Agenda Item No. 7

Meeting of the Public Health Select Committee – 18th September, 2023

Report of the Dudley Managing Director – Black Country Integrated Care Board

Development of Dudley's Integrated Model of Health and Care

Purpose of report

1. To advise the Committee of progress with work in relation to the development of an integrated model of health and care for Dudley people with specific reference to integrated pathway development.

Recommendations

2. It is recommended that the Committee note the current position in relation to integrated pathway development.

Background

3. The Committee will be aware from previous reports of work that has taken place in Dudley to develop an integrated model of health and care. The implementation of this has been overseen by an Integrated Pathways Group which meets monthly to provide oversight and assurance and reports to the Dudley Health and Care Partnership Board.

4. Despite areas of good practice, our data tells us, that at times we are failing our patients and that health inequalities persist across our borough, especially around the health of our children with inevitable lifelong consequences. There are also particular clinical areas with unexplained negative variance, for example, around lung cancer diagnosis and areas where pathways are increasing prescribing costs. Thirdly, we are aware of the ever-increasing pressures on access to both primary and secondary care and the need to manage this pressure for our patients and frontline colleagues.

5. The Integrated Pathways Group has initiated a series of Local Improvement Teams (LITS) that, by taking an appreciative inquiry approach, bring together stakeholders from different statutory, community and voluntary organisations to innovate, collaborate and effect change. The LITS were launched in March 2023 and although weighted at either end of the pathways where need is greater and impact most significant, reviews are taking place across the life course.

6.

7. The areas recommended for review by the Medical Directors of Dudley Group NHS Foundation Trust, Dudley Integrated Health and Care NHS Trust and Black Country Healthcare NHS Foundation trust are listed below with progress against each pathway:

1. Premature Baby Pathway	Project Initiation Document (PID) expected October
2. New-born Blood Spot Screening	Project Initiation Document (PID) approved. LIT underway. Small numbers but potential serious consequences if screening missed – leading to significant impact on both child and family's life as well as additional costs to NHS and wider social care.
3. Jaundice	Complete – case study attached as Appendix 1.
4. Vaccinations	Complete – investigations confirm we are performing above the England average.

5. First 1001 Days – ACES	Project Group is active. Dads' Social Prescriber role is out to advert. Project Initiation Document (PID) expected October.
6. Musculoskeletal	Plans to develop a single point of access in development. Significant capacity issues within Pain Clinic provision have been identified via the review. Agreement to work on a Black Country footprint to work collaboratively and ensure the strategic direction is aligned. Project Initiation Document (PID) expected November.
7. Lung Cancer	Dudley Group NHS Foundation Trust is currently working on implementation of the targeted Lung Health Checks Programme. A lack of capacity in radiology diagnostic services has been identified. Project Initiation Document (PID) expected October.
8. Clinical Hub	Project Initiation Document received, and significant progress made with improved patient outcomes - case study attached as Appendix 2.
9. COPD	Project Initiation Document received, and significant progress made to include psychological support added to the pathway. 3 GP Practices identified to participate in a virtual ward step up pathway pilot, with referral pathways through to the Clinical Hub.
10. Care Coordination	Project Initiation Document received, and significant progress made with improved patient outcomes - case study attached as Appendix 3.
11. Frailty	Scope of LIT yet to be established. Project management support now identified to drive this work forward. Project Initiation Document (PID) expected December.
12. End of Life	Strategy developed on a Black Country footprint to work collaboratively and ensure the strategic direction is aligned. Local implementation and governance currently being reviewed.

8. LIT progress continues to be variable due to the impact on clinicians of ongoing industrial action within the NHS. Despite these challenges, work is progressing.

9. The current list of LITs does not include any mental health pathways. It was agreed by the Group at the August meeting that the Dudley Mental Health Working Group will expand its remit beyond operational service delivery and transformation to include pathway review. The membership will be amended to include a wider group of stakeholders in Dudley (e.g. LA, Housing, Public Health, VCSE representatives, substance misuse services) and will work in partnership with the Dudley Mental Health JSNA Group to help define the priorities of the Working Group that will benefit from partnership working – e.g. suicide prevention, dual diagnosis, MH prevention and promotion.

