Reconfiguring older people’s services in Hambleton and Richmondshire

Vision and Case for Change: A document for discussion
A note on the focus for this document

The ‘Fit 4 the Future’ programme is intended to drive the reconfiguration of older people’s services across the whole of Hambleton, Richmondshire and Whitby.

“One vision, three localities, local delivery”
The over-arching vision will ensure there is consistency of access and equity of service provision across Hambleton, Richmondshire and Whitby as a whole, while allowing flexibility to respond to local needs.

The CCG recognises that the three different localities may be at different starting points, with different local issues and service pressures, and may need to progress at different paces. The intention is to allow different localities to respond to local circumstances, while all the time making sure that they each respond to the needs identified during the first engagement phase of ‘Fit 4 the Future’. Therefore, the more detailed service redesign work for each locality will be taken forward through local projects.

The Governing Body will retain the oversight for each project to make sure the objectives identified through ‘Fit for the Future’ are delivered in each locality. NHS Hambleton Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) will also work with North Yorkshire County Council (NYCC) through the Integrated Care Board to ensure consistency with emerging county-wide strategies.

Vision and Case for Change for Hambleton and Richmondshire
The focus for this document is the localities of Hambleton and Richmondshire. Its purpose is to provide an over-arching document to be used as the basis to start detailed discussions in both localities. As discussions progress further, it is increasingly likely that locality-specific ideas and issues will be identified, which will need to be reflected in locality documents and project plans accordingly.

Companion document published for Whitby
For information, discussions about the future of services in the Whitby area are being undertaken in parallel to the work in Hambleton and Richmondshire. This work is driven by specific pressures on the local hospital and the need to make changes to community services. A “Vision for community health and social care services in Whitby and surrounding area” was published by the CCG as a document for discussion in October 2013. This document also consolidated issues that have been raised in the locality over the previous two years. This revised vision is now being tested out with local service users and stakeholders as part of the local project to drive service change in that locality.
Foreword

Welcome to the Vision for ‘Fit 4 the Future’ in Hambleton and Richmondshire. This outlines – and sets the scene for open debate – the priorities for developing health and social care services in the area over the coming years.

This Vision introduces the engagement phase of our ‘Fit 4 the Future’ programme following on from its initial launch last year. We’d like to know what you think about the plans, what else should be in here and what we need to prioritise.

We have identified, thanks to their help, some of the main issues and priorities of our patients, their carers and our partners. We now move on to the next stage which is to present our initial thoughts and open up the debate again to canvass more views and refine the Vision. We have tried to detail the issues and challenges that we face and the opportunities that we have to address them.

The only certainty is that with an ever increasing frail elderly population and the health needs associated with this, services cannot remain as they are. We have a great opportunity to improve the services that we provide to our population while following our general principles of providing care closer to home wherever possible, allowing people to remain at home as long as possible and putting quality of care, patient safety and experience at the heart of what we do.

By the end of this engagement work we hope to have identified the changes that we need to make to ensure local NHS services are the best they possibly can be to meet future healthcare needs. We are looking forward to meeting as many people as possible and hearing your ideas and opinions.

Please take the time to read this Vision, and let us know you thoughts about the future of your local healthcare services.

Yours faithfully

Dr Mark Hodgson
GP in Aldbrough St John and Hambleton, Richmondshire and Whitby CCG Governing Body Member
Acknowledgements

The writing and development of this document has been carried out in partnership through a working group, SDIP 2 (Unplanned Care and Community) Group. Representatives from Hambleton, Richmondshire and Whitby Clinical Commissioning Group, South Tees Hospitals NHS Foundation Trust, North Yorkshire County Council and County Durham and Darlington NHS Foundation Trust sit on the group.

This Vision is intended to be a partnership document, led by NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group, in partnership with other local organisations.

