North Yorkshire County Council

Scrutiny of Health Committee

12 June 2015

REALISING OUR POTENTIAL - OUR NEW NORTH YORKSHIRE

A North Yorkshire Approach to Integration, Prevention and New Models of Care June 2015

On behalf of: *NHS Airedale, Wharfedale and Craven CCG / NHS Harrogate and Rural District CCG / NHS Hambleton, Richmondshire and Whitby CCG / NHS Scarborough and Ryedale CCG/ NHS Vale of York CCG*

Background

This paper is designed to be the starting point for a discussion with the Health and Well-being Board and across organisations. It is deliberately written in a 'green paper' style so that HWB can be involved in the development of these the models going forward. It focuses primarily on the adult population.

The NHS Five Year Forward View (5YFV) was published in October 2014 and describes an ambitious challenge to the NHS and Local Authorities to develop robust and resilient services that meet the very different needs of our population into the future:

> *It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948 between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details. One organised to support people with multiple health conditions not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we can't deliver the necessary change without investing in our current and future workforce.*
>
> ***5YFV***

Likewise in March 2014, the Association of Directors of Adult Social Services, which works with local authorities, the Local Government Association and the Government, to shape, co-ordinate and deliver adult social care policy, published it's equivalent forward look prospectus: Distinctive, Valued, Personal – why social care matters: the next five years. This prospectus sets out:

- Protecting the NHS also requires the protection of social care: together, both services need to be protected, aligned and re-designed, with greater use of pooled budgets
- Outcomes, rather than structural solutions, should be the focus of integrated services
- Health and Well-being Boards offer the best prospects of crafting local solutions tailored to local needs and circumstances
- Personalisation should be at the heart of public services and the voices and views of people who use services are integral to shaping services and to making individual decisions about care

- The core components of adult social care services should be good information and advice; building supportive relationships and resilient communities; services that help us get back on track after illness or support disabled people to be independent; care and support services that address our mental, physical and other forms of well-being and are much better joined up
- Health and social care should be seen as much greater contributors to a stronger economy and as sources of potential economic growth – social care alone contributes £43bn annually to the national economy through employment and goods and services

The recent devolution package for Greater Manchester ('Devo Manc'), which includes health and social care, offers new opportunities for developing approaches to investment and service delivery which combine both critical mass and local prioritisation - the mantra of Devo Manc is 'no decision about Greater Manchester, without Greater Manchester' and it was encouraged by the fact that, prior to the deal, only 16 percent of health and social care spend in the area was determined by organisations based in and directly accountable to Greater Manchester. Whilst the communities, service models and political landscape in North Yorkshire is very different to that of Manchester, the learning is significant, including the opportunity to develop a way of working which combines size, scale and reliability with the ability to make local, place based decisions.

The scope of change required to meet these challenges is huge and requires the participation of every sector of care. The ingredients that underpin successful change are complex but key ingredients are:

- Clarity of purpose and ability to describe the journey and the destination
- A motivated skilled resilient workforce
- Real involvement and ownership of change by staff
- The development of an ongoing conversation with the public and with patients and carers that fosters real co- creation.
- Capacity to make change happen (tools and time) for every organisation involved.

Together, each CCG in North Yorkshire and the County Council cover the full range of differences in demography and geography. Although there is great synergy around the over-arching vision, delivery of their objectives will be local and different. Each CCG put in a bid to become a Vanguard site for the 5YFV. Harrogate and Rural District CCG working with NYCC, Harrogate District Foundation Trust, TEWV and Harrogate Borough Council, were successful. The Vanguard sites will attract central NHS investment and expertise to facilitate their plans. The other CCG'S are committed to progressing their programmes of work and will continue. Each CCG has outlined their local plans in the appendices.

What we have achieved so far

All of the CCG's emerging from the former NHS North Yorkshire and York Primary Care Trust faced inherited financial deficits in their first year of operation. All of the 5 main CCGs have been able to repay inherited deficits and remained in surplus in 2015-16, providing the most stable NHS financial situation for over a decade.

Since the implementation of the 2012 Health and Social Care Act the county has seen significant advances across the health and social care communities. Some examples of these are:

- Large-scale improvements in Mental Health services such as:
    - The creation of health-based places of safety for those detained under section 136 of the Mental Health Act

    - Dramatically increased access to community based talking therapies (IAPT) from 2% of the potential population served to nearly 15%
    - Mental Health Liaison has been commissioned to support staff both in the Emergency Department and on Inpatient wards to provide the best possible care for people with mental health problems, with the aim of reducing inappropriate A and E attendances, unnecessary admissions and the length of inpatient stay for people with complex problems.

- Investment in community based services to prevent hospital admission and speed up hospital discharge including:
    - FAST response/intermediate care teams
    - Home from hospital schemes commissioned from the voluntary sector
    - Paramedics working in primary care and closer working between the ambulance service and GP's so that people are not automatically taken to hospital when they dial 999 if their problems can be managed locally.
    - Case finding in primary care to develop care plans to actively manage frail and vulnerable patients more effectively.

- Significant investment in, and commissioning of prevention and independent living services, including the roll-out of new extra care schemes, locally based weight management services and the healthy child programme

- New, comprehensive Public Health services for sexual health and substance misuse

- Implementation of the first phase of the Care Act, including new services for carers

- Greater use of personal budgets and direct payments, including the first personal health budgets – putting more people in control of their care and the funding that provides it

- The emergence of new ways of working as organisations and with the public, including through Health and Well-being Board, Healthwatch, provider partnerships , GP federations etc

Our approach to integration

The Better Care Fund has been a catalyst for new ways of working together in North Yorkshire. However, in many ways, it has been practical steps, like the management of winter pressures, which has begun to build confidence and to improve what we do and how we do it. These relationships and ways of working are still at an early stage.

The North Yorkshire Commissioner Forum has identified a series of principles which it believes should underpin how we develop our model of working together in the future.

We want to make the step from responding to national policy to, with local people, shaping policy and taking a step towards self-determination. We know that what works best is when we combine local knowledge and delivery with county-wide collaboration and scale. We want to combine together to be able to plan for the next ten years and beyond. We are therefore starting work on what a devolution deal might look like for North Yorkshire's health and social care services which:

- Reaffirms the importance of place based commissioning, centred around GP's in the County's main localities, and partners in local government and the voluntary sector

- Delivers services around clusters of GP practices and / or identifiable communities: Team around Primary Care or Team around the Community
- Commits to reinforcing this model irrespective of any subsequent changes to NHS – or even – local government boundaries and responsibilities
- Emphasises the increasing role of the public and particularly people who use services in having more choice and control over decisions which impact on their care and their lives, as well as in co-creating the plans and models which are developed for services in the future
- Makes sure the North Yorkshire Pound – and indeed, the Ryedale Pound, and the Scarborough Pound and the Hambleton Pound etc. is spent well and, where appropriate, more of it is pooled to get better impacts across the NHS and local government
- Focus on outcomes as the basis for change, rather than structural solutions
- Empowers local people to take control of their own health and well-being through expert programmes, peer support and inputs from the stronger communities programme
- Shifts focus and investment towards prevention, self-care and care at home, rather than hospitalisation and 24 hour care, so that patients only are admitted to hospital because they are too unwell to be managed at home. No one should be in hospital unless their care cannot be delivered safely in the community 24/7
- Ensures no-one should be discharged to long term care without the opportunity for a period of enablement
- Ensures that the County continues to have 3 sustainable general hospitals within its boundaries at Harrogate, Northallerton and Scarborough, which deliver high quality safe local services as well as hospitals in Darlington, Keighley, Middlesbrough and York which serve the County well. The ethos on which the hospital services are built is that all that can be delivered locally safely is and that only services that need to be delivered from specialist centres because of compelling quality and workforce issues are provided from more distant larger hospitals
- Improves health and reduces the variations in health outcomes and access to services experienced in some urban areas and the remotest rural areas

Our Emerging models of prevention and care

Whilst each local area has different needs and circumstances, there are some common approaches emerging in how we are developing models of prevention and care across the County.