10. In addition, PIDs were received for Child Obesity, Child Poverty and Early Years' Speech, Language and Communication. The Group agreed with the proposals but determined that ongoing oversight and assurance would be via the Children and Young People's Partnership Board, of which the ICB Managing Director is also Chair.

11. We will know we are doing things differently when the shared outcomes for all pathways are met:-

    - patients are empowered and supported to remain well at home;
    - care is provided out of hospital where possible;
    - there is appropriate discharge (at all tiers).

Finance

12. There are no immediate financial implications arising from this report. Any developments have been funded from within existing budgets or as the result of agreed business cases.

Law

13. The ICB, the Council and the Health and Wellbeing Board have complementary duties relating to the integration of health and care services.

Risk Management

14. There are no material risks identified

Equality Impact

15. Any significant service changes will be the subject of Equality and Quality Impact Assessments.

Human Resources/Organisational Development

16. No immediate implications

Commercial/Procurement

17. No implications

Environment/Climate Change

18. No implications

Council Priorities and Projects

19. Forging a Future – healthy, safe, resilient communities.

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September 2023

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Appendices

Appendix 1 – Jaundice Case Study
Appendix 2 - Clinical Hub Celebration Presentation
Appendix 2 – Community Partnership Teams Presentation

Appendix 1

Jaundice Case Study – prepared by Angela Cartwright SRO for the Children's Pathways

In January 2022, the Dudley Health and Care Partnership commissioned Capgemini Invent Consulting Services and their Accelerated Solutions Environment (ASE) to transform health and care in Dudley through the development of a new model of care. Infants, children and young people were agreed as a priority area where the new Integrated Model of Care is believed to have significant impact.

In September last year over 100 clinicans and stakeholders from statutory, voluntary and community sectors met to agree the main aims of the workstream and to propose recommendations to the Dudley Health and Care Partnership Board. The agreed aims were:

- An outcomes framework for all services working with children and young people.
- Increase recognition of clinical skills of staff, ease referrals and inter-profession discussions, increase staff job satisfaction therefore increasing recruitment and retention.
- Focus on preventative health and care, focused on needs of the population, not needs of providers or service delivery.
- Focus on universal offer, considering specialist where needed.

The ambition is that services need to operate as one "Dudley Children's Team" * regardless of the employing organisation enabled by a streamlined matrix management structure and a governance enabled system to agree and enact change at speed. Optimum conditions for implementation of the new Model of Care have been explored and new ways of working have been suggested.

In order to "test" the new way of working the Medical Directors of DGHFT, DIHC and BCH have proposed a series of pathways to be reviewed and the Jaundice Pathway was identified as one of the first that, without financial investment, could be redesigned to improve outcomes for infants in the First 1001 Days.

Prior to the redesign Dudley Health Visitors were not able to refer directly to the paediatric department at Russell's Hall Hospital. Despite the Health Visitors having the necessary clinical skills to make an appropriate referral and having assessed the child, families must be redirected to their own GP for an additional assessment. This posed the following problems:

- Delay in referral - worsening of condition

- Difficulty in obtaining an appointment in Primary Care / blocking of appointment phone lines
- Wasted appointment in Primary Care (HV has already assessed)
- Loss of GP appointment for other patients

In addition to the above it is widely recognised that vulnerable families with additional complexities (deprivation, ESOL, mental health conditions etc) are likely to fall through the gap without direct referral as the additional need to book/attend another medical appointment is prohibitive. This increases the risk for these already vulnerable children.

The following actions are in place:

Health Visitors from Dudley are now able to refer directly into the Paediatric Assessment Unit (PAU) for urgent review of children. This has been updated in the PAU Standard Operating Procedure.

In addition, Health Visitors can refer into directly into Children's Services via a specific email address. Completion of a proforma is required. This is monitored daily and responded to in a timely way.

This will result in timely intervention to issues by the acute hospital team and give the opportunity for triage of the referral to ensure appropriate review without multiple referrals.

In the case of prolonged jaundice there would be opportunity for the referral for prolonged jaundice to be directed immediately into the nurse led clinic at DGFT.

