of older people and their carers are not always being listened to or respected (which can lead to people choosing to not access services when in need in the future). This sort of insight will be carefully,

and continually considered to help inform and shape the priorities, and how change is delivered.

Approach

4.13 This section sets out the approaches being taken to respond to the needs, ahead of describing, in the next section, what has been achieved.

4.14 The focus since the strategy has been (and continues to be)

- ensuring data and insight driven change,
- maximising the benefits of connected and integrated provision,
- taking a strengths-based approach,
- actively sharing, learning and adapting across the system and
- developing and delivering improvement.

4.15 In considering approaches to the challenges set out in the needs section it should be noted that community health and care provision in Derby and Derbyshire is complex. There are approximately:

- 113 GP practices providing 7 million appointments a year
- 1.2 million nursing and therapy home visits a year
- 325 care homes with nearly 9000 residents
- 270 home care providers with 10,000 care workers supporting 11,500 residents
- Over 2000 registered charitable organisations
- 204 community pharmacies
- 91 funeral homes
- And more...

4.16 In such a complex, adaptive system, the transformation and integration of health and care could not be achieved or sustained through purely traditional commissioning processes or by isolated programmes or projects.

4.17 Instead, using Place-based structures to plan and deliver improvements we are using a model of distributed leadership, taking a strengths-based approach to give local partners the flexibility to find solutions together, with leadership and support from a central team, co-ordinating and connecting related initiatives.

4.18 Creating the conditions for working across organisational and professional boundaries, and with communities, is key to this work.

Culture

4.19 Since 2018, health, care and voluntary sector partners have come together in eight ‘Places’ in Derby and Derbyshire, that are broadly contiguous with Local Authorities. Their aim is to ensure that local people are able to live a healthy life for as long as possible. The trusting relationships that have been built as part of Place

enable this Key Area of Focus; they facilitate the transformation of care and support services at a local level.

4.20 In addition, we have the ambition to embed strengths-based approaches, recognising that individuals, communities and our workforce have the capacity to find their own solutions, supporting them to think through those solutions, and then to develop the skills to implement them. This in turns creates a sense of autonomy that stimulates motivation creating a virtuous cycle of improvement.

4.21 This frees a core programme team to focus on equity and consistency of care and outcomes for the population, clarity of expectations and supporting the development of skills and infrastructure.

Infrastructure

4.22 Developing greater coherence and integration between services is much easier if those services are organised on the same or similar footprints. Over many years organisations have been cognisant of this, taking opportunities to create greater alignment.

4.23 The City Council and Derbyshire Community Health Services are taking this alignment further, more formally. They already work closely together to deliver rehabilitation and reablement using multi-professional assessments, sharing staffing skills and undertaking joint training and development. A proposal is within current governance processes to enter a new ‘Section 75 partnership agreement’ to strengthen this. As part of the wider Team Up initiative, both organisations will be able to pool and share their resources, reduce duplication of effort and become more effective in managing demand for services between them. The intention is to provide a more seamless service to local people and to create additional capacity to help people get home from hospital more quickly, or to stay independent at home for longer.

4.24 The Team Up programme approach has established valuable infrastructure in the community which has supported the development of general practice at the right scale to interact with other providers and is building the foundations of integrated neighbourhood teams. This infrastructure includes:

- Consistent clinical and operational leadership.
- Electronic patient records.
- Cross organisational estates agreements allowing co-location in multiple neighbourhoods
- Clarity over CQC requirements and responsibilities in multi-agency teams
- Robust contracting arrangements
- Developing local hubs that support integrated triage and response for complex patients, and help maximize referrals from 999 to community provision.

4.25 Teams and projects identify issues where the current configuration and decision is organisationally focused in ways which can prevent effective integration. This can occur across a range of enabling functions such as estates planning, governance, finances and digital. Local operational and project leads address these issues where they can and increasingly escalate issues that may require a system solution to the Integrated Place Executive.

Learning networks

4.26 Forums for peer support are central to our approach. Peer-based assurance has been powerful in accelerating learning, relationships, and for keeping the programme leadership focused on things that make a difference to operational delivery. Where consistency matters, these forums have enabled this through consensus rather than direction.