<u>Prevention, self-care and community resilience</u>

Our aim is to keep people healthy and self- reliant for as long as possible: none of us wants to use services unless we really have to do so. We believe that we should focus more energy and investment towards enabling people to live healthily, to get the information and advice any of us need.

Examples include:

- Plans to introduce a network of prevention officers and village agents, working with the voluntary sector and statutory agencies to support people to remain independent and well at home
- Action to promote warm homes and reduce fuel poverty
- Falls prevention services
- Mental First Aid and suicide prevention
- Better information and advice for people on-line and in person about health and social care issues

- Good neighbours schemes, village hall hubs, carers support and other grassroots initiatives funded through the Stronger Communities programme and borough and district councils
- Work with pharmacists to support prevention around minor ailments
- The roll-out of extra care and supported living developments across the County

Re-designing the space between services

Whilst recognising that most of us would rather not use services unless we have to, when we need to do so, then we expect services to be high quality, responsive, in the right place at the right time, and, increasingly, taking account of our convenience, our views and making decisions with us rather than for us.

There are many examples of how we plan to re-model these services from around the county. These include:

- Integrated urgent care services, based in care hubs with staff from primary and secondary care working together to meet the needs of patients
- Physicians assistants and urgent care practitioners working alongside GP's and practice nurses in primary care together
- Intermediate care and reablement services coming together to develop seamless services
- GP hospitalists working in Acute Care medical assessment units to enhance medical capacity in small hospitals and bring a GP focus
- GP practice nursing reaching out into nursing homes and working to better manage frailty
- Individuals with long term conditions owning comprehensive care plans designed with them and there family/carers to support and maintain independence and reduce the need for an urgent intervention.

Building the foundations for new models of prevention and care

To integrate services effectively we need to consider a move away from traditional funding mechanisms including payment by results (PBR). An example of this would be an integrated hospital "front of house". At present patients can access both GP Out of hours services and A&E services which are often located very close to each other. GP out of hours services are commissioned as block contracts where as A&E is on a tariff. WE also need to consider if pooling budgets between organisations gives us increased flexibility and economies of scale. If the service is to be truly seamless we need to develop a single funding mechanism which rewards the best outcomes for patients.

Developing an appropriated skilled and motivated workforce to take forward this ambitious vision for the future is perhaps our biggest challenge. The reasons are complex and include:

- A history of poor workforce planning in the NHS
- A reduction in the hours worked and a desire for a better work –life balance by the clinical workforce over the last 15 years
- Preference for newly qualified professionals to work in larger towns and cities, making it hard to attract them into rural areas
- Preference for younger professionals to live and work in the south
- Relatively expensive housing costs in North Yorkshire when compared to surrounding areas (Co Durham, West Yorkshire etc.) and a perceived lack of local services in a deeply rural county
- Very localised labour markets, with significant differences in supply and demand, for example between Filey, Scarborough and Whitby

- Competition for those undertaking caring roles which are relatively poorly remunerated compared with the retail sector etc.

North Yorkshire Delivery Board has already started to look at these issues on behalf of the HWB and will report back in due course.

To deliver new models of care we will also need to develop new roles: physician's assistants, GP hospitalists, primary care emergency practitioners and generic care workers. The individuals filling those roles cannot simply be taken from those who at present fulfil other roles locally as that only creates another pressure, so we will need to make North Yorkshire a beacon of NHS and Social Care innovation attracting people into the area for the first time, or encouraging those originally from the county to return home to work in an energetic and forward thinking environment. Hosting local education and skills development opportunities together which will also bring together health and social care teams will be an essential component to success.

We will need to use new technologies to their maximum. Where better to really explore the benefits of e-consultation, supporting palliative care patients in their own homes, smart working, and enabling patients to better manage their own illness through technology than a deeply rural community such as ours?

We are committed to involving the public in a very different way from how we have done in the past. We want the patients, their carers and the public to work with us from the beginning to create our vision. This means we need to develop new ways of having those conversations, to welcome the public as team members into every piece of work we do. We will need to reach out to groups already in existence, fully exploiting social media, find ways of involving children and young people and find those who have traditionally been seen as hard to reach by thinking creatively beyond our normal models of working. This will take time. It is far away from a simple traditional "consultation". It will also require energy and real commitment from the public themselves to be active participants in both managing their own health and in service development. Across the county we have started those conversations but we know we have a long way to go.

We also need to ensure people are more in control of their own care and their own lives – shared decision making between people using services and professionals, personalisation, personal budgets and direct payments, across health and social care, are not the only ways of achieving this ambition, although they are important factors.

As we develop our new services it is vital we weave services which address mental health issues and which promote well- being and mindfulness into all our services from the foundations upwards rather than as an addition later in their design. Remembering every aspect of illness and care has a psychological component which needs to be addressed effectively.

<u>Developing new models of primary care through greater commissioning responsibilities</u>
The document 'Next steps toward Primary Care Co-commissioning' (NHS England 2014) was published in November 2014 and gave clinical commissioning groups (CCGs) the opportunity to choose the co-commissioning model they wish to assume for primary care. Primary Care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View and is an enabler in developing seamless, integrated, out-of-hospital services, based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning models CCGs could take forward:
Level 1. Greater involvement in primary care decision making
Level 2. Joint decision making

Level 3. Delegated commissioning arrangements

Each CCG submitted an application to NHS England on the 9th January 2015. The table below shows the level in place from April 2015.

Clinical Commissioning Group (CCG)	January Submission
Harrogate & Rural District CCG	Level 3 - Delegated commissioning
Scarborough & Ryedale CCG	Level 3 - Delegated commissioning
Vale of York CCG	Level 3 - Delegated commissioning
Hambleton, Richmondshire & Whitby CCG	Level 2 **-** Joint decision making

The scope of primary care co-commissioning in 2015/16 is General Practice (GP) services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. The terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

The CCGs who are undertaking Level 3 (Delegated) commissioning of primary care have established specific Governing Body committees. These will take the responsibility for decision-making on primary care commissioning and have been established to manage conflicts of interest and to involve wider stakeholders where appropriate. The Primary Care Commissioning Committees (PCCC) will manage the formally delegated responsibilities provided from NHS England (NHSE) including the financial budgets from GP contracts. (Some elements of primary care commissioning already sat with CCG financial resources, such as that for GP Out of Hours services and Local Enhanced Services. These will continue as before but now forming part of a wider responsibility for primary care.) The PCCC will be formal CCG committee with their main decision-making committees meeting in public, with agendas and papers accessible through the relevant CCG. Those CCGs engaging in Level 2 commissioning will cover the same areas of responsibility as level 3, but without the formally delegated budgets from NHSE. Furthermore, whilst Level 2 CCGs will still commissioning jointly with the primary care commissioning function from NHSE, for those at Level 3 the relationship with NHSE will be primarily that of providing assurance. The effective distinctions between the co-commissioning levels may become clearer as CCGs engage in actual GP primary care commissioning.