We anticipate the following outcomes:

- Timely assessment and intervention of child avoiding unnecessary delay
- Release of primary care appointments to GP's
- Improved professional satisfaction for health visitors as their expertise is recognised without the need to refer to GP's
- Opportunity to avoid expense to parents and carers due to loss time at work / travel if multiple appointments required

The following **Core Principles for Team Dudley can be assumed*

- *The voice of the child is fundamental to our working practice.*
- *Co-design is an agreed way of improving our services and relationships with families.*

We will work "with" families and aid them to seek their own solutions

Appendix 2

Clinical Hub Presentation

Spotlight - Dudley Clinical Hub

- The Dudley Clinical Hub is a community based integratedservice that co-ordinates care and give advice for patients. It receives and facilitates referrals and communication between primary care, community staff and secondary care.
- The team aims to ensure all patients get access to the appropriate clinician or service.
- Referrals are received via a Single Point of Access – telephone or e-mail.
- The service operates 08:00 – 21:00 7-days a week including bank holidays and serves the population of Dudley. Last referral accepted at 20.00

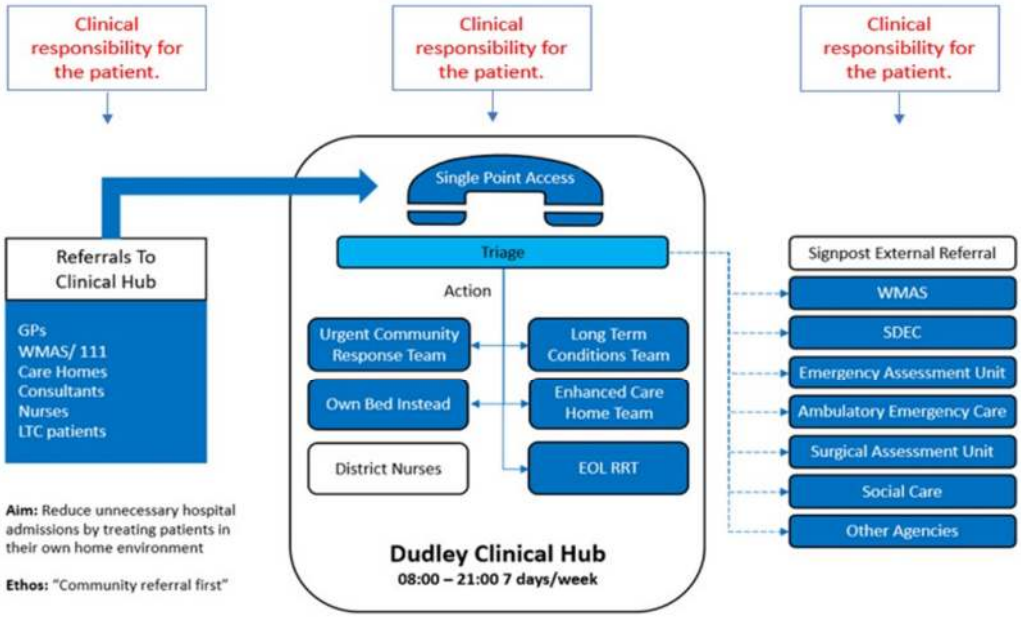
Single Point of Access

Telephone Triage/ Email referrals

The single point of access coordinate care delivery including:

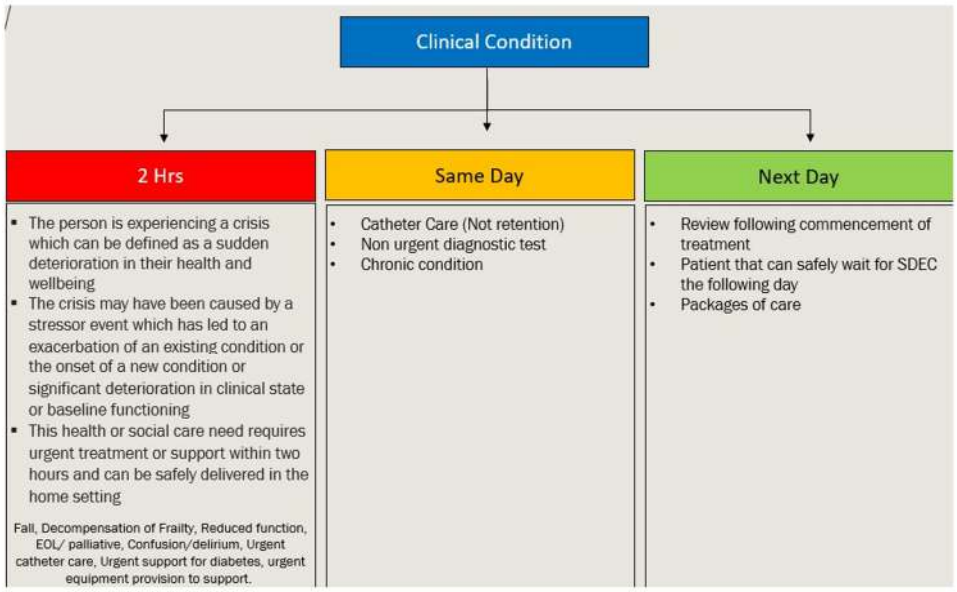
- Advanced assessments within two hours for patients needing urgent health interventions and care who can remain at home (2 hours, same day or the next day)
- Step-down to community nursing for longer term needs for patients needing district nursing care, long term condition management and treatment at home
- Provision of urgent equipment to avoid acute hospital admission
- Admission to community bed-based services, where appropriate
- Intravenous antibiotics
- Signpost to alternative pathways
- Access to Same day emergency care
- Give clinical advice
- Liaison with patient's GP to effectively manage clinical care at home and the wider health and social care system.

SPA Triage Process



Urgent Community Response Team

2hr, Same Day & Next Day



Patient story…

- 88 yr old lady
- Fall from bed
- Long lie >1hr
- Pressed pendent alarm, family found & contacted GP
- GP contacted patient/family
- History over past 2/7
- Chesty cough +++
- Rattling ++
- Not productive
- Reduced appetite
- Reduced balance/mobility

MDT collaboration with DCH

REFERRAL TRIAGED IN OBI @ 13:40

DECREASED FUNCTIONAL ABILITY = INCREASED RISK OF HOSPITAL ADMISSION REMAINED

OBI Ax

Physio assessed pt at home @ 14:15

Physical assessment conducted, pt not at baseline. Equipment needed to maintain safety

OBI Ax cont...

- Physio referred to A & I equipment driver to obtain immediate equipment for assessment
- Driver met physio at property within 30 mins
- Equipment Ax completed & family shown how to use

OBI Ax cont...

- Pt had reduced functional ability to maintain own PADL's therefore urgent POC needed
- In collaboration with OBI triage, TOC was completed & discussion held with urgent care
- Referral accepted by urgent care with an agreed start date of 48hrs
- POC consisted of QDS calls with x 2 carers