What have we achieved so far?

4.27 Some achievements are through investment into capacity and new types of provision. There is further gain through the building of coherence and connectivity between existing and emerging improvement priorities and programmes of work such as those to improve complex discharge and end of life care. The Place structures give a formal mechanism for that connectivity.

What have we achieved so far?

Team Up

4.28 As part of our system Team Up programme, strengths-based, distributed leadership approaches have created 12 locally led teams delivering integrated home visiting, urgent community response and falls recovery, simplifying pathways and adding extra capacity.

4.29 A growing multi-agency workforce, including paramedics, Advanced Care Practitioners, care coordinators, pharmacists and many others, is delivering over 5000 extra home visits every month. This provision covers 100% of the ICS, roughly a quarter of appointments providing proactive care, and 90% of appointments are managed entirely within the community. Workforce surveys demonstrate that 92% of respondents would recommend their service as a place to work and 87% say that their service helps free up GP capacity.

4.30 As part of this community team, DCHS Rapid Response Nursing and Therapy service delivers 550+ ‘2-hour’ visits per month consistently exceeding the 70% Urgent Community Response target.

4.31 We now have Community GPs across the whole ICS whose primary role is to support the integrated team. They have created consistent access to senior clinical decision making, and support considered clinical risk management e.g. supporting paramedics not to convey.

4.32 Provision of an enabling culture and local infrastructure has led to many local innovations within existing resources. These include:

- ARCH (Alfreton, Ripley, Crich and Heanor) PCN working with UHDB to support a new Community Geriatrician role
- Derby City identifying a gap in support to individuals with chronic pain and high intensity use of services, and developing support to help these cohorts.

Care Home Support

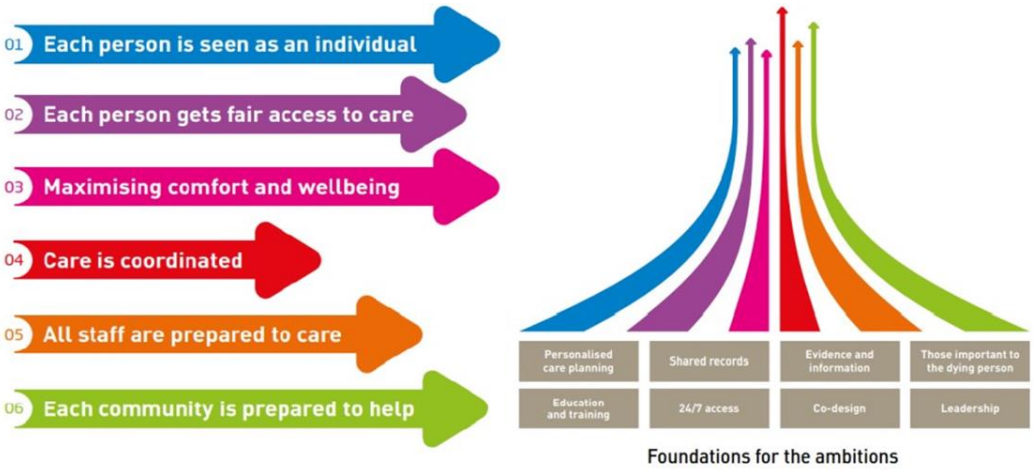
4.33 Providing more responsive, integrated and preventative care through teaming up and building integrated neighbourhood teams benefits residents in care homes as much as those in their own home. However there are additional opportunities to support improved working specifically with care homes and their residents. This next section briefly outlies the ambitions and achievements so far for that work:

- Supporting PCNs and Community Partners to deliver Enhanced in Care Homes DES and integrate with broader Team Up teams
- System wide group of various operational leads is sharing learning and good practice to try to reduce variation.
- Training to support signs of deterioration, capturing information and communicating to other health professionals in a structured way
- Greater emphasis on care home engagement and support to promote system and integrated working.