The development of primary care commissioning should be seen as part of the wider development of CCG service strategies, including service redesign and new models of care, rather than being treated in isolation as a discrete element of service commissioning. As such the emergence of commissioning new models of primary care fits within the local implementation of the NHS 5YFV. At this early stage it is unclear as to the specific changes in primary care that may come forward in the short and medium terms. CCG primary care commissioning will, however, need to respond to the evident challenges in GP services:

- The need to move to 7 day service provision
- The difficulties of maintaining and developing a primary care workforce
- The public sector financial environment in an age of austerity
- Increasing demand for fast access to healthcare

Responding to the challenges may require redesign of service provision, including:

- the skill-mix of primary care workforce;
- the offer of services to patients across 7 days;

- rationalisation and consolidation of service delivery models;
- greater promotion of self-care; and
- community models of care and support.

Enablers
To move the work forward a set of enablers may need to underpin progress:

1. A commitment to an overarching strategy for delivering new models of prevention and care, with an explicit agreement that localities will play a key role in the service design and architecture of delivery, whilst making best use of countywide economies of scale and critical mass
2. An agreement to work together to make North Yorkshire a more attractive place for people to come to live and work. We need to consider:
    a. Making care a positive career choice (New roles, remuneration, pay policies across organisations, market conditions, academic links etc).
    b. Housing policies.
    c. Other ideas?
3. A commitment to develop new funding models and risk pooling both in localities and across the county.
4. Development of new technologies.
5. Willingness to explore greater sharing of resources, such as capital estate.

Vicky Pleydell

Clinical Chief Officer
Hambleton Richmondshire and Whitby CCG

Appendix 1

Airedale, Wharfedale and Craven CCG

New Models of Care Briefing – Work to Date

Strategic Approach; Five Year Forward View

Our Vision is to create a sustainable health and care economy that enables people to be healthy, well and independent.

In order to achieve this vision we will:

- Promote self-care and illness prevention and improve the general health and well-being of the population
- Transform primary and community services and place the patient at the centre of their care
- Implement a 24/7 integrated care system across health and care economy
- Develop and deliver a sustainable system wide model for urgent care services
- Develop and implement a system wide model for delivery of planned care interventions

Integrated Care for Adults Programme (ICfA)

The Integrated Care for Adults programme is a programme across Bradford, Airedale, Wharfedale & Craven (AWC) with shared objectives and outcomes. Delivery is undertaken through separate programme arrangements in AWC to reflect local nuances and approaches. Please see governance diagram on Page 3.

Work to date - to transform the delivery of care

There is system-wide commitment to transform care and join up services. Significant progress has been made in developing integrated care teams based around local communities formed around clusters of GP practices. This has been undertaken through the ICfA programme.

There are 17 GP practices within AWC. **Integrated community teams** have been developed within 8 communities configured around clusters of GP practices.

Integrated Intermediate Care Teams have been established at locality level. Airedale Collaborative Care Team (ACCT) covering Airedale and Wharfedale locality and Craven Collaborative Care Team (CCCT) covering Craven locality. The teams are made up of health and social care professionals and include mental health workers and support for carers.

When the integrated community teams are unable to meet the needs of individuals in the community they could refer to the integrated intermediate care teams who would pick up care with a focus on admission avoidance. Depending on need assessment GP's may refer directly to the integrated intermediate care teams. The integrated intermediate care teams also accept 'step down' from acute hospital to facilitate earlier discharge. They provide a 'virtual ward' type service.

The integrated community and intermediate care teams will form the basis of wrap around health and social care teams supporting delivery of new models of care whether these are evidence based, enhanced primary care, both or a different model.

Intermediate care services have been in place for some time but have been strengthened and expanded and deliver an integrated offer across health and social care enablement services. Appendix 2 gives more detail of development of 'wrap around' community services at community and intermediate care level.

It is important to note that there are plans to deploy an 'intermediate care hub' mid-November. This will be staffed through current health and social care staff establishment and will oversee utilisation of the IC service capacity, undertake joint assessments and manage IC bed capacity, acting as a bed bureau.

Predictive Risk Stratification

Predictive risk stratification is now available in all practices and enables integrated multi-disciplinary teams at community level to identify people most at risk of hospital admission, undertake joint assessment and develop joint care plans. Lead practitioners are assigned to coordinate care to enable the person to remain at home and manage their condition more proactively.

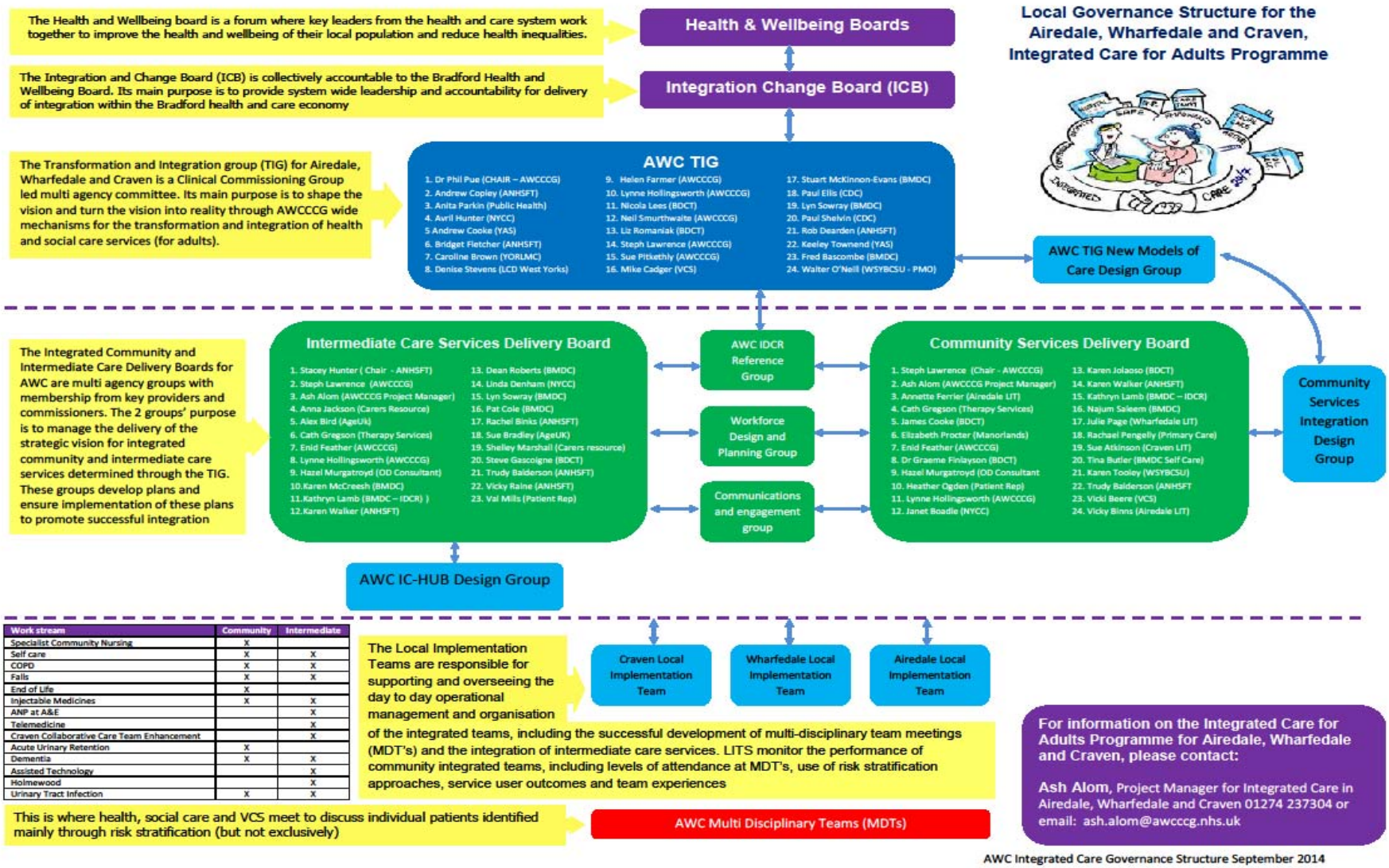
Self-care and preventative approaches are being developed and over the next five years will be adopted at scale and become the norm. The Third Sector will be central to this, supported by technology.