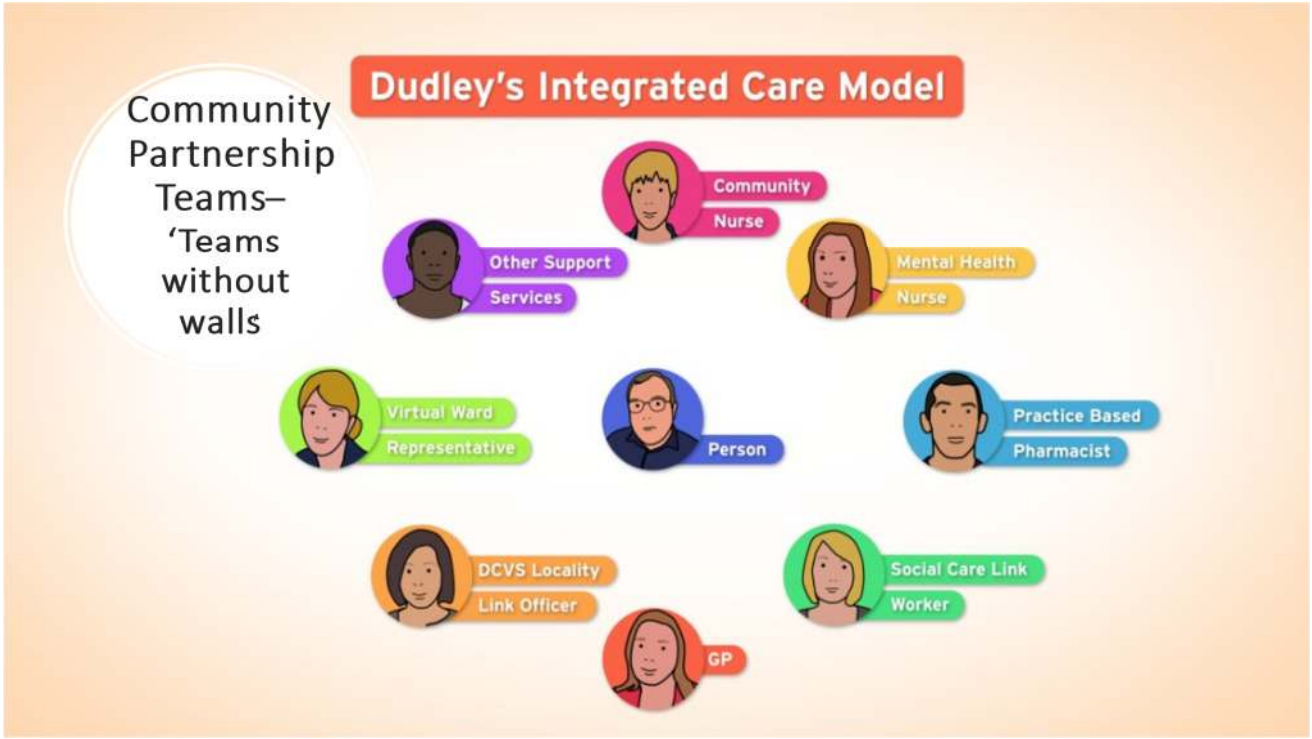
Appendix 3

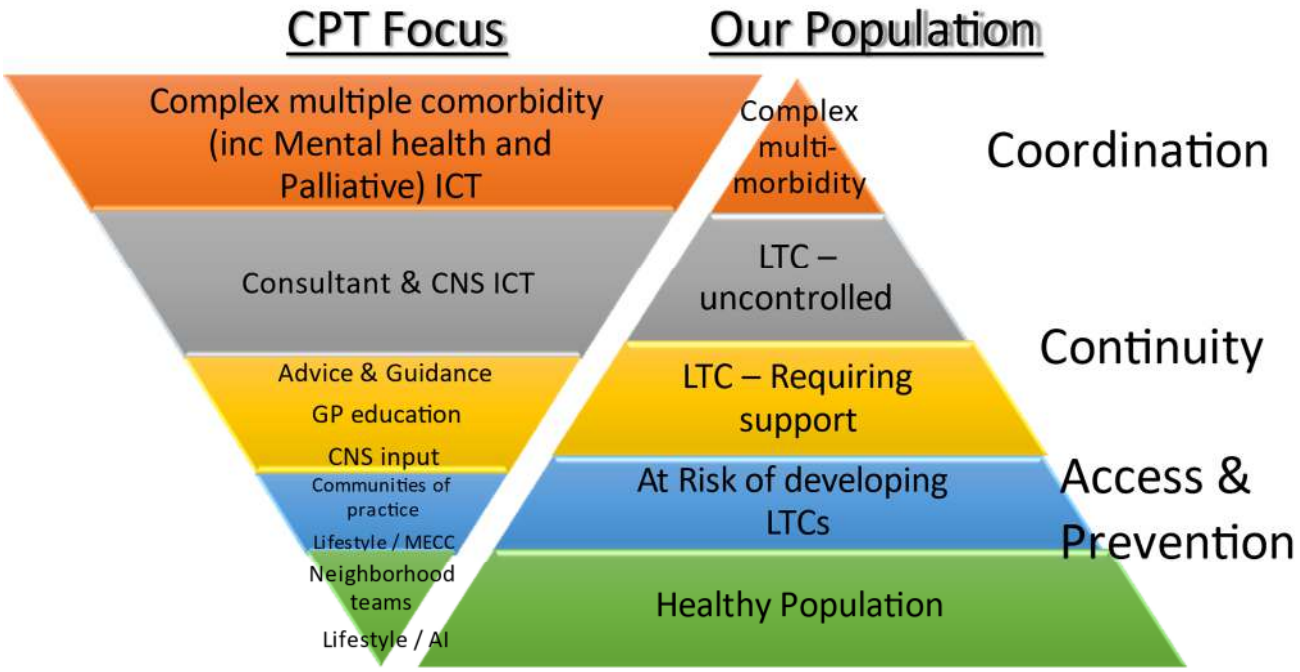
Community Partnership Teams Presentation

Dudley Integrated Care Model : Clinical Model for Community Partnership Teams

12 months progress update

Dudley Health and Care Partnership
Connecting communities and coordinating care to help citizens live longer, safer and healthier lives.





