

# North Yorkshire County Council

## Executive

15<sup>th</sup> January 2019

### Harrogate Adult Community Services Health and Social Care Integration

#### Report of the Corporate Director – Health and Adult Services

#### 1.0 Purpose of report

- 1.1 The purpose of this report is to
- a) seek the Executive's approval for the Programme Final Business Case (Appendix A); and to
  - b) delegate to named officers, in consultation with the relevant executive members, the consultation on, and completion of a Section 75 Agreement and any other alliance and partnership agreements that may be necessary to underpin the programme.

#### 2.0 Issues

- 2.1 North Yorkshire County Council (NYCC) is working alongside key partners in the Harrogate area to develop and create a new integrated health and social care service model for adults in the Harrogate and Rural locality for 2019 and beyond. This model builds on the strength of existing provider and commissioner relationships in the Harrogate and Rural area which have been developed through the New Care Models "Vanguard" Programme and other programmes.
- 2.2 The aim of continued collaboration across partners is to see a rapid impact and potential benefit for patients through the collaborative approach, putting the best interests of the Harrogate and Rural population first by engaging with local providers to see how improvements can be made.
- 2.3 The ambition for the new service is that it will:
- Have prevention as the starting point;
  - Develop a new model, anchored in primary care, based on Prevention, Planned Care and Unplanned Care, optimising all available resource;
  - Provide care at home wherever possible;
  - Focus on population health as opposed to organisations;
  - Where possible, it will be a GP practice centred model (hybrid model between practices and geography);
  - Include GP daily involvement and commitment, and;
  - Have active involvement from people who use services and carers.
- 2.4 A partnership Programme Board, 'The Harrogate and Rural Alliance', has been established to direct this work which includes NYCC, Harrogate and Rural Clinical

Commissioning Group (HaRD CCG), Yorkshire Health Network (YHN), Harrogate District Foundation Trust (HDFT) and Tees, Esk and Wear Valley NHS Foundation Trust (TEWV).

2.5 This programme represents radical change for Health and Social Care adult community services in the Harrogate and Rural locality. It will be:

- One of the first places in England to integrate all Health and Social Care adult community services.
- General Practice, community health and social care professionals working together as one team.
- About the whole caseload, rather than part of it.
- A genuine alliance – with people who use services, carers and wider partner organisations – co-produced by people who use the services.
- Owned by colleagues who work in the service
- Commissioners and Providers working together as an alliance.

2.6 A Programme Final Business Case (Appendix A) has been prepared for approval detailing the high level ambitions for the programme over the next few years and clarifying the plan for Year One of the Programme (April 2019 to March 2020). It is likely that a number of projects will be initiated to sit under this programme over the next few years to deliver some of the key programme benefits – more detail will be provided in project-level business cases where this is the case.

2.7 The Final Business Case outlines the case for change in more detail. Integration between health and social care is a fundamental part of both national policy and local strategy and commissioning intentions, with the aim of promoting health and wellbeing, delivering better outcomes for the population, promoting ease of access and ensuring a sustainable system for the future. Nationally and locally, health and social care systems are facing challenges around quality, sustainability and changing population needs.

2.8 Historically, care has been constrained by organisational and professional boundaries, resulting in reactive, fragmented and inefficient care. This has often resulted, in a person receiving support from teams working reactively and separately, diagnosing people in silo, where information on these diagnoses and other important health and care information is not shared. This often means the staff within these organisations have additional workload pressures, and have little time to give advice and support regarding self-care and the system often focusses on physical health needs, with social care needs being overlooked or not seen in conjunction with the person's physical needs. See the Programme Final Business Case (Appendix A – Section 1) for more information on the national and local drivers.

### **3.0 Performance Implications**

3.1 The Programme aims to deliver a number of key benefits to improve performance, and a set of shared metrics and Key Performance Indicators are being established.

3.2 High-level programme benefits include.

- National Primary Care Home model benefits will be met (more information on these can be found in the Programme Final Business Case - Appendix A - Section 3).
- CCG commissioning and budget requirements will be met. NYCC, HDFT and TEWV budget requirements will be met and GP practices will be resilient and sustainable.

- The health and social care system will remain affordable and sustainable.
- The quality of care will remain high.
- The Health and Wellbeing of people in the Harrogate and Rural District will be improved (Better health, Good Quality of Life, Reduced Inequalities).
- We will prevent, reduce and delay the need for long term use of community health and social care services.
- We will create opportunities to deliver more employment opportunities and career pathways to the population.
- We will empower individuals in relation to their care – improving outcomes and experience for local people.

3.3 These benefits will be achieved through the development of a workforce from across health and social care services, including mental health, who will work together to meet the needs of the local population.

#### 4.0 Options

4.1 The Programme Final Business Case (Appendix A - Section 6) details the Options Appraisal undertaken and the recommended options to progress. The recommended option takes into account analysis of key data sources, CCG commissioning options, proposed GP Primary Care Homes and feedback from those involved in engagement sessions.

4.2 It is recommended that the model is progressed through integrated working within existing NHS contracts and NYCC arrangements.

4.3 Consideration has been given with regard to how best to segment the locality from the point of view of service provision and Health and Social Care workforce arrangements. There are multiple levels and layers of collaboration across the partnership. It is recommended that there is:

- 1 Overall Service (Harrogate Alliance)
- 2 Localities (Harrogate Town and Ripon and Rural)
- 4 Workforce Teams (2 in each locality)

4.4 Within these options, a proposal for workforce modelling has been worked up. Additionally, consideration has been given to estates and options for co-location and better use of estates across partners, and; technology and data to support the model.

4.5 **Year One** - the aim for Year One is to identify how the existing workforce can be arranged to support the ambitions and aims of the programme so that those involved feel a difference in terms of the operating model and outcomes from 1<sup>st</sup> April 2019. Year One principally involves improving current services so that they operate more effectively. This includes ensuring better communication and integration in the localities (especially GPs). Primary Care will be an aligned service but is at the heart of the model and community services will be organised around groups of practices and local communities.

4.6 Key principles for Year One include:

- There is a need for a single senior manager to manage the service, accountable to relevant partners;
- The core services will continue to be managed by their current organisational manager – **everyone will be employed by their existing employer**. However, there is a need to assign these managers to a designated locality responsibility as well;

- There will be Multi-Disciplinary Team (MDT) meetings / huddles in every cluster of GP practices, involving core staff and aligned staff – and potentially wider partners like NY Horizons, VCS, etc;
- There will be an MDT leadership team around each cluster of practices – at locality and virtual hub level (GP, manager and relevant professional leads from health, social care, MH, etc);
- Existing organisations will provide professional leadership;
- Basic models for making contacts and referrals, avoiding multiple contact points and ensuring effective navigation will be put in place – this will be further developed in Year Two;
- An Induction Organisational Development (OD) programme and will be established for all 'core' staff and as many 'aligned' staff members as possible. This will be built on over Years Two and Three to further develop the integrated teams and managers.

4.7 During Year One, advantage will be taken of any opportunistic workforce initiatives that arise and may enhance the model further (for example, the opportunity to trial generic roles across partners where there are recruitment shortages).

4.8 **Beyond Year One** - throughout Year One, further plans will be drawn up and projects initiated which will bring about more fundamental change to services through workforce modelling, use of technology and estates. These projects will be delivered throughout Year Two and beyond and the detail will be included in project-level business cases underneath the wider programme.

4.9 Key principles for Year Two are detailed in the Programme Final Business Case (Appendix A - Section 7).

## 5.0 Financial Implications

5.1 The Financial Model (detailed in the Programme Final Business Case – Appendix A - Section 17) shows additional cost of £438k and an assumption that the funding envelope from partners will cover this. It should be noted that all organisations are experiencing financial pressures in this locality.

5.2 In the first instance, NYCC have underwritten the costs of £438k with the Improved Better Care Fund (IBCF) contingency funding but would expect all main statutory partners to make a proportionate financial contribution.

5.3 As part of this first year additional cost, IT expenditure is estimated to comprise £251k, but it should be noted that while there is an expectation that these costs will grow over time, the assumption is these will be covered by efficiencies made as a result of the programme.

5.4 It is also noted that consideration of a Section 75 or Alliance Agreement is required to confirm the integrated management position and potentially provide provision for a pooled budget.

5.5 The proposed core staffing establishment for integration programme will remain the same on the 1<sup>st</sup> April, 2019 as it is today with the exception of one additional senior manager post. The single senior manager is estimated to cost c£102k (including oncosts) in the first year.

5.6 At this stage, all additional support costs for training, supplies etc. have been estimated and will be further refined as plans are developed from the other workgroups.

5.7 A partnership Finance Sub-Group has been established for the programme and this will continue to meet during the transition year and to develop the financial model throughout this period tracking the cost of the programme and forecast outcomes.

## **6.0 Legal Implications**

6.1 The 'Harrogate and Rural Alliance' and Programme will need to be underpinned by formal agreements.

6.2 Local authorities and CCGs operate under different legislation and therefore, a partnership agreement seeks to provide a platform to enable joint working through using the provisions of Section 75 of the National Health Services Act 2006. This allows local authorities and NHS bodies (including the CCG) to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised.

6.3 In this case, a partnership agreement under Section 75 is sought to enable integrated management structures across NYCC and HDFT, and also to provide provision for a pooled budget should this be required (for example to recruit generic roles across Health and Social Care). Section 75 Agreements can be signed by statutory bodies and are a well-established framework for integrated service arrangements.

6.4 In addition, the Programme seeks to review whether an NHS Alliance agreement or other partnership agreement should also be required – this provides a standard agreement between NHS (including non-statutory) and local government partners.

## **7.0 Consultation Undertaken and Responses**

7.1 There has already been a significant amount of work to understand what the public want through the 'Vanguard' and previous work. There will be an on-going need for communication and engagement across organisations and staffing groups and with the public.

7.2 Engagement sessions have been held with team members across organisations, partners, people who use our services and carers during September and October 2018. The feedback from these sessions has been used to develop the proposals in the Programme Final Business Case (Appendix A). Further engagement on a quarterly basis is planned alongside more detailed input for those directly affected.

7.3 Customer Journey Mapping is planned to take place between January and April 2019 to understand the impact on the service users and carers who will be affected by the changes and how their experience will be altered.

7.4 A month's public consultation is required before a Section 75 agreement can be put in place. Permission is sought to commence a consultation exercise on the terms of the partnership agreement.

## **8.0 Risk Management Implications**

8.1 The programme risks and issues are managed via the risk and issues register and summarised in the Programme Final Business Case (Appendix A – Section 11).

## **11.0 Equalities Implications**

- 11.1 A full Equalities Impact Assessment can be found appended to the Programme Final Business Case (Appendix A – Section 14).

**12.0 Recommendations**

12.1 The Executive is asked to:

- (a) approve the Programme Final Business Case (Appendix A).
- (b) delegate to the Corporate Director - Strategic Resources, Corporate Director – Health and Adult Services and Assistant Chief Executive (Legal and Democratic Services), in consultation with the relevant executive members, the consultation on, and completion of a Section 75 Agreement and any other alliance and partnership agreements that may be necessary to underpin the programme.
- (c) approve that, prior to implementing any further developments beyond the milestones for Year One, further business case(s) will be brought back to the Executive for review.

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County Hall  
Northallerton  
15<sup>th</sup> January 2019

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# Programme Business Case

Document Version Control			
Version No.	Reason for Change	Author	Date
0.1	First Draft	Gemma Dickinson	20/11/2018
0.2	Amended Section 17 and Peter Banks comments	Gemma Dickinson	05/12/2018
0.3	Amends following partner feedback	Gemma Dickinson	05/12/2018
0.4	Financial amends and further partner feedback	Gemma Dickinson	07/12/2018
0.5	Further financial amends and partner feedback	Gemma Dickinson & Fred Chambers	14/12/2018
0.6	Amends to build in EIA considerations	Gemma Dickinson	19/12/2018
0.7	Further amends following HIHSCP Board	Gemma Dickinson	21/12/2018
1.0	Approved version to submit.	Gemma Dickinson	21/12/2018

Programme Overview			
<b>Programme Name:</b>	<i>Harrogate Integrated Health and Social Care Programme</i>		
<b>Programme Reference:</b>	2081	<b>Document Author:</b>	Gemma Dickinson
<b>Programme Sponsor:</b>	Richard Webb / Peter Banks	<b>Programme Manager:</b>	Gemma Dickinson
<b>Programme (this is part of):</b>	Health & Integration	<b>Organisational Programme Manager(s):</b>	Naomi Smith (NYCC) Jane Baxter (CCG)
<b>Directorate/Service Area:</b>	Health & Social Care (HAS)	<b>Senior User (Service Lead):</b>	Rachel Bowes (NYCC); Mike Forster (HDFT); Adele Coulthard (TEWV); Mark Beesley (YHN); Jane Baxter (CCG)

*The purpose of this Programme Business Case is to set out the high level ambitions for the programme over the next few years and clarify a plan for Year One of the Programme (April 2019 – March 2020). It is likely that a number of projects will be initiated to sit under this programme over the next few years to deliver some of the key programme benefits – more detail will be provided in project-level business cases where this is the case. Further information about the ambition for Year One and beyond can be found in [Section 7 – Recommended Option](#).*

## 1 PROGRAMME BACKGROUND

Please see [www.harrogatealliance.co.uk](http://www.harrogatealliance.co.uk) for more information.

*This programme aims to develop and create a new integrated health and social care service model for adults in the Harrogate and Rural locality for 2019, with an agreed staffing structure and costed options for delivery. It builds on the strength of the provider and commissioner relationships in the Harrogate and Rural area which have developed through the New Care Models “Vanguard” Programme and other programmes. This programme is now moving into the next phase to start to develop a new integrated health and social care service. It will also deliver the aims of the Keep Change Transition Plan (see below for more details) during 18-19 to pave the way for the new model.*

### **What will be Different?**

This programme represents radical change for Health and Social care adult community services in the Harrogate and Rural locality. It will be:

- One of the first places in England to integrate all Health & Social Care adult community services
- General Practice, community health and social care professionals working together as one team
- This is about the whole caseload, rather than part of it
- This will be a genuine alliance – with people who use services, carers and wider partner organisations – co-produced by people who use the services.
- Owned by colleagues who work in the service.
- Commissioners and Providers are working together as an alliance

### **Key Partners**

The key partners involved are below and the Programme Governance is via the partnership Harrogate Integrated Health and Social Care Programme Board.

- Harrogate & Rural District Clinical Commissioning Group (HaRD CCG)
- Yorkshire Health Network (YHN)
- Harrogate District NHS Foundation Trust (HDFT)
- Tees, Esk and Wear Valley NHS Foundation Trust (TEWV)
- North Yorkshire County Council (NYCC)

### **The Case for Change**

Please see **Appendix 1** for more information on the Case for Change including further information on both the National and Local Drivers for change. A summary is below.

Integration between health and social care is a fundamental part of both national policy and local strategy and commissioning intentions, with the aim of promoting health and wellbeing, delivering better outcomes for the population, promoting ease of access and ensuring a sustainable system for the future. Nationally and locally, health and social care systems are facing challenges around quality, sustainability and changing population needs.

Historically, care has been constrained by organisational and professional boundaries, resulting in reactive, fragmented and inefficient care. This has often resulted, in a person receiving support from teams working reactively and separately, diagnosing people in silo, where information on these diagnoses and other important health and care information is not shared. This often means the staff within these organisations have additional workload pressures, and have little time to give advice and support regarding self-care and the system often focusses on physical health needs, with social care needs being overlooked or not seen in conjunction with the person’s physical needs.



#### National Drivers for change include:

- The NHS Five Year Forward View (2014) and update (2017) – sets out aims to integrate health and social care nationally. The NHS Long Term Plan is also expected imminently.
- New Care Models, Sustainability and Transformational Partnerships (STPs) and the evolution of Integrated Care Systems (ICS) – pursuing the aims to integrate.
- GP Forward View – increased investment in Primary Care, GPs working together at scale, working from a more effective platform with other local health and care providers.
- Better Care Fund, Improved Better Care Fund, statutory role of the Health and Wellbeing Board – duties around integration.
- Care Act (2014) – duties around integration. Supporting people to be in control of their care and support. Emphasis on wellbeing. Prevention focus – local authorities and partners required to prevent, reduce or delay the need for care and support for all local people. Wider focus on the whole population in need of care through outcome focussed care and support assessments.
- Adult Social Care Green Paper (expected before the end of the year) – with a key principle to integrate health, housing and care.

#### Local Drivers for change include:

- Significant financial challenges across the system despite the delivery of cost saving programmes. The health and social care system overall is challenged in terms of continuing to deliver high quality care within reduced financial envelopes and within the context of austerity.
- Increased pressures on delivery leading to duplication in workforce and limited focus on patient experience. Like most health and care systems in England, Harrogate and Rural District is struggling to match demand and affordable supply.
- Harrogate and Rural district has an ageing population, an increase in the number of people with long term conditions, and the local population has changing expectations.
- System approach from partners to develop an integrated model of care with a focus on person-centred, proactive and coordinated care to improve patient and carer experience and outcomes.
- Strong existing local partnership arrangements that continue to be built upon.
- Regional and local work to align the new partnership approach to Integrated Urgent Care and Integrated Care.
- The importance of our local place working in alignment with the West Yorkshire and Harrogate Integrated Care System (ICS) strategy is recognised, including the Primary and Community Care and Urgent Emergency Care work streams led by the ICS.
- Learning from the New Care Models ‘Vanguard Programme’ (2015–2018) – see **Appendix 2** for the key elements and aims of this Programme and the [‘Sharing the Biscuits’](#) report for more information and key lessons learned). A workshop following the ‘Vanguard’ developed an action plan – the **‘Keep Change Transition Plan’** - to maintain momentum in the short term and pave the way for longer-term transformation.
- HaRD CCG commissioning intentions for the next phase of the ambition to deliver a fully commissioned integrated model of primary and community services in the locality – detailed in the [‘Your Community Your Care’ Green Paper](#)’ (February 2018) -

see **Appendix 3** for the CCG objectives, ambitions and draft principles to be applied to the integrated care delivery model.

### **Next Steps, Ambition and Vision**

The value of working together as commissioners and providers locally to bring about change in a meaningful way is recognised. There is a clear desire to build on the strength of the provider and commissioner relationships in the Harrogate and Rural area which have developed through the New Care Models “Vanguard” Programme and other programmes. The aim of continued collaboration across partners is to see a rapid impact and potential benefit for patients through the collaborative approach, putting the best interests of the Harrogate and Rural population first by engaging with local providers to see how improvements can be made.

The Harrogate Integrated Health and Social Care Programme (HIHSCP) has been initiated by the collective of partners to build on the work of the ‘Vanguard’ and other national models such as ‘Primary Care Home’ (see **Appendix 4**) and deliver this next phase of the ambition. It provides a whole system response to the CCG commissioning intentions laid out in the ‘Your Community, Your Care’ Green Paper.

The ambition for the programme is that it will:

*“Create a new integrated community health and social care service for adults in the Harrogate and Rural locality based on the commitments we have made”.*

*This service will:*

- *Have prevention as the starting point*
- *Develop a new model, anchored in primary care, based on Prevention, Planned Care and Unplanned Care, optimising all available resource*
- *Provide care at home wherever possible*
- *Focus on population health as opposed to organisations*
- *Where possible, it will be a GP practice centred model (hybrid model between practices and geography)*
- *Include GP daily involvement and commitment*
- *Have active involvement from people who use services and carers*

Further information on the ambition can be found in **Appendix 5**.

The vision for the programme is that it will:

*“Lead and oversee the integration of primary and community health and social care services for adults in Harrogate, build the model and finances to deliver this, and oversee the ‘Keep Change Transition Plan”.*

Therefore, the programme aims to develop and create a new integrated service model for the Harrogate locality to be delivered through phased implementation from April 2019, with agreed hub models, staffing structure and costed options for delivery. It will also deliver the aims of the Keep Change Transition Plan during 18-19 to pave the way for the new model.

The values for the programme continue to be developed in line with workforce modelling.

## 2 OBJECTIVES

The programme will build on the learning from the New Care Models 'Vanguard' and other national models including 'Primary Care Home' to design and develop a new integrated service model for the Harrogate locality to be put in place during 2019. The objectives, are informed by the commissioning objectives and ambitions (**Appendix 3**). The overarching programme objectives are

- Establish partnership governance including a Programme Board and Joint Management Team to manage the transformation and operational business across organisations in the locality (**Appendix 6**).
- Maintain momentum and deliver learning from the New Care Models Programme 'Vanguard' through completion of the Keep Change Action Plan throughout 2018-19.
- Design and develop a new integrated service model to support the expansion of health and care services, centred on high quality primary care, general practice and health and social care services closer to home.
- Deliver the following aims for Year One (key principles detailed in [Section 7 – Recommended Option](#))
  - Develop detailed workforce modelling for the existing workforce including plans for technology and use of estates to create a joint workforce structure and single management structure for Year 1.
  - Develop a phased implementation plan for delivery to include specific projects required. This will include further work to model the current workforce with a view to planning the future state required in Year 2. It may also include further work to audit technology skills and requirements and use of estates.
  - Ensure appropriate engagement throughout to inform and develop the recommended model.
- Implement the joint workforce model and continue to develop the new integrated service model for the Harrogate Locality from April 2019 (scope outlined in [Section 5](#) below) within the existing workforce to meet the programme aims and ambitions.

Further information on the aims for Year One and beyond can be found in [Section 7 – Recommended Option](#).

## 3 BENEFITS

The Joint Management Team (see **Appendix 6** for governance structure) is developing a set of shared metrics and KPIs to be managed via a Programme Dashboard. High-level programme benefits include:

- Primary Care Home model characteristics and benefits will be met through:
  - Provision of care will be to a defined, registered population hub.
  - A combined focus on personalisation of care with improvements in population health outcomes.
  - An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care, mental health and community services will be created.
  - Clinical and financial drivers will be aligned across partners.

- CCG commissioning and budget requirements will be met. NYCC, HDFT and TEWV budget requirements will be met and GP practices will be resilient and sustainable.
- The health and social care system will remain affordable and sustainable.
- The quality of care will remain high.
- The Health and Wellbeing of people in the Harrogate and Rural District will be improved (Better health, Good Quality of Life, Reduced Inequalities).
- We will prevent, reduce and delay the need for long term use of community health and social care services.
- We will create opportunities to deliver more employment opportunities and career pathways to the population.
- We will empower individuals in relation to their care – improving outcomes and experience for local people.

This will be achieved through the development of a workforce from across health and social care services, including mental health, who will work together to meet the needs of the local population.

A copy of the Benefits Realisation Plan for the Programme, including measures, is provided in **Appendix 7**. Further work will continue to define and set baselines for the benefits between January and March 2019.

#### **4 ASSUMPTIONS**

The following assumptions have been made when calculating the high level benefits and costs of the programme. It is assumed that:

**Year 1** – in the first year we will have a joint management and workforce structure for ‘core’ services and plan more detailed work to deliver the new service model.

**Year 2** – from the second year onwards we will start to deliver the new service model.

##### **Programme Aims/Ambition**

- The findings from the ‘Vanguard’ in terms of working collectively and collaboratively has a benefit for the public in this locality and this is the right direction of travel. We assume the model is therefore workable on this basis and that we should continue on this path.
- Model will be based on 3 aspects – prevention, planned and unplanned /crisis care. A key aim will be to prevent, reduce and delay the need for long term care.
- Social care services provided through NYCC’s reablement offer will be free of charge **up to** six weeks (where there is capacity to provide this), however other services will require customer contributions in line with eligible need, financial assessment and charging policies.
- Compliance with legislative and regulatory requirements will continue.
- Primary Care Home assumptions will be applied to the Harrogate model where this makes sense, including hub-based primary and community services.
- The operating framework needs to be developed during mobilisation to agree working arrangements across partners (Alliance Compact/Agreement / Section 75 to be reviewed) – see [Section 16](#) below.
- Further work to develop ‘aligned’ and wider services will progress from year 2, to determine how they might support the ambition, including supporting individuals/relatives to take responsibility for their own care.

### **Workforce**

- People will work in multidisciplinary teams clustered around GP practices.
- Most people will remain with their current employer and income will remain with the current organisation unless agreed otherwise by the partners.
- There will be a single line management arrangement introduced on a phased basis.
- Actual staffing arrangements from the point in time they were taken are broadly reflective of the current situation and are meeting current demand.
- Co-location supports the benefits of the programme and all partners will sign up to this for the longer term.
- Further work is required to link into the voluntary sector and determine how they might support the service model.

### **Programme Delivery**

- The model is deliverable within existing contract and employment arrangements.
- Data will be available and accurate to inform the development of the model.

### **Partnership**

- Appropriate organisational and democratic governance requirements will be followed.
- Accountability and risk will be shared appropriately through the partnership governance arrangements (see **Appendix 6**).
- Consideration of Section 75 / Alliance Agreements is required to support integrated management / pooled budget arrangements. See [Section 16](#) below.
- A joint vision for the service and joint understanding on appropriate financial arrangement is required to ensure the programme can be progressed.

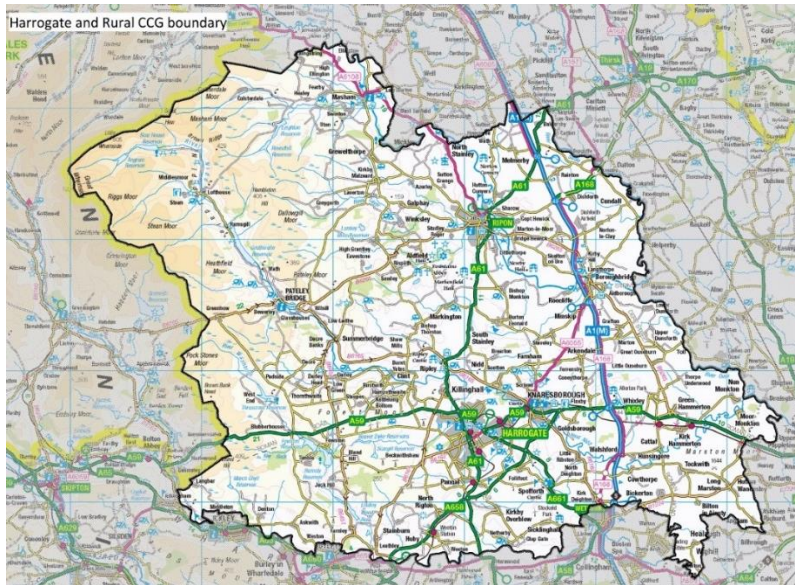
### **Financial**

- The model will support partner agencies to deliver their planned savings and will transform the overall experience both for the public and colleagues working in the service, reinforcing current savings plans.
- No spending above contract value will be committed until funding for the cost is identified and agreed.
- Funding available will be sufficient to meet the needs of the population within the parameters of the model.

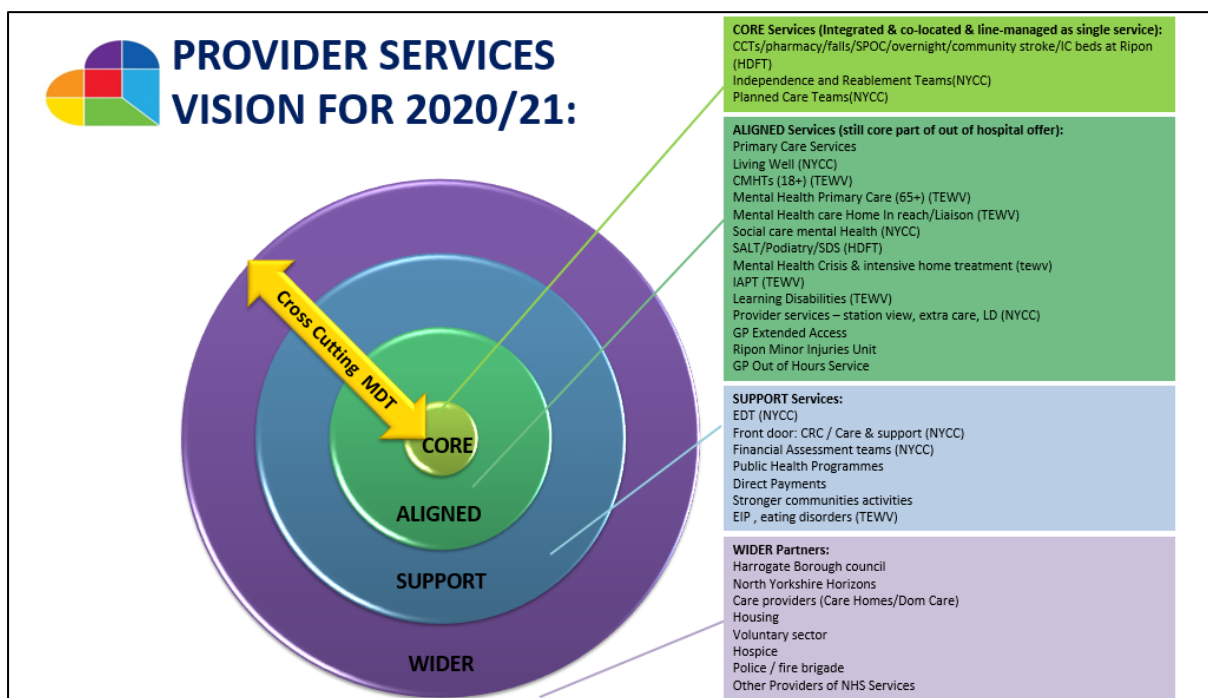
## **5 PROJECT SCOPE**

The following areas are in-scope for this programme:

- Harrogate and Rural Locality area (as per the map below)



- Ensuring combined resources are maximised and used to the best joint effect
- Health and Social Care primary and community services. Specific services in scope are shown in the diagram below. It is also noted that there is a distinction between the eligible population for social care and universal services through the NHS.
- The diagram below recognises core, aligned, support and wider services. Bringing together services in this way is intended to simplify key messages for people using our services to clarify the right services and pathways for them.



Further information on the scope and definitions of ‘Core’ and ‘Aligned’ services can be found in **Appendix 8**.

As the Programme progresses and individual projects are initiated, the Programme Board may agree that some areas may be ruled out of scope and others may be included. There may be opportunity to include a broader range of services than those with the statutory

obligations. Some areas under consideration include Direct Enhanced Services, National Enhanced Services, Core GP Services and Clinical Pharmacy.

A key element of the programme will be to be ambitious and creative about what services can be delivered in the community rather than in a hospital setting and to fundamentally shift the traditional access points and expectations of people who use services.

#### Out of Scope:

- New contract / commissioning arrangements - the new model should be delivered using existing contract arrangements.
- Anything that would change the existing contracting arrangements. NB. There may be some new sub-contracting arrangements via the Alliance Compact / Agreement / Section 75. See [Section 16](#) below.
- Children's Services
- Further consideration may be required to clarify scope (for example, community optometry).

## **6 OPTIONS APPRAISAL**

### **Outline Business Case**

The Outline Business Case considered a number of high-level delivery options for the new model to meet the required outcomes and benefits of the programme:

- A. Do nothing
- B. Procure a new service.
- C. Integrated working within existing NHS contracts and NYCC arrangements.

These options were assessed against the 5 case model to come up with a recommendation - Option C.

The Outline Business Case also considered options for segmenting the Harrogate District into localities or 'hubs' to best meet the Primary Care Home objectives and criteria. A data map was built of the locality to help inform how best to segment the area, based on PCH and other criteria, to meet the commissioning intentions of the CCG.

The data map is interactive and shows:

- Team / practice locations and boundaries
- Travel time by car/public transport for patients and staff
- Public Health data by output area
- Quality and Outcomes Framework (QoF) data
- Registered patients
- Population data

Through the data, a number of segmentation/hub options were identified:

1. Do Nothing
2. Segment Harrogate Town into one 'hub'
- 3a. Segment Harrogate town into 2 Hubs with Kingswood Surgery in the inner hub.
- 3b. Segment Harrogate town into 2 Hubs with Kingswood Surgery in the outer hub
- 4a. Segment Ripon & Masham together and Knaresborough and Boroughbridge together with Nidderdale Group Practice joining with Ripon and Masham

- 4b. Segment Ripon & Masham together and Knaresborough and Boroughbridge together with Nidderdale Group Practice joining with Knaresborough and Boroughbridge
5. Segment Harrogate town into 2 hubs with Kingswood Surgery in the inner hub and Nidderdale Group Practice in the Outer Hub. Segment Ripon and Masham together and Knaresborough and Boroughbridge together.

A sub-group of the Board was formed with representation across partners to review the data and options to arrive at recommendations. The Outline Business Case options appraisal can be found in **Appendix 9** and **Appendix 10**.

## **Final Business Case**

### **Primary Care Homes**

Following the Outline Business Case, the proposed GP Primary Care Homes have been identified (see **Appendix 4** for further information on Primary Care Home characteristics). There will be a 'bottom up' approach to implementing the Primary Care Homes, led by GPs. It is recognised that there are multiple levels of collaboration across partners, but that delivery models for this Programme will need to link to the proposed Primary Care Homes. The proposals are:

1. Harrogate Town Mowbray Square Practices (East Parade, The Spa, Park Parade) – population **29,578**.
2. Harrogate Town Outer Practices (Kingswood, Church Avenue, Leeds Road, Dr Moss & Partners) – population **51,148**.
3. Ripon & Masham (Ripon Spa, Dr Akester, Dr Ingram, North House) – population **28,758**.
4. Knaresborough, Boroughbridge, Green Hammerton and Pateley Bridge (Church Lane, Spring Bank, East Gate, Stockwell Road, Beech House, Nidderdale Group) – population **53,362**.

### **Hub Development Sessions**

Four engagement sessions have been held with team members from across the organisations involved during September and October 2018. An additional session was also held with partners and people who use our services and carers. These sessions sought views on the proposals to test out assumptions and ensure a viable delivery model is developed. Feedback from the sessions has been used to work up the final recommended model in more detail.

The sessions also identified a number of key pros and cons associated with the segmentation options recommended in the Outline Business Case. Key overall points included:

- General acceptance that there will never be a perfect fit.
- Need to identify best fit for the people using the services to fit population needs.
- The segments need to reflect the different needs of rural and town locations.
- Some services will need to be district-wide and there would be a risk splitting them down to smaller segmented services.
- Geographic boundaries across a number of agencies should be aligned as far as possible.



- There may be a resource impact especially for small organisations if involved in communications /MDTs regularly.

Given the feedback, and proposed Primary Care Homes, the options for segmentation have been further reviewed and 3 key options outlined below:

#	Description	Benefits	Risks	Costs	5 Case RAG	Recommendation
1.	Fewer overall segments with larger populations	<ul style="list-style-type: none"> <li>One large, co-located hub could be a more efficient use of public resource.</li> <li>Natural migration to bigger “centres”</li> <li>For small services, bigger hubs give greater chance of aligning dedicated staff</li> <li>Potentially less confusing for the customer.</li> <li>No natural split for Harrogate Town - artificial divide. Risk of “them” and “us” across 2 different hubs in Harrogate.</li> </ul>	<ul style="list-style-type: none"> <li>Communication will be challenging for larger hubs.</li> <li>Keeping the focus on the person not each organisation – risk of hub being too large and losing the personalisation of patients and staff.</li> <li>Size is a challenge e.g. Doncaster</li> <li>Risk of attracting &amp; retaining staff – getting to know individuals is positive, but 80k is too big to be personal &amp; for the more informal early conversations</li> <li>Risk of model being diluted if cohort is too wide</li> <li>80k puts a risk to continuity of both care and records – large hub with larger teams, records are less easily interpreted – staff who know each other personally can understand notes of tasks more easily</li> <li>Nothing may change if 80k</li> <li>New housing/res/nursing homes - will 80k become even larger?</li> </ul>	<ul style="list-style-type: none"> <li>Bigger hub for lower staff costs – more efficient use of resource.</li> <li>Potential for increased travel costs</li> </ul>	<b>YELLOW (2.6)</b>	Not Recommended
2.	More segments with smaller populations	<ul style="list-style-type: none"> <li>Distinct community identity.</li> <li>Smaller hubs more likely to facilitate individuals talking to each other, getting to know and trust each other. Personal relationships. Need to start with more face to face and getting to know each other.</li> </ul>	<ul style="list-style-type: none"> <li>If more hubs some services – e.g. Stroke Service - wouldn’t have dedicated resource.</li> <li>Huddles with smaller population would require tight process &amp; turnaround to ensure data aligned for escalation.</li> <li>Some splits may be artificial.</li> <li>Less efficient use of resources.</li> </ul>	<ul style="list-style-type: none"> <li>Smaller hubs may have increased staff costs – duplication?</li> </ul>	<b>YELLOW (2.6)</b>	Not Recommended

#	Description	Benefits	Risks	Costs	5 Case RAG	Recommendation
		<ul style="list-style-type: none"> <li>• 30-50k is recommended size – for a reason - PCH evidence base for hubs.</li> <li>• Provides options to ensure rural and town locations have approaches to meet their needs.</li> <li>• More likely to enable personalisation.</li> <li>• Opportunity to build on existing relationships (e.g. Mowbray Square).</li> </ul>	<ul style="list-style-type: none"> <li>• Potential to be confusing from a customer point of view.</li> </ul>			
3.	Hybrid model – a mixed approach to the number of segments. Larger overall segments with options for further segmentation / sub-division within.	<ul style="list-style-type: none"> <li>• Different levels of collaboration – some things could be at scale.</li> <li>• Combines the benefits of both Options 1 and 2.</li> <li>• Aligns better with both existing organisational workforce boundaries and proposed GP Primary Care Homes.</li> </ul>	<ul style="list-style-type: none"> <li>• Mitigates some of the risks of both options 1 and 2.</li> </ul>	<ul style="list-style-type: none"> <li>• Potential for duplication.</li> </ul>	<b>GREEN (3.8)</b>	<b>Recommended</b>

## 7 RECOMMENDED OPTION

The options below build on the Outline Business Case recommendations and also take into account the data, the proposed GP Primary Care Homes and feedback from those involved in engagement sessions.