Governance Structure

Diagram 1 sets out the governance structure for the delivery of the Integrated Care for Adults Programme. This programme forms a firm foundation upon which to develop new models of care and has established work streams and projects which will form a delivery mechanism.

It will be necessary to review the programme to avoid duplication including the 'Delivery Support Programme' which is undertaking infrastructure work as there will be co-dependencies. Development of new models of care may be undertaken through this existing programme, work streams within it or done separately with links/communications being maintained to ensure any conflicts are avoided. This is to be determined.

Diagram 1



AWC Integrated Care Governance Structure September 2014

Introduction

HRW CCG has been working on a programme of engagement and subsequent service transformation over the past two years. Branded as Fit 4 the Future this work has now developed into an ambitious programme of work across the three localities, informed through on-going engagement with the local population, clinicians and partner organisations. This whole system partnership working is led by the HRW Transformation Board.

Whitby

Following a rigorous and in-depth procurement process Virgin Care has been selected as the preferred bidder to provide community and out of hours services in Whitby and the surrounding area. Virgin care will provide services from 01 July 2015 and a range of key service improvements will be implemented including;

- Enhanced medical input and continuity of medical cover
- Involvement in the development of a health and wellbeing hub
- Innovation fund to work with the local voluntary sector
- Rapid assessment for frail and elderly
- More streamlined district nursing with the use of mobile working

The CCG is now preparing for the transfer of services to Virgin care and continues to engage with the community regarding the re-provision of the community hospital to ensure the long term sustainability of services.

Hambleton and Richmondshire

The outcomes of the Fit 4 the future engagement programme in 2013/14 enabled the CCG to outline its vision and case for change, regarding reconfiguring older people's services in Hambleton and Richmondshire. Key themes and messages included;

- Keeping people in their own homes for as long as possible
- More information for patients and their carers
- Better patient transport
- Facilitating social interaction
- More support for carers
- Utilise new technologies as part of the solution
- Where acute hospital care is needed, our communities want to receive care locally whenever possible, understanding that specialist services have to be provided in centres of excellence.

This work has now evolved and Fit 4 the Future in Hambleton and Richmondshire has been developed into an overarching programme and the key objectives are;

- To keep the Friarage Hospital at the centre of healthcare for the people of Hambleton and Richmondshire

- To address the immediate issues of the urgent care pathway
- To ensure that treating people at, or near to home, is a viable option wherever possible
- To work together across the system to shift the focus from illness to wellness
- To assess the future purpose of the community hospitals
- To create a step change in the integration of health and social care
- To radically re-think the delivery of health and care in rural areas, including the use of technology
- To radically rethink and take opportunities to reform our workforce

The partnership has developed an approach that seeks to co-create solutions with the local community and key stakeholders across the localities and has embarked on a further period of engagement over the course of the summer.

Work on the key objectives has commenced and new models of care are emerging and being tested in the following areas;

- Urgent care
- Integrated intermediate care
- Diabetes pathway
- Rural community services

Workforce redesign, technology and estates have been identified as key enabling themes across all areas and over the next 12 months we will have developed a vision, shaped and supported by stakeholders, implemented our infrastructure and embedded the model, mapped our services and understood our data, and tested out ideas and innovations on a small scale before proposing them as possible system wide solutions. By spring of 2016 we will hope to have designed in partnership with our communities our blueprint for beacon of health and care and will be in a position to undertake any formal consultation process that will be necessary to implement the redesign and reconfiguration of services across Hambleton, Richmondshire and Whitby.

The programme of work is led by our Transformation Board which brings together all our local stakeholders including all Health Trusts, District and County Councils, the voluntary sector, and the GP Federation and is informed by an Advisory Board of independent Experts and The Engagement Reference Group which leads public and patient involvement.

G Collinson

Associate Director Transformation

May 2015

NHS Harrogate and Rural District Clinical Commissioning Group

Vanguard Summary

The focus within Harrogate and Rural District has been upon co-creating a radically different model to secure a comprehensive integrated, locality based solution which makes best use of technology, skills and local infrastructure. This has been based upon robust stakeholder engagement with public and professionals.

The New Model of Care will introduce:

Community Hubs and Integrated Care Delivery
Each hub will integrate primary and community teams including GP's, community nursing, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector. A central Hub will offer access 24/7, with a number of smaller rural hubs offering advice, access and care on an extended basis. We will engage with local communities to design these.

Embedded and shared use of Care Plans
Multidisciplinary professionals will have access to and development of shared care plans for our patients which will enable more informed and consistent decision making. We will integrate and share IT systems to ensure this.

Virtual Hub
This will introduce a consistent information source for both professionals and the public regarding services in the area, ensuring "any door" access to services. The alternatives to Acute Secondary Care will be clear and accessible.

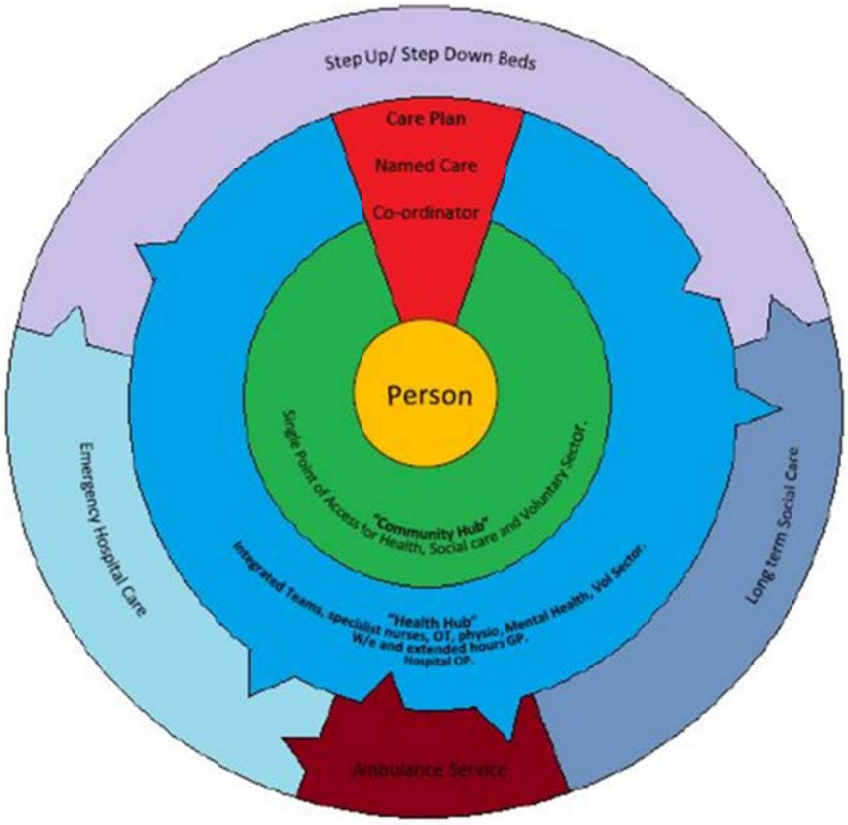
Benefits for people using services

- Access to advice and information for individuals in crisis/acute situation 24/7, without defaulting to A&E
- Resolution of issues at first point of contact wherever possible
- Personalised, accessible, holistic care designed around their needs with a single assessment process
- Support to remain independent, safe and well at home
- Care provided by a team they know and trust
- Access to telehealth / telecare solutions
- Targeted prevention work to support people on the cusp of care
- Common universal care plans

Principles of the model

- Care at home is the default position
- Involve people who use services and carers in decision-making
- Focus upon Prevention agenda
- Locality based integrated teams
- An acute bed is only used when only an acute bed will do

The involvement in the Vanguard New Models of Care Programme is intended to accelerate the development of the new model of care delivery. We will access expertise from the national team in areas of; new contracting vehicles, workforce development and system modelling. The delivery of the New Model of Care is overseen through the Harrogate Health Transformation Board. We have established a New Models of Care Delivery Board to lead delivery of the new system locally.

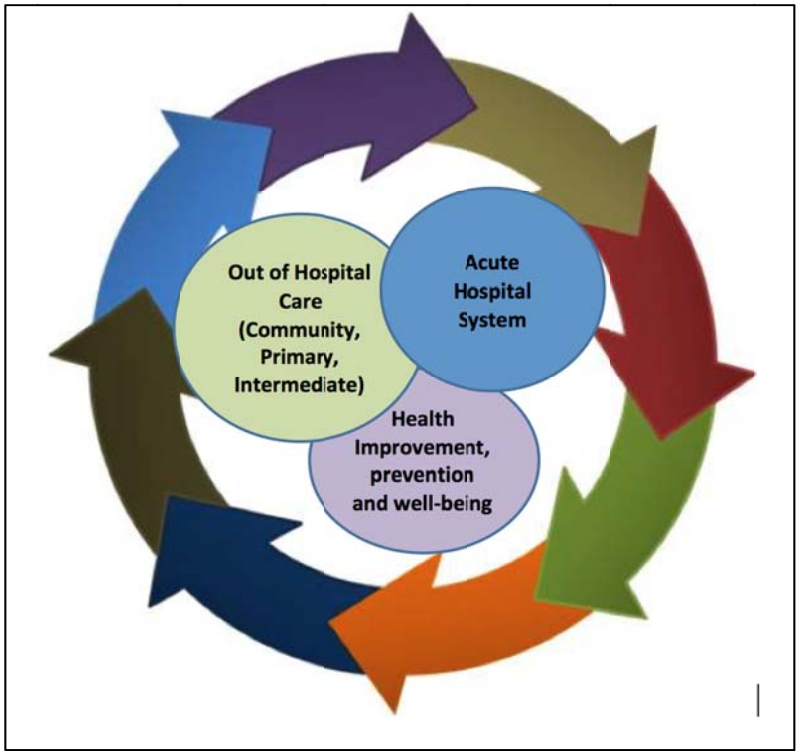


NHS Scarborough and Ryedale Clinical Commissioning Group
Summary of Planning for 2015-16

In 2015-16 NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG) will seek to consolidate the gains it made in its first two years of operation and address the significant service gaps identified from its analysis of health need. The major initiatives that will be implemented in 2015-16 include:

- Establishment of the Integrated Urgent Care Service
- Implementation of the actions described in the Better Care Fund, such as
  - Integrated Community Care teams
  - Health Prevention workers
  - Health Improvement in hospitals and care homes
  - Hospice at Home within an Integrated Palliative Care Team
- Improving access for planned care to reduce patient waiting times
- Improving access to urgent mental health care (including Crisis Response, Mental Health Liaison, and Street Triage)
- Reducing waiting times for primary care based counselling services
- Beginning delegated responsibility for the commissioning of primary care service

The actions planned in 2015-16 form part of a longer-term CCG plan that is itself part of a broader health community programme of redesign aimed to establish high-quality sustainable services on the East Coast. This programme will encapsulate three main themes across a range of partners.



NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York CCG is currently involved in 2 significant national programmes which will help us move towards our vision of new models of integrated health and social care , delivered though a locally owned multi-agency organisation. These programmes are closely linked and will run in parallel as they will both help us to deliver our agreed vision; the key elements of each programme are detailed below.

New Models of Care/Pioneer

- Programme to support changes/improvements to systems and processes
- Focussing on practical solutions to deliver new care models and new pathways of care
- Leading on the development of values and outcomes based commissioning
- Network of sites across the country who share learning and solutions development
- Ring fenced external support to help access additional funding and senior system decision makers
- Helps the CCG and its partners become smarter commissioners through evaluation of models and access to international best practice

Vanguard

- National programme to identify early adopters of new provider models
- Aligned to 5 year vision for NHS and focus on development of an integrated service provider based around the Multispecialty Community Provider Model
- Running in parallel with NMOC/Pioneer work stream and despite being unsuccessful in formal Vanguard programme, we will continue to develop the vehicle to deliver the outcomes expected from NMOC
- Work is currently underway to define and agree the initial 'shadow form' to deliver the new provider organisation

Developing and exploring new financial and contracting models that link across both programmes

Selby Care Hub

- Led by York Teaching Hospitals Foundation Trust in collaboration with Primary Care and North Yorkshire County Council
- Based on Primary and Acute Care System (PACS) with emphasis on early intervention and individual support packages to facilitate care outside of hospital
- Focus on greater use of Generic Care Workers to maximise efficiencies and reduce duplication. This approach will help shape future workforce requirements building on learning from International new Models of Care Programme
- Impact of Hub being measured through Joint Delivery Group (VoY CCG led) and NYCC monitoring processes (final details to be arranged)
- Hub also links with BCF schemes developed as part of North Yorkshire submission including Urgent Care Practitioners, Street Triage and Hospice at Home
- CCG working closely with YTHFT to agree next steps for developing the hub and future investment and risk share models.
- Longer term provision of this model may be assume by the provider integration work (OTIS)

Health and Adult Services

'2020 North Yorkshire' is the vision and approach for change for North Yorkshire County Council that will result in a changed and modernised Council.

Key elements of the 2020 vision are:

- Supporting communities to take a greater role in the provision of services.
- Developing new models for delivering services by working in partnership with other councils, or providing services through staff mutual or community based social enterprises.
- Changing the way customers access and/or receive services for example accessing services online, more contacts being dealt with by our Customer Resolution Centre, and changing the way people contact us face to face.
- Looking at opportunities to increase income, particularly around people who fund their own support.
- Reviewing our need for buildings in the context of new ways of working with partners and locally based activities.
- Looking at the skills and knowledge our staff will need.

In the future, we will need to think differently, and work differently with people and our partners. How we do this will reflect the changes taking place across the Council as part of the 2020 North Yorkshire programme, which looks at how, where and when services are delivered. We will work with our partners to provide a quicker response and better results for people, including being clear about our priorities, what we are able to provide and what we want to achieve. We also want to make the most of our strengths, including our committed staff.

The Changes We Will Make By 2020:

A Distinctive Public Health Agenda for North Yorkshire

By 2020 we will have:

- Put in place new arrangements for existing public health services so that more people get the right support to manage lifestyle issues such as substance misuse, smoking or being overweight.
- Put in place actions to support communities and individuals to reduce loneliness and social isolation.
- Worked with partners to support actions so that more homes across the County have affordable heating and housing is improved where it causes a serious impact on health.
- Improved preventative services for children and young people through the Healthy Child Programme.
- Invested in local community projects across North Yorkshire that support people to live longer, healthier and more independent lives.
- Worked with the Clinical Commissioning Groups to deliver their strategic plans to reduce health inequalities through prevention, and wellbeing services.

Independence - With Support When I Need It

By 2020 we will have:

- Introduced targeted prevention, so that more people can live independently for longer in their communities, needing less, or no traditional public health or social care services.
- Provided information and advice, and opportunities for self-assessment through the County Council website, telephone, face to face and via community organisations.

- Resolved the majority of initial contacts and concerns through the County Council's Customer Resolution Centre.
- Developed integrated reablement and Intermediate Care services with the NHS.
- Changed how we undertake assessments and review people's needs and plan for their support.
- Improved social care mental health services, so that more people recover their independence.
- Improved the way we support young people with disabilities to move into adulthood.
- Worked with the Clinical Commissioning Groups to ensure integrated service- delivery for reablement, Intermediate Care and supporting people with long term care needs.

Care And Support Where I Live

By 2020 we will have:

- Expanded Extra Care Housing provision across the County.
- Explored different models of accommodation for people.
- Improved the way people can choose, buy and fit equipment and Telecare so that more people can live independently.
- Increased the availability and choice of services for people who have complex needs.
- Developed local services and activities that mean that people are safe and can live independently at home for as long as possible.
- Worked with the Clinical Commissioning Groups to ensure that people have access to appropriate care and support, and that their experience is positive.

Better Value For Money

By 2020 we will have:

- Implemented and embedded requirements of the new Care Act.
- Become more efficient in the way we work, making more use of technology to produce better results for people.
- Supported new and existing providers of public health and social care to increase the range and quality of services.
- Developed a confident, skilled and knowledgeable workforce that works flexibly with a range of partners to provide services.
- Worked jointly with partners to integrate service delivery where appropriate.
- Reviewed our approach to performance and quality management.
- Kept more vulnerable people safe by raising awareness and understanding in the social care workforce and the public about what to do if they are worried about someone who is vulnerable.
- Developed a process for sharing information appropriately with partners that means less duplication and better overall results for people.
- Invested over £800 million in health and adult social care services in North Yorkshire.
- Achieved ongoing efficiencies of £21.5 million per year by reducing costs in management and other areas of service and changing the way we work.
- Worked with our NHS partners to ensure better value for money by reducing duplication.

Service Reconfiguration for joined up, person centred care – Early outline for delivery model

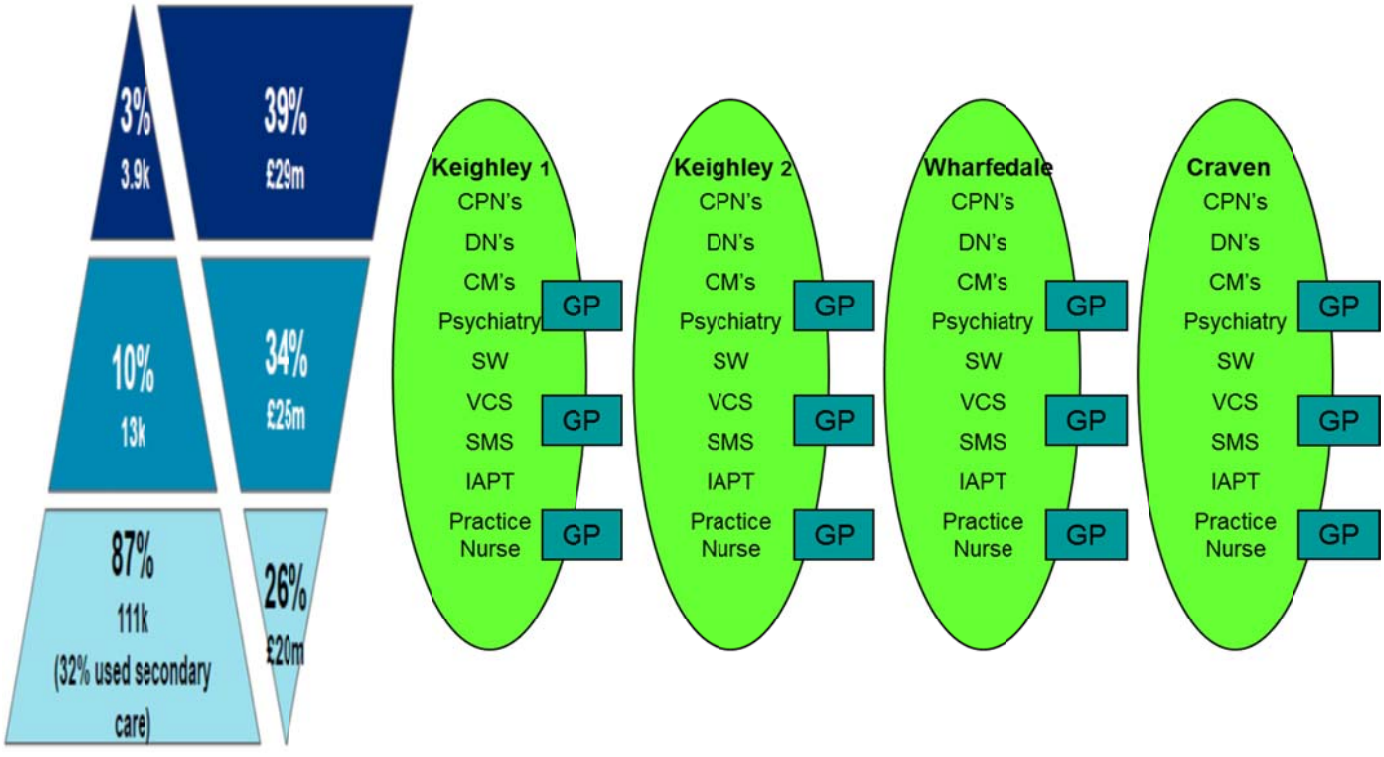
The attached diagram is a culmination of the early thoughts from BDCT regards the next steps for integration of community teams and how this links with the Oliver Wyman new models of care work and the enhancement of this from further thinking within the CCG. BDCT have also tried to embrace some of the findings from the community nursing review to enhance the provision of services for patients. This was presented in an earlier format at last weeks integrated SDG. We are going to use this diagram as a starting point for a group meeting to discuss the further integration of community teams and future service model.

This diagram is intended as a starting point to focus the discussion required around the future model for integrated community teams and how this integrates further with intermediate care services. Clearly a lot of further work is required to enhance, adapt, add to this model as required to ensure this is deliverable and truly meets the needs of our population now and in the future.

1. **Integrated community teams**: This reflects the current make up of the integrated community teams that come together on a monthly basis in 8 communities and approx 11 MDTs to discuss patients with complex needs who would benefit from an MDT approach, together with the GP's from each of the practice.