CPT Local Implementation Team (LIT)

- Transformation Group meeting since June 22
- Baseline assessment of current position - Staff survey and Staff focus Groups
- Development of model in collaboration with frontline Staff
  - CPT variation across the PCN's – number of recommendations to be implemented
  - Core aspects of Care Coordination
  - Improving discharge pathways and communication
  - Cross organisational OD and Culture - facilitated by Dudley Improvement Practice (DGFT)

Survey - *Successes you want to share*

"The ICT has helped many of my patients and has also made me aware of agencies and services on offer to patients that I previously didn't know about."

"There have been a number of times that I have fed back to my supervisor during supervision sessions the importance of the ICT meetings and how some excellent joined up working has been achieved as a result of them."

"I feel the ICTs are a very good platform to help Dudley residents to get the help they needs and with all professionals involved. It's nice to discuss and have different opinions and direction towards the correct support."

"The rapport that our team has is brilliant. We are lucky to have a (reasonably) stable core workforce and when there have been changes new members are made to feel welcome and slot into the team easily and feel part of it quickly."

"Great palliative care monitoring, shared decision making between teams, early involvement of community teams. Supporting women and men with domestic abuse, financial and social issues impacting on their health."

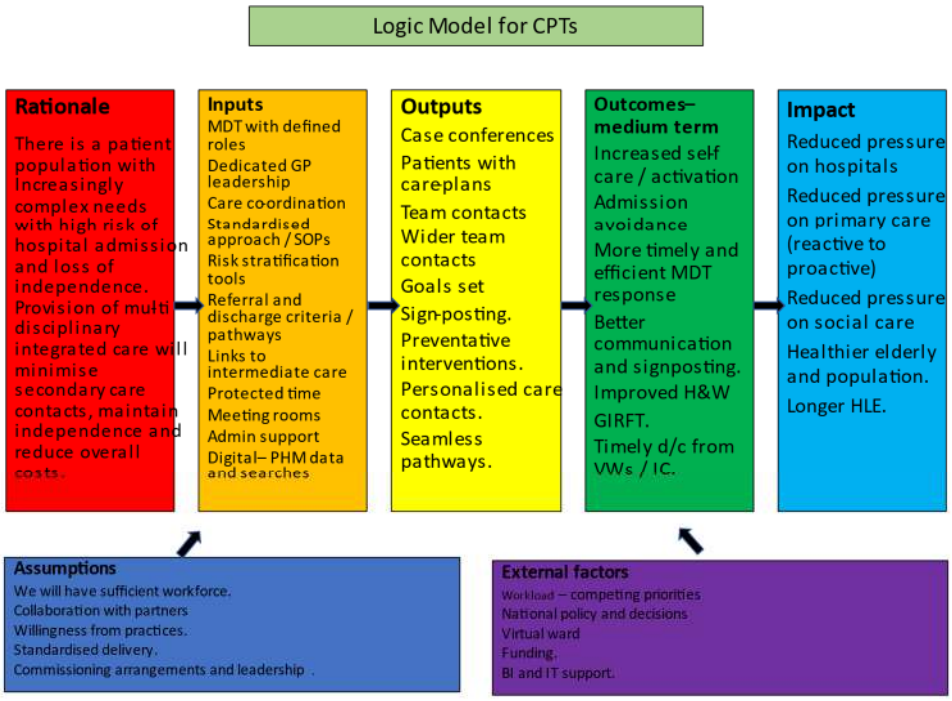
"Through the use of migrant social prescribing and mental health services, some of our Asylum seeker patients have been able to access care and support."