This document is primarily brought to you by:

Hambleton, Richmondshire and Whitby Clinical Commissioning Group

South Tees Hospitals NHS Foundation Trust

North Yorkshire County Council

Representatives from these organisations, and a number of other local health and social care organisations, met in early February 2014. The aim of this day was for all partners to help identify the most important areas for action, assess the impacts and implications, and confirm their agreement to working with HRW CCG in partnership to develop local services. The day was very positive, with a great deal of discussion focused on how the Vision will be delivered, and how partner organisations will work together to do this. The notes of discussions at this meeting are available on HRW CCG’s website.
1. Introduction

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) is responsible for the commissioning (buying) of the vast majority of the healthcare services received by its population. Ensuring that people receive the best possible care within the resources available is a complex task and HRW CCG is committed to undertaking this in partnership with patients, their carers, partner organisations and local stakeholders.

Once we were established, we quickly recognised that the growing numbers of elderly people in our area represented one of our biggest challenges and opportunities for improving the design and delivery of care. In this area alone, by 2021 we expect to see the number of people over the age of 65 increase by 30 per cent. Considering that people aged over 65 account for around 70 per cent of all health care spend, this will bring new and significant challenges for the local health economy.

In addition, as part of commissioning community services for adults, we also need to consider the wider needs of patients, for example those with mental health problems, learning disabilities or dementia.

Earlier in 2013, we launched the ‘Fit 4 the Future’ programme to involve local people and service users in the commissioning of services and prepare the local health and social care system to meet the challenges of an ageing population. The first phase was to take a blank canvas approach to understanding the views of patients and stakeholders. A series of events were held to understand the key themes and messages. These were:

- 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

The challenge of a rising elderly population will not just affect HRW CCG, but will impact upon North Yorkshire County Council (NYCC), a wide range of statutory providers of health and social care services, including South Tees Hospitals NHS Foundation Trust and services provided by the voluntary sector, as well as local towns, villages and communities.

The CCG intends to commission services in partnership. We will work closely with the North Yorkshire Joint Health and Wellbeing Board, which has identified “the increasing care needs of a rapidly growing population of older people” as one of its key challenges.

However, we also want to engage and consult directly with patients, service users, carers and communities as part of developing and agreeing our proposals and plans.

This document describes the key components of a successful health and social care system and explains why, at this current time, and supported by appropriate evidence, they are not yet optimally established to meet future needs. This information is intended to form the basis of an informed discussion about how services should be commissioned for the future.
2. The local challenge: rising numbers of elderly people

Hambleton, Richmondshire and Whitby is a predominantly rural area with a local population that is increasing and ageing, with significant in-migration from other parts of the UK in the pre-retirement and the recently retired age groups.

Many older people are healthy and well and make a major contribution to the health and wellbeing agenda as direct carers, as volunteers and through silent, often un-noticed work both with families, their neighbours and their faith groups. However, older people also have specific needs around accessing and receiving high quality support and information; managing their own support as much as they can; maintaining a family and social life, including contributing to community life; and avoiding loneliness or isolation.

It is well-recognised that age is directly linked to the prevalence of long term conditions, such as heart disease, diabetes, chronic obstructive pulmonary disease, or dementia. As people get older, people are increasingly likely to have at least one long term condition, with many older people having to manage several such conditions. In addition, frailty is increasingly being recognised as an important health and social care issue. Particularly in those patients who are over 85 years old, frailty makes people more vulnerable to falls, more at-risk of an admission to hospital, and less able to recover after a crisis or episode of ill-health (and then often not to the same level of function). Age therefore has a significant impact on the utilisation of health and social care services, both in acute hospital as well as the community, as well as significant impacts on housing, transport, and carers and families.

There will be much we can do to help people to self-manage and prevent deterioration of their condition through better education and awareness and putting plans in place to help them respond in a crisis. We can also provide better support for families and carers to help them understand and be part of the new approaches we are using to support people, for example, using new technologies for those at-risk of falling and caring for more people at home where possible.

It is vital that we do not just treat the health needs of older people, but consider what preventative strategies we can employ to keep people healthier for longer. We also need to look at investing in work with the younger population, who are both able to support the older generation now and who will become the elderly population of the future.