   The proposal is that the monthly MDT would continue as it is, but that the current communities further integrate to become localities to ensure MDT working becomes embedded on a daily basis rather than just a monthly MDT. The 4 localities suggested are 2 Keighley, 1 Wharfedale and 1 Craven locality.

   At the side of the diagram is the triangle from the Oliver Wyman showing the need in our population and where the majority of health care funding goes (social care data is still to be added)



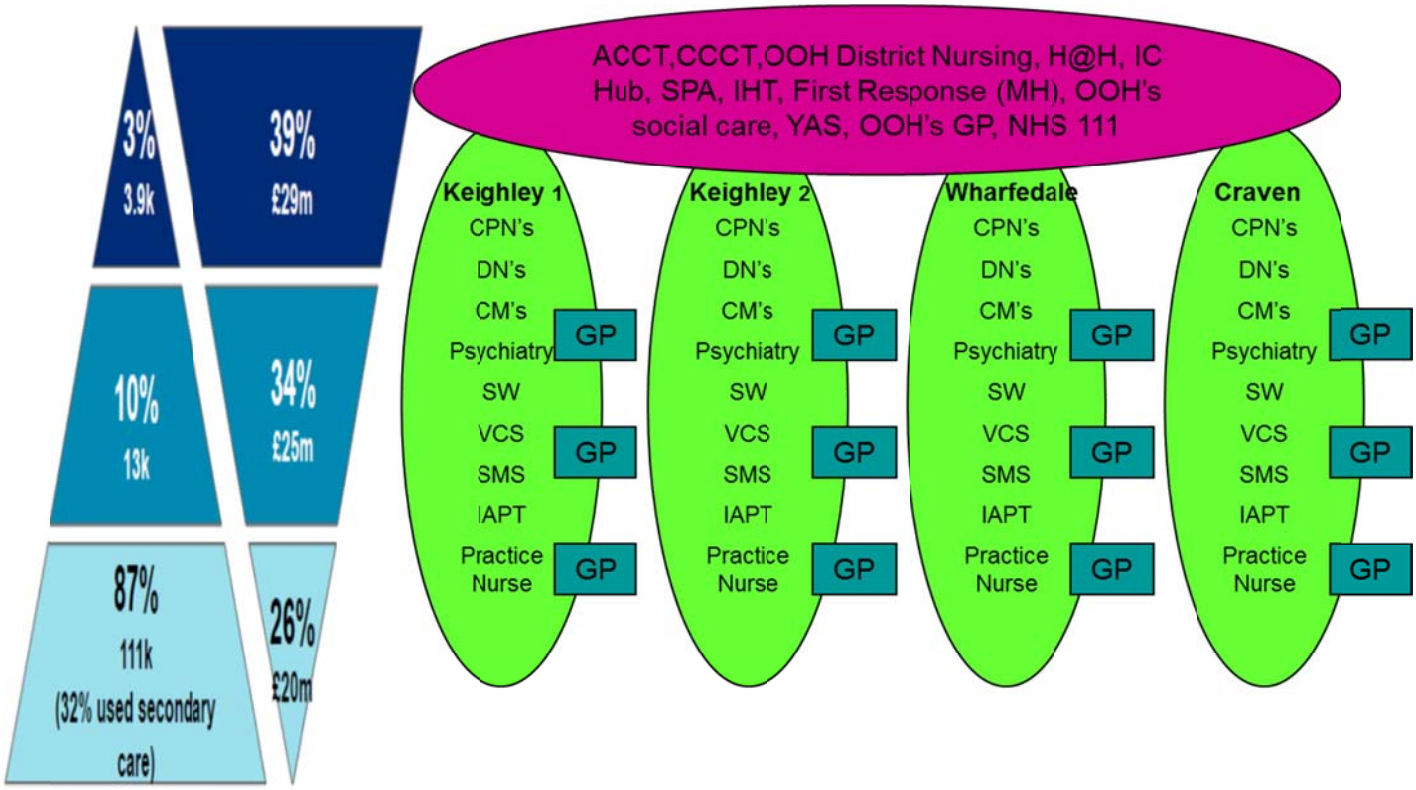
The model illustrated here suggests the need for a key link professional to ensure effective working with GP practices and across services in the locality. This link professional is envisaged to be from senior clinical staff e.g. community matron and senior mental health workers. They would act as a conduit between the GP and the wider MDT. They would have regular contact with the GP and feed into the team on a much more regular basis than happens now.

This is where further work up will be needed to consider how this might work in practice to ensure we can make a positive difference to patients and services users. For example – increasing the frequency of MDTs to weekly for the integrated team to ensure embedding of principles such as lead practitioner, a forum to air concerns and seek advice from the wider MDT and for the community matron or mental health worker to feedback from the GP etc. This would ensure that we work in a joined up way looking at more than simply health or medical needs and that wider social, therapy, nursing and lower level needs of these patients are considered. This would also need to ensure that self care is considered as part of care plans.

The operational model also needs to consider possibilities for co-location, agile working to enhance the MDT approach, how this links with the wider VCS and not just the navigators etc. The suggestion is that these services could potentially have a core team that works from 8am to 8pm and it is envisaged that this would be the layer and teams that support the enhanced primary care model.

2. Responsive services, supporting people in crisis or out of hours

The large pink oval describes the services that currently provide a more responsive service perhaps in a crisis or out of hours. A lot of these teams are currently described as intermediate care but there are other elements in this part as well.



It is envisaged that this could be the 24/7 element of services that is responsive and flexible and able to meet the needs of patients referred to enable them to stay in their own homes wherever possible and provide an increased level of support. This is the team that could become the team that wraps around the "Extensivist" model as we develop the new models of care. This team will need to work very closely with the integrated community teams and certainly the possibility needs to be considered that this in the future is organised around the localities to truly ensure seamless transition for patients.

There is also the potential that this team could take on new pathway developments to ensure we have a team that remains skilled in new competencies etc as they are doing them on a regular basis and have the capacity to respond to urgent need e.g. IV antibiotics, acute urinary retention etc. This would maintain a