Palliative and End of Life Care

4.34 The JUCD EoL Strategy (2023) sets out the ambition for ensuring that there is effective Place based planning which enables local End of Life Care services to become more coordinated, personalised, accessible, equitable, compassionate, and delivered by appropriately trained staff. The Strategy sets out the vision for collaborative action by system partners to make the improvements required for the benefit of our citizens, whilst maximising the most efficient use of the resources in Derby & Derbyshire.

4.35 The outcomes or commitments that fall out of this aim are:



4.36 To deliver against these ambitions there is an approach embedding strong engagement and co-production with NHS, hospice and other VCSE stakeholders, non NHS providers, primary care represented and working through the Palliative and End of Life Delivery Board which reports into the Integrated Place Executive. Five workstreams have been established

- Communities Driving Care.
- Informed Workforce.
- Commissioning and Sustainability (including data modelling)
- Symptom Management and
- an Operational Group linking to the Derbyshire EoL Alliance and Team Up.

Complex Discharges

4.37 Up to 95% of people leave hospital after an episode of care as soon as they are assessed to be medically fit and return to the place they call home. The remainder may need rehabilitation or reablement to ensure their maximum independence, others have new care needs that need to be met either in their own home of through nursing or residential care. Working effectively together to plan and deliver discharge improvements across health acute and community services and with adult social care is a vast amount of work and has its own set of sub structures and programmes of improvement. The majority of people requiring supported discharge are elderly and ensuring integrated and effective care at this key transition point is very important in terms of the ambition to 'maximise the return to independence following escalation' as set out in the Key Area of Focus.

4.38 Good progress is being been made and the Derby & Derbyshire system performs well compared to peers (11th best performer of the 42 Integrated care Systems on the measure of delays per 100,000 population on the most recent data) but significant challenges persist.

4.39 Below are a few highlights from the discharge improvement work underway that demonstrates the integrated, strengths based approach which is being taken:

- A key focus of this work has been making improvements for those people assessed as able to go home with reablement and support (known as Pathway 1). A Pathway 1 framework (final version Jan 24) has been co-produced with all system partners, giving a clear strategic aim that all partners are signed up to. This is now being used as a framework for delivery
- Work is ongoing with University Hospitals Derby and Burton (UHDB) to embed a strengths based approach to discharge on Ward 311
- VCSE joint working has been undertaken to develop schemes to support discharge and enable vulnerable people to stay well in their neighbourhood following discharge
- Joint working with all partners across the ICS supporting discharge improvement. Chesterfield Royal Hospital (CRH) have seen a significant decrease in delays for patients with a 7 day Length of Stay for Pathway 1 – this is in part due to enormous internal process improvements, as well as system work, and demonstrates important of all partner focus on a key topic.

4.40 The discharge improvement work reports into the Integrated Place Executive to ensure alignment with other programmes, shared learning and support.

Measuring improvement

4.41 Whilst there is tracking of activity either routinely for specific services or as part of improvement initiatives the aim is to 'turn some of the big dials' that indicate whether system level change is having an impact. This work is still in its infancy in terms of identifying relevant, meaningful and consistent measures.

4.42 In addition understanding the counter factual is hard eg activity make have increased but would it have grown more? Since the introduction of the Team Up work outlined above there have been low levels of growth in a few key measures including the need to transport a person to hospital following an ambulance Category 3 call (ie 'urgent' rather than emergency or life threatening), short lengths of stay (which could suggest the person did not need to be admitted) and re-admissions. Activity is less than half the population growth. Despite a 12.8% growth in the over 75 year old population there has been only a 6% growth in non elective admissions and a 4.5% growth in emergency department attendances (most of which was for non frailty).

4.43 If the activity rate correlated with population growth, there has been a prevention of approximately 2,300 ED attendances and 1,600 non elective admissions. There are multiple potential causal factors and more work needed to select and track valuable metrics but work so far gives an indication that things are making a difference

Where next?

Potential accelerated community transformation programme

4.44 As referred to in section 5.6 a comprehensive system 'diagnostic assessment' was undertaken in 2023 with the aim of identifying opportunities across the ICS improve outcomes for older residents. The operational improvements driving improved outcomes have been converted into equivalent financial values identifying significant potential sustainable annualised benefits.