The Joint Strategic Needs Assessment describes how we need to avoid seeing old age as an inevitable burden on society, but to recognise that some older people may be frail and in need of intense support for some period in their lives while many others are fit and well and a major asset to our communities. Nonetheless, we need to develop versatile and flexible local responses and services to reflect a person-centred, user-led approach for the population, and plan for increasing numbers of older people with more intensive needs. To do this we are likely to need to strengthen services for prevention and provision of care close to home as an alternative to continually investing in acute services.
3. National context and drivers for change

As well as local commissioning knowledge there is a wide range of policy, evidence and good practice drivers emerging nationally which are influencing our local plans.

Prioritise prevention and early intervention
Prevention and early intervention are widely recognised as being essential to improving health and wellbeing and in securing a sustainable health and care system for the future. A range of current national policies, including Sir Michael Marmot’s report on health inequalities (‘Fairer Society, Healthy Lives’, February 2010) have given renewed emphasis on the promotion of wellbeing, the prevention of ill health and early intervention. Evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective, universal and targeted preventive interventions can bring important benefits. Public health services have transferred to Local Authorities and North Yorkshire Council is leading the development of a prevention strategy which includes access to information and advice at an early stage at its heart.

Provide more personalised care
The Government and the Department of Health is rolling out a personal health budgets policy nationally in the NHS. A personal health budget is an amount of money to support a patient with identified healthcare and wellbeing needs and is planned and agreed between the patient and their local NHS/social care team. At the centre of a personal health budget is a patient care plan. This plan helps patients decide on their health and wellbeing goals together with the local care team who support them. It also sets out how their budget will be spent to enable them to reach their goals and keep healthy and safe.

Extend access to primary care and provide a named GP for elderly and vulnerable
Changes to the national GP contract are currently being announced, including that older patients will be assigned a single ‘named clinician’ who is accountable for their care at all times when they are out of hospital. Other developments include a new enhanced service for patients with complex care needs who may be at risk of unplanned admission to hospital and the roll-out of the ‘Friends and Family’ test.

Ensure Integrated Care and Support
From 2015/16, each CCG will need to create an Integration Transformation Fund which will comprise an almost four-fold increase in the pooled budgets with NYCC. This is intended to support investment in the integration of health and social care and the shift to community provision away from acute provision. Plans are to be jointly agreed between health and social care and will ensure:

- Protection for social care services (not spending)
- As part of agreed local plans, seven day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health & social care, based on individual NHS numbers
- A joint approach to assessments and care planning
- An accountable professional where funding is used for integrated packages of care
- Risk-sharing principles and contingency plans for where targets are not met (including redeployment of the funding if local agreement is not reached)
- Agreement on the consequential impact of changes in the acute sector
High quality care for all
In recent months the NHS has had to address the outcomes of recent reviews into significant failures of the health and care system. The CCG is fully committed to doing this and ensuring we foster a culture of compassionate care in which patients are genuinely and consistently at the centre of everything the service provides. The key reports published that the CCG will be taking into account include:
- Transforming Care, the Government’s final report on Winterbourne View; and
- The public inquiry chaired by Robert Francis QC on Mid Staffordshire NHS Foundation Trust and Patients First and Foremost, the Government’s initial response.

Provide sustainable housing models to meet future needs of local communities
Vulnerable and older people require homes and opportunities that meet their particular needs, foster self-determination and support a good quality of life. The needs of older and vulnerable people can be met in a variety of settings, such as shared specialist supported housing, extra care housing, care settings, as well as through general housing. We recognise that vulnerability can be a temporary or a permanent state and therefore a wide range of solutions need to be available. Locally, NYCC is deploying the largest procurement nationally, with 15 Extra Care facilities across North Yorkshire and development of up to 56 proposed. These facilities give people the opportunity to live independently in a home of their own, but with other services on hand if they need them.

Continue to improve financial efficiency of services
Nationally, both the NHS and Local Authorities face pressure on budgets and the need to make continued efficiencies if they are to remain in financial balance. For the NHS, the emphasis is on reducing inappropriate acute care activity, while Local Authorities need to reduce the long-term size of care packages and care home placements through more effective reablement and prevention of ill-health.

National evidence and good practice from elsewhere
HRW CCG doesn’t intend to ‘reinvent the wheel’ unnecessarily. We will develop proposals in line with the latest thinking from leading health research organisations, such as the King’s Fund. We are also adopting the recommendations from National Voices, whose work has been central to a local programme of multi-agency workshops, to create functionally integrated health and social care teams in the community and support the development of our integrated overnight fast response service.