Progress in the last 12 months

- Dedicated Leadership across all 6 PCN's
- Review of Commissioning arrangements – improve compliance and attendance
- Standardisation – roles and responsibilities, service model, agenda
- Change of name – ICT's to CPT's
- Alignment of Intermediate Care Team - facilitate better discharge co-ordination
- Palliative Care focused CPT's - monthly across all PCN's, Early tool pilot for better identification of EOL
- Complex Mental health CPT's – alignment of adult psychiatrists, older adults in progress

Progress in the last 12 months

- Dedicated substance misuse CPT – bimonthly with links into individual CPT's from Atlantic House
- Diabetes Population Health management – PARM tool, plans to transition to CPT model
- Respiratory focussed CPT – alignment of Respiratory consultants, pre -winter approach, step-up pathway for VW
- Updated CPT referral form
- EMIS template – process of revision to ensure systematic capture of data, will include specialist areas
- CPT contact protocol – contact details of all staff (including PCN)



Community Partnership Team Communication Tool

Name of Patient	
NHS Number	
Address	
DOB	
Name of Sender	
Job Role and team of Sender	
Mobile number for sender	
Sender's team phone number & email	
Urgency level*	Within 2 hours / Within 24 hours / Within 7 days
Information for recipient	
Actions for recipient	

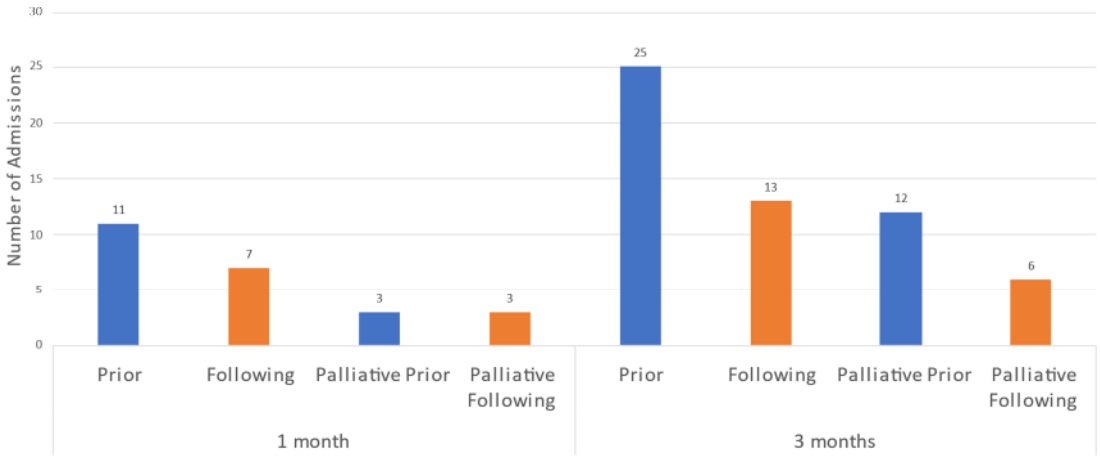
*(If within 2 or 24 hours the sender must phone the recipient: clinical responsibility remains with the sender until this phone contact is documented.)

Potential metrics for CPTs

- Unplanned admissions in over 75s in ICT footprint and ICT caseload (outcome and search tool)
  - Last 3 months – cumulative
  - Last 6 months – cumulative
- GP appointments (outside of ICT) in ICT caseload
  - Last 3 months
  - Last 6 months
- Goal Attainment Scaling– goals assessed and achievement GAS by individual practitioners eg walk to shops, BP to target, 2 social contacts per week.
- Frailty assessment and rate of movement 5/6 to 7/8 over 6 months / 1 year
- Mental health– WMWEBS change in score over 3 month period FAQs (warwick.ac.uk)– or similar scale– BCH approached.

CPT4 Admissions Audit

EMIS search for patients discussed in CPT meeting 1st July – 1st October.
Record review on those patients to count admissions in the 1 month prior to and following discussion and 3 months prior and following.



Number of admissions prior and post discussion at the CPT meeting between 1st July and 1st October 2022

Future

- Care plan
  - Named care coordinator
  - Optimisation plan (LTC, including lifestyle & social inclusion)
  - Exacerbation plan (including ceilings of care, ReSPECT)
  - Shared with patient and family
- Closer links to Clinical Hub and Care Homes
- IT – Shared EPR wouldsave substantial clinical time and would improve "care by conversation"
- Workforce
  - Universal offer, shared recruitment and training
- Prevention – how do we move current CPT's to cover preventativeagenga?
  - MECC, Social model of care, Early in age, Early in disease