4.45 The focus would be on three broad areas

- **Home based pathways** – working across community urgent response and reablement pathways building the platform for even further integration.
- **Complex discharges and bedded care** – optimising flow in the discharge pathways and designing the long term model required for bedded care in the community
- **Population Health Management and system visibility** - building the digital foundations for Population Health Management and the visibility and tools required to drive and maintain operational improvement.

4.46 Such an ambitious and complex whole system change management programme will require significant commitment from all partners and would be a flagship transformation piece for the Integrated Care Partnership. A business case is being considered through relevant governance structures within NHS and Local Authority structures proposing that the system needs complementary capacity and expert capability to enable realisation of the identified benefits, this will significantly affect

the ability and pace of delivery of transformation in the community to deliver the age well and die well ambitions.

4.47 Whilst this proposal is being considered work continues within the existing improvement initiatives including planning for delivery in 2024/25. The section below highlights work that will continue noting that this is as much about how things are planned and delivered as it is about the specific services changes which are often at very local level and not planned and tracked across the whole system.

Approach

4.48
- Further embedding strengths based approaches
- Ensuring appropriate governance, autonomy and support through Place. The ICS's traditional governance structure don't always effectively enable working across teams, but work is underway to test and embed collaborative decision making and assurance at Place, in order to support integration.
- Identify and address areas where 'enablers' are acting as barriers either operationally or strategically
- Develop leadership skills and confidence
- Embed a 'learning loop' - continuing to support our workforce to use their new skills and infrastructure to improve support to other patients who would benefit from a multi-disciplinary approach remains a priority.
- Support local innovation utilising infrastructure.

Services

4.49
- Driving realisation of the full benefits of new services such as the PCN home visiting services.
- Ensuring effective navigation throughout the system so that the capacity that is available for integrated decision making and care is fully accessible and utilised
- Establishing an integrated falls response in each local place and focusing on falls prevention – recognising that learning from this process can be applied to other frailty syndromes and ICS priorities
- Ongoing discharge transformation, moving to a focus on bedded care
- Implementation of the EOL strategy
- Continued enablement of local innovation.

Public/stakeholder engagement

5.1 Historically, evaluation of people's experience of care has been carried out by individual services, but many of the poor experiences are at the interfaces between services.

5.2 With expert advice from The King's Fund, system partners have worked with Traverse, an independent social value research company, to explore the feasibility of measuring integration. The outcome of this is a set of techniques, closely aligned to overall experience.

5.3 Work with the ICB ‘Insights’ team is ongoing to develop a support package for Places that will enable to embed quality improvement based on engagement and experiential evaluation with measures that are aggregable and evaluate both experience and integration.

Other options

6.1 None identified.

Financial and value for money issues

7.1 The Derby and Derbyshire system has placed integrated teams at the heart of its strategy, and financial certainty is a crucial enabler of this work. System financial commitment to this work needs to be maintained, even in the light of challenging financial deficits and urgent care system pressures.

7.2 There is a need to consider the evolution of existing funding mechanisms (alongside commissioning and contracting processes) to facilitate integration.

Legal implications

8.1 There have been some very specific legal and regulatory issues within the implementation of new ways of integrated working as many existing rules are designed for individual organisational compliance. For example within Team Up the inability to contract directly with PCNs for some of this integration work led to the ICB seeking legal advice, which in turn supported the development of robust contracting arrangements. Similarly, following detailed collaborative work, there is now far greater clarity over CQC requirements and responsibilities in multi-agency teams.

Climate implications

9.1 None identified.

Socio-Economic implications

10.1 The individuals targeted through this key area of focus are people who may have had an ill heath episode, or at risk as they are living with a long term disability or health conditions. Improving these services will mean that more people will be able to benefit and see an improvement to their overall heath and well being which is likely to positively impact on health inequalities, as many people experiencing health inequalities are disabled, older people and those affected by frailty.

Other significant implications

11.1 None identified.

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal		
Finance		
Service Director(s)		
Report sponsor	Kate Brown, Director of Joint Commissioning and Community Development, Derby and Derbyshire Integrated Care Board (ICB)	26/01/2024
Other(s)		

Background papers:
List of appendices: