INTEGRATION PIONEER BID NORTH YORKSHIRE AND YORK

North Yorkshire and City of York Health and Wellbeing Boards

In parallel with City of Bradford and the cross border Airedale, Wharfedale and Craven CCG.

June 2013

Changing our care landscape on a large scale

Our ambition

Together North Yorkshire and York serve the biggest area geographically in England. We are jointly committed to developing a person-centred and integrated approach to health and social care for the population we serve so that, irrespective of the complexity of our organisations and boundaries, their needs come first. By participating as a pioneer site we hope to accelerate our plans as well as contribute to the national work from our experience and learning. We believe if we can make it happen here, it can happen anywhere.

Introduction and vision

North Yorkshire and the City of York is a large geographical area, which presents significant challenges around bringing together numerous organisations across multiple boundaries and a mixture of urban and extremely rural communities. City of York is a unitary authority, and North Yorkshire is county council with seven district councils within its boundary. Historically this has resulted in fragmented services, with issues around access and service availability. There is a significant elderly population (above the national average), and recognition that social isolation and long term conditions including circulatory disease, dementia and diabetes present considerable challenges. There have been significant financial constraints across the locality for a number of years, which have resulted in disinvestment in community-based health services.

There is a need for all organisations to adopt a co-ordinated approach to these issues, to reduce fragmentation, eradicate unnecessary repetition, improve efficiency, but most crucially to deliver a better service for patients and carers.

Central to our vision is an acknowledgement that services must be co-ordinated around the needs of the individual and their carers, allowing them to shape and challenge their care. We propose to make the National Voices narrative - “I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me” – central to delivering and commissioning care at all levels of our organisations.

In keeping with this we are developing Local Integrated Care Teams, focussed around the individual, and bringing together health and social care delivery. Our intention is that for every individual there is a named point of contact within the team, whose role would be to ensure delivery and review of the care plan co-authored by the individual and their carers. They would liaise with other members of the immediate team, but also the wider health, social care and voluntary sector community as required.

We recognise that different localities and integrated care teams will need to work together in a bottom-up way to develop local solutions and ways of working that address the practical differences in individual localities that come from geography, different providers and, in some cases, differing health needs. Empowered, enthused teams will drive forward change and build a culture of integrated working and coordinated care in each local area.

Whilst the primary aim of this work is to deliver better care and experience to users of the service, it is anticipated that there will be potential for financial efficiencies. This may be through a reduction in duplication of work (particularly valuable in rural areas), prevention of hospital admission, better self-care, more proactive interventions and expedited hospital discharge.

The teams will also be clearly focussed on delivering the key aims of the outcome frameworks for both the NHS, and Adult Social Care, as well as contributing to the wider delivery of Public Health Outcomes. Explicitly we would expect that the described teams would enhance quality of life and experience of care for those with care

and support needs, by delivering care which is designed and agreed with the individual and their carers and by delivering a defined single point of contact to monitor and respond to changes in those needs.

By proactively engaging with these individuals and their carers, and working with primary care to "predict" needs through risk profiling, we would anticipate earlier diagnosis, intervention and reablement, reducing the need for additional care and support, reducing the number of people who need to move to 24 hour care facilities and preventing premature death. Having a service designed around needs, with a clear network of support, and integrated approach with a sense of mutual ownership and responsibility will assist with safeguarding and prevention of harm.

All of these proposed outcomes will need to be measured and evaluated as the work progresses. Many areas within North Yorkshire and York are already monitoring many of these outcomes, from reduced hospital admissions, to patient/ carer satisfaction. However further high-level outcome measures will need to be developed across the region to ensure uniformity and consistency – preliminary work locally has identified some required information that is not routinely collected at present. We will measure user experience, and test innovative models of delivery, predicted financial benefits, and health outcomes.

Whole system integration

As described, the region crosses local authority, CCG and NHS provider boundaries. Whilst this presents challenges, it also represents an opportunity for real, large-scale, whole system integration. From a pioneer perspective it also allows testing of these principles in both rural and urban settings, and the development of a system robust enough to support innovation and flexibility in these areas.

Ultimately the system will need to encompass all aspects of health and social care, including mental health, public health, education, housing and community and voluntary sector organisations. The Health and Wellbeing Boards are crucial to this process having oversight, leadership and democratic legitimacy. However it is crucial that this plurality of approach filters all the way down to patient, user and carer level, so that care plans can be truly holistic and respond to all needs, not just those perceived as the preserve of the organisation with which they interface.

Whilst it will take significant time and changes to deliver full integration of systems, the first step is to remove this complexity at the point of delivery for patients and carers, so that it feels simple. Integrated Care Teams, and the individual's advocate within them, will represent the portal through which patients can access this complex system – the teams will need to be afforded the flexibility and authority to respond to this challenge. Care Teams will need to be able to interact with specialist nurses, mental health teams, and the wider community and voluntary sector on behalf of their users.

There should only be one patient record in the home, to which all are expected to contribute. Where organisations within the team hold their own records, there will need to be a clear rationale for this, and a governance framework to ensure sharing of this with other organisations when appropriate, in line with Caldicott principles. (Ultimately a single IT system, with a patient facing shared portal is the ideal, but is unlikely to emerge in the short term, and should not stand in the way of progress.) The degree to which patients are prepared to have their information shared will need to become part of their initial assessment process.

There is already an expectation for General Practice to liaise with integrated teams as part of the national risk profiling directed enhanced services. We will actively encourage this multi-disciplinary team as a natural interface to facilitate discussion around individual patient needs and care plans. This will also allow identification of users who might most benefit from an integrated approach, through both formal risk profiling, but also information sharing regarding vulnerable and isolated adults.

This approach, along with the personalisation of care, should facilitate the prevention of ill health (or deterioration) as well as helping patients to be managed in the most appropriate manner when prevention is no longer an option.

There has already been significant work within the region looking at how we address the needs of some of our more vulnerable citizens in a more joined up way. These include a series of Rapid Improvement Workshops, involving all partners, aiming to improve services for dementia patients at home, in primary, social, community and acute care: and work with CCGs, Local Authorities, Mental Health providers and public health looking to address issues around substance misuse.

From an organisational perspective we will work together to develop an approach to joint commissioning and pooling of budgets to deliver integrated working, and address concerns regarding financial risk.

We will explore with our district, town and parish council partners and local communities the potential for social capital in delivering services, and also how we can best support carers, families and the wider community in their substantial ongoing role. Here we plan to draw on the expertise of both HealthWatch organisations and other partners.

We would be keen to explore how the NHS and social care funding and payment systems can be adjusted to be an enabler of these developments.

We recognise the importance of finding ways of pooling resources and financial modelling that does not destabilise the health and social care economy in North Yorkshire and York.

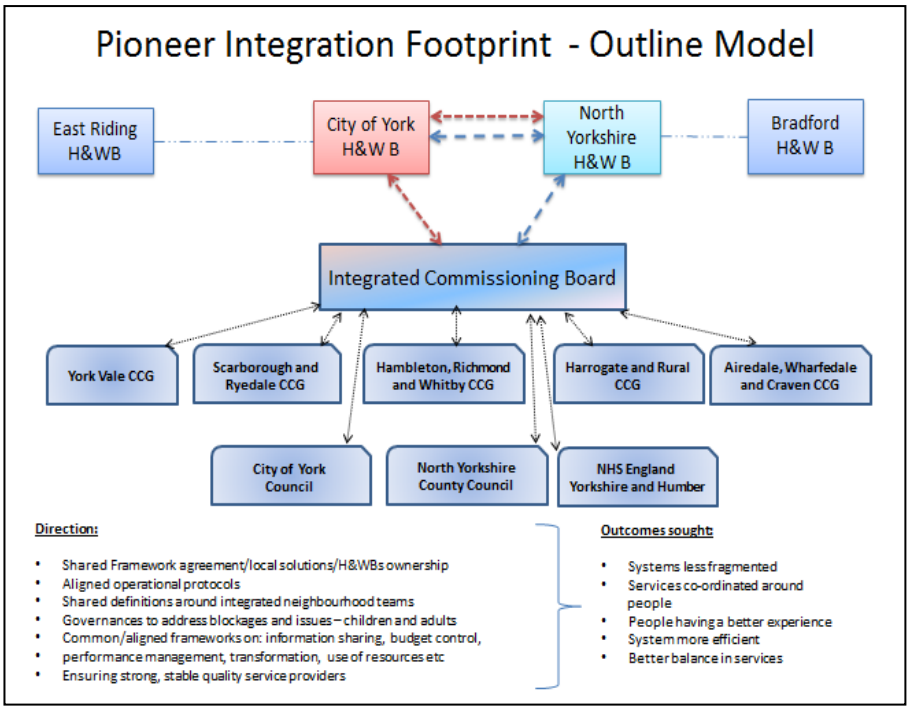
Finally, whilst there is a framework for Integrated Care across the entire region, we will be keen to look for best practice both nationally and internationally that we can apply, as well as an understanding that there will be a need for flexibility and innovation within local regions. This will be actively encouraged, with sharing of experiences and lessons learnt.

The framework for delivering our commitment to integration

Across our organisations and systems, we are seeking to have alignment and a clear line of sight between the front line staff and the two Health and Wellbeing Boards. While front line staff seek to ensure front line, person centred co-ordinated care, their senior managers will work to shape the care landscape and empower front line solution finders.

Senior Executives are working across organisations at Commissioning Board Level and are tasked with putting in place a permissions framework which will ensure consistency of access, ensure staff work within statutory frameworks and have integrated approaches on such things as safeguarding, continuing health care, substance misuse and a range of cross agency inter-related commissioning functions. This will then allow for variation and local solution delivery at locality level.

Over-seeing all of this are our Health and Wellbeing Boards tasked with seeing beyond organisations to the needs of communities and who have mandated agencies with driving forward integration and reporting back on a regular basis on progress.



Our integration model is outlined in the diagram. The Integrated Commissioning Group has agreed terms of reference and begun the task of addressing barriers and challenges.

Not detailed in this overview is a subgroup of the Integrated Commissioning Group called the Writing Group. This Group is developing, with support from Andrew Cozens, an Integrated Framework Agreement.

This Agreement reflects the commitment of local government and NHS commissioners in North Yorkshire and the City of York to work together bring services together to significantly improve outcomes and eliminate the fragmentation of services across health, care and support for patients, service users and carers. We will also work with neighbouring councils who share a CCG population with us (principally City of Bradford and East Riding of Yorkshire).

The Framework sets out a consistent approach to the key issues of governance, accountability, leadership and resources. Within the Framework, models for integration of commissioning and services will be developed, appropriate to the group, activities and locality.

Parallel implementation plans are being developed for each main level of commissioning activity, namely at CCG level (the Vale of York, Craven, Hambleton, Richmondshire and Whitby, Scarborough and Ryedale, Harrogate and Rural), and where relevant local authority levels, setting out intentions and timescales. The Agreement commits partners to work together on practical solutions to issues that create fragmentation and hinder progress in integrating services. Wherever possible a single model will be adopted.

This Framework will shortly be adopted jointly by North Yorkshire Health and Wellbeing Board and the City of York Health and Wellbeing Board to reflect their commitment to better coordinated health, care and support, centred on the individual and their carers. By working within this Framework, they expect to be better able to deliver the outcomes described in their own Joint Strategic Plans.

The Integrated Commissioning Board will have responsibility from the two HWB Boards for turning this intent into reality through joint, aligned and individual commissioning plans and by endorsing practical solutions to key issues identified in this Framework.

Both Health and Wellbeing Boards have identified the main priorities for integrated approaches in their Joint Strategies.

These are personalised models of care for:

- Frail older people;
- Dementia;
- Long term care (including access to urgent social care and mental health and physical health interface with long term conditions);
- Mental health and dual diagnosis; learning disability;
- Child and adolescent mental health.

Improving our arrangements for:

- Continuing care;
- Transition between children's and adults services;
- Working with voluntary sector on prevention;
- Addressing health inequalities and poor outcomes.

Developing new approaches for:

- Getting the model of primary care right and its interface with hospitals and social care;
- Shifting spend from hospital to community;
- Advice and information;
- Aligning personal health budgets with personal social care budgets and direct payments

Our framework document identifies a number of local barriers and plans to address these, including:

- The need for more workforce flexibility
- The need for a review of IT and information sharing arrangements
- The requirement for, and plans to develop, a shared performance framework
- The need to develop the necessary legal agreements for resource transfer.

In addition, there are a number of additional barriers. Arguably most crucial amongst these is addressing the historical differences and some mistrust, between organisations. This will clearly require strong leadership, but in addition, we are working on a joint communications strategy. In some of the areas where preliminary work has been performed there has also been significant benefit from encouraging job shadowing and joint proposals, to address some of the myths and confusion about roles.

As mentioned previously there have also been discussions about how we might start to more firmly pool resources, and even some early work with providers looking at potential changes to the funding model. Should we become a pioneer site, we would appreciate support in addressing these questions.

All parties commit to developing practical and simple solutions (a single one wherever possible) to the issues that have caused fragmentation of services and hinder integrated approaches. We recognise this will take time so propose a two stage approach:

Stage 1: addressing fragmentation; clarifying how partners can speed up decisions; encouraging innovation;
Stage 2: steps toward fuller integration

We commit to develop a streamlined approach to securing agreeing to local developments within this framework.

Although too detailed for this bid, evaluators should be aware the system has already mapped out its neighbourhood team footprints. This saw in North Yorkshire for example tweaking of existing alignments and a range of workshops involving health, social care, primary care and Foundation Trusts community staff come together in a series of workshops. This is rolling out at this time.

Capability and expertise

As detailed, there is firmly established commitment to delivering integration (irrespective of Pioneer status) across all organisations. We have already begun to develop a single unified Integrated Framework Agreement. There is programme management support already established across the region for implementation, and a range of section 75 agreements in place.

A number of projects have already started to bloom across the area with sharing of experience, and lessons learnt. In addition to working on specific Local Integrated Teams, there has also been extensive evidence of co-operation and co-ordination across organisations to develop solutions for specific communities.

These include the previously detailed work around dementia and substance misuse, as well as work looking at one of our local community hospitals. This work in Ripon for example, has involved the public, schools, churches; city, district and county councils and councillors, leisure services, the local hospital and community health provider, mental health services and the CCG looking at how to work together to offer a variety of services to the community. It demonstrates a level of engagement with service users and carers, which will need to be carried across to all of our integration work, if it is to succeed.

We also have experience of the use of enabling technology (both telecare and telemedicine) to aid clinical decision making, support people with long term conditions, support carers, end of life care, advice and support into nursing homes, as well as primary/secondary care IT interface e.g. Systmone available in Airedale, Wharfedale and Craven.

Testing new approaches

Work is already underway at a local level in different parts of North Yorkshire and York to experiment and learn how integration can be developed and sustained within local teams. This includes local programmes of organisational development where staff from different organisations have been brought together to build a shared sense of identity and the agreement of common priorities and solutions. Taking forward and properly embedding such large-scale organisational development and change will require continued commitment and energy over an extended period and is one of the areas that would benefit from North Yorkshire and York being a pilot site.

New joint approaches to commissioning are being tested in the area of substance misuse where an outcome based model is been specified and consulted upon. An initial joint commissioning involving four of the CCGs, North Yorkshire Council and Public Health together with two Mental Health Trusts has initiated the process of agreeing a similar approach in mental health.

In some areas, we have operational integrated protocols with the plan to role these out further. We have a range of examples from each CCG area of success already being achieved.

We would like support understanding the framework of rules on choice, competition and procurement as a means of driving and embedding integration. There has been initial discussion on moving from Payment by Results to per capita funding model with one acute partner.

North Yorkshire County Council's finance officer, CCG and acute provider finance colleagues have begun to explore open book accounting as we consider a whole community funding approach in Craven.

Sharing

There is already an established history of sharing experience locally and nationally – most recently and relevantly with sharing of experiences to date in working towards integrated care teams, and the development of an Integrated Care Framework. We have established a Joint Integrated Commissioning Team to help facilitate the sharing of experience across our region, and to learn from those elsewhere.

We expect to utilise, and contribute to, the Integrated Care and Support Exchange. Meanwhile we will continue to share information across CCGs, the wider health community, local authorities, voluntary sector, Health and Wellbeing Boards, Commissioning Support Units and clinical networks.

Evidence

We have studied the substantial evidence available regarding integration. Andrew Cozens, an associate of the King's Fund, the LGA and the WLGA, has supported our recent work on an integration framework. Clearly, there are numerous models, from the work in Torbay, the Chronic Care Demonstrator sites in Wales, to examples internationally such as Kaiser Permanente and the Veterans Health Administration System in the US. We have close ties with systems exploring a similar journey in Scotland. Whilst some evidence is encouraging, not all has shown the results hoped for or anticipated, particularly with respect to patient satisfaction or outcomes.

Our aim then is to ensure that patients and carers are central to our integration plans. We need to establish clear outcome measures so that we can respond quickly and effectively when we are not delivering on those outcomes, and we will also commit to sharing these findings widely, so that we can contribute further to the growing evidence base.

We will work with partners locally and nationally to ensure an on-going process of refinement of measurements, and of the resulting service.

National interest

This bid is made by partners in North Yorkshire and York, in alignment with City of Bradford Council and East Riding of Yorkshire Council to support CCGs with populations that overlap (in Craven District and the area covered by Vale of York CCG respectively).

The bid has a number of elements of national interest:

- Strong commitment of all parties including NHS England
- Combination of urban and very rural
- Unitary and county/districts local government models
- Multiple councils and CCGs working within a framework of collaboration
- Financial imperatives to address

Delivering integrated care across North Yorkshire and York is a significant challenge. It is also no longer optional. There is a clear national requirement to ensure services delivered to patients and carers are developed around their individual needs, and capable of anticipating and responding to, changes in those needs. North Yorkshire has an ageing population, challenging geography, and a severely restricted financial resource. As such addressing these needs will require a co-ordinated, integrated approach across all organisations. The over arching aim - to promote and contribute to the well being of the individual - are the same across all partners, but the historical differences in funding and culture have traditionally been barriers to joint working.

We propose to develop an integrated approach to care, focussed around the individual, and designed to ensure they experience a single cohesive package of care. This will require local flexibility, facilitated by an agreed framework across all organisations. In the longer term we plan to develop a financial model that facilitates appropriate transfer of resources, whilst addressing risks inherent in this.

It is anticipated that such work would result in financial benefits as we remove reproduction of work, facilitate better health and disease prevention, reduce hospital admissions and length of stay. The primary aim however must remain the improvement of outcomes and experience for the patient themselves.

We hope that these changes will benefit not just the local health economy, and our patients, but also contribute to the growing evidence base around integrated care. In our opinion there would be significant benefits to our becoming a pioneer site – it provides an opportunity to demonstrate integration across a large, complex region with varying health needs. It would lead the way in showing how integration might work across complex regional and organisational boundaries, on a background of financial deficit – perhaps even contributing to the resolution of these financial challenges.

Pioneer status would, in turn, be beneficial to ourselves in helping us to navigate some of the challenges in developing solutions around sharing financial risk and governance. It would also serve to underline our collective commitment to delivery and leadership.

Bid Partners

Parties to Application	Organisational lead
Health and Wellbeing Board – City of York	Chair: Councillor Tracey Simpson-Laing
Health and Wellbeing Board – North Yorkshire	Chair: Councillor Clare Wood
City of York Council	Dr Paul Edmondson-Jones
North Yorkshire County Council	Helen Taylor
NHS Vale of York Clinical Commissioning Group	Dr Mark Hayes
NHS Hambleton, Richmond and Whitby Commissioning Group	Dr Vicky Pleydell
NHS Airedale, Wharfedale and Craven Clinical Commissioning Group	Dr Colin Renwick
NHS Scarborough and Ryedale Clinical Commissioning Group	Simon Cox
NHS Harrogate and Rural District Clinical Commissioning Group	Amanda Bloor
Bradford District Care Trust	Simon Large
Airedale NHS Foundation Trust	Bridget Fletcher
Harrogate and District NHS Foundation Trust	Richard Ord
York Teaching Hospital Foundation Trust	Patrick Crowley
Tees, Esk and Wear Valleys NHS Foundation Trust	Martin Barkley
South Tees Hospitals NHS Foundation Trust	Professor Tricia Hart
Leeds and York Partnership NHS Trust	Chris Butler
Healthwatch North Yorkshire	Rob Salkeld
Healthwatch York	Sian Balsom
NHS England – North Yorkshire and Humber Area Team	Chris Long
NHS England – West Yorkshire Area Team	Andy Buck