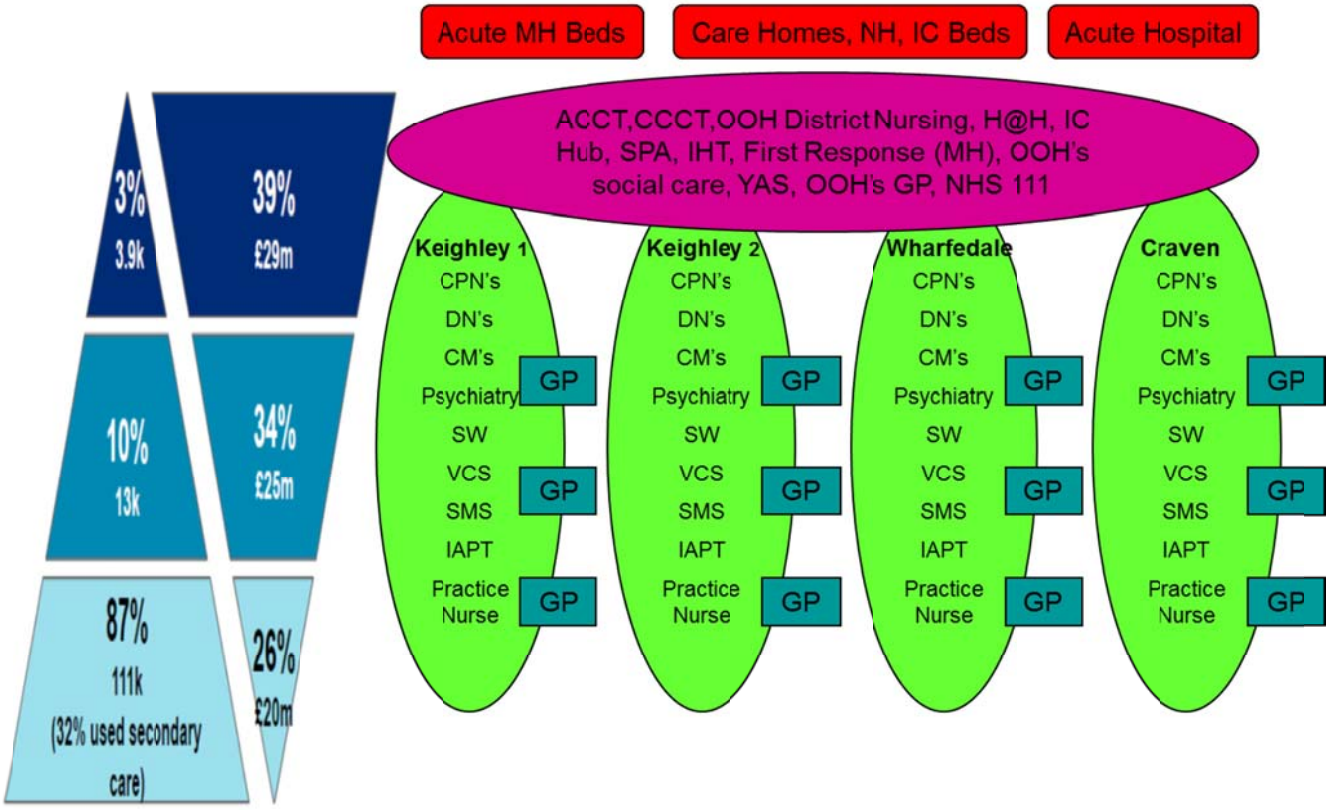
skill base to ensure there was no disparity in patients receiving the care required to help maintain them in their own home.

Consideration also needs to be given to how this element could work much more closely with YAS, NHS 111 and OOH's GP services etc. Again further work and discussion will be required around this.

The vision is that developing further this type of delivery model will enable us to merge the two delivery boards for integrated community teams and intermediate care and truly consider what is needed in the localities to meet the needs of the people in them.

3. Acute hospital, acute mental health beds, intermediate care and long term care

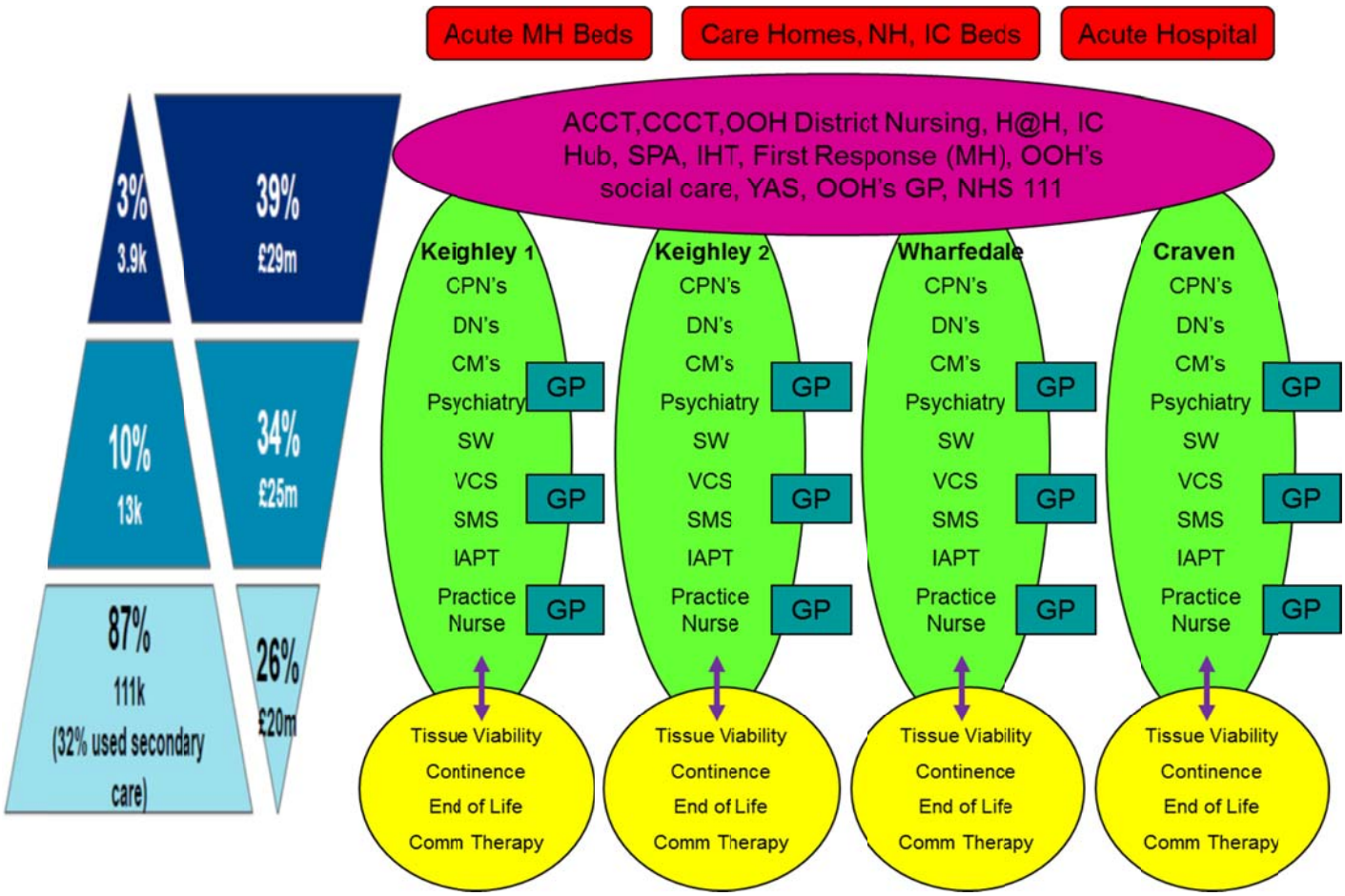
The red boxes at the top of the diagram are the acute hospital, acute mental health beds, intermediate care and long term care. These should only be required for the exceptions where it is not safe for someone to remain in their own home or there is an urgent medical need (physical or psychological) that requires specialist intervention.



Our vision must always be the patient's own home is the best place for them and we should be wrapping our services around individuals to enable them to remain there for as long as possible including ensuring they return there following any intervention required from the services in the red boxes.

4. Specialist services

In the yellow circles at the bottom of this diagram are specialist services that will in reach into the community teams as required and work closely with these teams where required.


Acute MH Beds
Care Homes, NH, IC Beds
Acute Hospital
ACCT,CCCT,OOH District Nursing, H@H, IC Hub, SPA, IHT, First Response (MH), OOH's social care, YAS, OOH's GP, NHS 111
3%
3.9k
39%
£29m
10%
13k
34%
£25m
87%
111k
(32% used secondary care)
26%
£20m
Keighley 1
Keighley 2
Wharfedale
Craven
CPN's
DN's
CM's
Psychiatry
SW
VCS
SMS
IAPT
Practice Nurse
GP
Tissue Viability
Continence
End of Life
Comm Therapy