As detailed in the Outline Business Case **Option C** - integrated working within existing NHS contracts and NYCC arrangements is recommended. Within this option, several hub options have also been appraised and reviewed. The recommended segmentation/hub options represents the best fit for all of the partner organisations. The recommendation is **Option 3 - Hybrid model** – a mixed approach to the number of segments. Larger overall segments with options for further segmentation / sub-division within.

Within these options, a proposal for the workforce modelling has been worked up. Additionally, consideration has been given to estates and options for co-location and better use of estates across partners; and technology and data to support the model.

### Year One

The aim for Year One is to identify how the existing workforce can be arranged to support the ambitions and aims of the programme so that those involved feel a difference in terms of the operating model and outcomes from the 1<sup>st</sup> April 2019. Year 1 will primarily focus on the 'core' services outlined in the scope (see **Appendix 8** for the definition) – approximately 277.7 FTE – and improving current services so that they operate more effectively. This includes ensuring better communication and integration in the localities (especially GPs). Primary Care will be an aligned service but is the heart of the model and community services will be organised around groups of practices and local communities.

Key principles for Year One include:

- There is a need for a single senior manager to manage the service, accountable to relevant partners – termed 'Alliance Director' for the purposes of this report.
- The core services will continue to be managed by their current organisational manager – **everyone will be employed by their existing employer**. However, there is a need to assign these managers to a designated locality responsibility as well.
- There will be Multi-Disciplinary Team (MDT) meetings / huddles in every cluster of GP practices, involving core staff and aligned staff – and potentially wider partners like NY Horizons, VCS, etc.
- There will be an MDT leadership team around each cluster of practices – at locality and virtual hub level (GP, manager and relevant professional leads from health, social care, MH, etc).
- Existing organisations will provide professional leadership.
- Basic models for making contacts and referrals, avoiding multiple contact points and ensuring effective navigation will be put in place – this will be further developed in Year Two.
- An Induction Organisational Development (OD) programme and will be established for all 'core' staff and as many 'aligned' staff members as possible. This will be built on over Years Two and Three to further develop the integrated teams and managers.

During Year One we will take advantage of any opportunistic workforce initiatives that arise and may enhance the model further (for example the opportunity to trial generic roles across partners where there are recruitment shortages).

## **Beyond Year One**

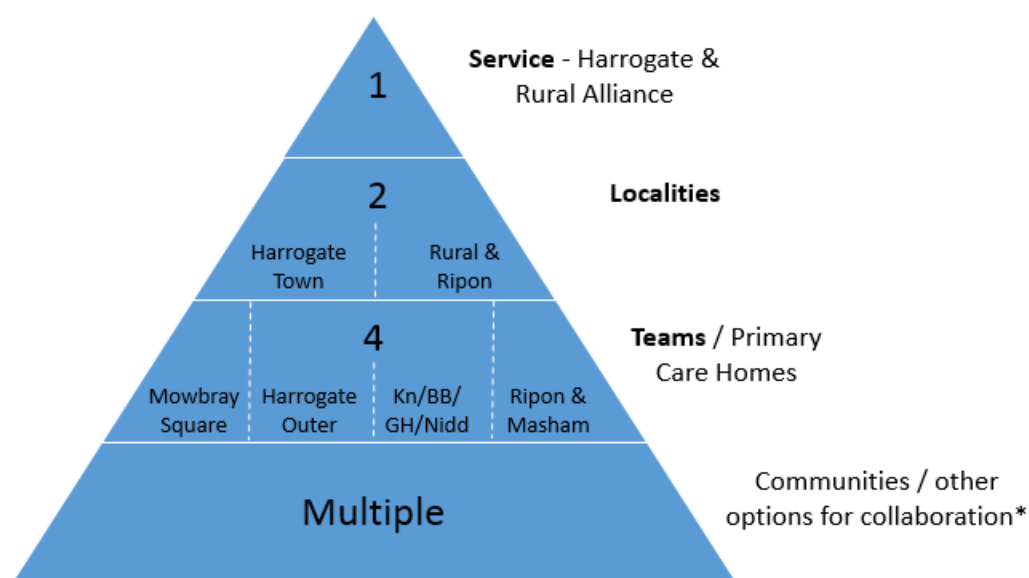
Throughout Year One, further plans will be drawn up and projects initiated which will bring about more fundamental change to services through workforce modelling, use of technology and estates. These projects will be delivered throughout Year Two and beyond and the detail will be included in project-level business cases underneath the wider programme.

Key principles for Year Two and beyond include:

- The 'Alliance Director' will manage a team which has multi-agency integrated line management responsibilities.
- Decisions will be made on which services will be managed district-wide and whether there is a need for a District-Wide Service Manager or whether Locality/Hub Managers each have some district-wide responsibilities. The likely district-wide services include specialist nurses and Supportive Discharge Service. Consideration will be given to where the Reablement Teams best fit.
- There will be a radical review of roles and skill mix – for example, generic health and social care workers, Advanced Nurse Practitioners, single Occupational Therapist roles (rather than separate NHS and NYCC Occupational Therapist roles), potentially generic technician roles, in-reach discharge facilitators, etc.
- More radical review of estates options for co-location and storage and potential new builds.
- Further review of technical and data requirements to ensure the technical ability to integrate across teams.
- Further focus on prevention and approaches to working with wider partners to support this.

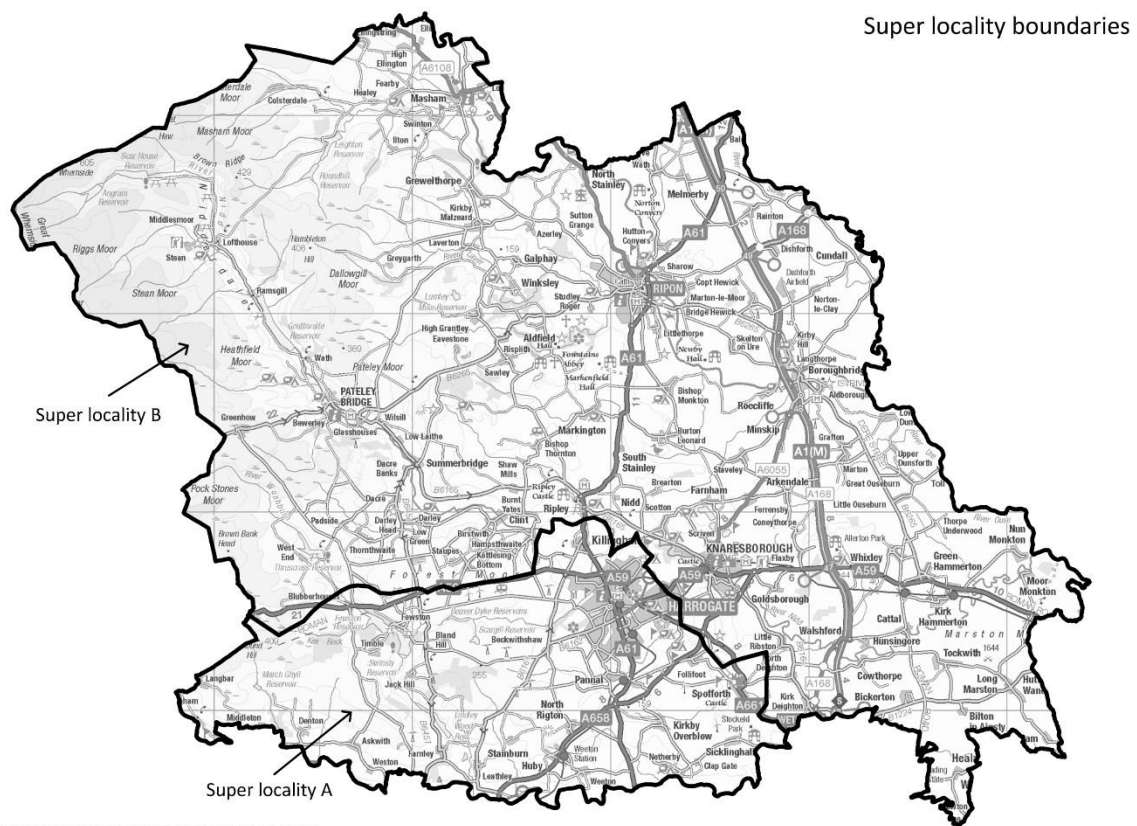
## **Segmentation**

There are multiple levels and layers of collaboration across the partnership. Based on the recommendations above and proposed Primary Care Homes, the following model is recommended:



\* e.g. Primary Care at Scale

The 2 main locality 'segments' A and B are shown below.



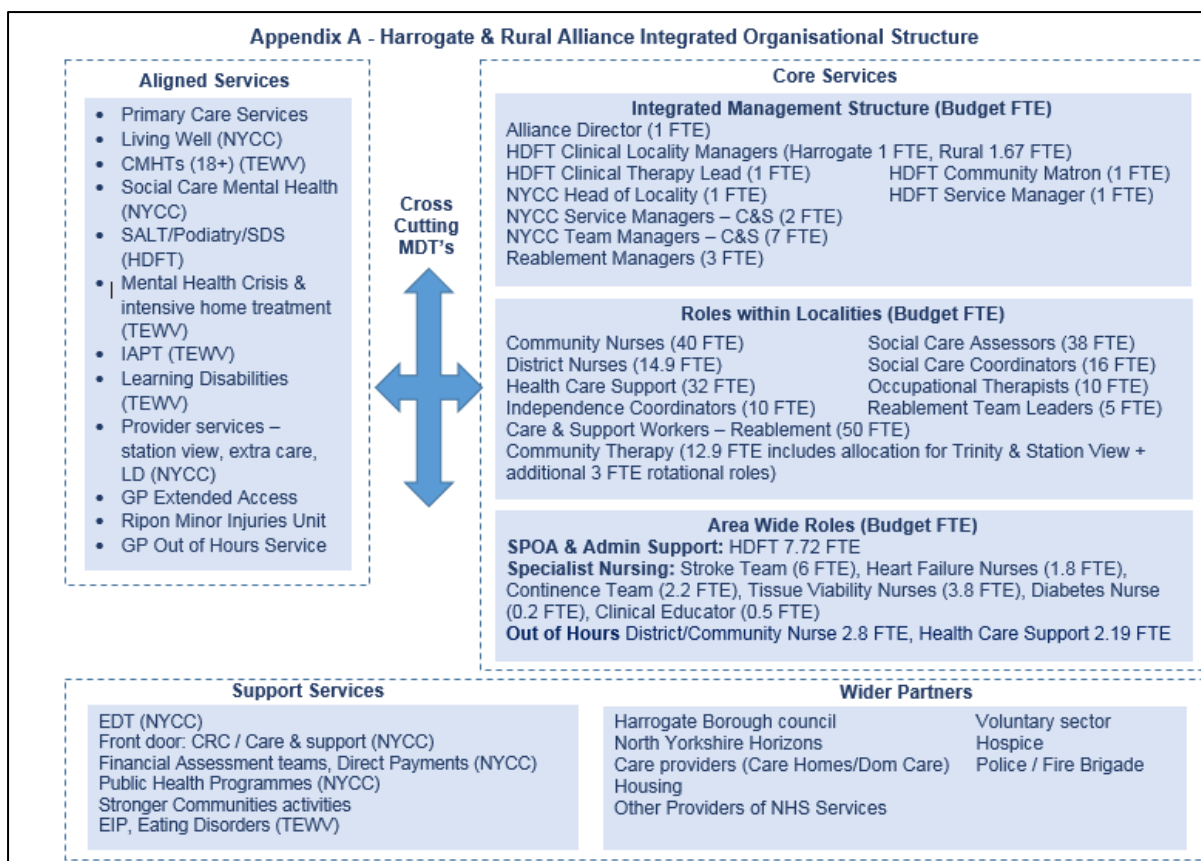
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## Workforce Modelling

A Workforce Subgroup has been formed to develop a workforce response to the service design outputs from the Hub Development engagement sessions and Harrogate Integrated Health and Social Care Programme Board. The first stage has involved undertaking an audit across partner organisations to establish a baseline understanding of the existing workforce. This workforce data has been mapped against the initial agreed boundary representing the Harrogate and Rural localities (represented as Locality A (Harrogate Town) and B (Rural and Ripon) for the purpose of the workforce model).

For Year One, taking into account the existing staffing profile and organisational boundaries, and the proposed locality boundary, an initial exercise has been undertaken to consider the best fit of the NYCC social care and HDFT community teams to deliver an integrated service model. For core services, the initial outline model articulates the roles working in the localities, area-wide roles, integrated management roles, and the associated budget FTE. It is intended to be used as a framework to demonstrate the scope of roles in the localities and area-wide structure, for further testing and validation.

The proposals are detailed in **Appendix 11**, including an outline of the overall workforce for core services and the proposed allocation of workforce within each locality. The overall workforce is also shown in the diagram below to illustrate the plans for Year One.



A comparison of organisational boundaries indicates there is not an obvious alignment between NYCC and HDFT teams. This is particularly apparent for the NYCC Independence teams whose boundaries run vertically across the area; it is also a challenge for Planned Care teams. The modelling proposes aligning the NYCC adult social care teams (Independence & Planned Care) to HDFT boundaries by allocating a percentage of resource proportionate to the population size. For example, the Harrogate North Planned Care team boundaries span Locality A and B; a 60:40 allocation of staffing is proposed based on the population size which falls into each locality.

In addition to the outline workforce model, the Workforce Subgroup has identified a number of areas which need to be addressed to ensure the model can effectively support service delivery from 1<sup>st</sup> April 2019. This is based on knowledge of challenges for the current workforce, as below.

<b>Workforce Challenges</b>	<b>Proposed Actions</b>
Feedback suggests that existing levels of District Nurse capacity meets scheduled activity but does not adequately support levels of unscheduled activity	Test the workforce model with HDFT & NYCC activity data to quantify capacity issues
Challenges relating to recruitment and retention of District Nurses; recent turnover, proportion nearing retirement, and context of continued organisational change suggests need to stabilise workforce and further develop DN pipeline	Identify opportunities to improve employment proposition for DN's as part of a whole system approach Develop robust comms & engagement plan including co-production of service model with staff
Vacancy levels within Reablement teams remain high (particularly Harrogate Dale & Central)	As above – look at opportunities to improve proposition to attract staff. Explore opportunities to join up recruitment activities between C&SW's and HCA's
Community Nursing teams would be enabled by KIT and technology which more effectively supports remote working. Specific suggestions include: visibility	Undertake IT audit to ensure all staff are operating with the same IT KIT & functionality to support remote working

<b>Workforce Challenges</b>	<b>Proposed Actions</b>
of shared records and ability to access / update records in real time	
Insight suggests that additional specialist nursing capacity would support the overall model by aligning the skills profile more closely to local health needs e.g. Respiratory Nurse in the community	Review the workforce model against local disease profile information and activity data to further understand skills gaps and workforce requirements
Service managers have highlighted feedback from staff who feel the impact of various models being piloted/implemented previously. There is a need to take on board the key learnings (e.g. Vanguard pilot in Knaresborough) and communicate how these have been applied	Review the model piloted in Knaresborough as part of workforce model testing. Act on cultural learnings from previous models in development of OD programme and comms & engagement plan.

A further stage of work is required to test and validate the initial outline workforce model. This work, including a review of activity data, will help identify longer term workforce solutions to current challenges through applying a whole system approach, and exploring opportunities to review roles and skills mix. The next key task for the Workforce Subgroup will be to review the model in terms of activity data, disease profile information, and feedback received from the Board.

### **Estates Modelling**

An Estates Subgroup has been formed to develop an estates response to the service design outputs from the Hub Development sessions and HHSO Programme Board. The first stage has involved undertaking an audit across the key partner organisations to establish a baseline understanding of the existing estates in the Harrogate and Rural district. This data has been reviewed by the group to identify opportunities for co-location and better use of estates across partners to deliver the aims of the new service model.

The estates audit identified 91 estates in the Harrogate and Rural district across key partners. The Estates Subgroup reviewed the full list to identify further data and fill gaps and have identified 13 immediate opportunities within this list. The opportunities can be summarised as:

- **Hot-desking/Meeting room availability** (Jesmond House; 68 High Street Starbeck; The Orchards; Manor Road; Boroughbridge Highways Office; Ripon Fire Station; Jennyfield Health Centre; Oak Beck House; Valley Gardens Resource Centre)
- **Record storage opportunities** - potential to free up further space in GP practices etc – new project opportunity to look at all record management requirements (Hornbeam Park; Valley Gardens Resource Centre, Jesmond House?).
- **Potential longer term co-location opportunities** (The Snooker Room, Black Swan Yard, rear of Ripon Hospital / Ripon Community Hospital – this is already a project that needs to be linked in. Harrogate Hospital, Briary Wing. GP Practices - should space be freed up through alternative records management arrangements).

The group are also aware of some further new/re-development opportunities that may provide further capacity. The main example of this is an opportunity currently under discussion to bring together 3 GP practices in Harrogate Town – Dr Moss and Partners, Leeds Road and Church Avenue. It is recognised that if this goes ahead it will need to be part of the wider service transformation plans.



A number of key considerations have been identified and the Estates Subgroup will review these through the mobilisation stage to pull together a clearer plan for the use of existing estates. These include:

- **Booking rooms** across partner estates.
- **Access** to partner buildings / ID badges.
- **Costs** – in principle, the group recommends that there should be no additional costs to partners for using space collaboratively. Further consideration would need to be given where considering full co-location (likely to be within a separate project though).
- **On-going collaboration** – any new major estates changes or procurements from the partner organisations should be brought to the group for consideration.
- **Culture** – work with HR/OD group to clarify issues of confidentiality, expectations around sharing space and benefits of co-location.
- **Kit / technology** –work with the Data, Technology and Digital group to ensure teams have the right technology to support working from a number of locations. Other considerations include access to printing, access to telephones and consideration of equipment where partners still use desktop machines.

During the mobilisation stage (Jan – March 19) and throughout Year One (April 19 – March 2020) further consideration will be given to estates and potential individual estates projects that need to be initiated to support the development and delivery of the programme aims. More detailed information around the data, technology and digital aims can be found in **Appendix 12**.

### **Data, Technology and Digital**

A number of common themes have been identified in response to the feedback from the hub development sessions which reinforced the approach and identified further actions to undertake. Work will continue to be progressed to further develop these key themes throughout Year One. These include:

- **Data sharing and consent** – the broader region has been successful in becoming a Local Health & Care Record Exemplar (LHCRE). This aims to deliver wider data sharing opportunities across the region and this programme will link in with this work to address this theme. Funding has also been drawn down to support work on Population Health Management which seeks to improve population health by data driven planning and delivery of proactive care to achieve maximum impact.
- **Access to the right employee technology** – through initial discussions access to the right employee technology appears in the main to be sufficiently covered between NYCC, TEWV, and GP Surgeries however access to appropriate mobile technology appears to be limited within HDFT. The next stage of development needs to evaluate the current technology mix and a **mobilisation fund** will be required to ensure that all 'core' employees have appropriate technology for Year One. Further work is also required on the development of the Virtual Huddle approach, sessions are planned to understand the scope of the activity and potential digital solutions. It is proposed to develop a pilot approach into Mowbray Square and Station View to test technology and working practices.
- **Connectivity infrastructure and inclusion** - currently all members of the Alliance are moving to Govroam as a wireless standard to aid cross team working within the current property portfolio with the exception of TEWV. Through discussion with the IT lead at TEWV appropriate contacts have been made to investigate TEWV rolling out

Govroam at least within the Harrogate estate. This will enable connectivity at all key organisational estates.

- **Digital skills and awareness** – during Year One it is recommended that a skills audit takes place as there is currently a mixed skill set across staff and organisations. Further investment may be required and projects initiated during Year One to address any skills gaps identified.

Through current discussions a **mobilisation fund** will be required to ensure that all employees of the Alliance have appropriate technology for launch and an appropriate budget will need to be put aside for a technology refresh during the life of the contract.

More detailed information around the data, technology and digital aims can be found in **Appendix 13**.

## 8 PROGRAMME MILESTONES

The high-level check-points and milestones for the programme are below. In addition, there will be regular informal ‘check in’ points to ensure the programme stays on track.

### Check-Points

Checkpoint	Assurance Required – Milestones	By When
1 OBC Development	<ul style="list-style-type: none"> <li>• Terms of Reference for each governance board agreed</li> <li>• Alliance agreement / Arrangement drafted</li> <li>• Communications Plan agreed</li> <li>• Risks and issues Register in place</li> <li>• Values and Vision statement agreed</li> <li>• Data gathering and sharing – sub-group in place and options appraisal drafted</li> <li>• Draft implementation plan (including hub options) agreed</li> </ul>	31 July 2018
	<ul style="list-style-type: none"> <li>• <b>Outline business case approved</b></li> </ul>	31 Aug 2018
2 FBC Development	<ul style="list-style-type: none"> <li>• Hub Development and Engagement Sessions complete</li> <li>• Implementation plan agreed (Year Zero and Year One)</li> <li>• Review of individual policies/procedures complete</li> <li>• Service delivery proposals developed</li> <li>• Sustainability and social values included in model</li> <li>• Reporting plans in place</li> <li>• Proposed systems and Information Management Technology solutions developed</li> <li>• Integrated model proposal finalised</li> </ul>	31 Oct 2018
	<ul style="list-style-type: none"> <li>• <b>Final business case approved</b></li> </ul>	31 Dec 2018
3 Mobilisation	<ul style="list-style-type: none"> <li>• Quality monitoring in place</li> <li>• Approach to organisational collaboration in place</li> <li>• Monitoring outcomes in place</li> <li>• Service delivery proposals (firmed)</li> <li>• Financial modelling complete</li> <li>• Mobilisation plan complete</li> <li>• Capital expenditure plans in place</li> <li>• Final implementation plan agreed</li> <li>• Final staff structures and workforce model agreed</li> <li>• Cost plan and savings proposals agreed</li> </ul>	31 Jan 2019
	<ul style="list-style-type: none"> <li>• <b>Phased Go Live begins</b></li> </ul>	April 2019

## Milestones

The implementation plan for Year One and future years will be refined over the course of the Programme. Indicative milestones are below:

Year	Phase	Milestones	By When
0	Mobilisation Jan – Mar 19	• OD model and review of values/behaviours complete	31 Dec 18
		• Testing and validation of workforce model complete	31 Jan 19
		• Staff engagement sessions complete (subject to winter pressures)	31 Jan 19
		• ‘Access to Technology’ plan in place for April 19 (including mobilisation funding)	31 Jan 19
		• Plan for use of existing estates in place	28 Feb 19
		• Data Sharing / Consent agreements in place	28 Feb 19
		• Formal partner governance arrangement in place	31 Mar 19
		• Plan and deliver an induction programme to support transition to new service - all staff	31 Mar 19
		• Leadership development programme to support managers/leaders transitioning to the new management structure begun	31 Mar 19
		• Digital skills audit complete	31 Mar 19
		• Consultation and engagement with the public initiated	31 Mar 19
		• Customer Journey Mapping complete	31 Mar 19
		• Data Protection Impact Assessment complete	31 Mar 19
• Recruitment of senior manager complete	31 Mar 19		
1	Year One Apr 19 – Mar 20	<ul style="list-style-type: none"> <li>• Implementation of Year One Model complete</li> <li>• Scoping and initiation of Phase 2 Workforce project.</li> <li>• Scoping and initiation of further Data, Technology and Digital projects as required.</li> <li>• Scoping and initiation of further Estates projects as required (e.g. Records Management review, longer-term co-location opportunities etc).</li> </ul>	31 March 2020
2-5	Future Years Post April 2020	<ul style="list-style-type: none"> <li>• Year One Evaluation complete</li> <li>• Delivery of Phase 2 Workforce Project</li> <li>• Delivery of further Data, Technology and Digital projects as required</li> <li>• Delivery of further Estates projects as required</li> </ul>	31 March 2024

## 9 PROGRAMME RESOURCES

A number of task and finish sub-groups across partner organisations have been established to progress the work to final Business Case and beyond. These include:

Task & Finish Sub-Group	Organisation Lead
Data, Technology & Digital	NYCC
Communications & Engagement	CCG
Workforce Modelling / Organisational Development (OD)	NYCC/HDFT
Finance	NYCC
Estates	YHN

A summary of resource requirements across partner organisations is below.

Area	Yes / No	Resources Required	Comments
<b>ICT</b> - Does the programme involve the purchase or development of any software programme, the procurement or building of any hardware, or has a major impact on the utilisation of ICT software or systems?	Yes	Data, Technology & Digital Sub Group reps	Data to support development of models. Technology to support the programme. Technology to support the final model including system integration.
<b>HR and training</b> - Does the programme involve staff transfers, training, or any other significant staff related issue?	Yes	OD and HR/ Workforce Planning sub-group reps <b>ALL ORG'NS TO PROVIDE</b>	OD / Cultural support. Workforce Modelling
<b>Finance</b> - Does the programme involve any complex assessment of financial information?	Yes	Finance Sub Group reps <b>ALL ORG'NS TO PROVIDE</b>	Financial modelling (Fred Chambers)
<b>Procurement</b> - Does the programme involve a procurement process and will this require the specialist advice and guidance from procurement specialists?	No		
<b>Communications</b> - Does the programme require Communications resource or consultation?	Yes	Communication & Engagement Sub Group reps. <b>ALL ORG'NS TO PROVIDE</b>	
<b>Business Change</b> - Does the programme have a process redesign element or a business improvement?	Yes	TEVV / 3P NYCC - Customer Journey Mapping	
<b>Programme Management</b> - Does the programme require a programme manager?	Yes	NYCC - Programme Management – Gemma Dickinson. Programme Support – Amy Sanderson	
<b>Legal</b> - Does the programme involve specialist legal advice and guidance?	TBC	<b>ALL ORG'NS TO PROVIDE</b>	<i>This is likely to be required by each organisation</i>
<b>External expertise</b> - Does the programme require any Expert knowledge or services?	Yes	HIHSCP NAPC / PCH Facilitation (Penny Jones) 3P facilitation (TEVV)	
<b>Property</b> - Does the programme involve any property management resource?	Yes	Estates Sub Group reps. <b>ALL ORG'NS TO PROVIDE</b>	
<b>Risk and Insurance</b> – Does the programme require any risk and insurance resource?	TBC	<b>ALL ORG'NS TO PROVIDE</b>	
<b>Business Support</b> – Does the programme require any specific admin support	Yes	Leadership and administrative support NYCC – provision of support to HIHSCP Board.	
<b>Customer Help Services / Access Points</b> – Does the programme require any specific input?	TBC	<b>ALL ORG'NS TO PROVIDE</b>	<i>May be some changes in terms of access to services.</i>
<b>Service Team(s)</b> - What commitment is required from the team(s) impacted? This includes availability to contribute towards the development of the OBC. (eg attending workshops)	Yes	HAS / TEVV / HDFT / YHN / CCG <b>ALL ORG'NS TO PROVIDE</b>	<i>Hub development events etc.</i>
<b>Other</b>			

## 10 CONSULTATION / ENGAGEMENT

There has already been a significant amount of work to understand what the public want through the 'Vanguard' and previous work. A communication and engagement sub-group has been established to build on this. There will be an on-going need for communication and engagement across organisations and staffing groups and with the public. This group is developing the Communication and Engagement Strategy and Plan for the Programme. Further work is needed to establish whether consultation will be required. If a formal consultation is required we would need to adhere to appropriate regulations and timeframes.

## **Engagement Sessions**

Engagement sessions have been held with team members across organisations, partners, people who use our services and carers during September and October 2018. The feedback from the sessions has helped us to refine the Outline Business Case options to feed into the Final Business Case and mobilisation plans. Further engagement is planned on a quarterly basis and more detailed input for those directly affected will be developed in terms of the OD and Induction Programmes.

The new model will be co-designed and co-owned by colleagues in the service and people who use our services.

## **Customer Journey Mapping**

A Customer Journey Mapping exercise will take place in the Mobilisation Phase, to be completed by 31<sup>st</sup> March 2019. The objective of this activity is to understand the impact on the service users and carers who will be affected by the changes and how their experience will be altered. The activities will focus on the areas of highest impact – initially the delivery of ‘core’ services. Through engagement with frontline staff and managers, and direct engagement with customers, the current ‘as is’ journeys will be understood and proposals for future ‘to be’ customer pathways developed.

The outputs will be visual representations of the current and future customer pathways/ journeys using a combination of storyboards, rich pictures and customer journey maps supplemented with a summary of the customer engagement outcomes. Further information can be found in **Appendix 14**.

## **11 RISKS AND ISSUES**

The programme risks and issues are managed via the risk and issues register. The key risks fall into the following categories:

<b>Theme</b>	<b>Risk that...</b>	<b>Mitigations</b>
<b>Identification and realisation of benefits</b>	... cultures and behaviours will not be changed if engagement of key stakeholders is not effective, including development of <u>shared</u> vision and understanding (public, staff, partners etc)	Staff engagement sessions; communications and engagement work-stream in place All partners to engage with their staff on behalf of the partnership and using partnership agreed and shared communications.
	... alternative arrangements may need to be made by the CCG if CCG commissioning intentions or PCH criteria are not met and/or progress cannot be demonstrated	CCG commissioning intentions have shaped business case and options; CCG engaged in governance; key focus on identifying measurable checkpoints and benefits to demonstrate impact and progress
	... wider locality issues, partner activity or national agendas are not taken into account in the programme or that these change during the lifetime of its development	All key partners engaged through governance; horizon-scanning for national changes
	... the new service design may negatively impact as some proposals may mean that people using services/ staff/ families/ carers have to travel further. See EIA.	Consideration and regular review of EIA and programme controls. Sub Groups/ Board to ensure any new locations are fully accessible and also that information is accessible.

Theme	Risk that...	Mitigations
<b>Development of a sustainable model</b>	... the type of service delivery model is as yet untested in North Yorkshire (although other models exist elsewhere) so this new way of working is currently not financially quantified and delivery not proven, especially given the complexity of the North Yorkshire locality and boundaries	Learning from other areas  Testing of models and assumptions through business cases, modelling and detailed development. Phased delivery plan.
	... the model may be unaffordable as a decision about options at this early stage will be made without a clear understanding of the detailed financials, as the financial modelling comes at the next stage.	Initial financial modelling to be followed up with detailed costings in the next stage; final business case to confirm financial viability of the model. Future project business case to develop future models and detailed costs.
	... the model will not be implemented successfully if key partners are not fully engaged and/or are unable to agree on the recommendations.	Governance in place
	... the model will not be sustainable if effective partnership working is not in place as there is no contractual arrangement between partners. There may be difficulties in terms of adding new providers in if this is not accounted for at the start.	Governance Regular meeting/decision points JMT MoU / Alliance Agreement New partnership board for the service underpinned by MoU
<b>Programme delivery</b>	... implementation may take longer than initially anticipated if - the model does not align to individual organisational strategic positions (including existing boundaries, estates, systems, teams etc) - formal consultation is required as regulatory timeframes would need to be adhered to	Consideration of phased approach to delivery in agreement with commissioners. Programme planning capacity Advice to be sought on formal consultation

## 12 DEPENDENCIES / LINKS

The programme is dependent on the National, Regional and Local strategic picture as identified in Section 1. There are links and dependencies to be made within each of the key partner organisations:

- HaRD CCG
- YHN
- NYCC
- HDFT
- TEWV

The governance diagram in **Appendix 6** also shows some key links and dependencies between this programme and other groups and boards. The key groups include:

- Harrogate Systems Leadership Executive (formerly HHTB)
- Joint Management Team
- Integrated Care Delivery and Commissioner Reference Group

Other links include:

- Public Health

- NYCC Health and Adult Services and Health and Integration Programmes (including Strength-based assessments and approaches, Living Well service, Transfers of Care)
- Stronger Communities Programme
- Voluntary Sector
- Integrated Urgent Care (there is a relationship between integrated urgent care and integrated community care models).

Dependencies on individual organisational existing programmes, including savings programmes should be identified given the financial pressures across all agencies. Plans should be shared across partners to identify any unintended consequences.

### **13 STAKEHOLDER MANAGEMENT AND COMMUNICATIONS**

See [Section 10](#) above. Key stakeholders will be across organisations, staffing groups and the public. Key stakeholders are included in the governance of the programme – see **Appendix 6**.

An initial stakeholder map has been drafted and this is included in **Appendix 15**. However, this will evolve and develop as the programme progresses.

### **14 EQUALITY IMPACT ASSESSMENT (EIA)**

The full EIA can be found in **Appendix 16**.

### **15 DATA PROTECTION IMPACT ASSESSMENT (DPIA)**

The full DPIA is currently in development but will be finalised during the mobilisation phase once the delivery model has been confirmed.

### **16 OTHER IMPLICATIONS AND IMPACTS**

Each individual organisation will need to ensure they adhere to their own organisational requirements and governance. The programme will need awareness of these areas to ensure the timelines can be appropriately estimated. There will be a need for all partners to ensure legal implications are identified and addressed.

Mobilisation and subsequent programme and project work may have an impact on existing partner operations or transformational activity. Partners will need to be aware of these and escalate any issues in a timely way.

#### **Formal Agreements**

Harrogate and Rural Alliance will need to be underpinned by formal agreements. Options being explored include one or more of the following:

- Section 75 of the NHS Act 2006, which allows for integrated management, integrated commissioning and pooled budgets. Section 75s can be signed by statutory bodies and are a well-established framework for integrated service arrangements. A month's

public consultation is required before a section 75 agreement can be put in place – if this option is pursued then the latest date for starting a consultation would be mid-February 2019. It is likely that a section 75 agreement would cover an integrated management structure and seek permission to establish a pooled budget to cover the costs of any generic worker posts

- NHS alliance agreement, which provides a standard agreement between NHS (including non-statutory) and local government partners
- Other forms of partnership agreement

Each partner organisation will need to seek its own legal advice on these options, following further consideration by the Programme Board in January 2019.

## **17 SUMMARY OF SAVINGS AND COSTS**

### **Finance Sub-Group**

A finance sub-group was established to undertake the financial modelling for the proposed programme and to establish the associated contributions and overall budget.

The purpose and role of the Finance Task and Finish Sub Group is:

- To agree and develop a Programme Budget to cover spend for the programme including in kind contributions (e.g. programme management provided by NYCC, chair of JMT provided by HDFT etc.) and financial contributions (e.g. venue hire costs, facilitation costs etc.).
- To agree spend against the Programme Budget and manage programme costs.
- To financially model the options and recommendations developed by the HR/Workforce Modelling Task and Finish sub-group. Modelling needs to be completed for the Final Business Case for late November 18/early December 18 and further work may be required following this for implementation.
- To report back, and present to, Harrogate Integrated Health and Social Care Programme and respective organisational governance arrangements.

### **Programme Budget and Spend**

The finance sub-group is presently identifying and agreeing designated staff assigned to the project and related sundry costs. This will not include partner organisation's staff that attend meetings, as these will be regarded as "in-kind" costs borne by each organisation. The finance sub-group will continue to report to the programme board the on-going programme costs and estimates.

### **The Financial Model**

This shows additional cost of £438k and an assumption that the funding envelope from partners will cover this. It should also be noted that all organisations are experiencing financial pressures and overspends in this locality. The proposal to invest will be reviewed and is to be agreed at a meeting of key partners on 10<sup>th</sup> January 2019.

As part of this first year additional cost, IT expenditure is estimated to be £251k, but it should be noted that there while there is an expectation that these will grow over time, the



assumption is these will be covered by efficiencies made as a result of the alliance programme.

It is also noted that consideration of a Section 75 or Alliance Agreement is required to confirm the integrated management position and potentially provide provision for a pooled budget (see [Section 16](#) above).

#### Harrogate Integration - options

Summary (as at 1 April, 2019)

	Current £000's	Proposed £000's	Additional £000's
<b>Core Budgets</b>			
Staff - admin & support	266	367	101
NYCC Staff - social care	4,770	4,770	-
HDFT Staff - clinical	4,475	4,475	-
Total Staffing	9,511	9,612	101
Training Year 1	-	86	86
IT Year 1 (2% of assumed contract value)	-	251	251
Service costs (Care package budgets) - NYCC	28,600	28,600	-
Service costs (Care package budgets) - CCG	1,449	1,449	-
Total Core	39,560	39,998	438
NYCC Core	33,449		
CCG Core	6,111		
	39,560		
<b>Aligned Budgets</b>			
NYCC Aligned	14,546		
CCG/NHS Aligned	12,901		
	27,447		
<b>NHS/CCG Budgets to be determined</b>		6,768	
<b>Total Core &amp; Aligned Budgets</b>			
	£000's		
NYCC		47,995	
CCG/NHS	19,012		
To be determined CCG/NHS	6,768	25,780	
		73,775	

The proposed core staffing establishment for integration programme will remain the same on the 1<sup>st</sup> April, 2019 as it is today, (at Full Time Equivalent 277.7), with the exception of one additional director post. The post of the Alliance Director is estimated to cost c£102k (including Employer's NI and Pension) in the first year.

At this stage, all additional support costs for training, supplies etc. have been estimated and will be further refined as plans are developed from the other workgroups.

The finance sub-group will continue to meet during the transition year and to develop the financial model throughout this period tracking the cost of the programme and forecast outcomes.

## Staffing Options - Harrogate Integration

Full-Time Equivalent	Staffing - current	Staffing - proposed
	Phase 1	Phase 1
	2019-2020	2019-2020
	FTE	FTE
<b>Admin &amp; Support</b>		
1A Admin Support - Stroke Team	0.6	0.6
28C Alliance Director	-	1.0
94C Head of Locality	1.0	1.0
78A SPOA & Admin Support	7.7	7.7
<b>Admin &amp; Support</b>	<b>9.3</b>	<b>10.3</b>
<b>Social Care</b>		
10A Care & Support Worker - Reablement	50.0	50.0
42A Independence Coordinator	10.0	10.0
52B Occupational Therapist - NYCC	10.0	10.0
58B Reablement Manager	3.0	3.0
59B Reablement Team Leader	5.0	5.0
64C Service Manager - Care & Support	2.0	2.0
73B Social Care Assessor	38.0	38.0
74B Social Care Coordinator	16.0	16.0
85C Team Manager - Care & Support	7.0	7.0
<b>Social Care</b>	<b>141.0</b>	<b>141.0</b>
<b>Clinical</b>		
3A Associate Practitioner	2.0	2.0
13C Community Matron (HDFT)	1.0	1.0
14B Community Nurse (B5 & 6)	54.9	54.9
15B Community Nurse (OOH)	2.8	2.8
37C Head of Therapy	1.0	1.0
40A Healthcare Support	34.2	34.2
46C Locality Manager (Clinical)	2.7	2.7
51B Occupational Therapist	6.2	6.2
53B Occupational Therapist - Stroke	1.2	1.2
55B Physiotherapist	6.7	6.7
61B SALT Therapist	0.6	0.6
65C Service Manager - Adult Community Services	1.0	1.0
72B Specialist Nursing - Clinical Educator	0.5	0.5
69B Specialist Nursing - Continence Team (B6)	1.5	1.5
69C Specialist Nursing - Continence Team (B7)	0.7	0.7
70B Specialist Nursing - Diabetes	0.2	0.2
68B Specialist Nursing - Heart Failure	1.8	1.8
67A Specialist Nursing - Stroke Team (B3&4)	2.4	2.4
67B Specialist Nursing - Stroke Team (B6)	0.6	0.6
67C Specialist Nursing - Stroke Team (B7)	0.6	0.6
71B Specialist Nursing - Tissue Viability (B6)	2.8	2.8
71C Specialist Nursing - Tissue Viability (B7)	1.0	1.0
<b>Clinical</b>	<b>126.3</b>	<b>126.3</b>
<b>Total FTE per scenario</b>	<b>276.65</b>	<b>277.65</b>

## 18 FUNDING

Estimated implementation costs and budget allocation		Funding Source		
	Amount Required (£)	Service (£)	Corporate (£)	Other (£)
Designated Staff	34,500			
Venue and Facilitator Costs	5,028			
<b>Total</b>	<b>39,528</b>			
Estimated Annual Cost	60,000			

# Appendix 1 – The Case for Change

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Integration between health and social care is a fundamental part of both national policy and local strategy and commissioning intentions with the aim of promoting health and wellbeing, delivering better outcomes for the population, promoting ease of access and ensuring a sustainable system for the future. Nationally and locally health and social care systems are facing challenges around quality, sustainability and changing population needs.

## The National Picture

Historically, care has been constrained by organisational and professional boundaries, resulting in reactive, fragmented and inefficient care. This has often resulted, in a person receiving support from teams working reactively and separately, diagnosing people in silo, where information on these diagnoses and other important health and care information is not shared. This often means the staff within these organisations have additional workload pressures, and have little time to give advice and support regarding self-care and the system often focusses on physical health needs, with social care needs being overlooked or not seen in conjunction with the person's physical needs.

The NHS Five Year Forward View (2014) and update (2017) sets out the aim to integrate health and care nationally. The aim is being pursued through the new care models, Sustainability and Transformational Partnerships (STPs) and the evolution of Integrated Care Systems (ICS). These developments propose different ways of working with an emphasis on place, populations and systems. Becoming an ICS (in shadow form) as part of West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) will mean that the CCG and partners can firm up specific actions in local and WY&H plans, which includes further developing services to help people stay well, whilst delivering more care in community settings. This includes further strengthening community care working with communities, redesigning services with and for people in ways that better meet their needs. The importance of our local place working in alignment with the WY&H ICS strategy is recognised, including the Primary and Community Care and Urgent Emergency Care work streams led by the ICS. The NHS Long Term Plan is also expected imminently.

GP Forward View describes that over the next five years the NHS will invest more in primary care, whilst stabilising core funding for general practice nationally over the next two years. It emphasises that local systems should encourage and support general practices to work together at scale in a variety of new forms enabling greater opportunities for them to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary sector organisations.

National drivers from the social care point of view include the Better Care Fund, the statutory role of the Health and Wellbeing Board and the Care Act duties around integration. The Care Act 2014 built on previous legislation setting out clear duties for local authorities and our partners (health, housing, welfare and employment) to support people to be in control of their care and support. The Act introduced a new emphasis on wellbeing. The focus on prevention requires local authorities and their partners to prevent, reduce or delay the need for care and support for all local people. The Act has a focus on integration requiring local authorities to collaborate, cooperate and integrate with other public authorities, including health and housing.

The local authority is required to offer anybody, including carers, who appears to be in need of care and support, an assessment which is outcome focused. Although local authorities

must apply a national eligibility threshold to determine whether an individual has eligible needs, the Act enables the local authority and our partners to have a wider focus on the whole population in need of care.

The Adult Social Care Green Paper is also expected before the end of the year with a key principle to integrate health, housing and care.

## **The Local Picture**

The current system has been constrained by organisational and professional boundaries, resulting in reactive, fragmented, inefficient care that impact on patient and care experience and outcomes.

Significant financial challenges across the system, increased pressures on A&E, gaps and duplication in workforce and limited focus on patient experience has resulted in a whole system approach from partners to develop an integrated model of care.

A focus on person centred proactive and co-ordinated care will support appropriate use of health and social care services, will improve patient and carer experience and outcomes, ensuring people will live longer with better quality of life. A key strength is our existing local partnership arrangements, and this continues to be built upon.

The redesign of urgent and emergency care services in line with the Five Year Forward View (5YFV) is developing across the WY HCP to provide a more integrated service for patients. The objective of the redesign is to enable commissioners to deliver functionally integrated 24/7 urgent care services that are joined up and makes sense to the people who use them. Information to date confirms interdependencies of NHS 111, GP Out of Hours (OOH) and Extended Access when commissioning urgent care pathways. As work is progressing at regional and local level to align the new partnership approach to Integrated Urgent Care and Integrated Care.

In terms of population and demographic data, our residents are relatively healthy compared to the rest of England. In addition, socio-economic risks to wellbeing are significantly lower in the Harrogate District than elsewhere in England.

Like most health and care systems in England, Harrogate and Rural District is struggling to match demand and affordable supply. There is a combination of an ageing population, an increase in the number of people with long-term conditions and the changing expectations of the local population. An ageing population presents several risks including:

- Isolation, and its mental health challenges;
- Access to public transportation;
- Capacity to meet the demand for health and social care services that increase with age such as dementia, frailty, sensory deprivations such as eyesight and hearing, falls and fractures, joint replacement, continence, chronic wounds, and multiple long term conditions.

All partner organisations face significant financial challenges despite delivering cost saving programmes over recent years. The health and social care system overall is challenged in terms of continuing to deliver high quality care within reduced financial envelopes and within the context of austerity. For example, analysis by health economists shows that the CCG spends 12% more on hospital services than it receives funding for, highlighting four factors:

- An older, relatively affluent population, more likely to present early
- An allocation formula that reduces per capita funding if health outcomes are high
- High quality primary care with accessible and responsive GPs
- Efficient local hospital with capacity to treat bigger catchment than Harrogate and Rural population.

Together these increase demand and create pressures on our health and social care system.

### **New Care Models ‘Vanguard Programme’**

The 3 year New Care Models ‘Vanguard’ Programme took place in the Harrogate locality between 2015 and 2018. This programme brought together the Harrogate and Rural District Clinical Commissioning Group (HaRD CCG), GP practices, primary and community care partners, social care partners, local people and communities to work in partnership to pilot the transformation of primary and community care. This pilot Programme had a number of key elements and aims – these are detailed in **Appendix 2** and include:

- Creation of integrated locality Community Care teams
- Review of intermediate care provision to increase access
- Provision of skills training, sharing skills, up skilling staff and support for new ways of working
- Pop-up experiment to achieve genuine integration of mental health, social care, primary care and community health services focussed on outcomes for people – designed by staff to test something radically different over a limited period of time.
- Partnership working to dissolve the boundaries between organisations.
- Provision of shared IT systems and infrastructure and estates
- Comprehensive communication and engagement for all stakeholders in the programme, in particular the staff and service users.

Following the closure of the New Care Models ‘Vanguard’ programme, a number of lessons have been learned and there are several key recommendations to take forward (see the [‘Sharing the Biscuits’](#) report for more information). A workshop following the ‘Vanguard’ developed an action plan – the ‘Keep Change Transition Plan’ - to maintain momentum in the short term and pave the way for longer-term transformation.

The HaRD CCG has also laid out its vision and commissioning intentions for the next phase of the ambition to deliver a fully commissioned integrated model of primary and community services in the locality in the [‘Your Community Your Care’ Green Paper](#) (February 2018) - see **Appendix 3** for the CCG objectives, ambitions and draft principles to be applied to the integrated care delivery model. The case for change is outlined in this paper -

*“The health and social care needs of our local population are changing. We have a combination of an ageing population, an increase in the number of people with long-term conditions and the changing expectations of our population. Together these increase demand and create pressures on our health and social care system”.*

## Appendix 2 – New Care Models ‘Vanguard’ Pilot – Key Elements and Aims

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- **Community Care teams** – create new integrated locality teams which help prevent avoidable illness, proactively manage long term conditions and maximise functioning, and respond effectively at times of crisis and offer care closer to home.
- **Intermediate care** – review intermediate care provision and access/discharge protocols as good alternatives to acute beds. Increase access to intermediate care provision and rehabilitation beds.
- **Skills and workforce** - provide skills training and support to new and existing staff to support new ways of working and team building. Support first line supervisors to manage change and develop teams that incorporate staff from all partner providers. Identify the opportunities for sharing skills and/or upskilling staff to support efficient delivery of services and avoid duplication across providers, using the Calderdale Framework process to uncover the areas to focus.
- **The pop-up experiment** – achieve genuine integration of mental health, social care, primary care and community health services focussed on outcomes for people. Strengthened leadership, organisational development, workforce development and business change support. New approach designed by the staff. To test something radically different over a limited period of time. The Leadership cell worked in direct support of the pop-up experiment, comprised of front-line, middle and senior leaders from across the Harrogate health and care system, including general practice.
- **Partnership working** - dissolve the boundaries between organisations. Partners working together to improve population health and wellbeing in Harrogate. Trusting relationships. To get the best out of the Harrogate pound.
- **Systems and infrastructure** – create a locality wide shared care record accessed and updated by all partners, covered by a robust information sharing agreement. This would provide a single patient view across all systems. IT infrastructure & estates provision suitable for co-location of staff from partners including access to necessary electronic recording systems. This would support day to day operations of multi-disciplinary teams and more flexible use of estates. Data for inclusion within a range of performance and activity reports through Business Intelligence services
- **Communications and Engagement** - comprehensive communication and engagement for all stakeholders in the programme, in particular the staff and service users.

# Appendix 3 – CCG Objectives, Ambition & Draft Principles

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The CCG '[Your Community Your Care' Green Paper](#)' Green Paper (February 2018) identifies three over-arching objectives to deliver either directly or through their commissioned services.

1. The population has improved health and wellbeing:
  - a. Better health
  - b. Good quality of life
  - c. Reduced inequalities
  
2. The quality of care is high with:
  - a. Effective Care
  - b. Good patient experiences
  - c. Safe care
  
3. The health system is affordable and sustainable by:
  - a. Reducing dependence on health and care services
  - b. Managing demand within resources

Learning from 'Vanguard' and other national models including 'Primary Care Home' sites, the CCG commissioning ambitions for the future local model are:

- Care delivered in practice-centred around populations of 30-50,000 registered patients.
- General practices supported to develop to operate at scale across the district in a federated model, whilst preserving high quality list based personal care.
- Being ambitious about what services could be delivered in the community rather than in a hospital setting, to fundamentally shift the traditional access points and expectations of people who use services.
- A community of clinicians and practitioners from across health and social care services, including mental health, working together to meet the needs of the local population.
- Tactical commissioning enabled through effective local expertise, knowledge and skills available in the community.
- Preservation of acute hospital capacity for those who are critically ill or who need diagnostics and speciality interventions that can only be delivered in a hospital setting.



<b>Draft principles to be applied to the integrated care delivery model</b>	
<b>1</b>	Demonstrates an integrated approach to care to include physical and mental health integrated with social care.
<b>2</b>	Focuses on self-care and prevention to promote independence and reduce pressures on the health and social care system.
<b>3</b>	Clear access points for patients to receive modern health and social care services from co-located teams.
<b>4</b>	Ensures patients have access to high quality services when needed within a simplified system.
<b>5</b>	Works closely with the community and the voluntary sector.
<b>6</b>	Evidence of Alliance Agreement/partnership to facilitate whole system approach.
<b>7</b>	Has effective governance arrangements.
<b>8</b>	Plans to variate flow of money and resources are identified and agreed underpinned by risk/gain share agreements.
<b>9</b>	Uses whole population budgets and is not based on paying for single events (e.g. “procedures”, “admissions”, “attendances”, “contacts”).
<b>10</b>	Describes how outcomes will be achieved within available resources and timeframe.
<b>11</b>	Any shift in activity between providers within the system needs to be balanced by demonstrable shift in resource where required.
<b>12</b>	The change management plan supports staff through change, identifies and introduces any required new skills and promotes innovation.
<b>13</b>	A clear estates strategy that supports delivery of a modern health and care estate.
<b>14</b>	Has a strategic leadership role for General Practice.
<b>15</b>	Enables strong clinical operational leadership, including the GP as the expert generalist with the patient.
<b>16</b>	To improve the quality and efficiency of services enables the sharing of records, data and information including integrating information management and technology.
<b>17</b>	Enables innovation in service provision using technology.
<b>18</b>	Seeks continuous and effective patient and staff involvement where service changes are proposed, ensure consultation in line with legislation and best practice.

# **Appendix 4 – Primary Care Home Model**

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Please see the [National Association for Primary Care](#) website for more information.

Primary Care Home has four key characteristics:

1. Provision of care to a defined, registered population of between 30,000 and 50,000.
2. A combined focus on personalisation of care with improvements in population health outcomes.
3. An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care.
4. Aligned clinical and financial drivers.

# Appendix 5 – Programme Ambitions

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## 1. PROGRAMME BACKGROUND

### What is this Programme about?

- Developing an **integrated/joined up community health and social care service**, which responds to the CCG vision for community services in Harrogate and District ‘Your Community, Your Care’ as well as to the other national and local drivers within the NHS and social care.
- Establishing **hubs in each locality** which comprise **multi-disciplinary teams based around GP practices** and supported by a number of health, social care, voluntary and independent sector and wider public services
- Having a service that is **owned by the community and by all of our colleagues** and delivers **good outcomes** and **value for money**
- Placing the **person and community at the centre** of everything we do based on a **strength-based approach**
- Ensuring **successful collaboration**, whilst partners retain their **own organisational identity**

### Our Commitments

- **Person and community at centre** and designed around needs and assets/strengths based approach
- **Work in partnership** with people who use our services to co-design the new model
- **Support and champion** our community services, managers and staff
- Be **realistic and ambitious** in exploring how we can work together
- Make **joint working and leadership** the norm rather than an exception or an initiative
- **Recognise and address** the very real pressures of service delivery in and around Harrogate and the surrounding areas

### What’s different?

- Commissioners and Providers are working together as an alliance
- This is about the **whole caseload**, rather than part of it
- Most colleagues will remain employed by their existing organisations
- This will be a **genuine alliance** – with people who use services, carers and wider partner organisations
- Together, we are shaping our own destiny: we are doing this for ourselves rather than because we are being told to do so!

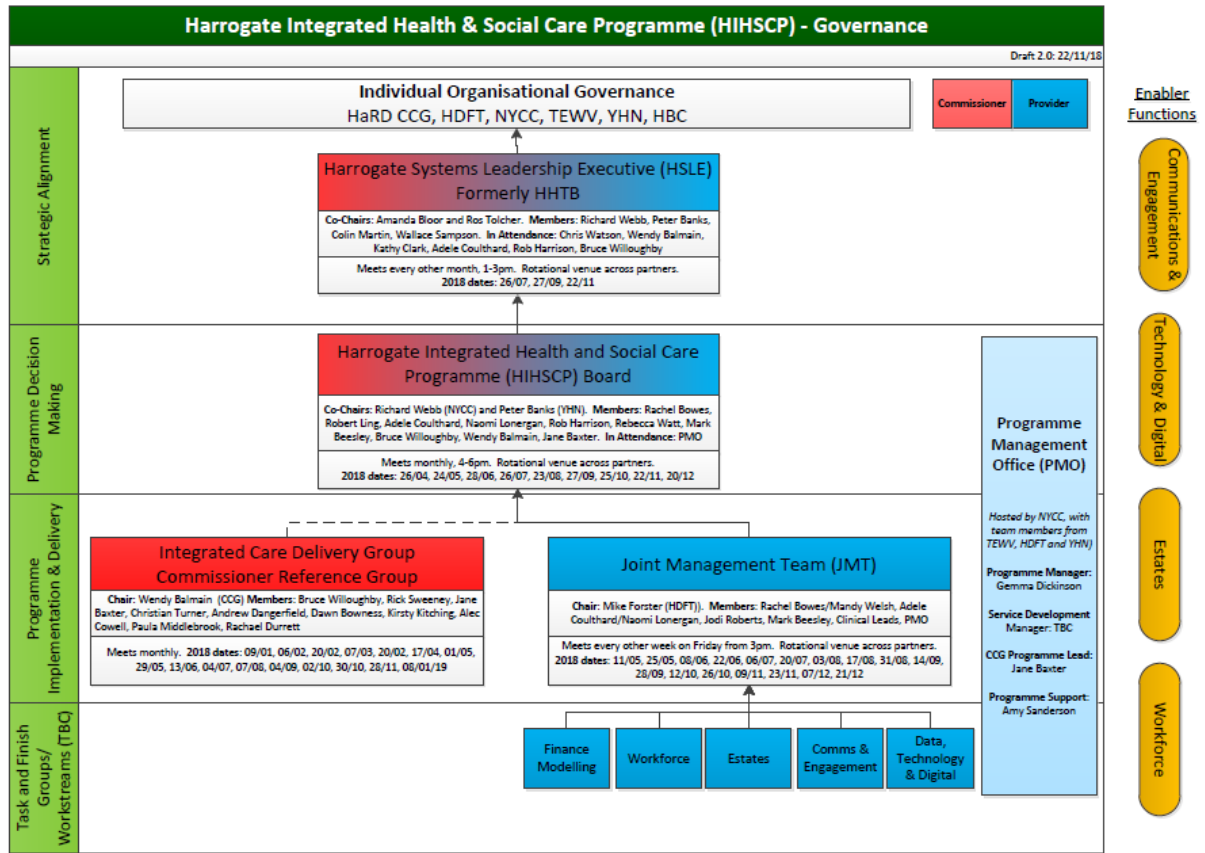
## 2. OUR AMBITION

Our ambition is to create a new integrated community health and social care service for adults in the Harrogate and Rural locality based the commitments we have made. This service will:

- Have prevention as the starting point
- Develop a new model, anchored in primary care, based on Prevention, Planned Care and Unplanned Care, optimising all available resource
- Provide care at home wherever possible

- Focus on population health as opposed to organisations
- Where possible, it will be a GP practice centred model (hybrid model between practices and geography)
- Include GP daily involvement and commitment
- Have active involvement from people who use services and carers

# Appendix 6 – Programme Governance



# Appendix 7 – Benefits Realisation Plan

## Benefits Realisation Plan STATUS KEY

<b>Prog</b>	Harrogate Integrated Health and Social Care Programme	<b>Green</b>	Still on target to achieve benefit	<b>Blue</b>	Benefit no longer applicable / rescinded
<b>Prog Manager</b>	Gemma Dickinson	<b>Amber</b>	Benefit still applicable, however, low/medium risk that it will not be achieved	<b>Purple</b>	Benefit not yet baselined
<b>Date Updated</b>	Dec-18	<b>Red</b>	Benefit still applicable, however, high risk that it will not be achieved	<b>Black</b>	Benefit Realised

No.	Area	Benefit Description	Benefit Measure	Baseline Capture Date	Actions Required to Achieve Measures	Planned Benefit Delivery Date	Actual Benefit Delivery Date	Cashable Y/N	Benefit Owner	Assigned to:	Status	Last Review Date	Comments
1a	PCH model characteristics and benefits will be met	Provision of care will be to a defined, registered population hub (30-50k).	Data mapping / proposed hubs.	01/04/18		01-Apr-20		No	HIHSC PB	Data / HR Subgroups	Green	19-Dec-18	Workforce model is being designed with these parameters in mind.
1b		PCH model characteristics and benefits will be met - A combined focus on personalisation of care with improvements in population health outcomes will be delivered	Population Health Management? Improvement from Self Assessment?	19-Oct-18		01-Apr-20		No	HIHSC PB	Data sub group	Green	19-Dec-18	PHM task and finish group to be set up by RL / BW

1c		An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care, mental health and community services will be created	Integrated workforce in place across Primary Care, NYCC, HDFT and TEWV for adult community services in the Harrogate & Rural locality.	01-Apr-18		01-Apr-20		No	HIHSC PB	HR sub group	Green	19-Dec-18	Changes will progress from Year 1 (April 19) but more radical integration expected from Year 2 (April 2020)	
1d		Clinical and financial drivers will be aligned across partners	Alliance Agreement/S75 Agreement in place.	01-Apr-18	Legal reps to agree approach Jan - Mar 19	01-Apr-19		No	HIHSC PB	Legal Reps	Green	19-Dec-18	Meeting to be schedule Jan 19.	
2	CCG	CCG commissioning and budget requirements will be met. NYCC, HDFT and TEWV budget requirements will be met and GP practices will be resilient and sustainable.	Successful meeting of check point requirements.	01-Apr-18	Programme Management approach to ensure checkpoints met and concerns escalated	01-Apr-20		Yes	HIHSC PB	CCG / Programme Manager	Green	19-Dec-18	Check point 1 requirements met	
3a	The Health & Social Care System will be affordable and sustainable	The H&SC system will be cost effective, within budget, resilient, sustainable and rewarding and attractive to work within (reducing dependence on health and care services, managing	Staffing levels / team capacity available (NYCC/HDFT/TEWV/PC)					No						
3b			Heat in system - number of extra appointments at the end of GP surgeries											
3c			Pressure on service - bed occupancy?											

3d		demand within resources)	HDFT - Stranded/Supper Stranded Patients - patients who've been in hospital more than 7 days and 21 days										
3e		Reduction in avoidable non-elective activity in secondary care	Increase in % of older people (aged 65 and over) who are still at home 91 days after discharge from hospital into re-ablement services	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
3f		Reduction in the average total monthly delayed transfers of care (attributable to either NHS, Social Care or both) per 100,000		TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
3g		Reduction in the number of non-elective admissions for patients in target population cohorts		TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.



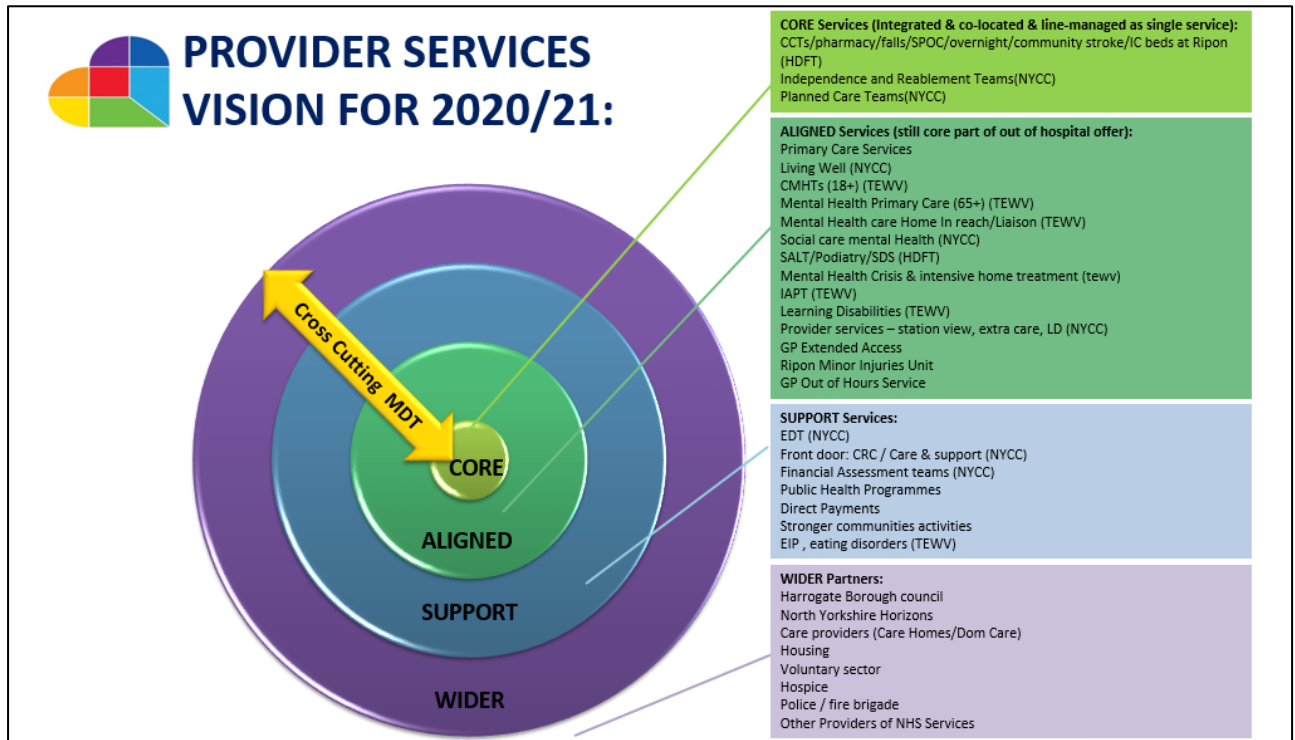
3h		Review of adult social care packages using a strength based model in order to ensure the appropriate individual outcomes are being met	More people receiving social care and having their needs being appropriately met ensuring independence and choice	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
3i			Annual planned reviews are undertaken of packages of care, looking at both quality and value for money	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
4a	The quality of care will remain high	The quality of care will remain high (effective care, good patient experiences, safe care)	Reduction in waiting times?					No					
4b			Effectiveness of interventions - % not going back into services following re-ablement increased										
4c			Effectiveness of interventions - % repeat admissions reduced										
4d			Reduction in hand-offs between partners - how to measure?										

5a	Prevention	Prevention - Contacts Diverted from the Front Door?	<b>Increase in PAM 'activation' score.</b> Patients who are 'activated' are likely to self-care and improve their own risks. Patients who are less activated should be targeted more.											
5b			NYCC - proportion of contacts diverted at the "front door"											
5c			HDFT/TEWV - number of external referrals in? Measures how busy service is?											
6a	Improve the Health and Wellbeing of people in the Harrogate and Rural District (Better health, Good Quality of Life,	Improvement in number of people supported to stay well and live independently wherever possible.	Maintain or reduce permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population.	TBC (by April 2019)	Data/Benefits workshops to be held Jan - March 19	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.	
6b			Reduction in LOS for NEL admissions for targeted cohorts	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.	

6c	Reduced Inequalities)		Reduction in A&E attendances for individuals within the target population cohorts	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
6d		Fewer people die early from conditions considered preventable	Reduce smoking prevalence to 15% or lower by 2021	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
6e			Increase proportion of new cases of cancer diagnosed at stage 1 or 2	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
6f			% of patients on repeat medications who have had a medication review in the last 12 months	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.
7	Create opportunities to deliver more employment opportunities and career pathways to the population.	TBC	TBC	TBC (by April 2019)	To review in Data/Benefits workshops	01-Apr-20		No	HIHSC PB		Purple	19-Dec-18	Workshop sessions set up for Jan- Mar 19.

8a	Empower individuals in relation to their care – improving outcomes and experience for local people.	Improvement in true collaborative working, co-designed with real outcomes	Increase the proportion of carers/patient groups/representatives who report that they have been included or consulted in discussions.	TBC (by April 2019)	TBC Customer Journey Mapping	01-Apr-20		No	HIHSC PB	Comms Sub Group	Purple	19-Dec-18	
8b			Improved patient experience	TBC (by April 2019)	TBC Customer Journey Mapping	01-Apr-20		No	HIHSC PB	Comms Sub Group	Purple	19-Dec-18	

# Appendix 8 – Scope – Core and Aligned Services



## Core Services:

The core services will be fully engaged in the Alliance in that they will work with a one team approach in the defined hub / sub-hub. The service representatives / team members will coordinate activity through MDT / Huddle and allocation of work via the management team. This will provide a response to the person that is centred around them rather than continuing to work as different teams with the same person. Where there are people receiving support who are not known to any of the other core services (and not needing any support from these core services)\*, they will be managed within the business as usual service for the individual partner within the hub. The services within each hub (and where necessary across other hubs) will however share pressures to ensure team-wide resilience and appropriate and timely response for the person.

\*E.g. someone who is receiving complex wound care but with no other health or social care need; or someone needing long term care provision from an independent care provider and associated financial assessment.

## Aligned Services:

These services are part of a county / district wide offer and will contribute to the offer within the Harrogate Alliance area. These services will provide support to the person as and when required and will become involved when the need is identified for the person. This may be through assessment by the core team who make a referral or identified through a huddle and may trigger an involvement to an individual planning MDT for a person with complex needs. (E.g. Tissue Viability Nurse or Mental Health Services).

# Appendix 9 – OBC Options Appraisal Summary

## Overall

Evaluation against the '5-Case' model can be found in below. The '5-Case' model evaluates the options against strategic, economic, commercial, financial and managerial criterion to identify the options that best meet the benefits of the programme. Each option has been assessed for each criterion and scored as follows, with the criteria all of equal weighting:

Assessment	Description of assessment	Score
Green	No additional impact / most desirable outcome compared to other options ( <b>Recommended Option</b> )	4
Yellow	Low additional impact / more desirable outcome compared to other options ( <b>Possible/Recommended Option</b> )	3
Amber	Medium additional impact / less desirable outcome compared to other options ( <b>Not Recommended Option</b> )	2
Red	High additional impact / least desirable outcome compared to other options ( <b>Not Recommended Option</b> )	1

In the first instance 3 key high-level options have been considered to meet the required outcomes and benefits of the programme.

Option	Description of option	Benefits	Risks	Costs (high-level estimated)	"5-case RAG"	Recom'n
A	Do nothing	No benefits	Does not address commissioning intentions of the CCG. Does not meet any of the PCH criteria	No integration efficiency. No impact on travel time/ cost savings in terms of co-location	RED (1)	Not Recommended
B	Procure a new service	Specification could address commissioning intentions of CCG and PCH criteria	Potential lengthy time to undertake exercise. No guarantee of improved models. Undermines existing partner working.	Cost of undertaking procurement may not release best value.	AMBER (2)	Not Recommended
C	Integrated working within existing NHS	Addresses commissioning intentions of CCG and PCH	Timelines to deliver are still tight. Partner engagement	Delivery costs for new model. Programme	YELLOW (3.4)	Recommended

	contracts and NYCC arrangements	criteria. Builds of previous partner working. Potential efficiency savings.	will be vital to success. Partners to agree on the right model and right ways of working	delivery costs.		
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### **Hubs Options Appraisal**

Within Option C above, a number of possible options to implement a Primary Care Home approach have been appraised. These are detailed below in summary. The full options appraisal and data can be found in **Appendix 9**.

A data map was built of the locality to help inform how best to segment the area, based on PCH and other criteria, to meet the commissioning intentions of the CCG.

The data map is interactive and shows:

- Team / practice locations and boundaries
- Travel time by car/public transport for patients and staff
- Public Health data by output area
- Quality and Outcomes Framework (QoF) data
- Registered patients
- Population data

Through the data, a number of segmentation/hub options were identified. A sub-group of the Board was formed with representation across partners to review the data and options to arrive at recommendations.

