Calderdale: Integrating Intermediate Tier Services

Calderdale Clinical Commissioning Group

Our Vision & Values

Improving health, improving lives
The new NHS

• PRIMARY CARE PHYSICIANS WILL CONTROL 80% OF NHS EXPENDITURE

Opportunities

• System wide health and social care arrangements are changing
• Develop the capability of the Microsystems to deliver improvement
• Develop Clinical Leadership
• Establish integrated metrics across the (macro to micro) system
What has changed so far?

- GP board in place
- Delegated responsibility
- Management structure developing
- Reducing administration costs

Our ambition

Calderdale Council

Single approach
Single business plan
Shared posts

NHS Calderdale

Long-term investment in enduring partnerships
The Ackroyds: What does it mean for them?

The Intermediate Tier

Services that support people to:
- remain in their own home (if safe) or in the community following a deterioration of health; and
- return to mobility and independence following
  - operation,
  - accident or illness, or
  - deterioration in a long-term condition(s)
Why did we redesign the Intermediate Tier?

Pressures in the system:

POPULATION over next 20 years:
• Expect to rise by 17% and
• Over 75yrs by 69%

INCREASED DEMAND FOR HEALTH CARE
• 7% increase each year in emergency admissions to local hospital
• 22% people attending Accident & Emergency Department then admitted to hospital (national average 16%)
• 48% people admitted from the A&E department then discharged with no procedure in less than 48 hours
• 47% of all emergency admissions were for patients over the age of 60

INCREASED DEMAND FOR SOCIAL CARE
• 4% increase in the take up of social care in previous 4 years
• 5% increase in number of people admitted into long-term care over previous 12 mths
• More than 33% of all care home admissions were from the hospital
• 22% increase in the average amount of ‘home care support’ provided

Why did we decide to redesign the Intermediate Tier?

Summary:
• Number of older people increasing rapidly
• Therefore more people with long-term conditions
• More people being admitted to hospital but not staying overnight or not staying long
• More people receiving help at home
• More people with long-term care needs being placed into care homes

So we can help more people stay at home or receive care outside hospital
Intermediate Tier Project Board

1 doctor from GP Board (NHS)
1 nurse/manager (NHS)
Chairwoman (NHS & Council)
1 doctor from GP Board (NHS)
2 Council managers
4 NHS managers

Old model

GP  Nurse  Patient  Carer  Social worker  Ambulance crew  Hospital

Gateway to Care
Rapid response  Falls prevention  Community rehabilitation  Reablement  Other social care

BEFORE
Delays/risk for patients + confusion for professionals = Poor experience 😞
Improvement methodology

Involving local people.....

This is where we are at the moment
One integrated team providing:
• Rapid response
• Falls prevention
• Community rehabilitation
• Reablement

AFTER
Quick help and support for patients + easy system = Good experience

What does this mean for the Ackroyds?
• Quicker response to problems, so they can stay more healthy and more independent
• Single assessment and single package of care
• Joined up services – no gaps
• Right care at the right place at the right time
• Better experience of services
What does this mean for commissioners?

- Shared vision of care
- Better experience for patients/users and carers
- Quicker response to problems, so people can stay more healthy and more independent
- Better use of resources

What does this mean for service providers?

- Opportunity to provide an integrated response instead of separate services
- Better experience of services for patients/users and carers
- Investment in developing the Gateway to Care team
- Opportunity to work differently and use the skills of staff in the best way
- Better use of resources
Yes, but always problems with pooling resources, priorities, local democratic process, central policy agendas, control, etc

Tension between national market competition and local sustainable partnerships and continuity

But, we’ve found a way of dealing with these by working together, finding new ways of doing things and making sure we concentrate on the patient/user and their carers.

Remember the Ackroyds?

Hasn’t this been tried before?

So what has been achieved so far .......

- **A Single Point of Access** to the Service:
  - delivered through Calderdale Council’s *Gateway to Care*
  - Generic advisors
  - Senior nurses
  - Senior social workers

- **One full assessment**, based on the wishes and needs of the person, regularly reviewed and updated

- **Integrated team** – being developed (due to be in place by October 2012)
A formal evaluation of Phase 1 is underway but we already getting good feedback from people using the new arrangements:

As busy GPs we love single point of access services and Gateway to Care is a great example of this. There is now no duplication of services and communications and record-keeping is much more efficient. All contacts with the team are dealt with in a professional and courteous manner and I feel this is a flagship service moving forwards."

Hi – I had to text to thank you properly for all you have done today, the relief is indescribable, my mum is very happy that she will be visited four times a day for now and our family has had a great weight taken off its mind. Thanks for everything.”

A text from Greece from the daughter of a lady who suddenly needed urgent support

A Calderdale General Practitioner
Integration is the future

- We have the door to integration set up (Gateway to Care)
- We know that people want services to feel joined up
- We want to build services around individuals not the other way round
- The Government sees integration as vital in developing a system that meets people’s health and care needs
- The Dilnot Commission on Funding of Care and Support states that more effective integration of health and social care is essential
- The Government’s recent Future Forum report on integration emphasises its importance in improving the experience and outcomes of care for people using services

Phase 2 – Right type of support to help people stay at home (if safe) or in the community, and to support people coming out of hospital

Don’t need to be in hospital?  
Not safe to be at home?

Bed in a nursing or residential home with the right rehabilitation/reablement
Phase 3 – Extending the arrangements to cover other local services