The North Yorkshire and Humber Commissioning Support Unit (NYH CSU) has researched examples of best practice across the country and beyond. A consistent theme is that patients, particularly the frail elderly, are more likely to be able to remain in their own homes if they receive care there rather than being admitted to hospital. The overall cost to the NHS and social care is also reduced if unnecessary admission can be avoided and patients receive the right level of care at the right time and in the right place.

Appendix 1 provides a more detailed summary of the King’s Fund and National Voices. It also details the range of ideas and initiatives that have emerged from the investigation by NYH CSU of what has been published and recommended.
4. The Case for Change: ‘i.e. what’s not working locally’

Patients and service users, particular as they get older, will require a wide range of services which they will access at different times and to different extents depending on circumstances. Many patients already have a very good experience of care and may feel that services are already working effectively. However, when we look across the system as a whole, it becomes apparent that clear problems and service gaps emerge. This means the system isn’t able to care for patients as effectively as it could do, and certainly isn’t prepared for the rising numbers of elderly people in the area.

This next section takes a subject-by-subject view of the deficiencies of services in the local area, explaining why the issues raised are important, and highlighting where improvements need to be made in order to realise HRW CCG’s over-arching vision. It is essential that these services place the patient at the centre of care and are commissioned and delivered so as to provide an integrated and co-ordinated experience of care.

Supporting themes:
- IM&T
- Transport
4.1 Acute hospital provision

Good quality, acute hospital care is an essential part of the system of healthcare support for older people. Patients, when they become ill, need access to effective assessment, diagnostic tests, and in some cases an acute stay while they receive medical treatment. The population of HRW CCG is fortunate in that they have access to good quality care at the Friarage Hospital in Northallerton (FHN), as well as further afield, for example, at James Cook University Hospital in Middlesbrough or Darlington Hospital.

However, an acute hospital stay, especially for a prolonged period, is not always in a patient’s best interest. Hospitals are busy, noisy places with (necessarily) less privacy and limitations on access by family and friends. Older people may find their capability and level of independence deteriorates when they are away from their own home and not able to undertake their usual routines and interests. Hospital staff work hard to minimise hospital acquired infections and outbreaks, but these do occur on occasions, particularly during busy winter periods.

We have considerable evidence that patients are spending longer than they need to in local hospitals, either because they are admitted unnecessarily when they could be managed in their own home or community facility, or once admitted, the systems and support services are not in place to bring them home quickly enough. South Tees Hospitals NHS Foundation Trust undertook a Bed Utilisation Audit in October 2011 that showed that 36% non-elective patients in the Friarage Hospital did not require an acute bed.

The reasons why acute stays are understood to be too long include:

- lack of capacity across health and social care fast response and intermediate care services to rehabilitate and reable patients in their homes or community hospitals
- There isn’t rapid-enough access to a comprehensive geriatric assessment to enable a patient to have their needs assessed and to return home with a package of support through A&E or the Clinical Decisions Unit at FHN
- lack of access to 24/7 senior-decision making at the ‘front door’ of the Friarage Hospital, both within A&E and the Clinical Decisions Unit, which means more conservative decisions may be taken leading to admission. There is also a lack of regular ward rounds seven days a week to facilitate discharge
- transport arrangements to bring people to hospital for assessment are not sufficiently responsive, particularly where a ‘999’ response is not required. The result is that many older people arrive for assessment from noon to mid-afternoon, which is often too late to prevent an unnecessary admission

4.2 Community Facilities

Hambleton and Richmondshire are two of the most rural locations in the country with highly dispersed populations, particularly across the Dales. The provision of community facilities with inpatient beds enables care to be delivered closer to a patient’s own community and is a fundamental part of our approach to meeting the needs of our local population.

Currently, there are three designated community facilities: the Friary Hospital in Richmond, the Rutson facility within the Friarage Hospital in Northallerton, and Lambert Memorial Hospital in Thirsk. They allow patients who do not need acute care, but who would be too
vulnerable to be cared for at home, to receive care and rehabilitation away from a busy acute hospital setting. The Rutson facility is housed within an acute ward and increasingly cares for acutely ill patients suffering from stroke repatriated from James Cook University Hospital.

The current model and practice of care through these three community facilities is not currently ideal. Patients remain in beds for longer than necessary. A bed utilisation audit in 2011 showed that many patients didn’t meet the criteria for a community hospital bed (38% patients for the Friary Hospital, rising to 90% for the Lambert Hospital). Admitted patients are not necessarily local to that particular hospital, with both the Friary and the Lambert taking patients from across the CCG’s geographical area. In addition, while the facilities at the Friary Hospital are relatively modern, those at the Lambert Memorial Hospital are compromised because they are located in an old building which is expensive to maintain and limited in its suitability for provision of sub-acute care.

In common with acute hospital services, insufficient numbers of patients are supported with effective rehabilitation at home, where it would be possible and preferable, because there is insufficient capacity within intermediate care and fast response services. This means that the overall number of community hospital beds provided is possibly higher than the true need if intermediate care services were properly established.

In the area south of the River Tees further community hospitals are managed by South Tees Hospitals NHS Foundation Trust. These predominantly provide a service for patients on Teesside (Middlesbrough, Redcar, Guisborough, etc), but occasionally North Yorkshire residents may access them. It is noted that South Tees NHS Foundation Trust is looking at the future of these hospitals and there will be a public consultation later in 2014.

4.3 Intermediate care, Fast Response Services and START (Short Term Assessment and Reablement Team)

A range of services are provided, through both health and social care, to help prevent crises escalating to an acute hospital stay or long-stay care home placement, or to step-down patients back to their own homes or communities as quickly as possible. Generally these services last for a period of up to six weeks, are free to the service user, and are intended to stabilise, rehabilitate and re-able patients to the highest level of function possible.

Services in Hambleton and Richmondshire are relatively comprehensive. South Tees Hospitals NHS Foundation Trust provides intermediate care and fast response services.

Intermediate Care is therapy-led (physiotherapy and occupational therapy) and proactively rehabilitates patients in their own homes or by in-reaching into community hospitals, including for those patients identified as at-risk of falls. Fast Response Services are provided by a multi-disciplinary team on a 24/7 basis and provide multiple intensive interventions for generally up to 3-5 days. START (Short Term Assessment and Reablement Team) services are provided by NYCC and focus on reabling people in activities of daily living with a view to promoting their independence and reducing their ongoing care requirements.

However, as explained in 4.1 and 4.2, there are problems with both the current service model and capacity meaning that acute and community hospitals are unable to return people to their own homes quickly enough and very often people are going into hospital
unnecessarily. During 2013/14, some limited pump-priming investment has been made in intermediate care through health and social care monies, but some fundamental issues remain:

- Therapy provision is not properly available on a 7 days a week basis, which limits the capability to properly rehabilitate and care for patients in a community setting
- The START service doesn’t always have capacity to easily respond to requests for social care assessment within 72 hours from community hospitals or services
- While on occasions services work closely together, there isn’t a fully integrated response and there is much greater potential for joint working
- Patients recovering from stroke particularly suffer from a lack of sufficient specialist expertise and capacity to continue their care once the acute phase is over

4.4 Health and social care integrated community teams

Vulnerable patients and service users will sometimes need support within the community to maintain their basic health and social function. This is provided from a range of organisations and services, including both health and social care.

District nursing services provide care for housebound patients or those whose care is most appropriately provided in a home setting, many of whom will be older people, including: wound care and dressings, catheter care and palliative care. The service works in partnership with GP practices and social care assessment services which identify the ongoing social care support required for people in greatest need. Increasingly, services are being targeted at patients who are at-risk of deterioration and those with complex needs, for example multiple long term conditions.

There are significant capacity issues within these community services. During 2013/14, additional temporary capacity has been put into three community teams in Hambleton, but recurrent investment has not yet been identified. There are also, on occasions, capacity problems within the local social care Health Interface Team (HIT).

Currently, health and social care teams working in the community are not working in a sufficiently integrated way. We are in the process of undertaking a development programme to bring teams together, which is led by the Centre for Innovation in Health Management at the University of Leeds. This is already leading to improvements, but has clearly shown that services were not built around the patient. A number of barriers and obstacles to integrated working have been identified:

- Ineffective liaison between staff and organisations, through multi-agency meetings and other forms of communication
- Lack of co-ordinated working and duplication of assessments, due to poorly aligned teams, limited hot-desking and co-location opportunities and lack of processes to share and feedback information
- Lack of an effective Information Management and Technology (IM&T) infrastructure as an enabler
- Lack of an integrated team identity, with staff not fully aware of who their colleagues are and how to contact them and a lack of understanding of the roles of staff in different organisations
4.5 Continuing Health Care (CHC)

Some patients may need to go into long term care, supported with continuing healthcare funding, where this is assessed as appropriate. Assessments for long term CHC should usually take place in the home or at least in a community setting, where the patient’s maximum level of function and properly thought-through long term wishes are understood. However, very often these decisions are taken while the patient is still in an acute hospital, at the point where their long term needs are less clear. This can lead to some patients choosing to leave their home earlier than is necessary than if they had had better access to support and rehabilitation following an acute episode or crisis.

The variety of CHC provider options in Hambleton, Richmondshire and Whitby is also more limited, given the rural nature of the patch. This can lead to reduced choice, increased costs and delayed transfers of care.

4.6 Mental health services

As the numbers of older people in the area rise, so then do the links between physical and mental health of older people need to be clearer and more effective. In the future, the local health economy will need to be much better at identifying and supporting patients with dementia and managing acute mental health problems, for example, delirium, closer to patient’s homes and communities.

Currently, there is a lack of an integrated approach between older people’s mental health services and the mainstream health and social care community teams. This can lead to a lack of early diagnosis of dementia and inadequate proactive responses that are able to keep people self-caring for as long as possible, enabling them to stay in their own homes for longer. Better integration would also help to reduce the stigma of dementia and help to create dementia-friendly communities. There are also gaps in support to carers of people with mental health problems and liaison services with nursing homes. More work could be done to establish how health and social care teams could work better with these individuals and services.

4.7 GP practices

GP practices across the CCG have the highest patient satisfaction rating in the country and are working effectively to provide a wide range of services in primary care. Nevertheless, practices will need to undergo some significant development in the next few years. There is a national move through the up-dated GP contract towards some level of seven day working, proactive identification of at-risk individuals through risk profiling, and identifying lead professionals for complex vulnerable patients.

The mechanisms for the integrated team to engage with GPs are opportunistic and depend more on effective personal relationships rather than good processes. There is sometimes a lack of effective involvement from GP practices with the work of the integrated teams and a lack of cohesive working between practice nurses, who manage chronic disease, with the needs of housebound patients with long term conditions.
4.8 Extra Care Housing and care home sector

For some people, there may come a time when they need to live in some form of supported housing or care home, either on a short-term or a longer-term basis. NYCC has placed great emphasis on reducing the numbers of people going into long-term residential care and instead is actively promoting the development of Extra Care Housing. However, there are some patients for whom a long-term care home placement will be appropriate. There are also opportunities for statutory services, through intermediate care or Fast Response, to place a patient within a care home on a short term basis closer to their homes or families as place of safety while they recover.

There are only 25 nursing and residential homes across Hambleton, Richmondshire and Whitby approved by NYCC. Their locations mean that some rural parts of the patch, particularly in Hambleton and Richmondshire, do not have a home particularly close to their local community, in comparison to the rest of the county. A significant number of beds (17% as of December 2013) are under suspension. This can put pressure on the ability to place people where needed on either a short-term or a long-term basis.

4.9 Voluntary sector/local communities

Services provided from the voluntary sector play a vital role in supporting people in their own communities. However, services may often be fragmented, disconnected and dependant on short-term funding. The result is that services do not always work effectively together and staff working in statutory organisations may not know what services exist and so are unable to sign-post patients to them effectively. Services are also patchy or incomplete in some areas, with unequal access depending on where a person lives in relation to services such as voluntary transport, support for shopping or home laundry, social opportunities, befriending etc.

4.10 Information Management and Technology

While in recent years there have been great advances in the opportunities available through IM&T, some significant obstacles remain. Currently there are no consistent systems and processes for using the NHS number as a single patient identifiable number across all health and social care organisations to help co-ordinate care, using safe and secure e-mail addresses to share information, obtaining shared consent, and limited capability to access different provider record systems in common locations, let alone a single common shared IM&T solution between health and social care.

4.11 Transport

Funded transport to access health and social care services is not an automatic right and is dependent on clinical need. Patients and service users therefore need a range of options to access available services, dependant on circumstance.

In Hambleton and Richmondshire, emergency and patient transport services are provided by Yorkshire Ambulance Service NHS Trust. There are also voluntary transport schemes operated by the voluntary sector.
While these services are available, there is more potential for patient transport services (or alternative arrangements) to be put in place to enable people to get to hospital more quickly and efficiently when they are referred urgently by a GP, rather than when the patient has called 999. There are also opportunities to better promote the use of voluntary transport schemes and to extend their coverage within the area.
5. The overarching vision for Hambleton and Richmondshire

Hambleton, Richmondshire and Whitby Clinical Commissioning Group’s overarching strategic vision is “To commission (buy) first class healthcare which improves the health and well-being of everyone living in Hambleton, Richmondshire and Whitby”. For older people, this means looking at a wide range of services, including those which respond to and rehabilitate patients when they are in crisis, as well as considering a range of more proactive services, both through statutory services and the voluntary sector, which can promote health and independence and hence improve well-being.

The intention is to make a real impact on population and system health outcomes, including:

- Enabling older people to enjoy the maximum possible good health for as long as possible
- Maintaining the number of emergency admissions at a constant level over the next five years, despite increases in the number of elderly people
- Reducing the overall number of average bed days (and lengths of stay) for emergency admissions in both acute and community hospitals
- Reducing the number of long term placements in residential and care homes

The priorities set out below are drawn from the feedback from our service-users and stakeholders, national and international evidence, and our local commissioning knowledge of how well the current health and social care system is performing.

“We want to keep older people safe and well in their own homes for as long as possible”

We believe that not only does this keep people healthier, but it is also more clinically-suitable and cost-effective for the health and social care system overall. We do not want patients to go into hospital unless it is absolutely necessary, except to access appropriate diagnostics and assessment, and where patients are admitted, we want to return people to their own homes as quickly as possible.

In order to achieve this, we think we need:

- Access to high quality and responsive acute care services at the Friarage Hospital, Northallerton, including provision of assessment, diagnostics and inpatient treatment, supported by rapid and effective decision-making at the ‘front door’ (i.e. A&E, Clinical Decisions Unit), and effective discharge arrangements, supported by hospital case managers, so that those patients requiring acute care access this quickly admitted and those who are able to return home with a package of support do so
- One hospital with community facilities in each of our three localities (Hambleton, Richmondshire and Whitby) that is able to provide diagnostics, intermediate care beds, geriatric assessment, palliative care support and other services that help meet the needs of older people
- Effective district nursing teams, working as part of integrated teams with social care professionals, that are able to provide care for patients in their own home, whether responding to a crisis or illness or helping patients to recover from a spell in hospital
• Comprehensive geriatric assessment for patients with complex, multiple illnesses or frailty, which is available seven days a week in hospital and community locations in all three of our localities

• Round-the-clock, integrated nursing and social care services that are able to provide short-term packages of intensive support for patients in a crisis so that they are able to remain in their own homes as an alternative to a hospital admission

• Sufficient rehabilitation services that can deliver care in both community settings and the patient’s own home, seven days a week, including for those with more specialist needs, for example, those patients recovering from stroke

• An effective equipment service, seven days a week, that ensures fast provision for patients in need and minimises the time spent by clinical staff on arranging and fitting

• A viable and high quality care home sector with homes in locations across our three localities, which is able to provide short and long-term stays, in line with NYCC’s contracting arrangements, for people recovering from a crisis or illness from which they can then return home. For those patients who self-fund their care, they should have access to independent advice to maximise the use of their own funding

• Greater integration with mental health services for older people, so that frail elderly patients receive holistic, co-ordinated care for both their physical and mental health needs, including supporting patients with dementia and delirium.