## Options Summary

OPTION	OPTION DESCRIPTION	TOTAL REG. PATIENTS	TOTAL PRACTICES
1. Do Nothing	Continue to operate within existing system. Make no further changes to the current arrangements in place for collaboration across the GP practices.	162,846	17
2. Segment Harrogate town into 1 Hub	Harrogate is segmented into 1 hub to include Kingswood Surgery, East Parade Surgery, The Spa Surgery, Church Avenue Medical Group, Park Parade Surgery, The Leeds Road Practice, Dr Moss & Partners	80,726	Harrogate Town - 7
3 a Segment Harrogate town into 2 Hubs with Kingswood Surgery in the inner hub.	<u>Hub – Harrogate Inner</u> Kingswood Surgery, East Parade Surgery, The Spa Surgery, Park Parade surgery	Harrogate Inner: 36,328	Harrogate Inner - 4
	<u>Hub - Harrogate outer</u> Church Avenue Medical Group, Leeds Road Practice, Dr Moss & Partners	Harrogate Outer: 44,398	Harrogate Outer - 3
3 b Segment Harrogate town into 2 Hubs with Kingswood Surgery in the outer hub	<u>Hub – Harrogate inner</u> East parade surgery , The Spa Surgery, Park Parade Surgery	Harrogate Inner: 29,578	Harrogate Inner – 3
	<u>Hub – Harrogate outer</u> Kingswood Surgery, Church avenue medical group, The Leeds Road Practice, Dr Moss & Partners	Harrogate Outer: 51,148	Harrogate Outer – 4
4 a Segment Ripon & Masham together and Knaresborough and Boroughbridge together with Nidderdale Group Practice joining with Ripon and Masham	<u>Hub Ripon/Masham/Nidd</u> Nidderdale Group Practice, Ripon Spa Surgery, Dr Akester & Partners, Dr Ingram A J & Partners, North House Surgery	Hub Ripon/ Masham/ Nidd: 39,239	Hub Ripon/ Masham/ Nidd – 5
	<u>Hub Knaresborough/Boroughbridge</u> Church Lane Surgery, Spring Bank Surgery, Eastgate Medical Group, Stockwell Road Surgery, Beech House Sur.	Hub Knaresb/ Boroughbridge: 42,881	Hub Knaresb/ Boroughbridge – 5
4 b Segment Ripon & Masham together and Knaresborough and Boroughbridge together with Nidderdale Group Practice joining with Knaresborough and Boroughbridge	<u>Hub Ripon/Masham</u> Ripon Spa Surgery, Dr Akester & Partners, Dr Ingram A J & Partners, North House Surgery	Hub Ripon/ Masham: 28,758	Hub Ripon/ Masham – 4
	<u>Hub Knaresborough/Boroughbridge/Nidd</u> Nidderdale Group Practice, Church Lane Surgery, Spring Bank Surgery, Eastgate Medical Group, Stockwell Road Surgery, Beech House Surgery	Hub Knaresb/ Boroughbridge/ Nidd: 53,362	Hub Knaresb/ Boroughbridge / Nidd – 6
5. Segment Harrogate town into 2 hubs with Kingswood Surgery in the inner hub and	<u>Hub – Harrogate Inner</u> Kingswood Surgery, East Parade Surgery, The Spa Surgery, Park Parade surgery	Harrogate Inner: 36,328	Harrogate Inner - 4



OPTION	OPTION DESCRIPTION	TOTAL REG. PATIENTS	TOTAL PRACTICES
Nidderdale Group Practice in the Outer Hub. Segment Ripon and Masham together and Knaresborough and Boroughbridge together.	<u>Hub - Harrogate outer</u> Church Avenue Medical Group, Leeds Road Practice, Dr Moss & Partners, Nidderdale Group Practice	Harrogate Outer: 54,879	Harrogate Outer - 4
	<u>Hub Ripon/Masham</u> Ripon Spa Surgery, Dr Akester & Partners, Dr Ingram A J & Partners, North House Surgery	Hub Ripon/ Masham: 28,758	Hub Ripon/ Masham – 4
	<u>Hub Knaresborough/Boroughbridge</u> Church Lane Surgery, Spring Bank Surgery, Eastgate Medical Grp, Stockwell Road Surgery, Beech House Sur.	Hub Knaresb/ Boroughbridge: 42,881	Hub Knaresb/ Boroughbridge – 5

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## Detailed Options Appraisal

OPTION	REG. PATIENTS	PRACTICES	BENEFITS	COSTS	RISKS	"5-CASE RAG"	RECOMMENDATION
1. Do Nothing	162,846	17	No benefits.	No integration efficiency. No impact on travel time/ cost savings in terms of co-location	Does not address commissioning intentions of the CCG. Does not meet any of the PCH criteria	<b>RED (1)</b>	<b>NOT RECOMMENDED</b>
2. Segment Harrogate town into 1 Hub	80,726	Harrogate Town - 7	Avoids artificial divide. Service continuity. Single point of access for patient. Easier management of capacity. Increased collaboration due to proximity of practices and overlap of registered patients. Potential for co-location. Good fit with combined HDFT Harrogate North and South teams. Potential to sub-divide for some functions.	Possible increase in travel time if central hub not identified. Possible cost of multiple hubs.	Exceeds PCH target at 80,726 (NB. PCH have confirmed this is possible). Difficult to establish estates for central hub. Potential lack of alignment for NYCC boundaries	<b>GREEN (3.6)</b>	<b>RECOMMENDED</b>
3 a. Segment Harrogate town into 2 Hubs - Kingswood Surgery in the inner hub.	Harrogate Inner: 36,328	Harrogate Inner - 4	Greater potential for co-location in inner Harrogate. Increasing collaborative working practices could lead to improvements in patient outcomes. Travel is improved. Improved extended access. Meets PCH target registered population sizes. Kingswood fits better with inner from an estates point of view.	Duplication of Harrogate town hub estates. Duplication due to artificial divides	Divisions are artificial Estate option for Harrogate Outer not obvious	<b>YELLOW (3)</b>	<b>POSSIBLE</b>
	Harrogate Outer: 44,398	Harrogate Outer - 3					
3 b. Segment Harrogate town into 2 Hubs -	Harrogate Inner: 29,578	Harrogate Inner - 3	Greater potential for co-location in inner Harrogate Increasing collaborative working practices could lead to	Duplication of Harrogate town hub estates	Divisions artificial. Inner hub slightly under and Outer hub slightly over PCH target. Estate option	<b>AMBER (2)</b>	<b>NOT RECOMMENDED</b>

OPTION	REG. PATIENTS	PRACTICES	BENEFITS	COSTS	RISKS	"5-CASE RAG"	RECOMMENDATION
Kingswood Surgery in the outer hub	Harrogate Outer: 51,148	Harrogate Outer – 4	improvements in patient outcomes. Travel is improved. Improved extended access		for Harrogate Outer not obvious. Kingswood fits better with Inner estates.		
4 a. Segment Ripon, Masham & Nidd together and Knaresborough and Boroughbridge together	Hub Ripon/ Masham/ Nidd: 39,239	Hub Ripon/ Masham/ Nidd – 5	Registered population size meets PCH criteria Fits better with other boundaries/geographies. Potential for better links with Ripon hospital. Recommended due to the geography. Closer cluster – less patient (e.g. physio) /staff travel time. The 'enhanced Primary Care' offer would be more accessible for patients under this structure rather than alternatives. Accessibility / travel time better. Better for potential for extended access - additional primary care services would be available. Better able to allocate resources between GP practices -potential for reduced clinician travel time. The interoperability of the systems exists in the current system and community teams work across more than one system.	Duplication due to use of 2 systems	Use of two systems - currently the two systems do not have interoperability function – duplication. Sharing of staff resources would be impacted as they would be accessing more than one system. Impact on quality of service to patients if systems not aligned. NYCC teams not currently in alignment with boundaries for the hubs. Workload of care homes not spread across the hub due to lower density of care homes. No clear direction from the data to guide where Nidd would best fit - some joint working already in place between Nidd & Knaresb / BB and Nidd is in the KGB cluster.	<b>GREEN (3.6)</b>	<b>RECOMMENDED</b>
	Hub Knaresb/ BB: 42,881	Hub Knaresb/ BB – 5					
4 b. Segment Ripon & Masham together and Knaresborough, Boroughbridge	Hub Ripon/ Masham: 28,758	Hub Ripon/ Masham – 4	HDFT teams split across the Hubs would help to enable sharing of skills across the Hubs. Travel by car/accessibility would be easier to manage. Better fit for systems – Nidderdale would be with other practices on System	NYCC and HDFT boundaries may need to change – <b>IMPACT ON OTHER AGENCIES.</b> Potential additional travel cost of split hubs	Team would be split between hubs - potential impact on travel. No clear direction from the data to guide where Nidderdale would best fit. This option may make it more difficult to determine a single hub	<b>YELLOW (3.2)</b>	<b>POSSIBLE</b>
	Hub Knaresb/ BB / Nidd: 53,362	Hub Knaresb/ BB - 6					

OPTION	REG. PATIENTS	PRACTICES	BENEFITS	COSTS	RISKS	"5-CASE RAG"	RECOMMENDATION
e & Nidd together			One. Some joint working already in place between Nidd & Knaresb / BB and Nidd is in the KGB cluster.		point easily. Doesn't fit easily with NYCC and HDFT boundaries - <b>IMPACT ON OTHER AGENCIES..</b>		
5. Segment Harrogate town into 2 hubs - Kingswood Surgery in the inner hub and Nidderdale Group Practice in the Outer Hub. Segment Ripon and Masham together and Knaresborough and Boroughbridge together.	Harrogate Inner: 36,328	Harrogate Inner - 4	Better fit for systems – Nidderdale would be with other practices on System One. .	NYCC and HDFT boundaries may need to change - <b>IMPACT ON OTHER AGENCIES.</b> Potential additional travel cost of split hubs	Lack of a clear location for a central hub for Harrogate Town Outer – this hub would have a diverse population of rural and urban possibly having different needs. Doesn't fit easily with other organisational boundaries which impacts ability to integrate - <b>IMPACT ON OTHER AGENCIES..</b> Harrogate Outer hub is greater than the recommended PCH size and Ripon/Masham is slightly lower.	<b>YELLOW (2.6)</b>	<b>POSSIBLE</b>
	Harrogate Outer: 54,879	Harrogate Outer - 4					
	Hub Ripon/Masham: 28,758	Hub Ripon/Masham – 4					
	Hub Knaresb/Boroughbridge: 42,881	Hub Knaresb/Boroughbridge – 5					

## 5 CASE MODEL EVALUATION

The benefits, costs and risks against each option are shown above, along with an assessment of how each option meets the “5-case model” criteria for business cases. The “5-case model” assessment has been calculated based on appraisal against the areas below.

Criterion	The proposed option must...	How this criterion applies to this business case
Strategic	Be supported by a compelling case for change that provides holistic fit with other parts of the organisation and public sector	Alignment with other partner strategies / priorities
Economic	Represent best public value for North Yorkshire as a whole (i.e. benefits, dis-benefits, costs and risks), following consideration of a range of options	Economic value of services. Impact of not having the service on those needing support, including potential for cost-shunting to partners / other services to provide other support. Deliverability within contract values.
Commercial	Be attractive to the market and viable to deliver / procure	Impact on and attractiveness to the market
Financial	Be affordable over the lifetime of the service, and with agreed sources of finance and support	Sustainability of the model.
Management	Be achievable, with appropriate governance, plans and resources in place for successful implementation / evaluation, and agreed systems / processes for operation based on proven best practice	Implementation considerations including resource to deliver, timescales and plans.

Each option has been assessed for each criterion and scored as follows, with the criteria above all of equal weighting:

Assessment	Description of assessment	Score
Green	No additional impact / most desirable outcome compared to other options	4
Yellow	Low additional impact / more desirable outcome compared to other options	3
Amber	Medium additional impact / less desirable outcome compared to other options	2
Red	High additional impact / least desirable outcome compared to other options	1

	Description	5-case model evaluation					Total score	Overall “5-case RAG”
		Strategic	Economic	Commercial	Financial	Management		
A	Do Nothing	Does not address commissioning intentions of the CCG. Does not meet any of the PCH criteria	No integration efficiency. No impact on travel time/ cost savings in terms of co-	No procurement. Potential difficulties in terms of attracting	Unlikely to be sustainable in terms of contract cost longer term.	Continue ‘as is’ so no changes to deliver. Will not deliver best practice in terms	5	RED (1)

	Description	5-case model evaluation					Total score	Overall "5-case RAG"
		Strategic	Economic	Commercial	Financial	Management		
			location. Unlikely to be deliverable long term within contract values	and retaining staff.		of lessons from the 'Vanguard' or PCH criteria.		
B	Procure a new service	Does not fit with partnership working ambitions of the key partner organisations. However, specification could address commissioning intentions of CCG and PCH criteria.	Cost of undertaking procurement may not release best value. Deliverability within contract values untested.	Potentially attractive to the wider market but viability untested.	Sustainability untested and dependent on tenders.	Potential lengthy time to undertake exercise. No guarantee of improved models. Undermines existing partner working.	10	AMBER (2)
C	Integrated working within existing contract	Addresses commissioning intentions of CCG and PCH criteria. Builds of previous partner working.	Programme delivery costs. Cost-shunting less likely. Represents best public value as a whole. Model still to be costed to prove value for money.	Workforce ambitions likely to improve ability to attract and retain staff. Viable to deliver.	Potential efficiency savings – improved sustainability.	Timelines to deliver are still tight. Partner engagement will be vital to success. Partners to agree on the right model and right ways of working	17	YELLOW (3.4)
1	Do Nothing	Does not address commissioning intentions of the CCG. Does not meet any of the PCH criteria. Benefits not met.	No integration efficiency. No impact on travel time/ cost savings in terms of co-location. Unlikely to be deliverable	No procurement. Potential difficulties in terms of attracting and retaining staff.	Unlikely to be sustainable in terms of contract cost longer term.	Continue 'as is' so no changes to deliver. Will not deliver best practice in terms of lessons from	5	RED (1)

	Description	5-case model evaluation					Total score	Overall "5-case RAG"
		Strategic	Economic	Commercial	Financial	Management		
			long term within contract values			the 'Vanguard' or PCH criteria.		
2	Segment Harrogate town into 1 Hub	Avoids artificial divide. Service continuity. Single point of access for patient. Increased collaboration due to proximity of practices and overlap of registered patients. Potential for co-location. Good fit with combined HDFT Harrogate N & S teams. Potential to sub-divide for some functions.	Best value as avoids artificial duplication and makes best use of existing organisational structures. Limited changes to partner boundaries. May be difficult to establish estates for one central hub – may require more than one. Potential lack of alignment for NYCC boundaries.	Attractive to deliver as does not create artificial divide. Easier management of capacity and good fit for all organisations.	Possible increase in travel time if central hub not identified. Possible cost of multiple hubs. Exceeds PCH target at 80,726 (NB. PCH have confirmed this is possible) – sustainability to be tested.	Avoids artificial divide and potential duplication and mostly fits with existing arrangements.	18	GREEN (3.6)
3a	Segment Harrogate town into 2 Hubs - Kingswood Surgery in the inner hub.	Meets PCH target registered population sizes. Greater potential for co-location in inner Harrogate. Increasing collaborative working practices could lead to improvements in patient outcomes. Improved extended access.	Not optimum best value as artificial divisions will cause duplication.  Estate option for Harrogate Outer not obvious	Less attractive to deliver due to artificial divide. Likely to fit ok with most organisations but may create an additional divide for some.	Duplication of Harrogate town hub estates. Duplication due to artificial divides. Travel is improved. Kingswood fits better with inner from an estates point of view..	Potential for duplication given the artificial divide.	15	YELLOW (3)

	Description	5-case model evaluation					Total score	Overall "5-case RAG"
		Strategic	Economic	Commercial	Financial	Management		
3b	Segment Harrogate town into 2 Hubs with Kingswood Surgery in the outer hub	The 2 hubs are slightly above and below the PCH recommended registered population sizes - inner hub slightly under and Outer hub slightly over PCH target. Divisions artificial. Increasing collaborative working practices could lead to improvements in patient outcomes. Improved extended access. Greater potential for co-location in inner Harrogate	Not optimum best value as artificial divisions will cause duplication.  Estate option for Harrogate Outer not obvious.  May be additional cost as Kingswood fits better with Inner estates.	Less attractive to deliver due to artificial divide. Likely to fit ok with most organisations but may create an additional divide for some.	Travel is improved. Duplication of Harrogate town hub estates – may be less affordable as additional estates costs may be created with Kingswood in Outer.	Potential for duplication given the artificial divide.	10	AMBER (2)
4a	Segment Ripon, Masham & Nidd together and Knaresborough and Boroughbridge together	Registered population size meets PCH criteria Fits better with other boundaries/geographies. Potential for better links with Ripon hospital. Recommended due to the geography. Closer cluster – less patient (e.g. physio) /staff travel time. The 'enhanced Primary Care' offer would be more accessible for patients under this structure	Duplication due to use of 2 systems – may be a risk to implementation and add to costs therefore decreasing value for money.	Attractive to deliver as best fit organisational boundaries (except NYCC) and existing geographies.	Use of two systems - currently the two systems do not have interoperability function – duplication. Sharing of staff resources would be impacted as they would be accessing more than one system. Impact on quality	Best fit with most organisational boundaries (except NYCC) so good implementation fit.	18	GREEN (3.6)



	Description	5-case model evaluation					Total score	Overall "5-case RAG"
		Strategic	Economic	Commercial	Financial	Management		
		rather than alternatives. Better for potential for extended access - additional primary care services would be available. The interoperability of the systems exists in the current system and community teams work across more than one system. Workload of care homes not spread across the hub due to lower density of care homes. No clear direction from the data to guide where Nidd would best fit - some joint working already in place between Nidd & Knaresb / BB and Nidd is in the KGB cluster.				of service to patients if systems not aligned. Accessibility / travel time better. Better able to allocate resources between GP practices - potential for reduced clinician travel time.		
4b	Segment Ripon & Masham together and Knaresborough, Boroughbridge & Nidd together	The 2 hubs are slightly below and above the PCH recommended registered population sizes – Ripon/Masham slightly under and Kn/BB/Nidd hub slightly over PCH target.	Does not represent best value for money as the team would be split between hubs - potential impact on travel. No clear direction from the data to	Attractive to deliver as some joint working already in place between Nidd & Knaresb / BB and Nidd is in the KGB cluster.	NYCC and HDFT boundaries may need to change - <b>IMPACT ON OTHER AGENCIES.</b> Potential additional travel cost of split hubs	Reasonable implementation fit given Nidd's existing working practices but <b>IMPACT ON OTHER AGENCIES</b> of Nidd in the	16	YELLOW (3.2)

	Description	5-case model evaluation					Total score	Overall "5-case RAG"
		Strategic	Economic	Commercial	Financial	Management		
		HDFT teams split across the Hubs would help to enable sharing of skills across the Hubs. Better fit for systems – Nidderdale would be with other practices on System One.	guide where Nidderdale would best fit. This option may make it more difficult to determine a single hub point easily. Doesn't fit easily with NYCC boundaries.		but travel by car/accessibility would be easier to manage.	Kn/BB hub – other organisations likely to need to change boundaries.		
5	Segment Harrogate town into 2 hubs - Kingswood Surgery in the inner hub and Nidderdale Group Practice in the Outer Hub. Segment Ripon and Masham together and Knaresborough and Boroughbridge together.	Harrogate Outer hub is greater than the recommended PCH size and Ripon/Masham is slightly lower. Better fit for systems – Nidderdale would be with other practices on System One. Doesn't fit easily with other organisational boundaries which impacts ability to integrate.	Less desirable in terms of value for money. Lack of a clear location for a central hub for Harrogate Town Outer – this hub would have a diverse population of rural and urban possibly having different needs.	Less attractive to deliver as doesn't fit with existing boundaries and Harrogate Town Outer would have a diverse population with potentially different needs.	NYCC and HDFT boundaries may need to change - <b>IMPACT ON OTHER AGENCIES.</b> Potential additional travel cost of split hubs	Difficult to implement due to <b>IMPACT ON OTHER AGENCIES</b> and diverse needs of the recommended Harrogate Town Outer hub.	13	YELLOW (2.6)

## **Outline Business Case – Recommended Options**

The options below represent the best fit given the analysis of the data. The recommended options will be worked up in more detail for the Final Business Case and used as a framework for discussion for hub development sessions to be held with staff and partners in September/October 2018. These sessions will be vital to test the assumptions and the recommendations and to develop an achievable and sustainable model for delivery.

**Option C** - integrated working within existing NHS contracts and NYCC arrangements is recommended. Within this option, several hub options have also been appraised. The recommended segmentation/hub options represent the best fit for all of the partner organisations. They are:

- **Option 2** – One Harrogate town Hub (with possible sub-divisions for certain functions)
- **Option 4a** – Ripon/Masham/Nidd Hub and Knaresborough/Boroughbridge/Green Hammerton Hub

However, it is recommended that:

- Further risk assessment is needed to determine impacts of a hub larger than the PCH recommendation (Option 2). Work is also required to look at potential sub-divisions. If the risk is too high, Option 3a (or 5) will be recommended.
- GP practices are to be consulted with to determine which of the hubs they feel would be the best fit to join with. However, the data shows the recommended options to be the best fit for all partner organisations. GP practices should be made aware of the disproportionate impact and cost on other agencies of alternative options and mitigations will need to be identified.

# **Appendix 10 – OBC Options Appraisal**

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See separate document.

DRAFT

# Appendix 11 – Workforce Modelling Proposal

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## Summary Report Harrogate & Rural Alliance – Initial Outline of Workforce Model HIHSC Programme Board, 21 November 2018

### Purpose

The purpose of this report is to summarise the initial proposals regarding a workforce model to support the requirements for an integrated service model from 1<sup>st</sup> April 2019.

### Background

A Workforce Subgroup has been formed to develop a workforce response to the service design outputs from the Hub Development sessions and HIHSC Programme Board. The first stage has involved undertaking an audit across partner organisations to establish a baseline understanding of the existing workforce. This workforce data has been mapped against the initial agreed boundary representing the Harrogate and Rural ‘super’ localities (represented as Locality A and B for the purpose of the workforce model).

Taking into account the existing staffing profile and organisational boundaries, and the proposed locality boundary, an initial exercise has been undertaken to consider the best fit of the NYCC social care and HDFT community teams to deliver an integrated service model. For core services, the initial outline model articulates the roles working in the localities, area-wide roles, integrated management roles, and the associated budget FTE. It is intended to be used as a framework to demonstrate the scope of roles in the localities and area-wide structure, for further testing and validation.

### Summary

There are two diagrams in the Appendices which outline the overall workforce for core services (Appendix A, below), and the proposed allocation of workforce within each locality (Appendix B, below).

A comparison of organisational boundaries indicates there is not an obvious alignment between NYCC and HDFT teams. This is particularly apparent for the NYCC Independence teams whose boundaries run vertically across the area; it is also a challenge for Planned Care teams. The modelling proposes aligning the NYCC adult social care teams (Independence & Planned Care) to HDFT boundaries by allocating a percentage of resource proportionate to the population size. For example, the Harrogate North Planned Care team boundaries span Locality A and B; a 60:40 allocation of staffing is proposed based on the population size which falls into each locality.

In addition to the outline workforce model, the Workforce Subgroup has identified a number of areas which need to be addressed to ensure the model can effectively support service delivery from 1<sup>st</sup> April 2019. This is based on knowledge of challenges for the current workforce, as below.

Workforce Challenges	Proposed Actions
Feedback suggests that existing levels of District Nurse capacity meets scheduled activity but does not adequately support levels of unscheduled activity	Test the workforce model with HDFT & NYCC activity data to quantify capacity issues
Challenges relating to recruitment and retention of District Nurses; recent turnover, proportion nearing retirement, and context of continued	Identify opportunities to improve employment proposition for DN's as part of a whole system approach

<b>Workforce Challenges</b>	<b>Proposed Actions</b>
organisational change suggests need to stabilise workforce and further develop DN pipeline	Develop robust comms & engagement plan including co-production of service model with staff
Vacancy levels within Reablement teams remain high (particularly Harrogate Dale & Central)	As above – look at opportunities to improve proposition to attract staff. Explore opportunities to join up recruitment activities between C&SW's and HCA's
Community Nursing teams would be enabled by KIT and technology which more effectively supports remote working. Specific suggestions include: visibility of shared records and ability to access / update records in real time	Undertake IT audit to ensure all staff are operating with the same IT KIT & functionality to support remote working
Insight suggests that additional specialist nursing capacity would support the overall model by aligning the skills profile more closely to local health needs e.g. Respiratory Nurse in the community	Review the workforce model against local disease profile information and activity data to further understand skills gaps and workforce requirements
Service managers have highlighted feedback from staff who feel the impact of various models being piloted/implemented previously. There is a need to take on board the key learnings (e.g. Vanguard pilot in Knaresborough) and communicate how these have been applied	Review the model piloted in Knaresborough as part of workforce model testing. Act on cultural learnings from previous models in development of OD programme and comms & engagement plan.

A further stage of work is required to test and validate the initial outline workforce model. This work, including a review of activity data, will help identify longer term workforce solutions to current challenges through applying a whole system approach, and exploring opportunities to review roles and skills mix. At the next meeting in December the Workforce Subgroup will review the model in terms of activity data, disease profile information, and feedback received from the Board.

#### **Recommendations and Decisions Required**

1. Agree the proposed outline workforce model that will inform staffing costs for the Business Case (Year 1)
2. Agree the proposed Workforce Action Plan (Appendix C, below); including actions required to further develop the workforce model and ensure appropriate resource levels for 1<sup>st</sup> April 2019

#### **Areas of Clarification Required**

1. Single Point of Access; existing staffing does not currently support an integrated SPOA function. If this is a requirement for the service model for Year 1, current HDFT staffing may not be sufficient, and proposed staffing for this function would need to be reviewed
2. Boundary Re-alignment; there is a need to review the impact of the proposed model on organisational boundaries and, taking into consideration the context of previous/recent organisational changes, determine what is appropriate in terms of re-aligning boundaries and impacts for staff (the initial outline workforce model results in changes to team boundaries but is not expected to result in any changes to work bases).

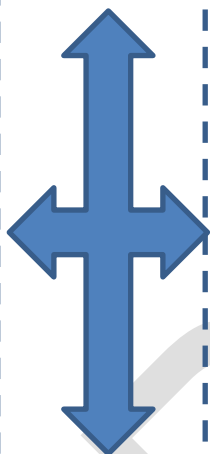
Justine Brooksbank  
Assistant Chief Executive (Business Support), North Yorkshire County Council

# Appendix A - Harrogate & Rural Alliance Integrated Organisational Structure

## Aligned Services

- Primary Care Services
- Living Well (NYCC)
- CMHTs (18+) (TEWV)
- Social Care Mental Health (NYCC)
- SALT/Podiatry/SDS (HDFT)
- Mental Health Crisis & intensive home treatment (TEWV)
- IAPT (TEWV)
- Learning Disabilities (TEWV)
- Provider services – station view, extra care, LD (NYCC)
- GP Extended Access
- Ripon Minor Injuries Unit
- GP Out of Hours Service

Cross Cutting MDT's



## Core Services

### Integrated Management Structure (Budget FTE)

Alliance Director (1 FTE)  
 HDFT Clinical Locality Managers (Harrogate 1 FTE, Rural 1.67 FTE)  
 HDFT Clinical Therapy Lead (1 FTE)  
 NYCC Head of Locality (1 FTE)  
 NYCC Service Managers – C&S (2 FTE)  
 NYCC Team Managers – C&S (7 FTE)  
 Reablement Managers (3 FTE)  
 HDFT Community Matron (1 FTE)  
 HDFT Service Manager (1 FTE)

### Roles within Localities (Budget FTE)

Community Nurses (40 FTE)  
 District Nurses (14.9 FTE)  
 Health Care Support (32 FTE)  
 Independence Coordinators (10 FTE)  
 Care & Support Workers – Reablement (50 FTE)  
 Community Therapy (12.9 FTE includes allocation for Trinity & Station View + additional 3 FTE rotational roles)  
 Social Care Assessors (38 FTE)  
 Social Care Coordinators (16 FTE)  
 Occupational Therapists (10 FTE)  
 Reablement Team Leaders (5 FTE)

### Area Wide Roles (Budget FTE)

**SPOA & Admin Support:** HDFT 7.72 FTE  
**Specialist Nursing:** Stroke Team (6 FTE), Heart Failure Nurses (1.8 FTE), Continence Team (2.2 FTE), Tissue Viability Nurses (3.8 FTE), Diabetes Nurse (0.2 FTE), Clinical Educator (0.5 FTE)  
**Out of Hours** District/Community Nurse 2.8 FTE, Health Care Support 2.19 FTE

## Support Services

EDT (NYCC)  
 Front door: CRC / Care & support (NYCC)  
 Financial Assessment teams, Direct Payments (NYCC)  
 Public Health Programmes (NYCC)  
 Stronger Communities activities  
 EIP, Eating Disorders (TEWV)

## Wider Partners

Harrogate Borough council  
 North Yorkshire Horizons  
 Care providers (Care Homes/Dom Care)  
 Housing  
 Other Providers of NHS Services  
 Voluntary sector  
 Hospice  
 Police / Fire Brigade

## Appendix B - Harrogate & Rural Alliance Integrated Structure – By Locality (Core Services)

### Locality A (Harrogate)

#### Management Roles

Clinical Locality Manager 1 FTE  
 Care & Support Service Manager 1 FTE  
 Care & Support Team Manager 3 FTE  
 Reablement Manager 2 FTE  
 Reablement Team Leader 2 FTE

Roles	Budget FTE	Actual FTE
District Nurse Band 6	7.1	4.5
Community Nurse Band 5	19	18.32
Occupational Therapist / Physiotherapist HDFT Band 5/6	4.6	3.87
Occupational Therapist NYCC Band 11/12	5	5
Social Care Assessor Band 11/12	16.6	13.32
Social Care Coordinator Band 10	7	6.29
Independence Coordinator Band 7	4.2	4.19
Care & Support Worker Reablement Band 5	21	13.7
Health Care Support HDFT Band 3	15	14.2
<b>Total</b>	<b>99.5</b>	<b>83.39</b>

Average span of control (excluding therapy staff) is 10.54

### Locality B (Ripon & Rural)

#### Management Roles

Clinical Locality Manager 1.67 FTE  
 Care & Support Service Manager 1 FTE  
 Care & Support Team Manager 4 FTE  
 Reablement Manager 1 FTE  
 Reablement Team Leader 3 FTE

Roles	Budget FTE	Actual FTE
District Nurse Band 6	7.8	7.46
Community Nurse Band 5	21	19.62
Occupational Therapist / Physiotherapist HDFT Band 5/6	8.3	5.9
Associate Practitioner Band 4	2	1
Occupational Therapist NYCC Band 11/12	5	5
Social Care Assessor Band 11/12	21.4	17.7
Social Care Coordinator Band 10	9	8.9
Independence Coordinator Band 7	5.8	5.76
Care & Support Worker Reablement Band 5	29	20.47
Health Care Support HDFT Band 3	17	14.96
<b>Total</b>	<b>126.3</b>	<b>106.77</b>

Average span of control (excluding therapy staff) is 11.06



**Appendix C - Harrogate Alliance & Rural Alliance  
Workforce Sub-group High Level Action Plan – Phase 1 (to 1<sup>st</sup> April 2019)**

	<b>Activities</b>	<b>Timeframe</b>
<b>Workforce Modelling</b>	Map existing workforce against Harrogate Alliance & Rural Alliance Locality boundaries, Public Health intelligence and available activity data - Workforce Data Gathering	<b>By 16<sup>th</sup> November 18</b>  October – 16 <sup>th</sup> Nov 18
	Workforce Subgroup to review alignment of existing workforce to the new model - Identify specific resource gaps, challenges and risks to inform detailed workforce planning and risk assessment 16 <sup>th</sup> Nov - Outputs: - Organisational chart with core/aligned roles per locality and integrated management structure - Workforce model – total FTE by role and grade for 1 <sup>st</sup> April 2019	<b>16<sup>th</sup> November 2018</b>  <b>21<sup>st</sup> November 2018</b>
	Workforce Subgroup provide to the Board a workforce model (and financial costings) that will support Day 1 service delivery	<b>21<sup>st</sup> November 2018</b>
	Testing and development of Workforce Model; including review of disease profile information, activity data, exploring skills gaps and workforce requirements	November – December 2018
	Develop and implement detailed workforce plan to ensure safe service delivery and support the transition for Day 1	November 2018 – March 2019
	<b>OD Programme</b>	Development of shared organisational mission / purpose; review alignment of values and behaviours across organisations
	Engagement sessions with staff	January 2019 [to be reviewed in view of winter pressures]
	Plan and deliver an induction programme to support transition to new service - all staff	March 2019
<b>Implement Integrated Management Structure</b>	Recruitment of Operational Manager	December 2018 - January 2019
	Plan and deliver a leadership development programme to support managers/leaders transitioning to the new management structure	January – March 2019

# Appendix 12 – Estates Modelling

## Background

An Estates Subgroup has been formed to develop an estates response to the service design outputs from the Hub Development sessions and HIHSC Programme Board. The first stage has involved undertaking an audit across the key partner organisations to establish a baseline understanding of the existing estates in the Harrogate and Rural district. This data has been reviewed by the group to identify opportunities for co-location and better use of estates across partners to deliver the aims of the new service model.

## Feedback from Hub Development Engagement Sessions

A number of key observations on estates were raised through the hub development engagement sessions with team members, partners, people who use our services and carers. The group has considered these and they have helped formulate the plans and discussions around estates. The feedback is summarised below:

Area	Feedback
Benefits of Co-Location	<ul style="list-style-type: none"> <li>- Encourages greater co-operation across services – access to other services.</li> <li>- Previous co-location worked well at Ripon hosp.</li> <li>- Like the idea of a hub/place in Ripon – one central building (incl. Masham)</li> <li>- Co-location worked really well in Boroughbridge for Vanguard</li> </ul>
Opportunities / Improvements	<ul style="list-style-type: none"> <li>- Review estates &amp; resolve issues with current property – stocktake existing buildings to review how they are best used collectively. We don't collectively understand available estates/capacity.</li> <li>- Some GP practices are at capacity for space – notes to be stored centrally rather than wasting space in hub locations?</li> <li>- Possible co-locating opportunity (Ripon Hospital)</li> <li>- Opportunities to attract development in the rural area (new builds)</li> <li>- Need truly integrated space</li> <li>- Option of multiple geographic locations/bases?</li> <li>- Physical space important to people who use services/carers</li> </ul>
Risks	<ul style="list-style-type: none"> <li>- Practical risks around knowing who is in work.</li> <li>- Risk of 'just throwing people together'.</li> <li>- Need to consider wider resources/facilities around hubs eg. Parking / facilities – important to attracting/retaining staff. Lone working/home visits mean people need cars. E.g. Jesmond House.</li> <li>- Constraints on available estates especially if looking at satellite hubs.</li> </ul>
Other considerations	<ul style="list-style-type: none"> <li>- Co-location key to communication</li> <li>- Need space to use equipment</li> <li>- How to manage rurality?</li> <li>- Buildings to be attractive – recruitment and retention</li> <li>- Physical assessment bays</li> <li>- Ripon Hospital limited by small rooms</li> <li>- Opportunity to link into planning of housing? Can developers help in providing purpose built facility?</li> </ul>

## Current Position

The estates audit identified 91 estates in the Harrogate and Rural district across key partners. The Estates Subgroup reviewed the full list to identify further data and fill gaps, specifically:

- Location
- Partner leasing/owning estate
- Leased or owned (contract end dates and potential break points)
- Size / Capacity
- Current occupation
- Condition
- Opportunity for consideration in the programme

Of the 91 estates, the group identified 13 opportunities.

## Opportunities

Property Name	Comment	Opportunity
1. Jesmond House Offices - Harrogate	Limited options for hot-desking, meeting spaces etc.	Possible
2. 68 High Street, Starbeck	Limited office space	Possible
3. The Orchards, Ripon	May be future opportunity for hot-desking	Yes
4. The Snooker Room, Black Swan Yard (Rear of Ripon Hospital)	Linked to Ripon Community Hospital. Project underway to look at this site - OPE bid.	Yes
5. Manor Road Site, Knaresborough	Some availability for office space.	Yes
6. Boroughbridge Highways Office	Potential hot desk space - need discussions around access and access sites. Good location. Conference room. Not permanent office space though – hot desk / drop in.	Yes
7. Ripon Fire Station	Community room available - Fire Service looking at options for sharing the space.	Yes
8. Ripon Community Hospital	Link to The Snooker Room. Project underway to look at this site - OPE bid.	Yes
9. Jennyfield Health Centre	Some sessional space.	Yes
10. Harrogate Hospital - Briary Wing	TEWV potentially moving out of the space (unlikely to move out before April/May 2020). Consultation underway but will find out from NHS England this month. Should know Feb/March 19 and then can confirm what will be freed up.	Yes
11. Hornbeam Park	HDFT - community teams and records. Opportunity - can use for records management rather than a staff base? Potential project in its own right.	Yes
12. Oak Beck House	Opportunities for hot-desking / meeting room.	Possible
13. Valley Gardens Resource Centre	Potential to re-house some of the records storage here. Limited hot-desk availability.	Possible

The opportunities can be summarised as:

- Hot-desking/Meeting room availability
  - Jesmond House
  - 68 High Street Starbeck
  - The Orchards
  - Manor Road
  - Boroughbridge Highways Office

- Ripon Fire Station
  - Jennyfield Health Centre
  - Oak Beck House
  - Valley Gardens Resource Centre
- Record storage opportunities (potential to free up further space in GP practices etc) – new project opportunity to look at all record management requirements.
    - Hornbeam Park
    - Valley Gardens Resource Centre
  - Potential longer term co-location opportunities
    - The Snooker Room, Black Swan Yard (Rear of Ripon Hospital) / Ripon Community Hospital – this is already a project that needs to be linked in.
    - Harrogate Hospital, Briary Wing
    - GP Practices (should space be freed up through alternative records management arrangements).

The group are also aware of some further new/re-development opportunities that may provide further capacity. The main example of this is an opportunity currently under discussion to bring together 3 GP practices in Harrogate Town – Dr Moss and Partners, Leeds Road and Church Avenue. It is recognised that if this goes ahead it will need to be part of the wider service transformation plans.

### Key Considerations / Next Steps

A number of key considerations have been identified and the Estates Subgroup will review these through the mobilisation stage to pull together a clearer plan for the use of existing estates.

- **Booking rooms** – how will team members secure meeting rooms in estates belonging to other partners?
- **Access** – how will team members access estates belonging to other partners? There is a need to consider ID badges etc.
- **Costs** – in principle, the group recommends that there should be no additional costs to partners for using space collaboratively. Further consideration would need to be given where considering full co-location though (this is likely to be within a separate project though).
- **On-going collaboration** – the group recommends that any new major estates changes or procurements from the partner organisations should be brought to the group for discussion and consideration in terms of impact and opportunity for the programme.
- **Culture** – learning from previous experiences of collaborate/co-location suggests some work may be needed to support its sustainability. For example, team members/receptionists need to be clear on issues of confidentiality, expectations around sharing space and benefits. There is a requirement to work with the HR/OD group on this.
- **Kit / technology** – there is a requirement to work with the Data, Technology and Digital group to ensure teams have the right technology to support working from a number of locations. Other considerations include access to printing, access to telephones and consideration of equipment where partners still use desktop machines.

During the mobilisation stage (Jan – March 19) and throughout Year One (April 19 – March 2020) further consideration will be given to estates and potential individual estates projects that need to be initiated to support the development and delivery of the programme aims.

# **Appendix 13 – Data, Technology & Digital**

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In response to the roundtable sessions run as part of the wider engagement programme for the Harrogate Integrated Community Health and Social Care Programme. A number of common themes have been identified from all of the sessions which reinforced the approach and identified further actions to undertake.

Approaches now need to be developed to address the common themes identified:

- Data sharing and consent
- Access to the right employee technology
- Connectivity infrastructure and inclusion
- Employee digital skills and awareness
- Citizen digital skills and awareness

## **1. Data Sharing and Consent**

During the development of the Harrogate Alliance proposition the broader region has been successful in becoming a Local Health & Care Record Exemplar (LHCRE). This is a significant achievement for the region with an £7.4m investment from central government. However a number of the data sharing and interoperability issues between systems will now be handled at the Yorkshire level, the work within the Alliance must align to this broader work.

By March 2020, NHS England expect the Exemplars to have delivered all of the following objectives, and to have demonstrated significant progress towards them by March 2019:

- Health and care professionals involved in a person's care have safe and secure access in near real-time to a comprehensive care record and care plans that have been linked, de-duplicated and normalised to standard coding terminologies, comprising the pertinent individual level information they need to inform their care decisions, when and where they need it, fed from local systems and with links to the other LHCREs;
- That solutions are based on open standards and create a common longitudinal record for an individual regardless of the source systems contributing to that record;
- De-personalised information from the records are being used to support the delivery of population health management approaches;
- Demonstrating the ways in which they have engaged and communicated to the public and evidence that those messages have been heard and understood and any feedback acted upon;
- Citizens and carers are empowered to manage their own care through having access to their own health and care record.

To date, a number of regular groups have been established to which a number of representatives from partner organisations sit. They include the Monthly Delivery Board and the overarching Digital Care Board. A range of engagement groups have also been created to engage with broader stakeholders such as the Architecture Reference Group (28/9), IG Reference Group (21/11), Clinical and Care Professionals Workshop (27/11). North Yorkshire County Council and Harrogate District Trust have put themselves forward for early adopter status.

## **Population Health Management**

Population Health Management (PHM) seeks to improve population health by data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

NHS England have defined three core capabilities for Population Health Management:

- Infrastructure - basic building blocks that must be in place
- Intelligence - Opportunities to improve care quality, efficiency and equity
- Interventions - Care models focusing on proactive interventions to prevent illness, reduce the risk of hospitalisation and address inequalities

Funding has been made available (working assumption £37k) for the Harrogate and Rural District area to be spent this financial year through the West Yorkshire and Harrogate Health and Care Partnership. In order to develop population health management (PHM) capability and capacity, NHS England would like systems to make demonstrable progress by the end March 2019, in applying the PHM development cycle (see Figure below) in order to design care around specific cohorts, including at least one clinical priority (with evidence of how this aligns to local need). Work is now underway to deliver to this timescale. Similar discussions are underway within the Cumbria and North East ICS, including HRW partner organisations.

### **2. Access to the Right Employee Technology**

Access to the right employee technology appears in the main to be sufficiently covered between NYCC, TEWV, and GP Surgeries however access to appropriate mobile technology appears to be limited within HDFT. The next stage of development needs to evaluate the current technology mix to the developing Operating model. Through current discussions a mobilisation fund will be required to ensure that all employees of the Alliance have appropriate technology for launch and an appropriate budget will need to be put aside for a technology refresh during the life of the contract. Further work is also required on the development of the Virtual Huddle approach, sessions are planned to understand the scope of the activity and potential digital solutions. It is proposed to develop a pilot approach into Mowbray Square and Station View to test technology and working practises.

### **3. Connectivity, Infrastructure and Inclusion**

Currently all members of the Alliance are moving to Govroam as a wireless standard to aid cross team working within the current property portfolio with the exception of TEWV. Through discussion with the IT lead at TEWV appropriate contacts have been made to investigate TEWV rolling out Govroam at least within the Harrogate estate.

### **4. Next Steps**

As part of the next stage of the engagement programme it would be advisable to undertake a Digital Skills audit of the broader Harrogate Alliance workforce. It was clear from the roundtable engagement session the wider team has a mixed skill set and a baseline will be required to ensure the correct investment to maximise the benefit of any wider technology investment in the wider project.

# Appendix 14 – Customer Journey Mapping

## Business Change Work Charter

The purpose of this work charter is to describe the work to be undertaken by business change to meet the requirements of the commissioner. The contents of this document may be used to inform the Start Up Work Agreement that is now drafted by a PCO or this document may be used to describe a stand-alone piece of work such as a PIR or one off consultancy.

Document Identification	
<b>Project Title:</b>	Harrogate Integrated Health and Social Care Programme (Harrogate and Rural Alliance)
<b>Project ID:</b>	2081
<b>Directorate / Service Area:</b>	HAS / Partnership
<b>Date(s):</b>	November 2018

Responsibilities	Name
<b>Service Lead:</b>	Rachel Bowes (NYCC); Mike Forster (HDFT); Adele Coulthard (TEWV); Mark Beesley (YHN); Jane Baxter (CCG)
<b>Commissioning DPM / BP / Theme Programme Manager:</b>	Gemma Dickinson
<b>Business Change Analyst / Officer:</b>	Hazel Etherington

### Business Change Work Objectives

State here the objectives for this work (these are not the wider project objectives, rather they are the specific objectives of business change activity to be undertaken.

The Harrogate and Rural Alliance aims to develop and create a new integrated health and social care service model for adults in the Harrogate locality. This will involve changes to how services are delivered with the focus on community led delivery.

The objective of the business change activity is to understand the impact on the service users and carers who will be affected by the changes and how their experience will be altered.

The activities will focus on the areas of highest impact. These have been identified as the Core services:

- NYCC Reablement services
- HDFT Community care services (district nursing)

## Approach / Activities / Planned days and timescale

Describe here the approach to meeting the objectives above, e.g.: undertaking desk research, interviews, workshop, use of specific tools such as CJM, user stories etc. Provide a breakdown of effort (days) against each activity.

The initial work undertaken will focus on understanding how customers currently access and journey through the services (As Is). This will involve a review of existing documentation/case studies and working directly with frontline staff/managers in NYCC HAS and HDFT to understand and document the current customer pathways within the identified core services.

5 - 10 days December 2018 & January 2019

The To Be customer pathways/case studies will be designed to reflect the proposed new integrated working practices for the core reablement and district nursing services. This will involve direct input from frontline staff and managers from NYCC HAS and HDFT. 5 - 10 days January/February 2019

To fully understand the impact of the changes on the customers from their perspective, direct engagement will be required to review the proposed future customer pathways and example case studies. The method for undertaking the engagement is still to be agreed. 5 – 10 days February/March 2019

## Business Change Outputs

List the specific outputs that business change will deliver as a result of completing the work described above.

The outputs will be visual representations of the current and future customer pathways/journeys using a combination of storyboards, rich pictures and customer journey maps supplemented with a summary of the customer engagement outcomes.

### Total Estimated Effort – (days)

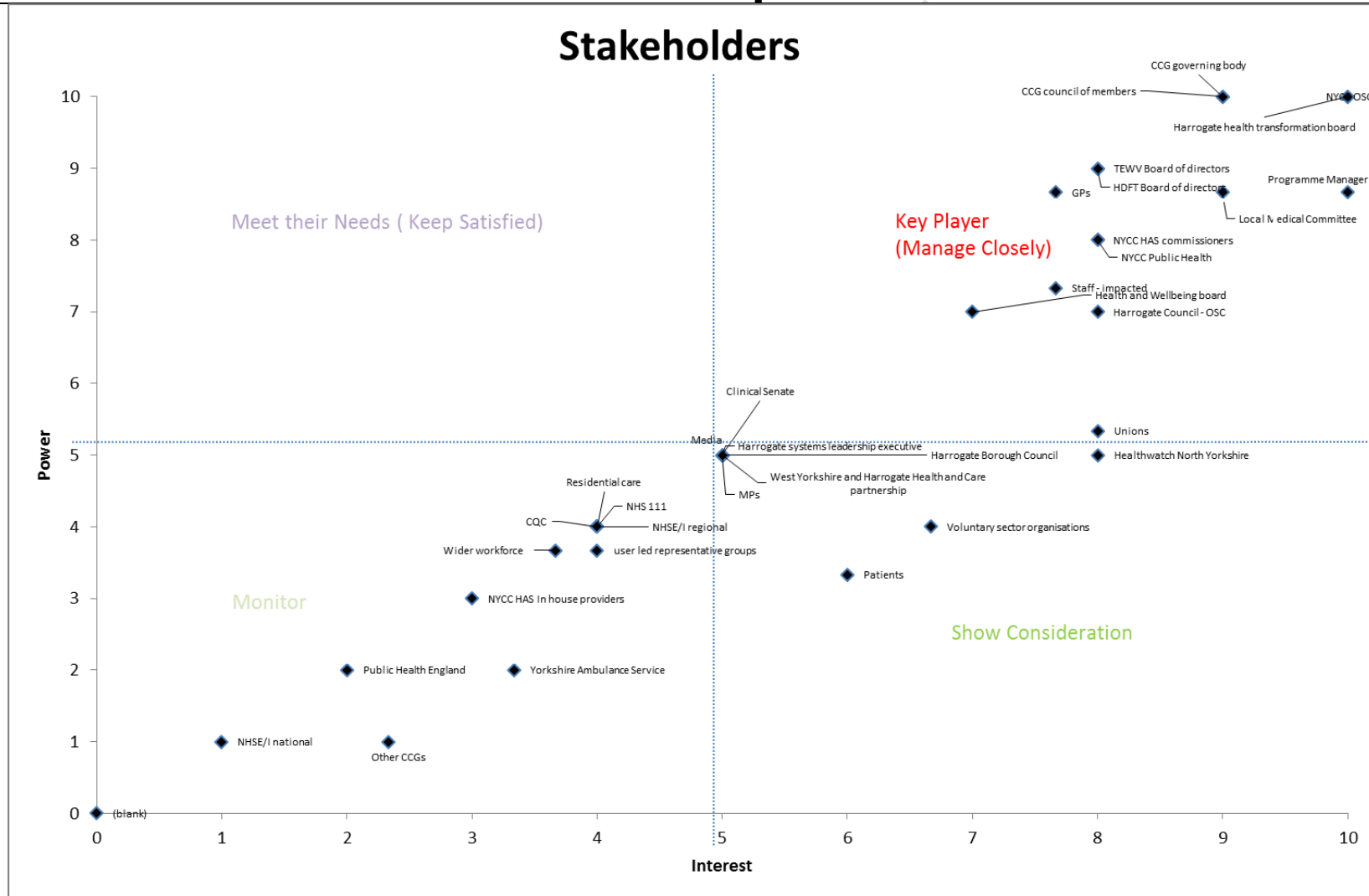
20 days

Signed off by Commissioning DPM /  
BP / Theme Programme Manager:

Date:



# Appendix 15 – Draft Stakeholder Map



# Appendix 16 – Equality Impact Assessment

## Equality impact assessment (EIA) form: evidencing paying due regard to protected characteristics

(Form updated May 2015)

### Harrogate Integrated Health and Social Care Programme

If you would like this information in another language or format such as Braille, large print or audio, please contact the Communications Unit on 01609 53 2013 or email [communications@northyorks.gov.uk](mailto:communications@northyorks.gov.uk).



যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদেরকে বলুন।

如欲索取以另一語文印製或另一格式製作的資料，請與我們聯絡。

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

Equality Impact Assessments (EIAs) are public documents. For NYCC, EIAs accompanying reports going to County Councillors for decisions are published with the committee papers on our website and are available in hard copy at the relevant meeting. To help people to find completed EIAs we also publish them in the Equality and Diversity section of our website. This will help people to see for themselves how we have paid due regard in order to meet statutory requirements.

Name of Directorate and Service Area	Partnership Programme across Health & Social Care - Harrogate & Rural District (HaRD) Clinical Commissioning Group - Yorkshire Health Network (YHN) - Harrogate District NHS Foundation Trust (HDFT) - Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) - North Yorkshire County Council (NYCC) Health and Adult Services (HAS)
Lead Officer and contact details	Richard Webb and Peter Banks
Names and roles of other people involved in carrying out the EIA	Members of the Harrogate Integrated Health and Social Care Programme Board and Joint Management Team.
How will you pay due regard? e.g. working group, individual officer	Via review and discussion via the Harrogate Integrated Health and Social Care Programme Board and Joint Management Team.
When did the due regard process start?	From Programme 'Start Up'

#### Document Version Control

Version No.	Reason for Change	Author	Date
0.1	First Draft reviewed with JMT	Gemma Dickinson	06/12/2018
0.2	Amends from Shanna Carrell (NYCC) and Andrew Dangerfield (CCG)	Gemma Dickinson	19/12/2018

**Section 1. Please describe briefly what this EIA is about** (e.g. are you starting a new service, changing how you do something, stopping doing something?)

This EIA supports the Harrogate Integrated Health and Social Care Programme (HIHSCP). This Programme aims to develop and create a new integrated community health and social care service model for adults in the Harrogate and Rural area, to be delivered through phased implementation from April 2019. The Programme Business Case provides more detail.

The programme is about:

- Developing an **integrated/joined up community health and social care service**, which responds to the CCG vision for community services in Harrogate and District 'Your Community, Your Care' as well as to the other national and local drivers within the NHS and social care.
- Establishing **hubs/segments in each locality** which comprise **multi-disciplinary teams based around GP practices** and supported by a number of health, social care, voluntary and independent sector and wider public services
- Having a service that is **owned by the community and by all of our colleagues** and delivers **good outcomes** and **value for money**
- Placing the **person and community at the centre** of everything we do based on a **strength-based approach**
- Ensuring **successful collaboration**, whilst partners retain their **own organisational identity**

The outcomes will be met through a variety of projects sitting beneath the programme and contributing to the same overall aims. Where appropriate, these projects will develop their own individual EIAs.

**This EIA covers the overall high level programme ambitions over the next few years and the plan for Year One of the Programme (April 2019 – March 2020).** Year One will work across 5 key partner organisations (listed above) within existing contract arrangements to create a joint workforce and management model for 'core services' in the locality<sup>1</sup>. Plans and projects for future years will be scoped in more detail during Year One.

#### **Programme Ambition (overall)**

The ambition for the programme overall is that it will:

- Have prevention as the starting point
- Develop a new model, anchored in primary care, based on Prevention, Planned Care and Unplanned Care, optimising all available resource
- Provide care at home wherever possible
- Focus on population health as opposed to organisations
- Where possible, it will be a GP practice centred model (hybrid model between practices and geography)
- Include GP daily involvement and commitment
- Have active involvement from people who use services and carers

In **Year One**, the 'core' services will be fully engaged and will work with a one team approach in the defined localities within the area. The service representatives / team members will coordinate activity through MDT / Huddle and allocation of work via the management team. This will provide a response to the person that is centred around them rather than continuing to work as different teams with the same person. Where there are people receiving support who are not known to any of the other 'core' services

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<sup>1</sup> 'Core' services include primarily the community teams from HDFT (CCTs etc) and NYCC (Independence and Reablement Teams, Planned Care Teams).

(and not needing any support from these 'core' services<sup>2</sup>) they will be managed within the business as usual service for the individual partner within the locality segment. The services within each locality segment (and where necessary across other locality segments) will, however, share pressures to ensure team-wide resilience and appropriate and timely response for the person.

**Section 2. Why is this being proposed? What are the aims? What does the partnership hope to achieve by it?** (e.g. to save money, meet increased demand, do things in a better way.)

### **The Case for Change – why is this being proposed?**

Integration between health and social care is a fundamental part of both national policy and local strategy and commissioning intentions, with the aim of promoting health and wellbeing, delivering better outcomes for the population, promoting ease of access and ensuring a sustainable system for the future. Nationally and locally, health and social care systems are facing challenges around quality, sustainability and changing population needs.

Historically, care has been constrained by organisational and professional boundaries, resulting in reactive, fragmented and inefficient care. This has often resulted, in a person receiving support from teams working reactively and separately, diagnosing people in silo, where information on these diagnoses and other important health and care information is not shared. This often means the staff within these organisations have additional workload pressures, and have little time to give advice and support regarding self-care and the system often focusses on physical health needs, with social care needs being overlooked or not seen in conjunction with the person's physical needs.

#### **National Drivers for change include:**

- The NHS Five Year Forward View (2014) and update (2017) – sets out aims to integrate health and social care nationally. The NHS Long Term Plan is also expected imminently.
- New Care Models, Sustainability and Transformational Partnerships (STPs) and the evolution of Integrated Care Systems (ICS) – pursuing the aims to integrate.
- GP Forward View – increased investment in Primary Care, GPs working together at scale, working from a more effective platform with other local health and care providers.
- Better Care Fund, Improved Better Care Fund, statutory role of the Health and Wellbeing Board – duties around integration.
- Care Act (2014) – duties around integration. Supporting people to be in control of their care and support. Emphasis on wellbeing. Prevention focus – local authorities and partners required to prevent, reduce or delay the need for care and support for all local people. Wider focus on the whole population in need of care through outcome focussed care and support assessments.
- Adult Social Care Green Paper (expected before the end of the year) – with a key principle to integrate health, housing and care.

#### **Local Drivers for change include:**

- Significant financial challenges across the system despite the delivery of cost saving programmes. The health and social care system overall is challenged in terms of continuing to deliver high quality care within reduced financial envelopes and within the context of austerity.
- Increased pressures on delivery leading to duplication in workforce and limited focus on patient experience. Like most health and care systems in England, Harrogate and Rural District is struggling to match demand and affordable supply.
- Harrogate and Rural district has an ageing population, an increase in the number of people with long term conditions, and the local population has changing expectations.

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<sup>2</sup> E.g. someone who is receiving complex wound care but with no other health or social care need; or someone needing long term care provision from an independent care provider and associated financial assessment.

- System approach from partners to develop an integrated model of care with a focus on person-centred, proactive and coordinated care to improve patient and carer experience and outcomes.
- Strong existing local partnership arrangements that continue to be built upon.
- Regional and local work to align the new partnership approach to Integrated Urgent Care and Integrated Care.
- Learning from the New Care Models ‘Vanguard Programme’ (2015–2018) – see the [‘Sharing the Biscuits’](#) report for more information and key lessons learned). A workshop following the ‘Vanguard’ developed an action plan – the **‘Keep Change Transition Plan’** - to maintain momentum in the short term and pave the way for longer-term transformation.
- HaRD CCG commissioning intentions for the next phase of the ambition to deliver a fully commissioned integrated model of primary and community services in the locality – detailed in the [‘Your Community Your Care’ Green Paper](#) (February 2018).

The value of working together as commissioners and providers locally to bring about change in a meaningful way is recognised. There is a clear desire to build on the strength of the provider and commissioner relationships in the Harrogate and Rural area which have developed through the New Care Models “Vanguard” Programme and other programmes. The aim of continued collaboration across partners is to see a rapid impact and potential benefit for patients through the collaborative approach, putting the best interests of the Harrogate and Rural population first by engaging with local providers to see how improvements can be made.

The Harrogate Integrated Health and Social Care Programme (HIHSCP) has been initiated by the collective of partners to build on the work of the ‘Vanguard’ and other national models such as ‘Primary Care Home’ and deliver this next phase of the ambition. It provides a whole system response to the CCG commissioning intentions laid out in the ‘Your Community, Your Care’ Green Paper.

### **Programme Aims**

The programme aims to build on the learning from the New Care Models ‘Vanguard’ and other national models including ‘Primary Care Home’ to design and develop a new integrated service model for the Harrogate locality to be put in place during 2019. The objectives, are informed by the commissioning objectives and ambitions. The overarching programme objectives are to:

- Establish partnership governance including a Programme Board and Joint Management Team to manage the transformation and operational business across organisations in the locality.
- Maintain momentum and deliver learning from the New Care Models Programme ‘Vanguard’ through completion of the Keep Change Action Plan throughout 2018-19.
- Design and develop a new integrated service model to support the expansion of health and care services, centred on high quality primary care, general practice and health and social care services closer to home.
- Deliver the following aims for **Year One**:
  - Develop detailed workforce modelling for the existing workforce including plans for technology and use of estates to create a joint workforce structure and single management structure for Year One.
  - Develop a phased implementation plan for delivery to include specific projects required. This will include further work to model the current workforce with a view to planning the future state required in Year 2. It may also include further work to audit technology skills and requirements and use of estates. **NB this will be reviewed in separate project EIAs.**
  - Ensure appropriate engagement throughout to inform and develop the recommended model.

- Implement the joint workforce model and continue to develop the new integrated service model for the Harrogate Locality from April 2019 within the existing workforce to meet the programme aims and ambitions.

### **Section 3. What will change? What will be different for customers and/or staff?**

Overall the customer experience should improve – there should be reduced hand-offs between different services and a single point of access. Customer Journey mapping is planned for January – March 2019 to better understand current pathways and ensure the design of future pathways does improve the journey for customers. For staff, it is planned that the changes will improve relationships across services and reduce hand-offs. We also aim to improve current experiences by learning from the lessons of the Harrogate Vanguard Programme.

In comparison to previous integration models, this programme is different because:

- Commissioners and Providers are working together as an alliance
- This is about the **whole caseload**, rather than part of it
- Most colleagues will remain employed by their existing organisations in Year One.
- This will be a **genuine alliance** – with people who use services, carers and wider partner organisations
- Together, we are **shaping our own destiny**: we are doing this for ourselves rather than because we are being told to do so!
- Any changes will be done **in co-production** with people who use our services and carers.

**Section 4. Involvement and consultation** (What involvement and consultation has been done regarding the proposal and what are the results? What consultation will be needed and how will it be done?)

There has already been a significant amount of work to understand what the public want through the 'Vanguard' and previous work. A communication and engagement sub-group has been established to build on this. There will be an on-going need for communication and engagement across organisations and staffing groups and with the public. This group is developing the Communication and Engagement Strategy and Plan for the Programme and has drafted a Stakeholder Map. Further work is needed to establish whether consultation will be required. If a formal consultation is required we would need to adhere to appropriate regulations and timeframes.

#### **Engagement Sessions and Co-Design**

Engagement sessions have been held with team members across organisations, partners, people who use our services and carers during September and October 2018. The feedback from the sessions has helped us to refine the Outline Business Case options to feed into the Final Business Case and mobilisation plans. Further engagement is planned on a quarterly basis and more detailed input for those directly affected will be developed in terms of the OD and Induction Programmes.

The new model will be co-designed and co-owned by colleagues in the service and people who use our services.

#### **Customer Journey Mapping**

A Customer Journey Mapping exercise will take place in the Mobilisation Phase, to be completed by 31<sup>st</sup> March 2019. The objective of this activity is to understand the impact on the service users and carers who will be affected by the changes and how their experience will be altered. The activities will focus on the areas of highest impact – initially the delivery of 'core' services. Through engagement with frontline

staff and managers, and direct engagement with customers, the current 'as is' journeys will be understood and proposals for future 'to be' customer pathways developed.

The outputs will be visual representations of the current and future customer pathways/ journeys using a combination of storyboards, rich pictures and customer journey maps supplemented with a summary of the customer engagement outcomes. This will be used to understand the impact on customers and mitigate and detrimental effects.

**Section 5. What impact will this proposal have on budgets? Will it be cost neutral, have increased cost or reduce costs?**

In **Year One**, the Programme is expected to be cost neutral as existing budgets and contracts will be utilised. There will be some small-scale additional costs to mobilise and implement from April 2019 and these are detailed in the Business Case.

In future years the Programme aims to support partners to meet commissioning and budget requirements so that they remain resilient and sustainable. Any future cost reductions or increased would be detailed in separate project Business Cases with their own EIAs.

DRAFT

Section 6. How will this proposal affect people with protected characteristics?	No impact	Make things better	Make things worse	Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.
Age		✓	Potential risk (added to Risk Log)	<p><b>Overall Demographics</b>  The population in Harrogate Borough is ageing. By 2025, there will be an 18% increase in the population age 65+ and a 5% decrease in the working age group. This will lead to increased health and social care needs with fewer people available to work in health and care roles.</p> <p>Overall, Harrogate Borough has an older population than England, with more residents between the ages of 45-84, and fewer aged under 45. The population has a long life expectancy and low birth rate. There are about 10,400 people aged 65+ with a limiting long term illness (42% of this age group, compared with 50% in England), nearly 40% report that their daily activities are limited a lot because of their illness.</p> <p><b>People who use our services / Carers</b>  This Programme is aimed at Adult Community Services and will therefore impact on adults rather than children and young people. The services tend to impact those who are:</p> <ul style="list-style-type: none"> <li>- Older/Frail</li> <li>- Disabled / working age disabled adults including those with learning disabilities</li> <li>- Living with a Long Term health condition</li> <li>- Living with mental health conditions</li> <li>- Carers</li> </ul> <p>The programme aims to ensure the quality of care remains high; improve the Health and Wellbeing of people involved (Better health, Good Quality of Life, Reduced Inequalities); and prevent, reduce and delay the need for long term use of community health and social care services. Therefore, the programme aims to improve care and outcomes for older people, who are the main users of community health and social care.</p> <p>It is recognised that there is a risk of <b>potential negative impact</b> as some of the proposals may mean that people have to travel further to have better access or the right types of treatments as different hubs /segments /practices may specialise in certain areas. This will be kept</p>



Section 6. How will this proposal affect people with protected characteristics?	No impact	Make things better	Make things worse	Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.
				<p>under review but should ensure that better services are provided for all users. This is potentially a negative impact particularly in light of reduction in public transport and costs (offset by bus passes but not if using community transport). This will be included in consideration of programme controls (risk log etc), needs assessments etc. Increased travel times could also impact on family carers who would have to make arrangements for cared-for person, in their absence, or take more of their time to accompany someone.</p> <p>It is recognised that there is a need to ensure any new locations are fully accessible and also that information is accessible including the ways in which services are contacted (e.g. think about options for people who can't use telephone).</p> <p><b><u>Workforce</u></b> We have an ageing workforce across all partners. However, from 1<sup>st</sup> April 2019 the plans are unlikely to detriment the workforce. Further projects will consider workforce impacts in more detail.</p>
Disability		✓	Potential Risk (added to risk log)	<p><b><u>People who use our services / Carers</u></b> As noted above, the changes aim to improve the quality of care and user experience. This will benefit those who are disabled / working age disabled adults including those with learning disabilities.</p> <p>The programme aims to ensure the quality of care remains high; improve the Health and Wellbeing of people involved (Better health, Good Quality of Life, Reduced Inequalities); and prevent, reduce and delay the need for long term use of community health and social care services. Therefore the programme should not worsen the situation for anyone involved, but aims to make things better.</p> <p>Some of the proposals may mean that people have to travel further to have better access or the right types of treatments as different hubs/segments/practices may offer specialised services. This will be kept under review but should ensure an improved service is</p>

Section 6. How will this proposal affect people with protected characteristics?	No impact	Make things better	Make things worse	Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.
				<p>accessed. (see above comments around travel as this can also be a major issue for people with disabilities).</p> <p><b><u>Workforce</u></b> The programme does not anticipate any adverse impacts on this characteristic. Where individuals are affected reasonable adjustments will be made. From 1<sup>st</sup> April 2019 the plans are unlikely to detriment the workforce. Further projects will consider workforce impacts in more detail.</p>
Sex (Gender)	✓			<p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of sex (Gender).</p> <p><b><u>Workforce</u></b> There is a predominantly female workforce across partners. The proposals are unlikely to impact on the gender profile. From 1<sup>st</sup> April 2019 the plans are unlikely to detriment the workforce. Further projects will consider workforce impacts in more detail.</p>
Race	✓			<p><b><u>Overall Demographics</u></b> Approximately 4% of the population is from black, Asian and minority ethnic groups, compared with 2.8% in North Yorkshire and 15% in England.</p> <p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of race.</p> <p><b><u>Workforce</u></b> The race profile mirrors that of the Harrogate area. The proposals are unlikely to impact on the race profile. From 1<sup>st</sup> April 2019 the plans are unlikely to detriment the workforce. Further projects will consider workforce impacts in more detail.</p>
Gender reassignment	✓			<p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of gender reassignment.</p> <p><b><u>Workforce</u></b> No adverse impact anticipated as a result of gender reassignment.</p>

<b>Section 6. How will this proposal affect people with protected characteristics?</b>	<b>No impact</b>	<b>Make things better</b>	<b>Make things worse</b>	<b>Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.</b>
Sexual orientation	✓			<p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of sexual orientation.</p> <p><b><u>Workforce</u></b> No adverse impact anticipated as a result of sexual orientation.</p>
Religion or belief	✓			<p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of religion or belief.</p> <p><b><u>Workforce</u></b> No adverse impact anticipated as a result of religion or belief.</p>
Pregnancy or maternity	✓			<p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of pregnancy or maternity.</p> <p><b><u>Workforce</u></b> No adverse impact anticipated as a result of pregnancy or maternity.</p>
Marriage or civil partnership	✓			<p><b><u>People who use our services / Carers</u></b> No adverse impact anticipated as a result of marriage or civil partnership.</p> <p><b><u>Workforce</u></b> No adverse impact anticipated as a result of Marriage or civil partnership.</p>

<b>Section 7. How will this proposal affect people who...</b>	<b>No impact</b>	<b>Make things better</b>	<b>Make things worse</b>	<b>Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.</b>
..live in a rural area?	✓			<p>In Harrogate Borough, most of the population (85%) lives within a 30 minute travel time, by public transport, from a general practice. There are about 27,000 residents of Harrogate Borough with longer travel times.</p> <p>The model has been built using data which included travel times to minimise the impact for those living in a rural area. It aims to improve outcomes, but it is recognised that access to public transport is reducing and there is a need to future proof the model. This will need to be an on-going area of consideration.</p>

Section 7. How will this proposal affect people who...	No impact	Make things better	Make things worse	Why will it have this effect? Provide evidence from engagement, consultation and/or service user data or demographic information etc.
				<p>Some of the proposals may mean that people have to travel further to have better access or the right types of treatments as different hubs/segments/practices may specialise in certain areas. They may also mean that workers need to travel further. This will be kept under review but should ensure an improved service is accessed. There is a need to make sure that modelling takes full account of impact of greater distances to travel and the availability of affordable transport options.</p>
...have a low income?	✓			<p>Harrogate Borough is the least deprived district in North Yorkshire but has areas of disadvantage leading to worse health outcomes. There is an 11 year gap in life expectancy between wards and five wards where more than one-in-five children are growing up in poverty (1,250 children). Employment rates are higher than the county (78%) and national (75%) average in Harrogate in 2016/17. However, despite the high levels of employment, rates have decreased by 3% from 2016/17 to 2017/18 in Harrogate.</p> <p>Housing affordability affects where people live and work. It also affects factors that influence health, including the quality of housing available, poverty, community cohesion, and time spent commuting. There is increasing evidence of a direct association between unaffordable housing and poor mental health, over and above the effects of general financial hardship. Housing in Harrogate is becoming less affordable relative to earnings. Harrogate also has one of the highest rates of homelessness in North Yorkshire.</p> <p>The model should improve outcomes overall and therefore income should either have no impact or the situation should be improved for those with a lower income. However, see access/travel comments above. Public transport is expensive and availability is reducing.</p>

**Section 8. Will the proposal affect anyone more because of a combination of protected characteristics?** (e.g. older women or young gay men) **State what you think the effect may be and why, providing evidence from engagement, consultation and/or service user data or demographic information etc.**

There may be a combined impact for older people or disabled working age adults on fixed incomes or more likely to be reliant on benefits. If certain hubs/segments/practices specialise in certain areas there may be an impact. Where some may be able to walk to a service at the moment they may need

to travel further at an increased cost. Further consideration will be given to this as the Programme progresses.

<b>Section 9. Next steps to address the anticipated impact. Select one of the following options and explain why this has been chosen. (Remember: we have an anticipatory duty to make reasonable adjustments so that disabled people can access services and work for us)</b>	<b>Tick option chosen</b>
1. <b>No adverse impact - no major change needed to the proposal.</b> There is no potential for discrimination or adverse impact identified.	
2. <b>Adverse impact - adjust the proposal</b> - The EIA identifies potential problems or missed opportunities. We will change our proposal to reduce or remove these adverse impacts, or we will achieve our aim in another way which will not make things worse for people.	✓
3. <b>Adverse impact - continue the proposal</b> - The EIA identifies potential problems or missed opportunities. We cannot change our proposal to reduce or remove these adverse impacts, nor can we achieve our aim in another way which will not make things worse for people. (There must be compelling reasons for continuing with proposals which will have the most adverse impacts. Get advice from Legal Services)	
4. <b>Actual or potential unlawful discrimination - stop and remove the proposal –</b> The EIA identifies actual or potential unlawful discrimination. It must be stopped.	
<p><b>Explanation of why option has been chosen. (Include any advice given by Legal Services.)</b></p> <p>Overall, the programme aims to improve adult community services in this area. It aims to ensure the quality of care remains high; improve the Health and Wellbeing of people involved (Better health, Good Quality of Life, Reduced Inequalities); and prevent, reduce and delay the need for long term use of community health and social care services. Therefore the programme should not worsen the situation for anyone involved, but aims to make things better or have no adverse impact. However, there are some potential risks noted above around travel and access to services – this will be kept under review and proposals developed to ensure that any impacts are addressed or mitigated.</p> <p>There is a need to continue to review the programme to ensure that there is no adverse impact or potential for discrimination. The programme plans to undertake customer journey mapping and this should provide additional assurance that there is no adverse impact. There will also be a need for individual projects that are scoped throughout Year One to complete their own EIAs as part of the process as they are more likely to affect more immediate and fundamental change.</p>	

**Section 10. If the proposal is to be implemented how will you find out how it is really affecting people? (How will you monitor and review the changes?)**

The customer journey mapping exercise will identify key impacts on the workforce, people who use our services and carers. The consultation and engagement sub-group will also be responsible for continuing to seek the views of those affected throughout the life of the programme. Progress will be monitored through the HIHSCP Board and Joint Management Team, and the EIA will be reviewed throughout the life of the Programme and used as a working document.

**Section 11. Action plan.** List any actions you need to take which have been identified in this EIA, including post implementation review to find out how the outcomes have been achieved in practice and what impacts there have actually been on people with protected characteristics.

Action	Lead	By when	Progress	Monitoring arrangements
Accessibility / Travel times – to keep under review.	JMT	On-going		Via HIHSCP Board and JMT
Review workforce equality data to determine impact.	JMT	March 2019		Workforce Modelling Sub-group / JMT
Complete the Customer Journey Mapping to feed into the Programme and EIA.	H Etherington	April 2019		Via HIHSCP Board and JMT
Review EIA and impacts regularly throughout the Life of the Programme.	HIHSCP Board JMT	On-Going		Via HIHSCP Board and JMT

**Section 12. Summary** Summarise the findings of your EIA, including impacts, recommendation in relation to addressing impacts, including any legal advice, and next steps. This summary should be used as part of the report to the decision maker.

**Section 13. Sign off section**

This full EIA was completed by:

**Name:**  
**Job title:**  
**Directorate:**  
**Signature:**

**Completion date:**

**Authorised by (signature):**

**Date:**



# HARROGATE ALLIANCE

**Health & Social care working together with you across all of our communities**

## Harrogate and Rural District Segmentation / Hubs

Options Appraisal



# Contents

- Aim of Options Appraisal
- Context & Background
- Options Evaluation Criteria
- Overview of Options
- Options Appraisal - Summary
- Recommendations
- Next Steps and Actions
- Supporting Documents – Detailed Options Appraisal





# Aim of Options Appraisal

The role and purpose of the Harrogate Integrated Health and Social Care Programme is:

*To lead and oversee the integration of community health and social care services in Harrogate, build the model and finances to deliver this, and to oversee the Joint Management Team's 'Keep Change Transition Plan'.*

This options appraisal is the first step in developing the model for the integration of community health and social care services in the Harrogate and Rural district locality. It builds on the commissioning intentions of the CCG and national (Primary Care Home) and local (Harrogate Vanguard) best practice. At this stage it provides a high-level overview of potential options for segmenting the locality and developing hubs based on data analysis and input from the partners involved.

The options appraisal and recommendations will be used to develop an Outline Business Case for the Programme. Staff, managers and key partners will be given the opportunity to be involved in designing each locality hub in more detail through development workshops in September and October 2018.



# HARROGATE ALLIANCE

**Health & Social care working together with you across all of our communities**

## Context and Background



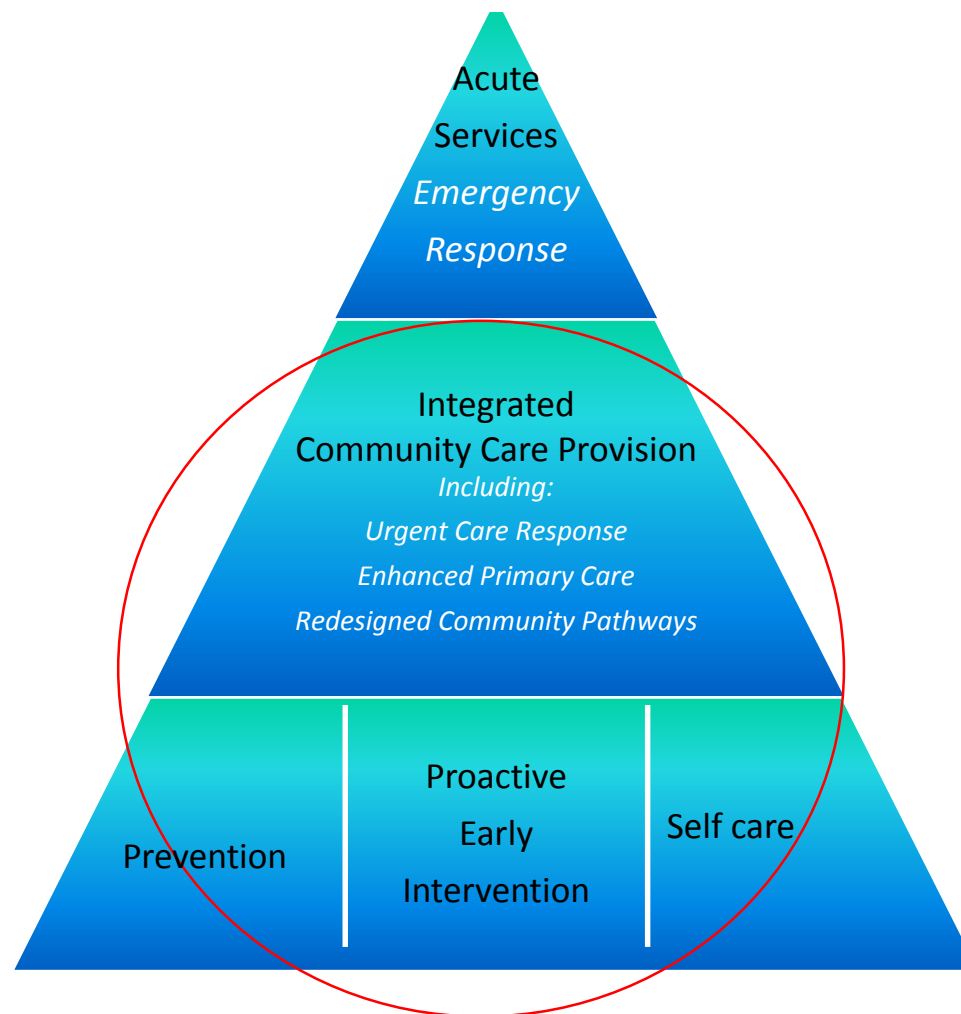
# Our Population – Public Health Data

## In the HaRD CCG area of 162, 000 people:

- A baby girl born between 2013-15 is expected to live to 84.4 (8.1 years gap between most and least deprived areas).
- For a boy [life expectancy](#) is 80.9 (7.7 years gap between most deprived to least deprived)
- 1,920 children living in poverty (7.45%)
- An ageing population with 1 in 5 people aged over 65. This is 10 years ahead of the national profile
- 23,464 people living with long-term health problem or disability of these 63% of them are aged 65 and over
- Woodfield ward in Harrogate is within the 20% most deprived wards in England
- High proportion of people registered with dementia (1.2%), learning disabilities(0.64%) , asthma (7.8%), depression(9.43%) and diabetes (6.6%)
- A high proportion of inpatient admissions are due to general surgery, gastroenterology and geriatric medicine
- A high proportion of A&E admissions are related to injuries/fractures, cardiac conditions, gastrointestinal conditions etc.
- Major killers are circulatory diseases (CHD, Stroke, heart failure etc.), cancer, respiratory diseases. Lots of these deaths can be prevented through early identification and prevention
- Premature mortalities in under 75 are due to cancer, circulatory and respiratory diseases.



# Commissioning Integrated Care: CCG's Approach





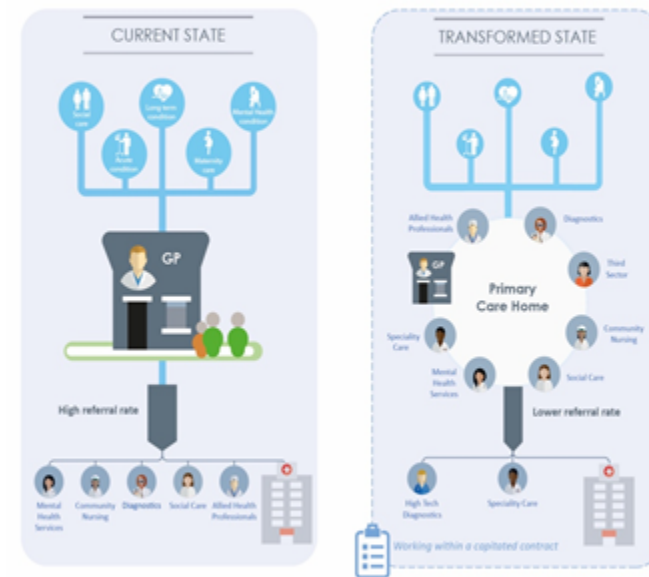
# Delivery through a 'primary care home' – like approach

## Delivery through a 'primary care home'- like approach



## PCH has four key characteristics

- 1 provision of care to a defined, registered population of between **30,000 and 50,000**.
- 2 a combined focus on **personalisation of care** with improvements in **population health outcomes**
- 3 an **integrated workforce**, with a strong focus on partnerships spanning primary, secondary and social care
- 4 aligned **clinical and financial drivers**;



01/03/2018 | John Pope and Cathy Wybrow



# Features

- Primary care home-like model
- Shared vision
- Alignment of workforce
- Co-location
- Clinically led and input into hubs and MDTs, working across practices to serve neighbourhood. Consultant time in community
- Geriatricians and psychiatrists working alongside integrated hubs and primary care
- Population-based: 30-50k
- Hubs with: primary, mental health, community services, social care, VCS
- Paramedics
- Urgent response to avoid admission
- Integrated NHS and social care therapy service
- Coherent planned community response
- Better infrastructure
- Flex access to beds
- Clarity over what's free and what's charged for
- Care navigator operating across the system not for each organisation
- Practices share workload between them
- Generic roles across NHS and social care: generic set of skills
- Trusted assessor model e.g. NHS staff member can switch on care package and vice versa
- Common assessment: assessing person's needs not for the service
- More complex left within hospital
- Establish clear clinical governance and manage risk insurance/risk/indemnity issues explicitly
- Therapy: bring together
- Avoiding the experience of multiple SPOAs (even if there are multiple SPOA!)
- Community services case managed and 'owned' even when going into hospital: no hand-offs until service ends
- Prevent-reduce-delay principles: don't assume a package of NHS/social care is the right or only solution
- Team around the person
- Use of total resource more efficiently and effectively
- Career pathway opportunities and workforce development across the system



# Primary Care Home – Case Studies (1)

Organisation	Number of PCHs	Population	GP practices	Partnership	What they did	Lessons learnt
<b>The Healthy East Grinstead Partnership</b>  Sussex and East Surrey	1	40,000  (struggling to recruit and retain staff and cope with increasing demand from ageing population with long-term conditions)	4	4 GP practices, CCG, acute, community and MH trusts, council, ambulance trust, fire and rescue service, voluntary sector	Community nursing team and MDT care team merged with a focus on patients at highest risk of hospital admission. Provide joined up care, treating people at home. Care co-ordinators used in practices to sign post patients.	<ul style="list-style-type: none"> <li>Requires time to develop relationships</li> <li>Collaborative mind-set is essential</li> <li>Buy-in from staff comes from explaining specific changes and benefits to teams and individuals.</li> </ul>
<b>Team BDP</b>  Cheshire and Merseyside	1	33,300  (Semi-rural population. Variations in hospital admissions and LOS, lack of community coordination )	4	East Cheshire GP practices, acute and community trusts, ambulance service	Practices teamed up with health and social care professionals from many different backgrounds to provide a co-ordinated service. Providing as much care within the home and local community. MDTs assess the most frail and complex patients, including those at risk of falling and people with long term conditions. A joint call and advice centre has been established to direct patients.	<ul style="list-style-type: none"> <li>GPs don't like being left behind.</li> <li>Peer support has encouraged all other practices to form community hubs.</li> </ul>
<b>Larwood and Bawtry</b>  South Yorkshire and Bassetlaw	1	35,000  (High levels of deprivation and disease)	2	Primary care, acute and community trusts, CCG, county council, district council, voluntary sector	2 GP surgeries created integrated teams co-locating community and voluntary services in the practices. Community matrons and community nurses worked with practice nurses to form integrated neighbourhood teams. Community advisors work from surgeries running citizens advice clinics. Also working with district council to support people with housing needs. Social care clinics are held on site to reduce waiting time for assessments. A practice pharmacist carries out medication reviews in care homes. Joint training with the integrated teams.	<ul style="list-style-type: none"> <li>Need to engage with staff and have a 'do and build' attitude.</li> <li>Co-location of integrated teams has a huge impact on joint working, increasing skills and sharing of patient information.</li> </ul>



# Primary Care Home – Case Studies (2)

Organisation	Number of PCHs	Population	GP practices	Partnership	What they did	Lessons learnt
<b>Thanet Health and Community Interest Company</b>  Kent and Medway	4	144,000 (Elderly population with deep pockets of deprivation. 40% is over 60 years. Recruitment problems, Practices closing, huge pressures on existing staff)	14	Primary Care, acute, community and MH trusts, CCG, police, county council, ambulance, voluntary sector, hospice, local pharmaceutical, dental and ophthalmic committees	An integrated nursing team established to provide an enhanced frailty pathway and an acute response team created to provide a range of treatment and personal care support to keep people out of hospital. The team is a GP, nurses, health care assistants, physiotherapist, OT, voluntary care and care agency working closely with social services. They assess patients and put a package of care in place to enable them to remain in their home or be discharged.	<ul style="list-style-type: none"> <li>Commitment and buy-in from all organisations involved, effective staff engagement, commitment and leadership from CCG.</li> </ul>
<b>Granta and Shelford</b>  Cambridgeshire and Peterborough	1	42,000  (Historic model of small practices was unsustainable)	2	Practices, acute and community trusts, community services	Communication with local acute hospital trust has been improved and projects underway include collaborative delivery of paediatrics, ENT services and ophthalmology. PCH has extended surgery hours, giving patients access from 6.30am to 8pm. Two emergency care paramedics are available to make home visits.	<ul style="list-style-type: none"> <li>Partners and staff had to change long standing habits to accommodate new ways of working.</li> <li>Operational executive of 3 partners and a senior practice management set up with delegated authority to run the organisation.</li> </ul>
<b>Beacon Medical Group</b>  Devon	1	33,000  (GPs frustrated with fragmentation of local services. High demand for GP appts which did not need GP expertise)	1	One practice, acute, community and mental health trusts, CCG, City council, local pharmaceutical committee and voluntary sector	Expanded urgent care team – GPs, a paramedic, nurse practitioners and pharmacists. Screen all patients seeking on the day appointments on the phone and invite in those who need to be seen. GP and pharmacist carry out weekend ward rounds visiting patients most at risk of hospital admission. PCH holds monthly MDT team meetings to discuss patients of particular concern and agree plans. Psychiatrist is based in surgeries 2 days a week.	<ul style="list-style-type: none"> <li>Willingness to take risks and take on new initiatives without waiting for full funding to drive visible change.</li> </ul>





# Scarborough Model – Shared Learning

## Scarborough & Ryedale Community Health and Social Care Partnership





# Scarborough – the final model

- 4 hubs – 3x4 practices and 1x3 practices
- Planned and crisis interventions (intermediate care) from each hub
- 8-8 service from each hub (7 days/week)
- Reduced Nursing/Generic Worker cover overnight across hubs
- In-reach Discharge Facilitators linked to multiple hubs
- Integrated generic health and social care workers
- Enhanced prevention offer e.g. Living Well, Income Maximisation, Mental Health, across hubs, with direct links
- Community beds in Malton Hospital (reduced) and extra care schemes/care homes
- Community Geriatric Service
- Specialist nurses including development of Practice Nurses
- Sub-contracting to Practices
- Daily MDTs



# Scarborough – the final model

- All community health and social care colleagues working in joint teams
- All community health and social care colleagues managed by a joint Director, reporting to the GP Fed and NYCC from day 1
- Community health and social care colleagues managed functionally in Year 1 and then by MDT Locality Managers from Year 2
- Total service includes all community health and NYCC Care and Support spend, managed through separate accountabilities and governance
- Closely linked services, managed elsewhere but integral to model e.g. Primary Care, mental health, Living Well, social care provider services



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## Options Evaluation Criteria

What are the benefits against which we will review the options?



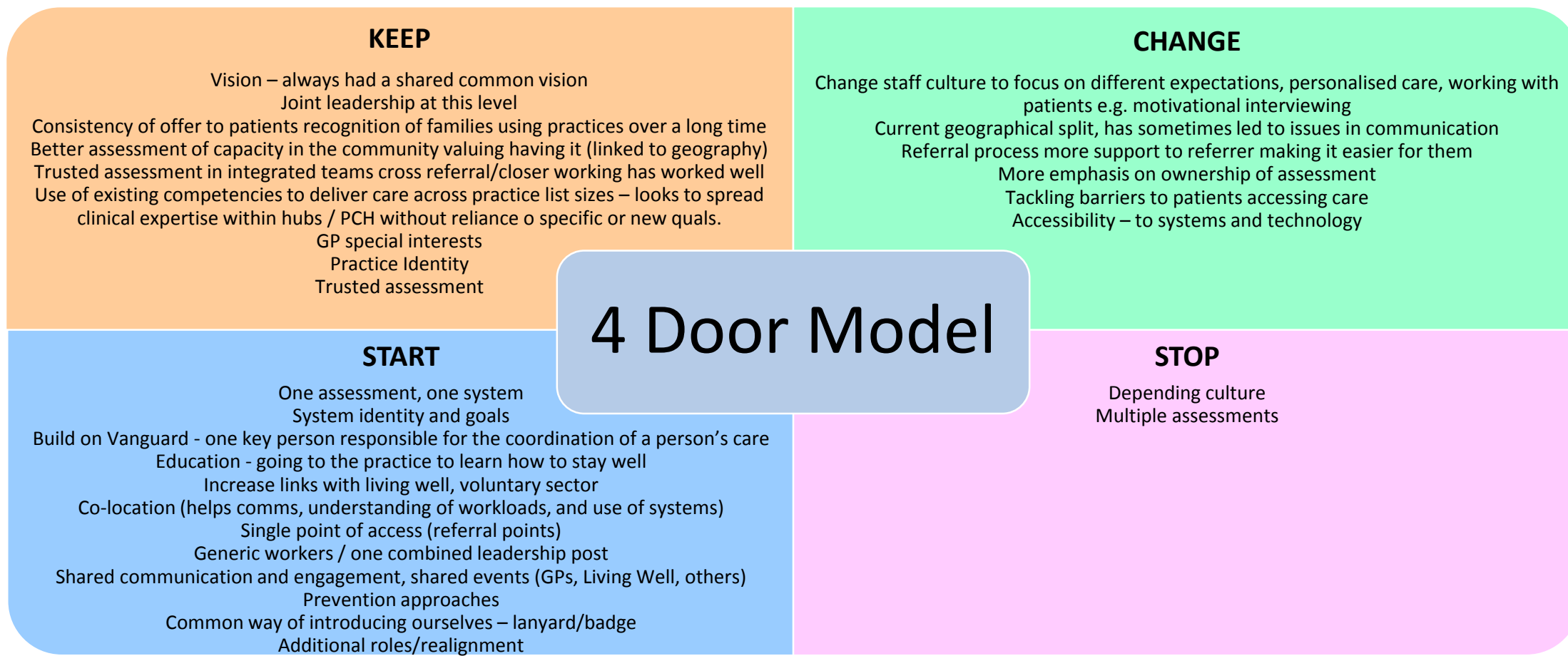
# Primary Care Home Criteria

1. Provision of care to a defined, registered population of between **30,000 and 50,000**.
2. A combined focus on **personalisation of care** with improvements in **population health outcomes**
3. An **integrated workforce**, with a strong focus on partnerships spanning primary, secondary and social care
4. Aligned **clinical and financial drivers**



# Group Review of Additional Criteria

Links to PCH criteria 2 and 3.





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## Overview of Options



# Overview of Options - Method

A data map was built of the locality to help inform how best to segment the area, based on PCH and other criteria, to meet the commissioning intentions of the CCG.

The data map is interactive and shows:

- Team / practice locations and boundaries
- Travel time by car/public transport for patients and staff
- Public Health data by output area
- QoF data
- Registered patients
- Population data

Through the data, a number of segmentation/hub options were identified. A sub-group of the Board was formed with representation across partners to review the data and options and come up with some recommendations.





# Overview of Options – Summary

The table below summarises the options. These are presented in more detail on the following slides and in the Supporting Documents section.

OPTION	OPTION DESCRIPTION	TOTAL REG. PATIENTS	TOTAL PRACTICES
1. Do Nothing	Continue to operate within existing system. Make no further changes to the current arrangements in place for collaboration across the GP practices.	162,846	17
2. Segment Harrogate town into 1 Hub	Harrogate is segmented into 1 hub to include Kingswood Surgery, East Parade Surgery, The Spa Surgery, Church Avenue Medical Group, Park Parade Surgery, The Leeds Road Practice, Dr Moss & Partners	80,726	Harrogate Town - 7
3 a Segment Harrogate town into 2 Hubs with Kingswood Surgery in the inner hub.	<u>Hub – Harrogate Inner</u> Kingswood Surgery, East Parade Surgery, The Spa Surgery, Park Parade surgery	Harrogate Inner: 36,328	Harrogate Inner - 4
	<u>Hub - Harrogate outer</u> Church Avenue Medical Group, Leeds Road Practice, Dr Moss & Partners	Harrogate Outer: 44,398	Harrogate Outer - 3
3 b Segment Harrogate town into 2 Hubs with Kingswood Surgery in the outer hub	<u>Hub – Harrogate inner</u> East parade surgery , The Spa Surgery, Park Parade Surgery	Harrogate Inner: 29,578	Harrogate Inner – 3
	<u>Hub – Harrogate outer</u> Kingswood Surgery, Church avenue medical group, The Leeds Road Practice, Dr Moss & Partners	Harrogate Outer: 51,148	Harrogate Outer – 4
4 a Segment Ripon & Masham together and Knaresborough and Boroughbridge together with Nidderdale Group Practice joining with Ripon and Masham	<u>Hub Ripon/Masham/Nidd</u> Nidderdale Group Practice, Ripon Spa Surgery, Dr Akester & Partners, Dr Ingram A J & Partners, North House Surgery	Hub Ripon/ Masham/ Nidd: 39,239	Hub Ripon/ Masham/ Nidd – 5
	<u>Hub Knaresborough/Boroughbridge</u> Church Lane Surgery, Spring Bank Surgery, Eastgate Medical Group, Stockwell Road Surgery, Beech House Surgery	Hub Knaresb/ Boroughbridge: 42,881	Hub Knaresb/ Boroughbridge – 5
4 b Segment Ripon & Masham together and Knaresborough and Boroughbridge together with Nidderdale Group Practice joining with Knaresborough and Boroughbridge	<u>Hub Ripon/Masham</u> Ripon Spa Surgery, Dr Akester & Partners, Dr Ingram A J & Partners, North House Surgery	Hub Ripon/ Masham: 28,758	Hub Ripon/ Masham – 4
	<u>Hub Knaresborough/Boroughbridge/Nidd</u> Nidderdale Group Practice, Church Lane Surgery, Spring Bank Surgery, Eastgate Medical Group, Stockwell Road Surgery, Beech House Surgery	Hub Knaresb/ Boroughbridge/ Nidd: 53,362	Hub Knaresb/ Boroughbridge – 6



# Options Appraisal – Summary

OPTION	REG. PATIENTS	PRACTICES	BENEFITS	COSTS	RISKS	RECOMMENDATION
1. Do Nothing	162,846	17	No benefits.	No integration efficiency. No impact on travel time/ cost savings in terms of co-location	Does not address commissioning intentions of the CCG. Does not meet any of the PCH criteria	<b>NOT RECOMMENDED</b>
2. Segment Harrogate town into 1 Hub	80,726	Harrogate Town - 7	Avoids artificial divide. Service continuity. Single point of access for patient. Easier management of capacity. Increased collaboration due to proximity of practices and overlap of registered patients. Potential for co-location. Good fit with combined HDFT Harrogate North and South teams. Potential to sub-divide for some functions.	Possible increase in travel time if central hub not identified. Possible cost of multiple hubs.	Exceeds PCH target at 80,726 (NB. PCH have confirmed this is possible). Difficult to establish estates for central hub. Potential lack of alignment for NYCC boundaries	<b>RECOMMENDED</b>
3 a. Segment Harrogate town into 2 Hubs -Kingswood Surgery in the inner hub.	Harrogate Inner: 36,328	Harrogate Inner - 4	Greater potential for co-location in inner Harrogate. Increasing collaborative working practices could lead to improvements in patient outcomes. Travel is improved. Improved extended access. Meets PCH target registered population sizes. Kingswood fits better with inner from an estates point of view.	Duplication of Harrogate town hub estates. Duplication due to artificial divides	Divisions are artificial Estate option for Harrogate Outer not obvious	<b>POSSIBLE</b>
	Harrogate Outer: 44,398	Harrogate Outer - 3				
3 b. Segment Harrogate town into 2 Hubs -Kingswood Surgery in the outer hub	Harrogate Inner: 29,578	Harrogate Inner – 3	Greater potential for co-location in inner Harrogate Increasing collaborative working practices could lead to improvements in patient outcomes. Travel is improved. Improved extended access	Duplication of Harrogate town hub estates	Divisions artificial. Inner hub slightly under and Outer hub slightly over PCH target. Estate option for Harrogate Outer not obvious. Kingswood fits better with Inner estates.	<b>NOT RECOMMENDED</b>
	Harrogate Outer: 51,148	Harrogate Outer – 4				



# Options Appraisal – Summary

OPTION	REG. PATIENTS	PRACTICES	BENEFITS	COSTS	RISKS	RECOMMENDATION
4 a. Segment Ripon, Masham & Nidd together and Knaresborough and Boroughbridge together	Hub Ripon/ Masham/ Nidd: 39,239	Hub Ripon/ Masham/ Nidd – 5	Registered population size meets PCH criteria Fits better with other boundaries/geographies. Potential for better links with Ripon hospital. Recommended due to the geography. Closer cluster – less patient (e.g. physio) /staff travel time. The ‘enhanced Primary Care’ offer would be more accessible for patients under this structure rather than alternatives. Accessibility / travel time better. Better for potential for extended access - additional primary care services would be available. Better able to allocate resources between GP practices - potential for reduced clinician travel time. The interoperability of the systems exists in the current system and community teams work across more than one system.	Duplication due to use of 2 systems	Use of two systems - currently the two systems do not have interoperability function – duplication. Sharing of staff resources would be impacted as they would be accessing more than one system. Impact on quality of service to patients if systems not aligned. NYCC teams not currently in alignment with boundaries for the hubs. Workload of care homes not spread across the hub due to lower density of care homes. No clear direction from the data to guide where Nidd would best fit - some joint working already in place between Nidd & Knaresb / BB and Nidd is in the KGB cluster.	<b>RECOMMENDED</b>
	Hub Knaresb/ BB: 42,881	Hub Knaresb/ BB – 5				
4 b. Segment Ripon & Masham together and Knaresborough, Boroughbridge & Nidd together	Hub Ripon/ Masham: 28,758	Hub Ripon/ Masham – 4	HDFT teams being split across the Hubs would help to enable sharing of skills across the Hubs. Travel by car/accessibility would be easier to manage. Better fit for systems – Nidderdale would be with other practices on System One. Some joint working arrangements already in place between Nidd & Knaresb / BB and Nidd is in the KGB cluster.	NYCC and HDFT boundaries may need to change Potential additional travel cost of split hubs	Team would be split between hubs, and there would be a potential impact on travel No clear direction from the data to guide where Nidderdale would best fit. This option may make it more difficult to determine a single hub point easily. Doesn’t fit easily with NYCC boundaries.	<b>POSSIBLE</b>
	Hub Knaresb/ BB / Nidd: 53,362	Hub Knaresb/ BB - 6				



# Recommendations

It the recommended segmentation/hub options are:

- Option 2 – One Harrogate town Hub (with possible sub-divisions for certain functions)
- Option 4a – Ripon/Masham/Nidd Hub and Knaresborough/Boroughbridge Hub

However, it is recommended that:

- Further risk assessment is needed to determine impacts of a hub larger than the PCH recommendation (Option 2). Work is also required to look at potential sub-divisions. If the risk is too high, Option 3a will be recommended.
- Nidderdale Group Practice are consulted with to determine which of the other hubs they would prefer to join with.



# Next Steps and Actions

- Further work on risk assessment of a larger than recommended hub
- Further work to develop options appraisal into the Outline Business Case
- More detailed work on recommended options to further understand impact
- Further work to cost up potential staffing and other implications of the models (based on the agreed key features and criteria\*)
- Design and development of Staff Workshops for September and October to further develop the recommended options

\*NB this will be at a high, illustrative level for outline business case. The detailed workforce and financial modelling will be done for the Final Business Case.



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## Supporting Documents

Detailed Options Appraisal



# Option 1: Do Nothing – continue to operate within existing system and processes

## Benefits

## Costs

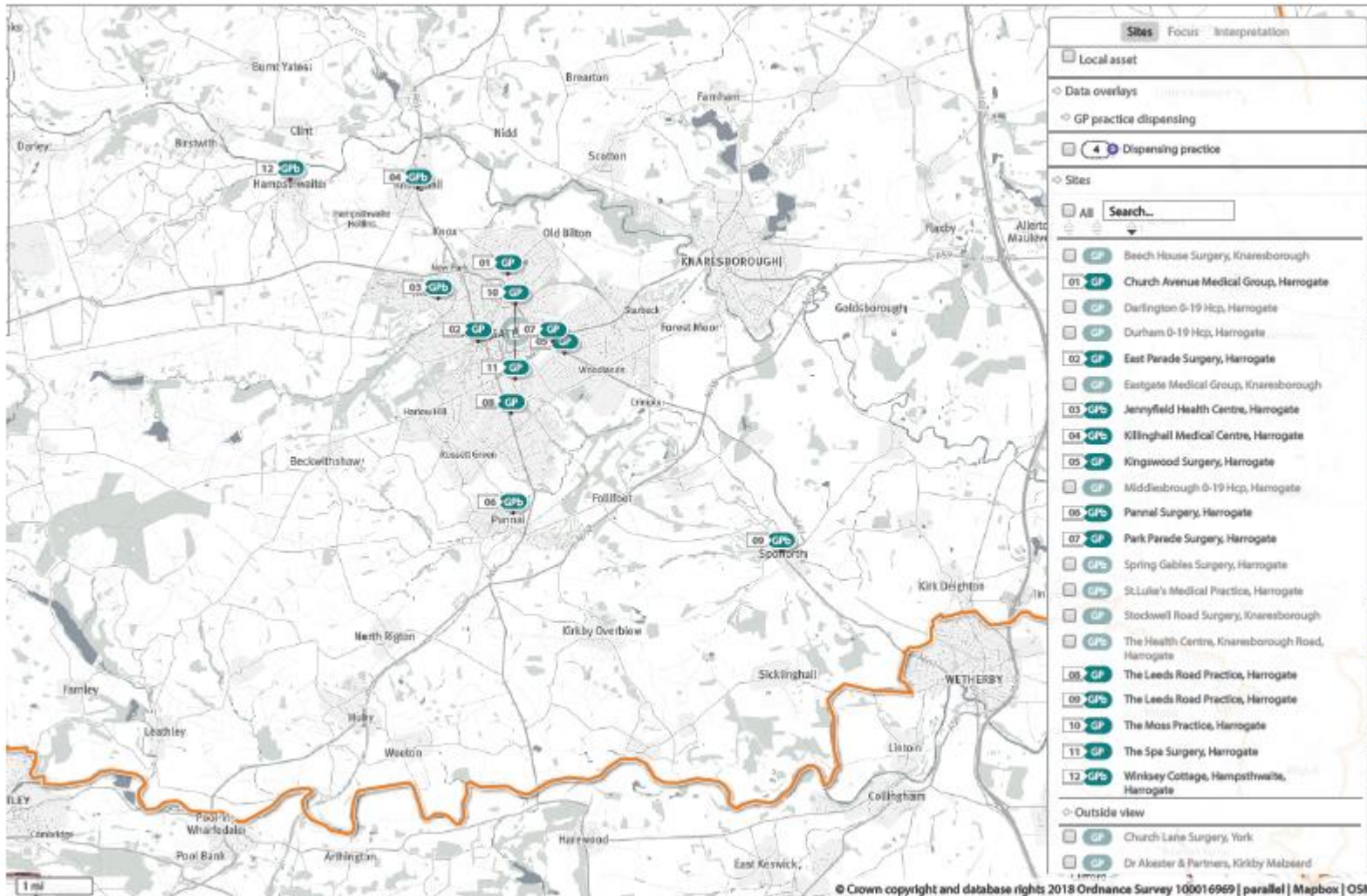
- No opportunity for efficiency through integration
- No improvements in terms of travel time
- No further cost savings in terms of co-location

## Risks

- Does not address commissioning intentions of the CCG
- Does not meet any of the PCH criteria



# Option 2: Segment Harrogate Town into One Hub



Map shows geographical area

GP Practices included:

- Kingswood Surgery
- East Parade Surgery
- The Spa Surgery
- Church Avenue Medical Group
- Park Parade Surgery
- The Leeds Road Practice
- Dr Moss & Partners

Hub is larger than the PCH recommended size with 80,726 registered patients.

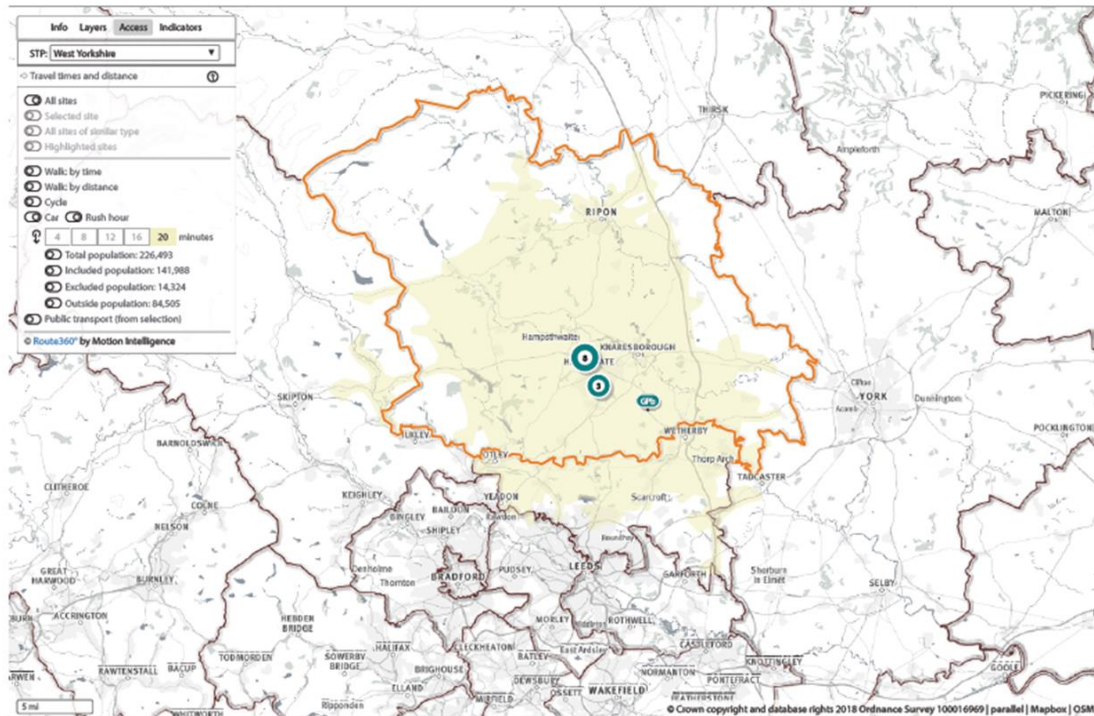
Difficult to find a meaningful way to segment the Harrogate town that isn't an artificial divide.



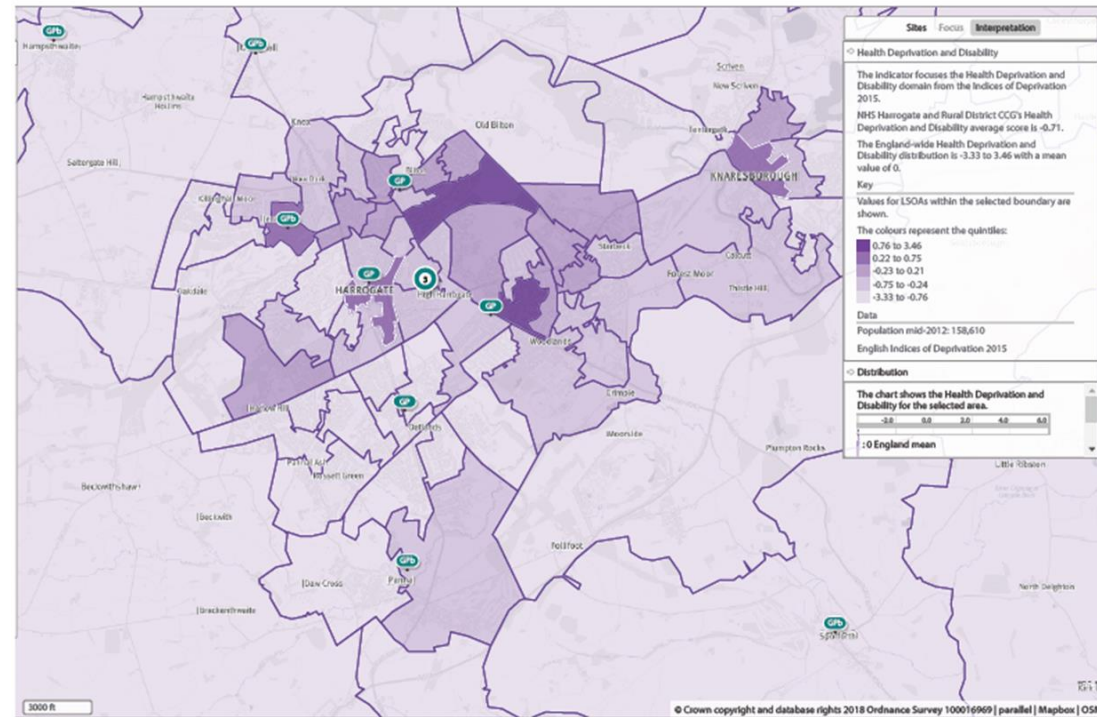


# Option 2: Segment Harrogate Town into One Hub

## Accessibility by transport within 20 mins



## Health Deprivation & Disability Indices





# Option 2: Segment Harrogate Town into One Hub

## Benefits

- Avoids artificial divide of Harrogate town centre given the overlap across practices - continuity of service to patients
- Benefit of single point of access for patient due to review of the referral pathway.
- Due to the catchment area having a higher population size this would lead to easier management of capacity across teams and increased collaboration due to proximity of practices and overlap of registered patients
- Potential for co-location and potential to add value through more collaborative working practices.
- Good fit with combined HDFT Harrogate North and South teams.

## Costs

- Possible increase in travel time if one central hub not identified
- Possible costs of multiple hubs

## Risks

- Greatly exceeds target PCH registered population of 30-50,000 at 80,726 (NB. PCH have confirmed this is possible)
- Lessons learned regarding pros and cons of higher population size to be reviewed from PCH case studies **ACTION:** Chris Watson to pick this up and provide feedback.
- Difficulty in establishing estates for central hub,
- Due to ongoing review of NYCC staff boundaries potential for the boundaries not to be in alignment for Harrogate.



# Option 3a: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer



## Harrogate Inner

Map shows geographical area

GP Practices included:

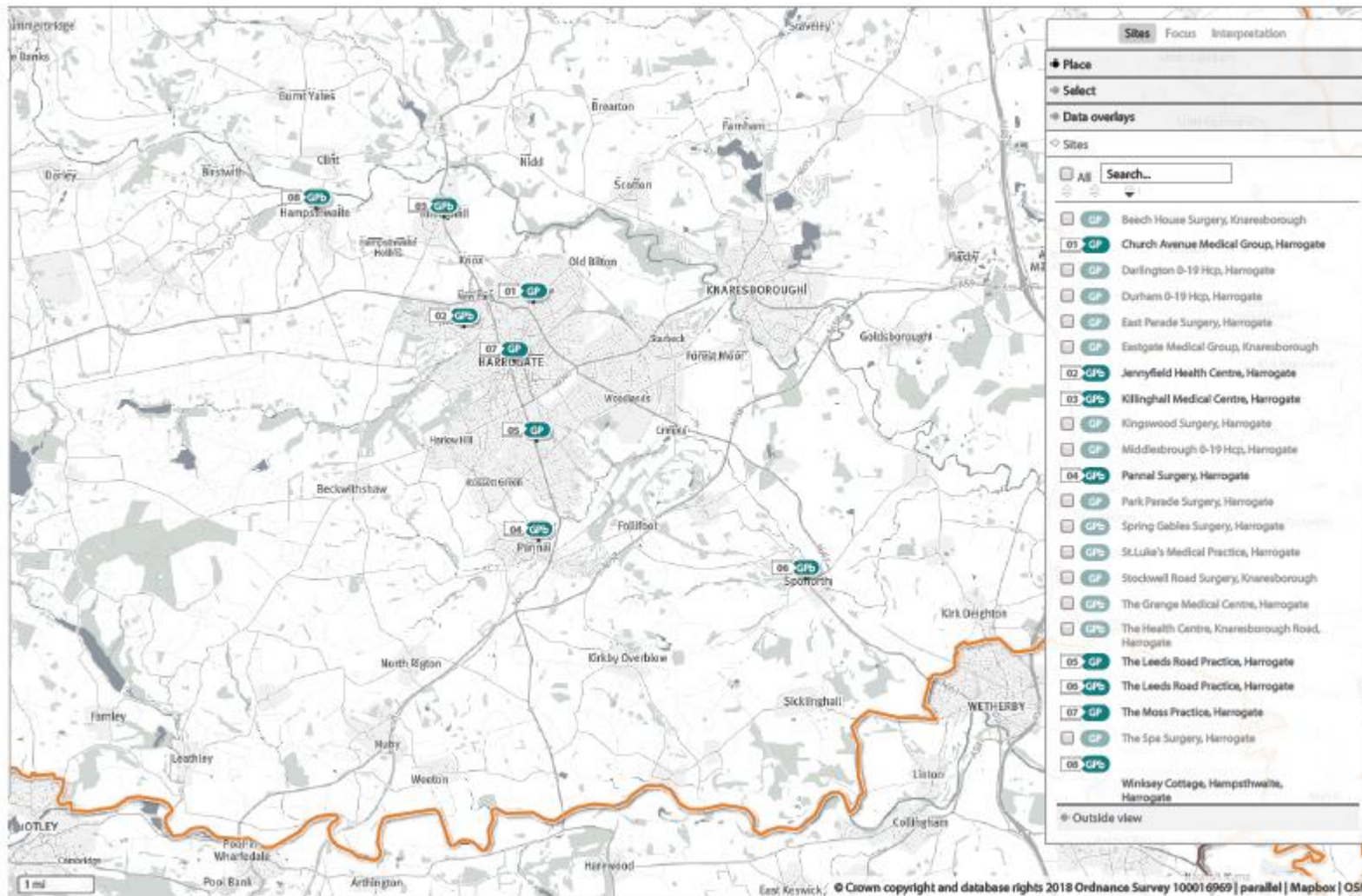
- **Kingswood Surgery**
- East Parade Surgery
- The Spa Surgery
- Park Parade Surgery

Hub meets PCH recommended size with 36,328 registered patients.

Difficult to find a meaningful way to segment the Harrogate town that isn't an artificial divide.



# Option 3a: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer



## Harrogate Outer

Map shows geographical area

GP Practices included:

- Church Avenue Medical Group
- The Leeds Road Practice
- Dr Moss & Partners

Hub meets PCH recommended size with 44,398 registered patients.

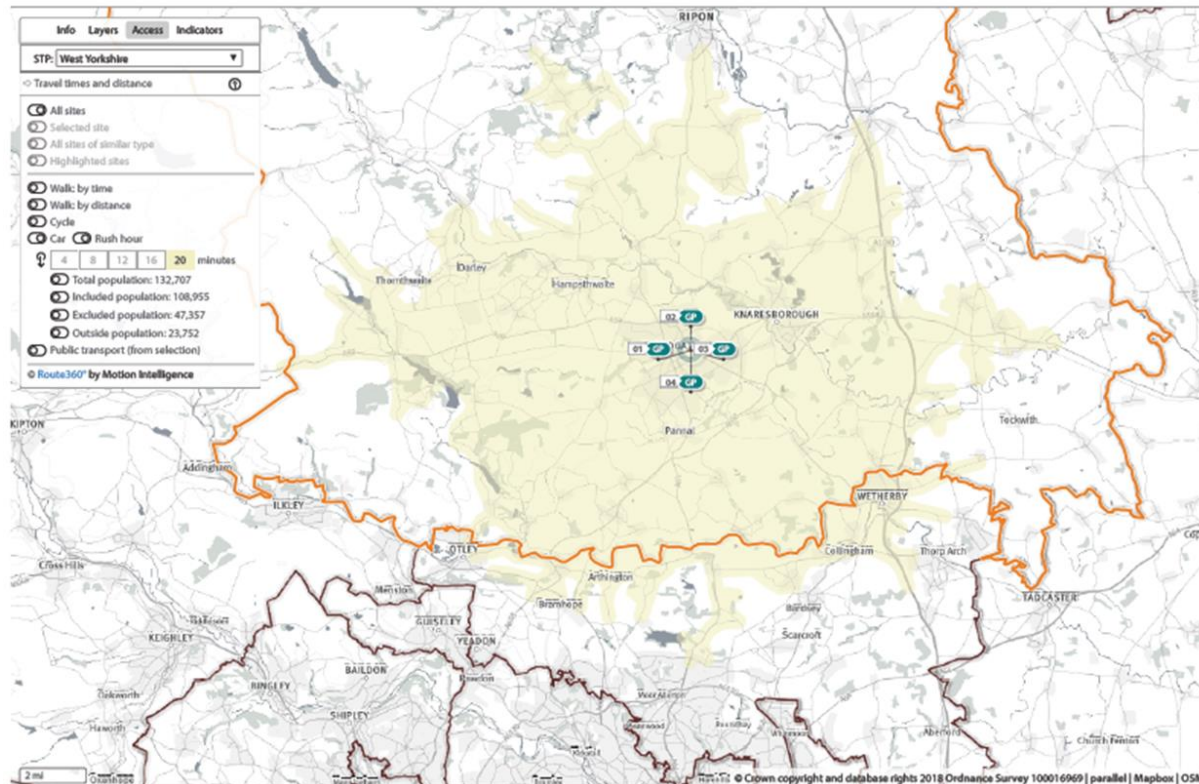
Difficult to find a meaningful way to segment the Harrogate town that isn't an artificial divide.



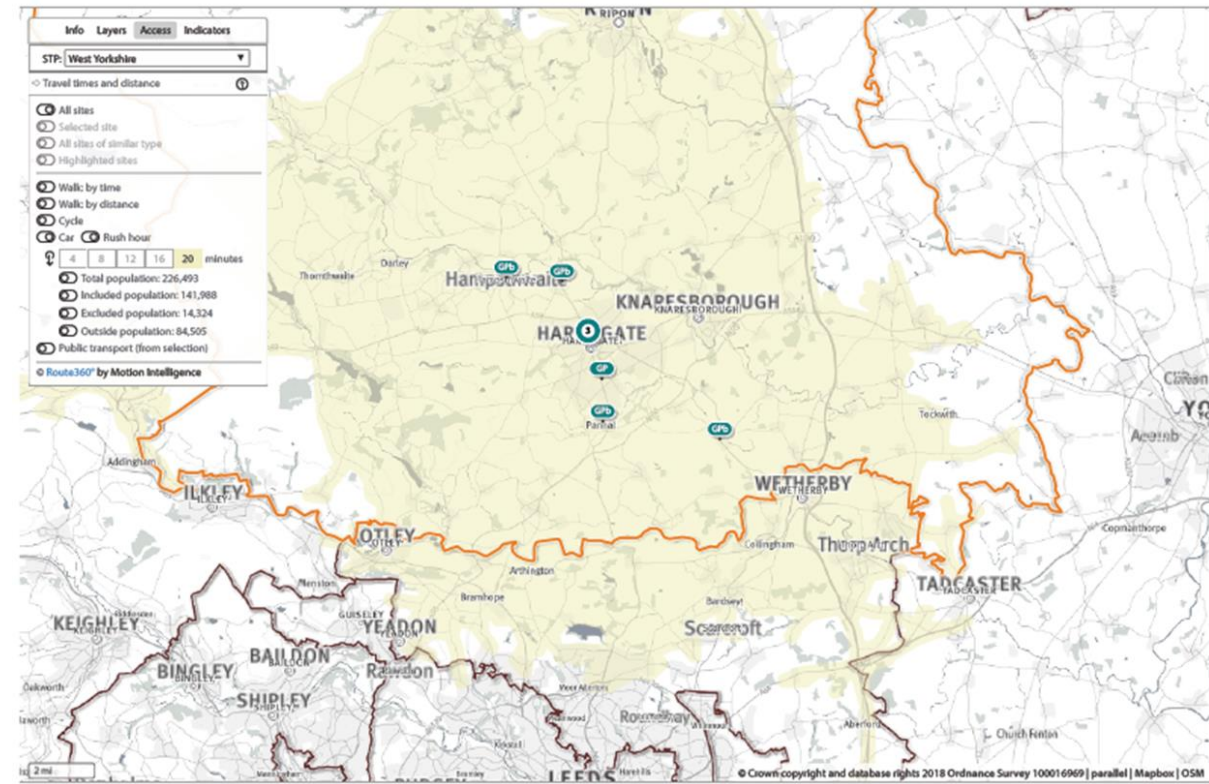
# Option 3a: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer

Accessibility by transport within 20 mins

## Harrogate Inner



## Harrogate Outer



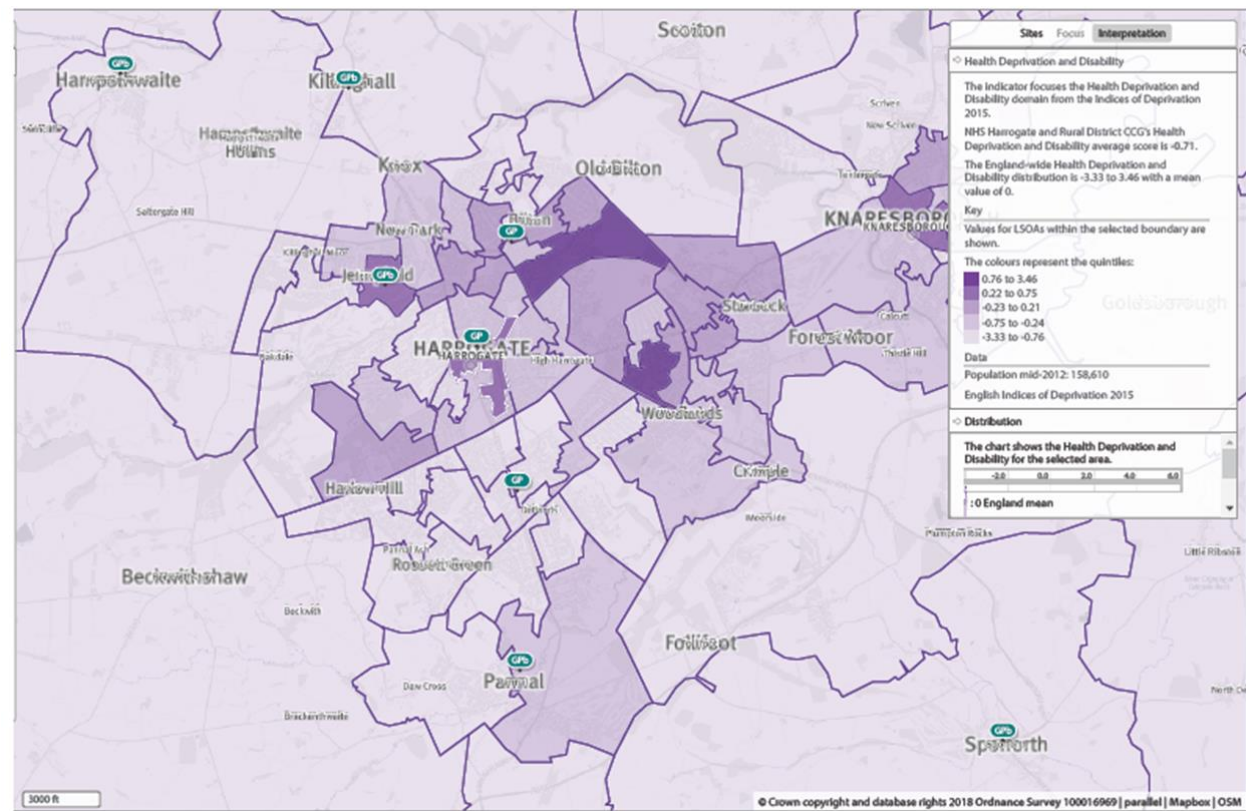
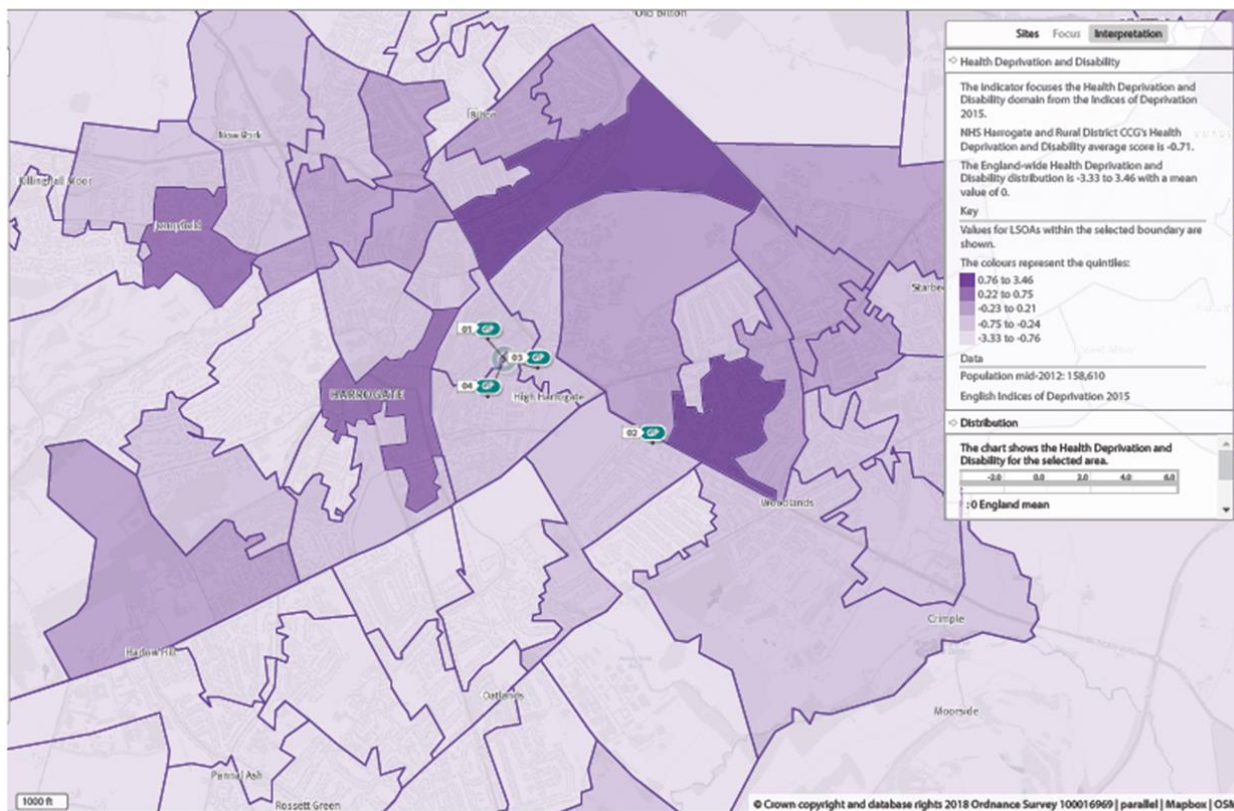


# Option 3a: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer

## Health Deprivation & Disability Indices

### Harrogate Inner

### Harrogate Outer





# Option 3a: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer – Kingswood in Inner

## Benefits

- Greater potential for co-location in inner Harrogate
- Increasing collaborative working practices could lead to improvements in patient outcomes.
- Travel is improved
- Improved extended access
- Meets PCH target registered population sizes
- Kingswood fits better with inner from an estates point of view

## Costs

- Duplication of Harrogate town hub estates
- Duplication due to artificial divides

## Risks

- Divisions are artificial
- Estate option for Harrogate Outer not obvious



# Option 3b: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer



## Harrogate Inner

Map shows geographical area

GP Practices included:

- East Parade Surgery
- The Spa Surgery
- Park Parade Surgery

Hub just about meets PCH recommended size with 29,578 registered patients.

Difficult to find a meaningful way to segment the Harrogate town that isn't an artificial divide.





# Option 3b: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer



## Harrogate Outer

Map shows geographical area

GP Practices included:

- **Kingswood Surgery**
- Church Avenue Medical Group
- The Leeds Road Practice
- Dr Moss & Partners

Hub just about meets PCH recommended size with 51,148 registered patients.

Difficult to find a meaningful way to segment the Harrogate town that isn't an artificial divide.

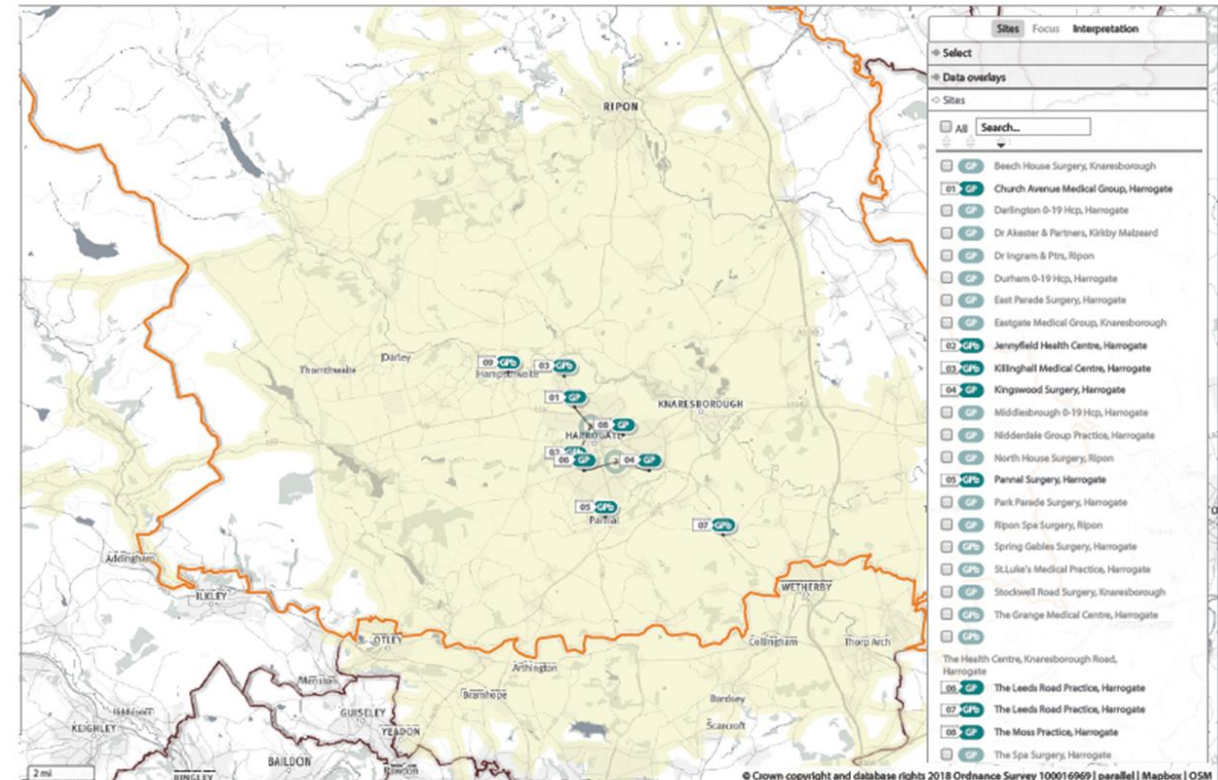
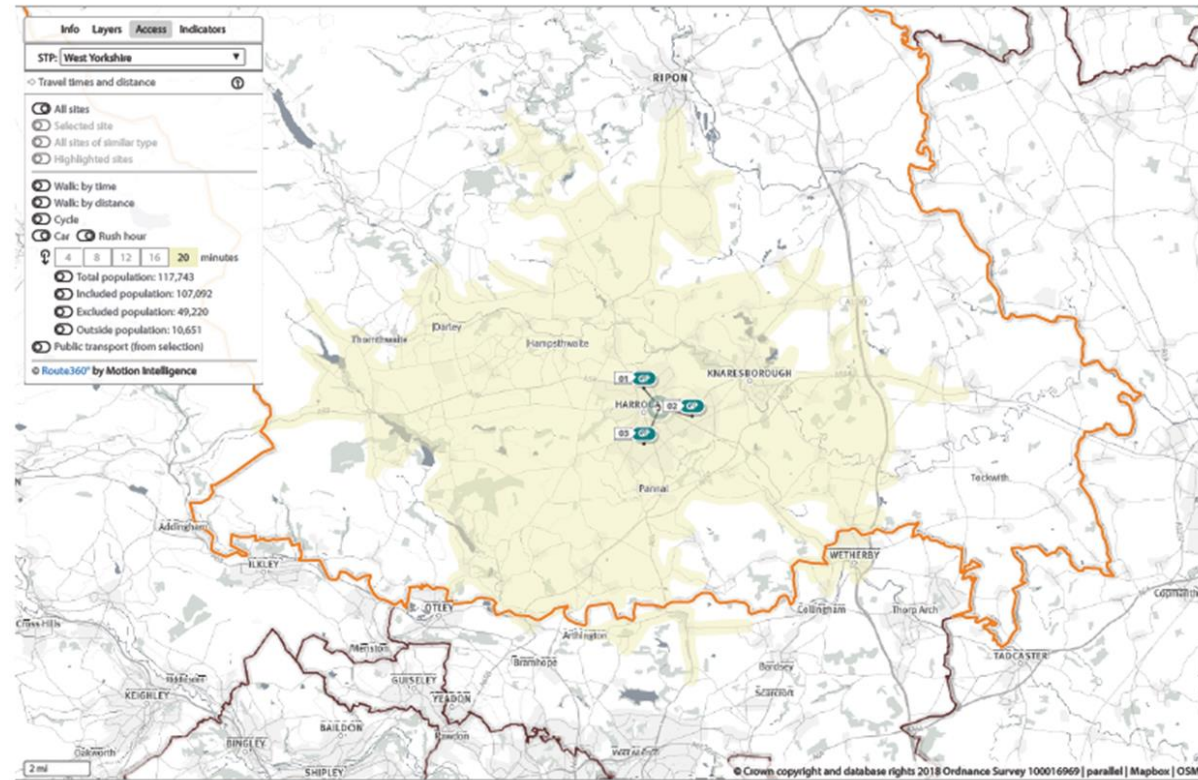


# Option 3b: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer

Accessibility by transport within 20 mins

## Harrogate Inner

## Harrogate Outer

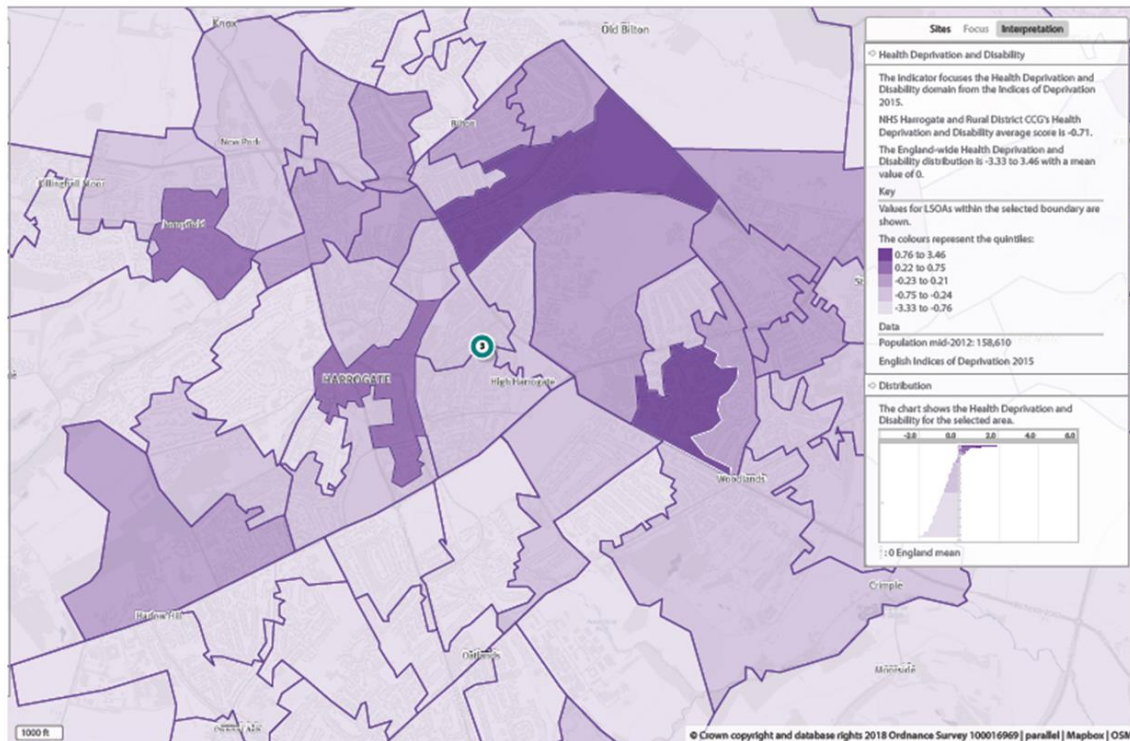




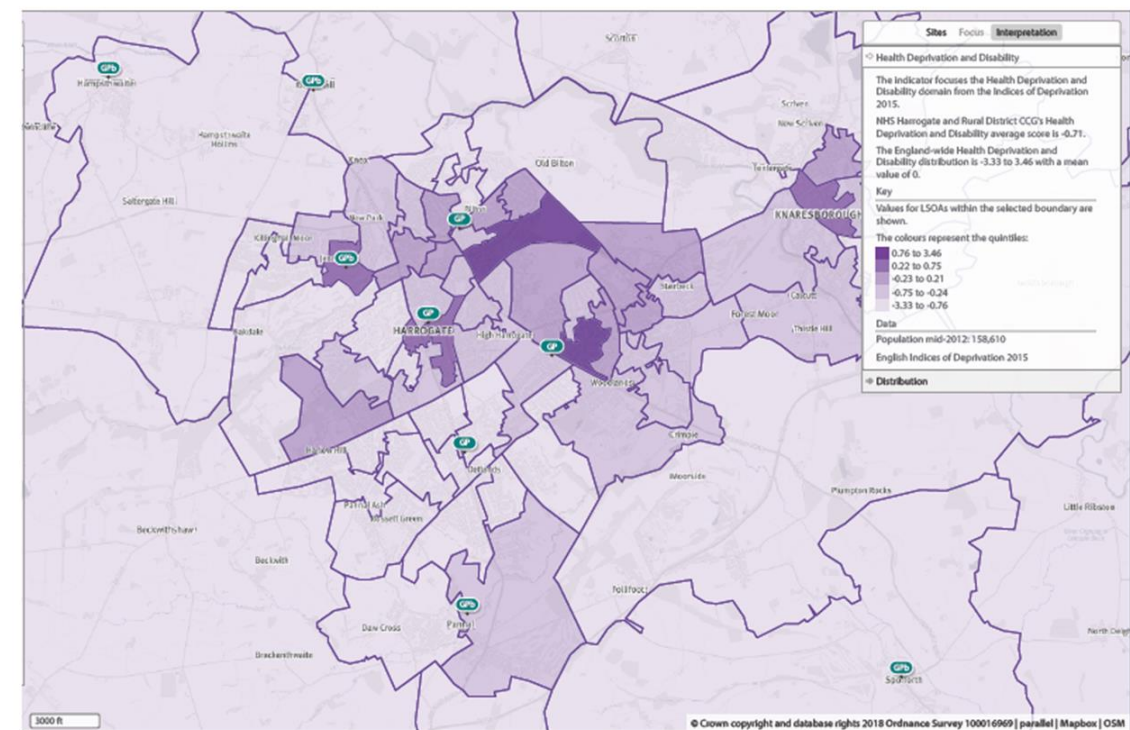
# Option 3b: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer

## Health Deprivation & Disability Indices

### Harrogate Inner



### Harrogate Outer





# Option 3b: Segment Harrogate town into 2 Hubs – Harrogate Inner and Harrogate Outer – Kingswood in Outer

## Benefits

- Greater potential for co-location in inner Harrogate
- Increasing collaborative working practices could lead to improvements in patient outcomes.
- Travel is improved
- Improved extended access

## Costs

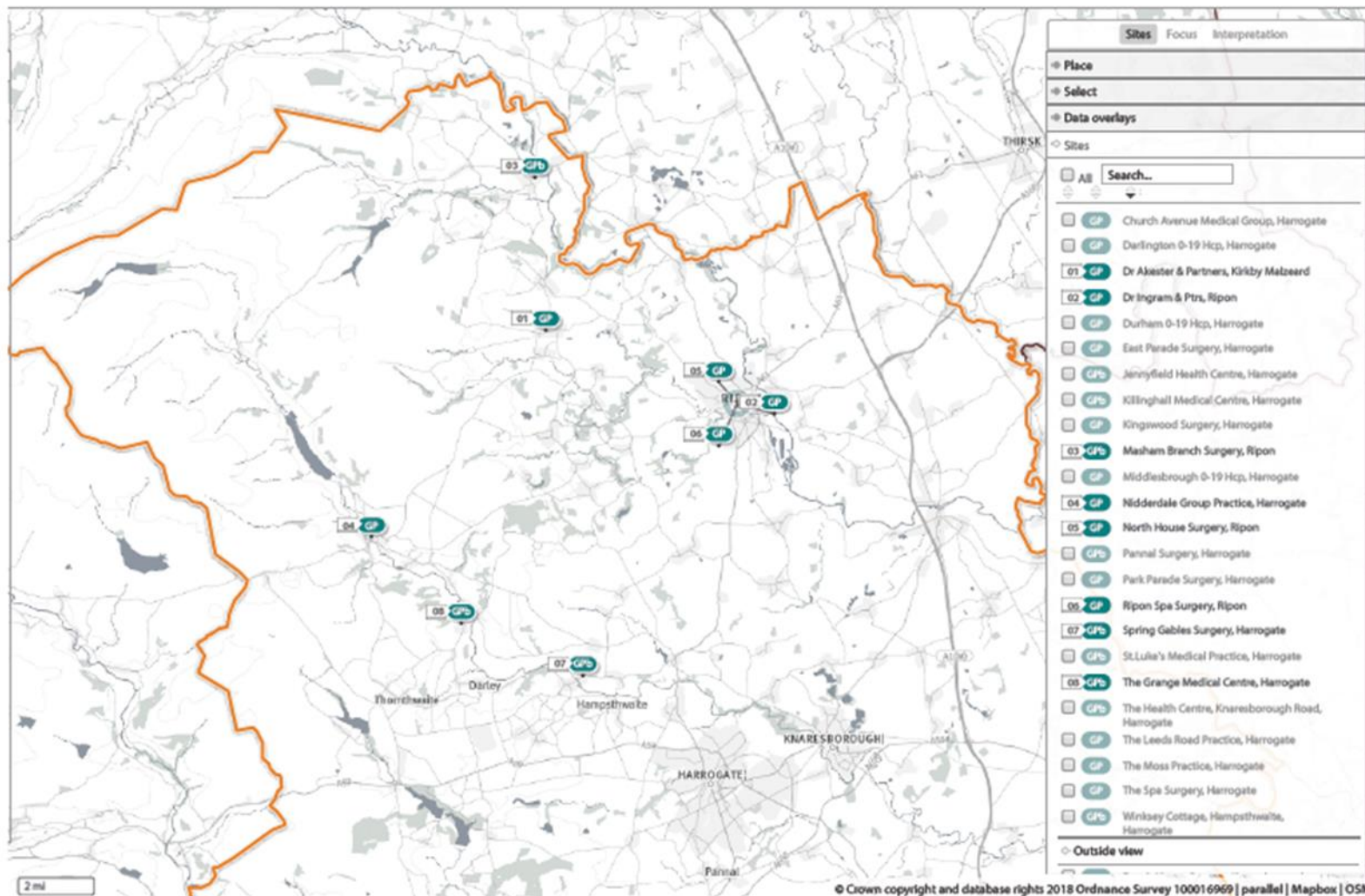
- Duplication of Harrogate town hub estates

## Risks

- Divisions are artificial
- Inner hub slightly under PCH recommended size and Outer hub slightly higher (only just)
- Estate option for Harrogate Outer not obvious
- Kingswood fits better with Inner from an estates point of view



# Option 4a: Segment Ripon & Masham together and Knaresborough and Boroughbridge together



## Ripon & Masham

Map shows geographical area

GP Practices included:

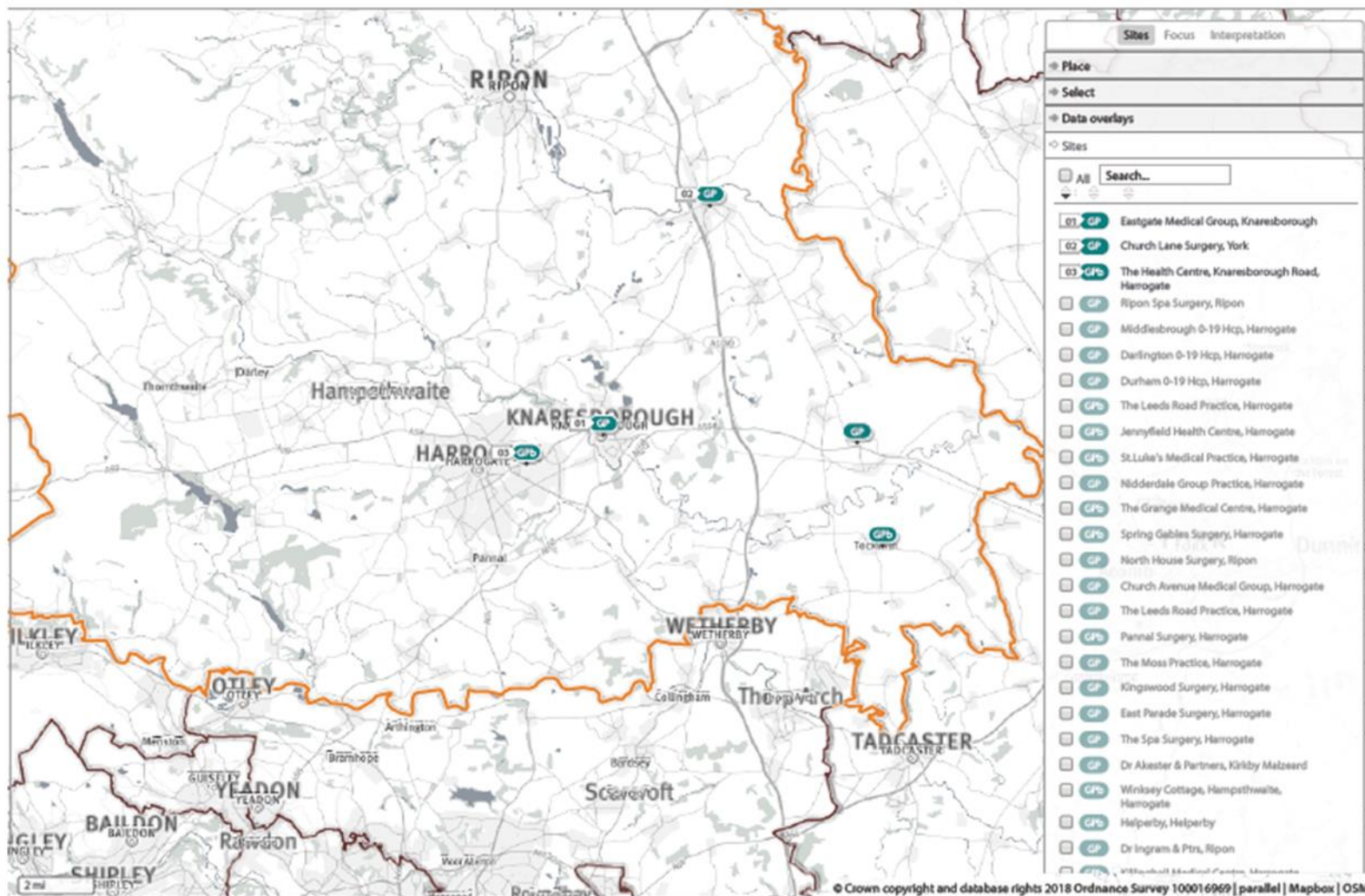
- **Nidderdale Group Practice**
- Ripon Spa Surgery
- Dr Akester & Partners
- Dr Ingram A J & Partners
- North House Surgery

Hub meets PCH recommended size with 39,239 registered patients.

Includes Nidderdale Group Practice although they are on a separate system from the other GP practices.



# Option 4a: Segment Ripon & Masham together and Knaresborough and Boroughbridge together



## Knaresborough & Boroughbridge

Map shows geographical area

GP Practices included:

- Church Lane Surgery
- Spring Bank Surgery
- Eastgate Medical Group
- Stockwell Road Surgery
- Beech House Surgery

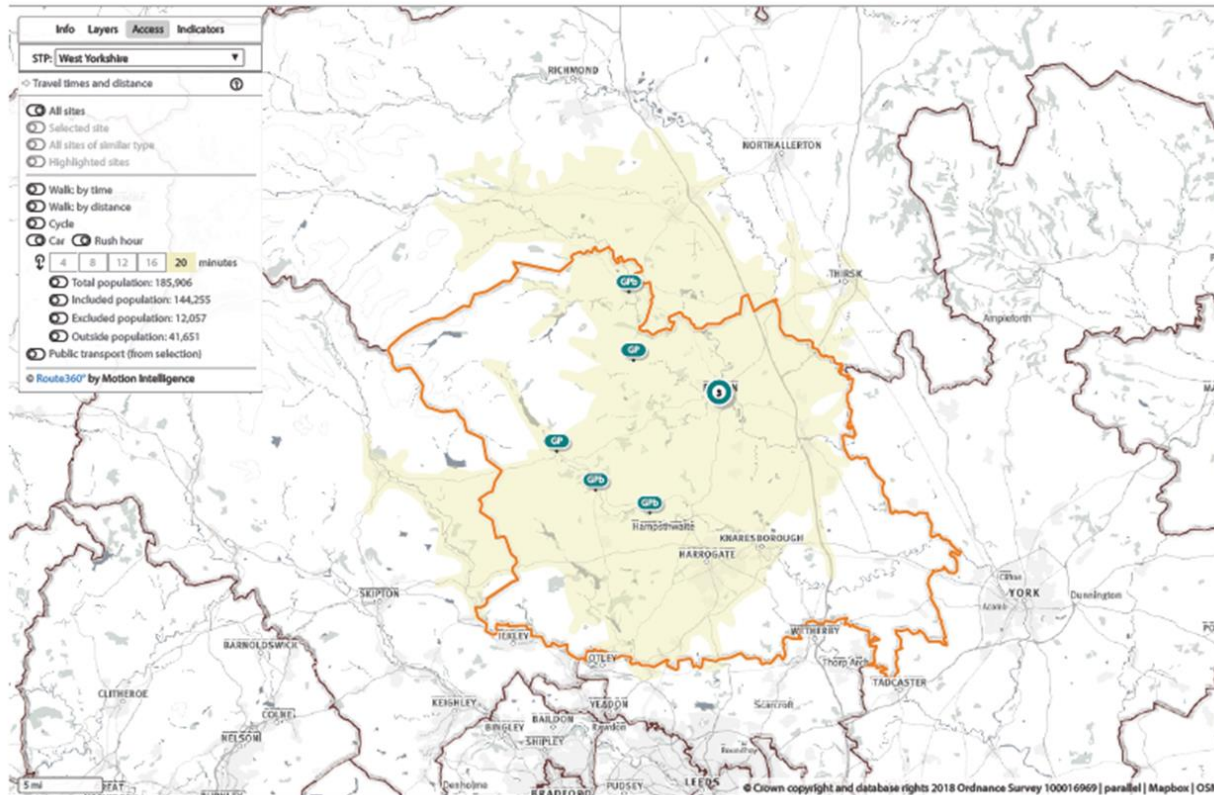
Hub meets PCH recommended size with 42,881 registered patients.



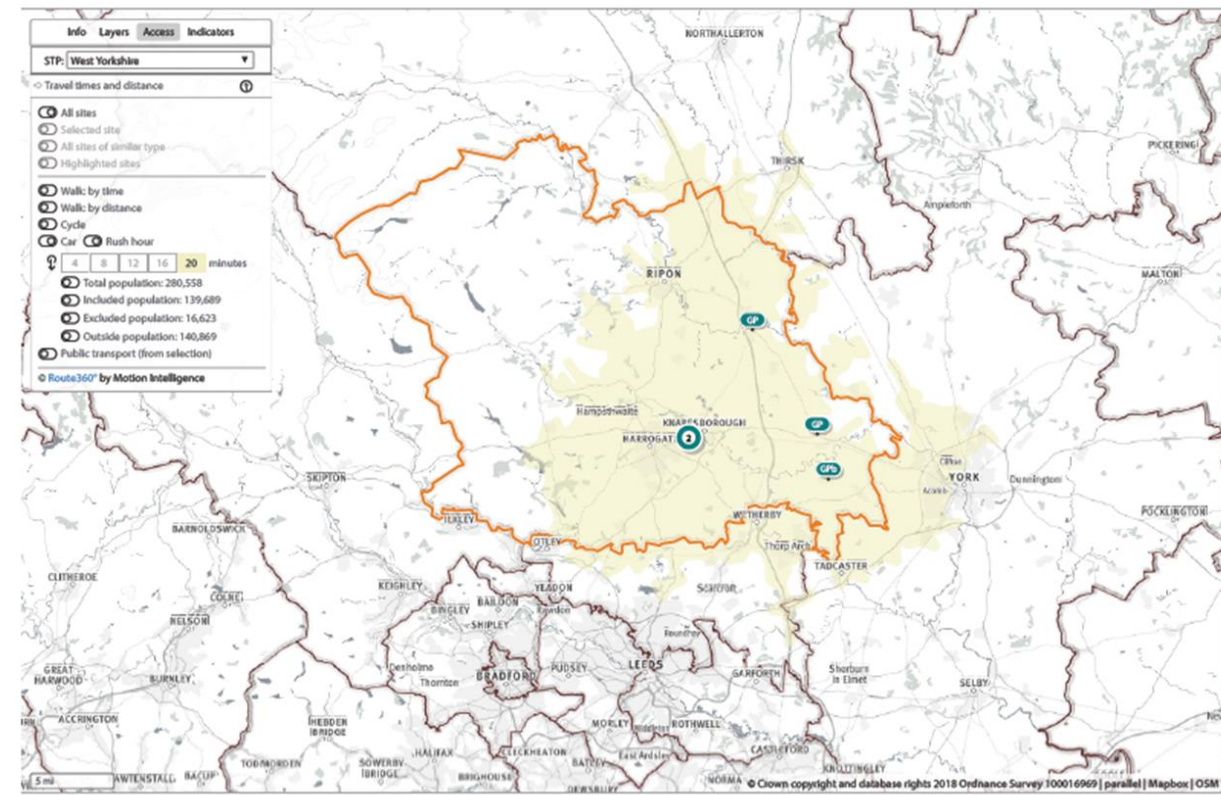
# Option 4a: Segment Ripon & Masham together and Knaresborough and Boroughbridge together

Accessibility by transport within 20 mins

Ripon/Masham/Nidd



Knaresborough/Boroughbridge



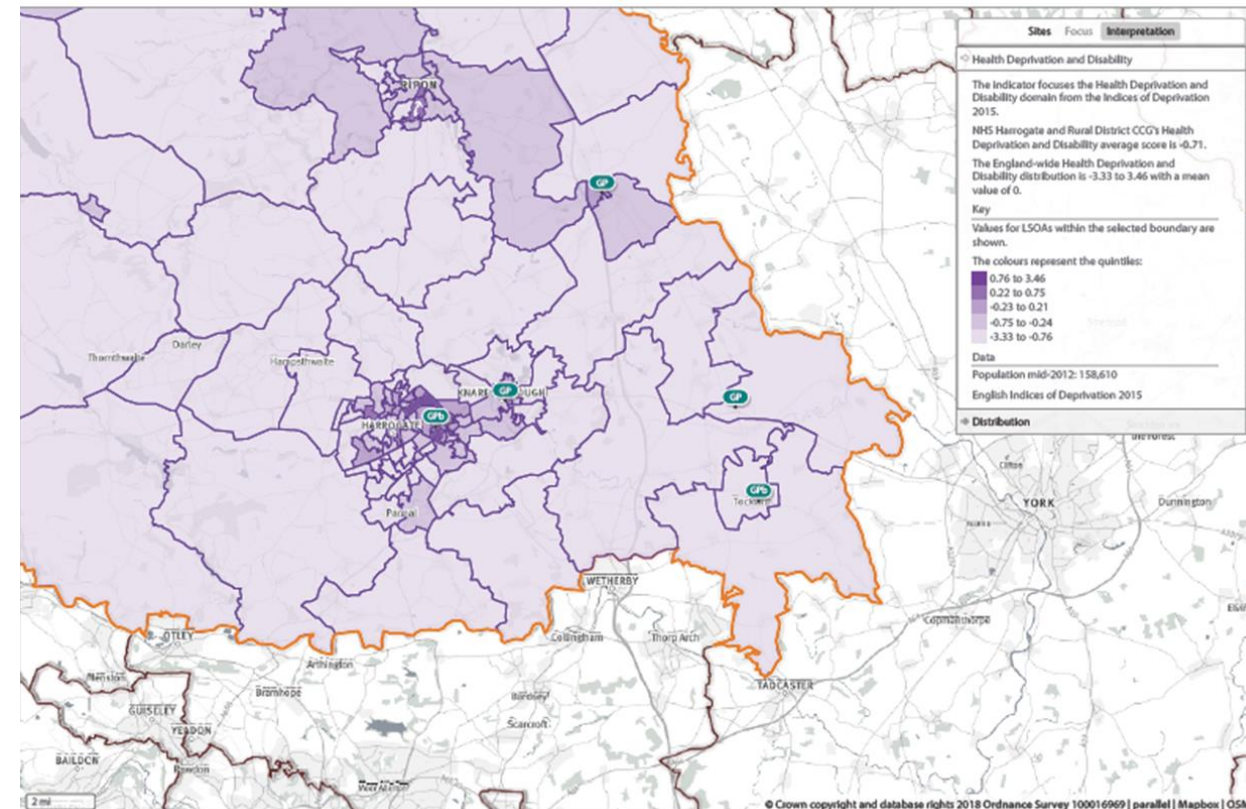
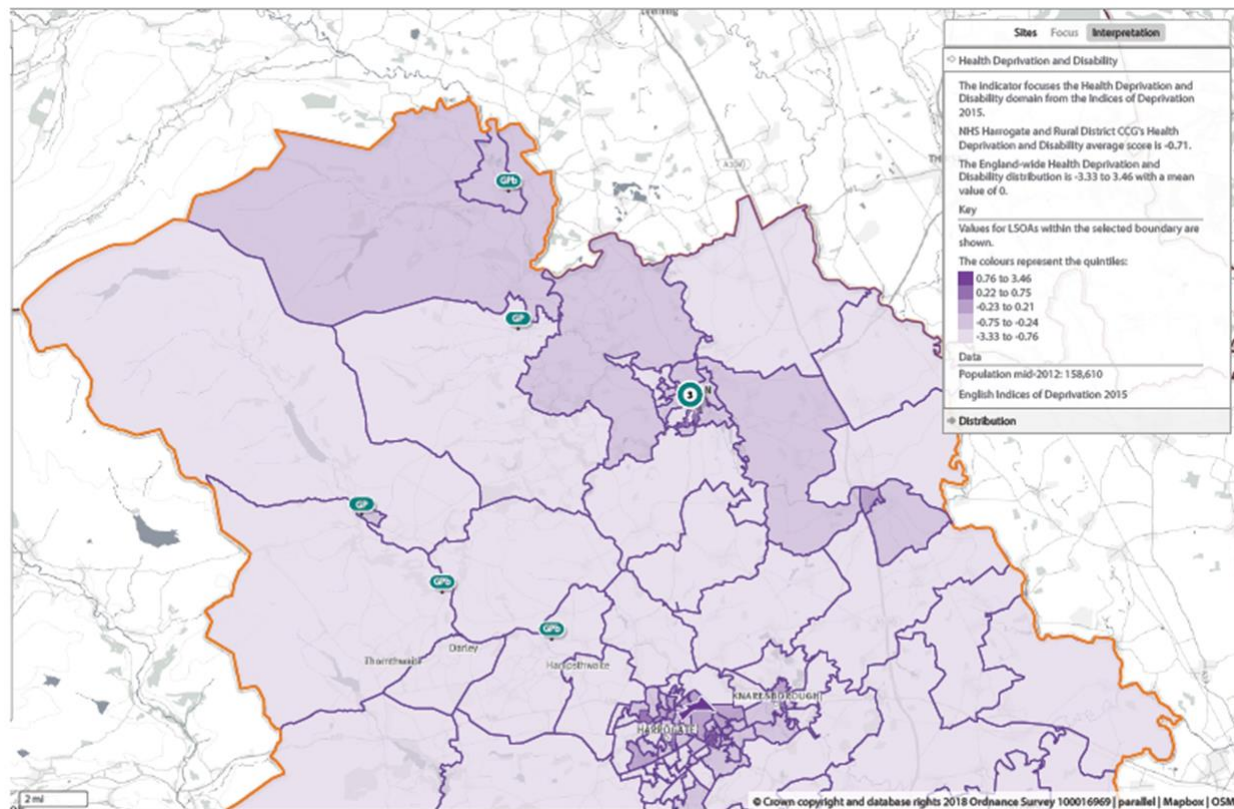


# Option 4a: Segment Ripon & Masham together and Knaresborough and Boroughbridge together

## Health Deprivation & Disability Indices

### Ripon/Masham/Nidd

### Knaresborough/Boroughbridge







# Option 4a: Segment Ripon, Masham & Nidd together and Knaresborough and Boroughbridge together

## Benefits

- Registered population size meets PCH criteria
- Fits better with other boundaries/geographies (HDFT, CCT, NYCC boundaries). Potential for better links with Ripon hospital.
- **Nidd with Ripon/Masham recommended due to the geography. Closer cluster – less patient (e.g. physio) and staff travel time.**
- **The ‘enhanced Primary Care’ offer would be more accessible for patients under this structure rather than alternatives.**
- Accessibility / travel time better - 144k travel within 20 minutes, 110'000 can travel by public transport.
- Better for potential for extended access - additional primary care services would be available, due to travel time for Nidd patients
- Better able to allocate resources between GP practices as there would be potential for reduced travel time for clinicians.
- The interoperability of the systems exists in the current system and community teams work across more than one system – if systems are shared there is an opportunity for greater transparency of data.

## Costs

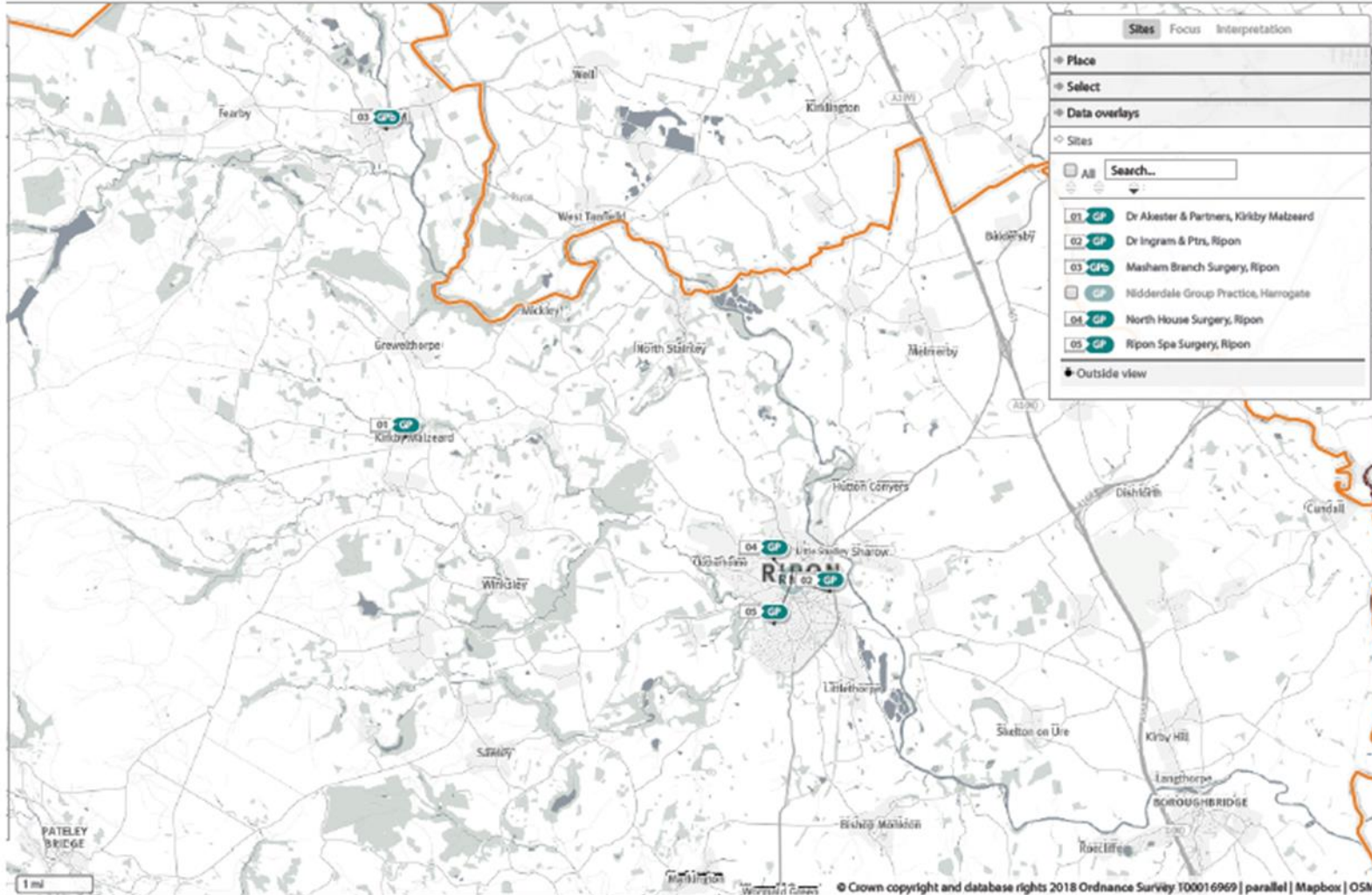
- Duplication due to use of 2 systems

## Risks

- Use of two different systems - Nidderdale use System one and Ripon and Masham use Emiss - currently the two systems do not have interoperability function
- Sharing of staff resources would be impacted as they would be accessing more than one system. Duplication of system entry
- Impact on quality of service to patients if systems are not aligned.
- NYCC teams not currently in alignment with the new boundaries for the hubs.
- Workload of care homes is not spread across the hub due to lower density of care homes
- No clear direction from the data to guide where Nidderdale would best fit. However, some joint working arrangements already in place between Nidd and Church Lane (Knaresborough/Boroughbridge) and Nidd is in the KGB cluster.



# Option 4b: Segment Ripon & Masham together and Knaresborough and Boroughbridge together



## Ripon & Masham

Map shows geographical area

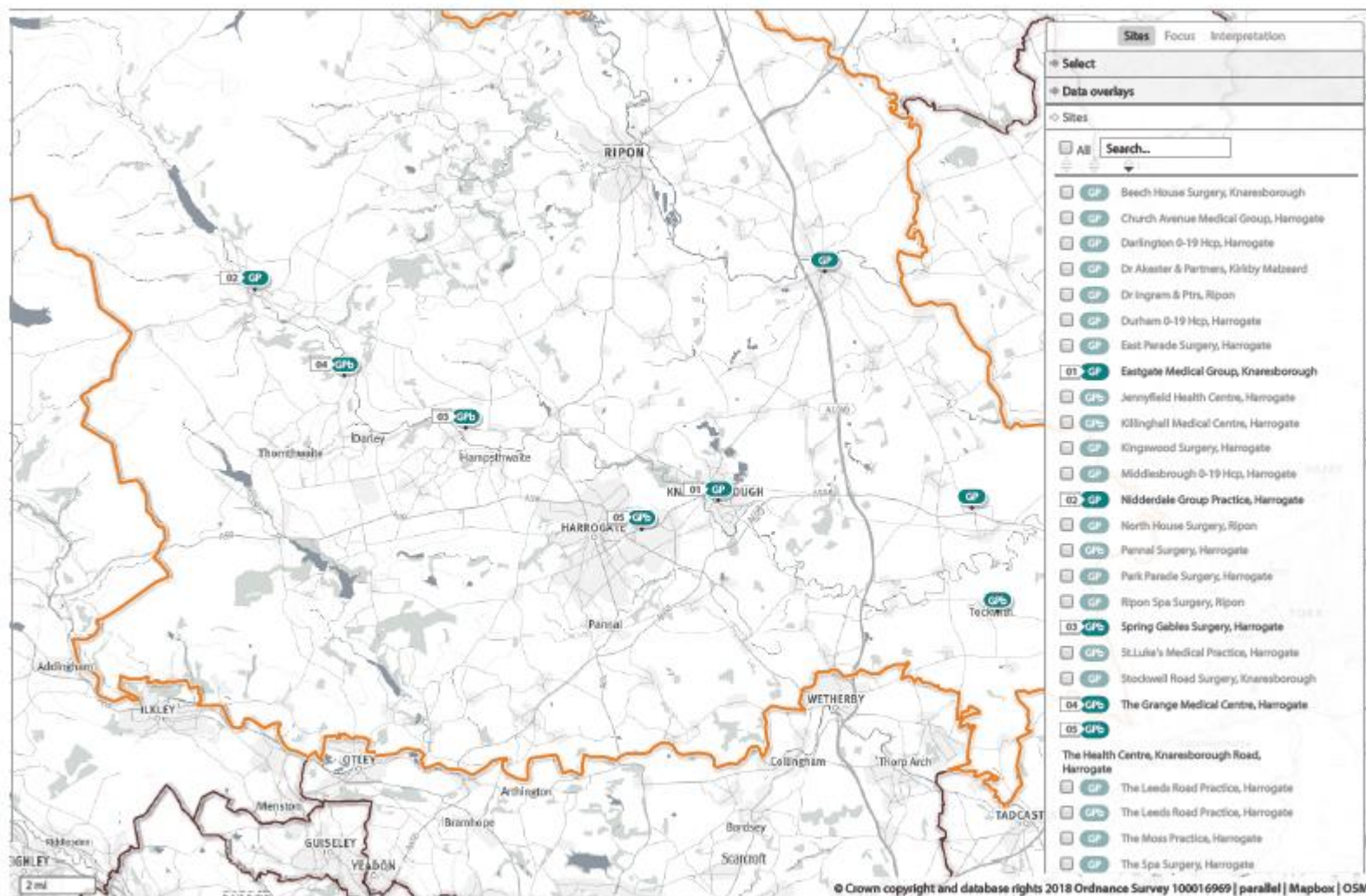
GP Practices included:

- Ripon Spa Surgery
- Dr Akester & Partners
- Dr Ingram A J & Partners
- North House Surgery

Hub meets PCH recommended size  
with 28,758 registered patients.



# Option 4b: Segment Ripon & Masham together and Knaresborough and Boroughbridge together



## Knarsborough & Boroughbridge

Map shows geographical area  
GP Practices included:

- **Nidderdale Group Practice**
- Church Lane Surgery
- Spring Bank Surgery
- Eastgate Medical Group
- Stockwell Road Surgery
- Beech House Surgery

Hub just about meets PCH  
recommended size with 53,368  
registered patients.

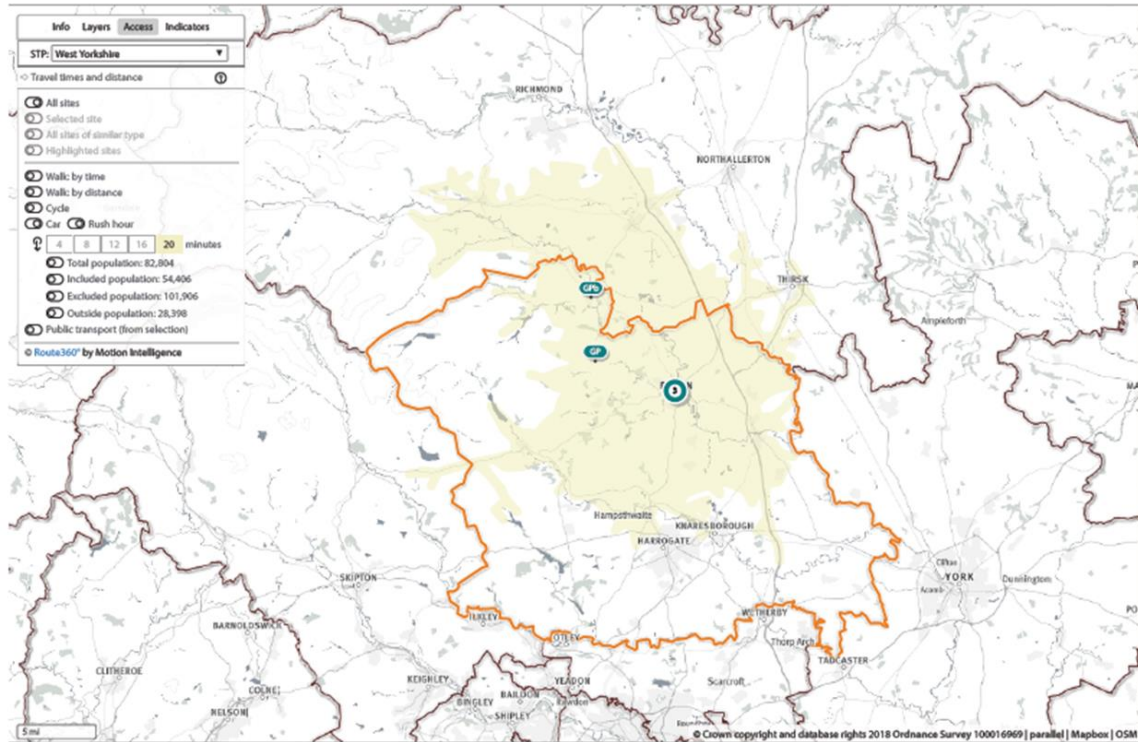
Includes Nidderdale Group Practice  
although they are on a separate  
system from the other GP practices.



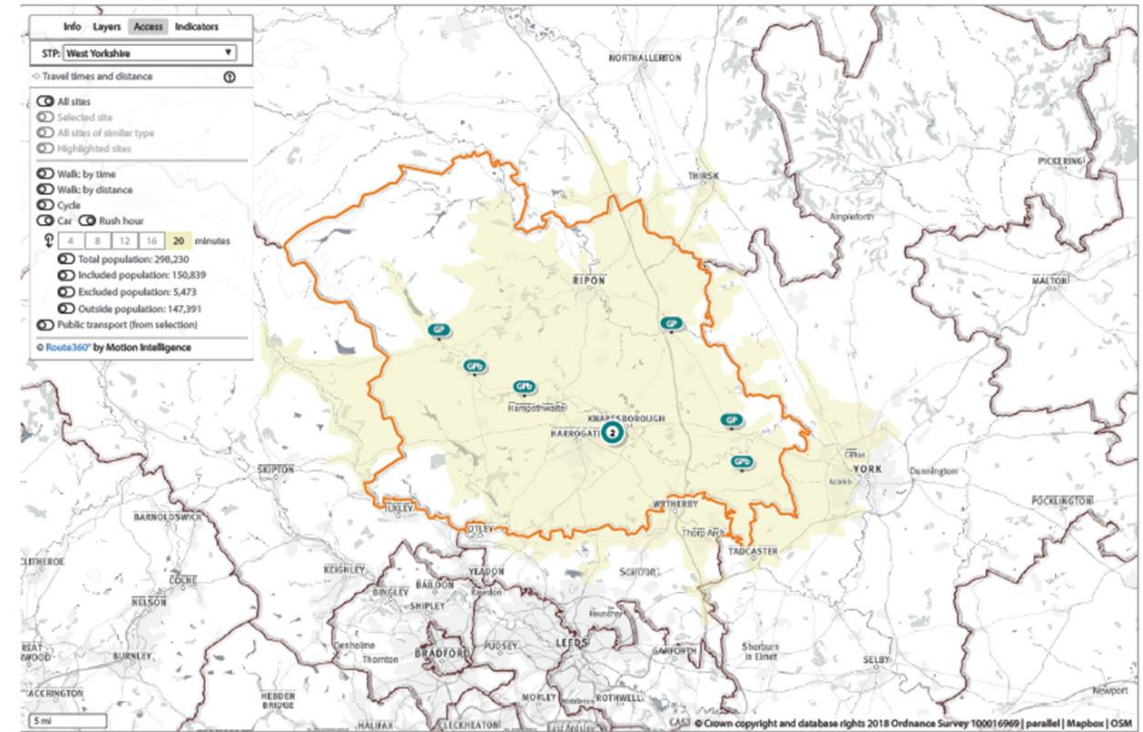
# Option 4b: Segment Ripon & Masham together and Knaresborough and Boroughbridge together

Accessibility by transport within 20 mins

Ripon/Masham



Knaresborough/Boroughbridge/Nidd

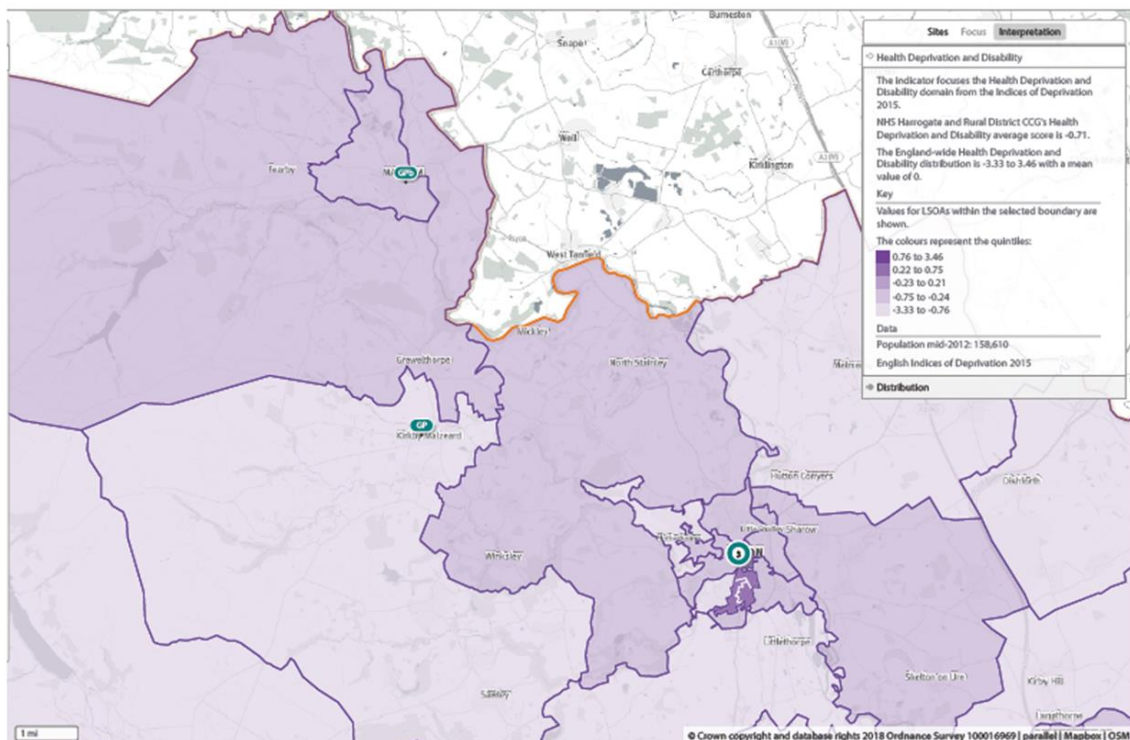




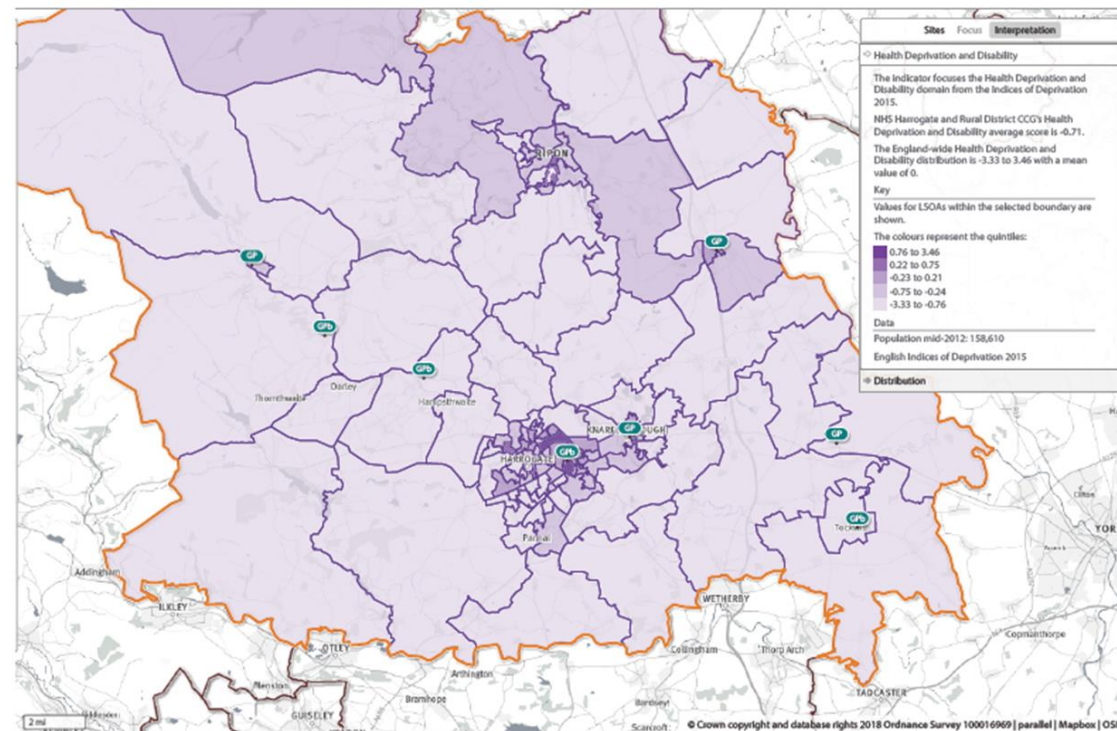
# Option 4b: Segment Ripon & Masham together and Knaresborough and Boroughbridge together

## Health Deprivation & Disability Indices

### Ripon/Masham



### Knaresborough/Boroughbridge/Nidd





# Option 4b: Segment Ripon & Masham together and Knaresborough, Boroughbridge & Nidd together

## Benefits

- HDFT teams being split across the Hubs would help to enable sharing of skills across the Hubs.
- Travel by car/accessibility would be easier to manage
- Better fit for systems – Nidderdale would be with other practices on System One
- Some joint working arrangements already in place between Nidd and Church Lane (Knaresborough/Boroughbridge) and Nidd is in the KGB cluster.

## Costs

- NYCC and HDFT boundaries may need to change
- Potential additional travel cost of split hubs

## Risks

- Team would be split between hubs, and there would be a potential impact on travel
- No clear direction from the data to guide where Nidderdale would best fit. This option may make it more difficult to determine a single hub point easily.
- Doesn't fit easily with NYCC boundaries.