• No increase in the numbers of acute hospital beds, despite the rise in numbers of elderly people, because the evidence suggests that patients are already spending more time in acute care than would be necessary if community services were available

• Assessments for continuing care and long term placement in nursing or residential homes to be undertaken in the patient’s own home or a community setting, with appropriate reablement and therapy support, rather than in an acute hospital bed, so that their choices can be better aligned to their needs and capabilities

• Access to appropriate palliative care so that those patients who wish to do so are able to die at home.

“We want patients to be empowered and better able to self-care, supported by more information for patients and their carers”

We recognise that if patients and service users are to achieve their personal goals and maximise their health and independence, then we need to commission support for them from across the health and social care sector to enable them to do this. In order to achieve this, we think we need:

• Integrated and properly aligned health and social care teams within the community, which are able to sign-post people effectively to all appropriate health and social care services, as well as acting as a gateway to the wide range of services provided by the voluntary sector and services such as housing

• For patients with more complex needs to receive a generic health and social care assessment from community services that is enshrined in a holistic care plan which describes a patient’s actions and responsibilities, the range of services that a patient is receiving and information on how to respond in a crisis

• Extended services within primary care from GPs and pharmacists which are able to provide a greater range of services closer to the patient’s own homes so that patients
are better able to access care and self-manage their condition(s) and general health more effectively

- Improved management of medicines leading to improvements in compliance and outcomes through greater review by professionals, better patient information and aids and systems for supporting the most vulnerable patients where they are not in receipt of a social care package of care
- Identified lead clinicians who are responsible for the care of the most complex, vulnerable people
- A preventative approach based on a model of “health trainers”, specifically supporting people with long term conditions, to work on a one-to-one basis to motivate and signpost members of the public to make long-term healthy lifestyle choices
- Better access to online information both for patients, to enable themselves to self-care, and for professionals to understand what options for support are available

“**We want improved transport options for patients to enable older people to access services, so they are not disadvantaged by the rural nature of the area**”

Accessing health services can be particularly difficult for older people, especially if they are unable to drive. While we intend to bring as many services as we can as close to the patient’s own home as possible, we will also need to improve transport options for patients so that they are not failing to access care to the detriment of health outcomes and quality of life. In order to achieve this, we think we need:

- Timely urgent transport in the event of a crisis, so that a patient requiring an urgent assessment is able to arrive sufficiently early at hospital for appropriate tests and consultation, and for them to go home with a suitable package of support that day if possible and appropriate.
- A responsive patient transport service that helps people to access the care they need in a timely manner, which recognises people’s clinical and mobility constraints and that applies the national criteria for both patients and their escorts correctly to help achieve this
- For those patients for who patient transport services are not suitable or appropriate, further transport options to be available within the voluntary sector to enhance existing public and private transport options that work in an integrated way with NHS clinical and transport services

“**We want to better equip local communities with the skills and resources they need to care for their older population and facilitate greater social interaction**”

It is well-known that older people can experience greater social isolation, leading to loneliness, depression and poorer health outcomes. Even where older people are usually able to manage quite effectively, they may find that they are less able to manage during and after a crisis or episode of ill-health. HRW CCG wants to work with local councils, the voluntary sector, and patient and community groups to support community-based approaches to caring for older people that recognise the importance of local networks of support. In order to achieve this, we think we need:
• A range of services commissioned from the voluntary sector, such as befriending schemes, village agents and volunteering ‘time banks’, that make greater support accessible when needed from a person’s own community
• Voluntary sector “hubs” for older people in each area that can be a focal point for patients to contact, and partner organisations to refer to, so that people are more easily access to the range of opportunities available
• Ensure that people have easy and early access to information and advice as part of a concerted strategy to prevent ill-health and deterioration

“We want to ensure carers are better supported so that they are better able to look after they are caring for as well as maintaining their own health and wellbeing”

The CCG supports the North Yorkshire-wide Carers’ Strategy. The vision is to have carers in North Yorkshire recognised and valued as being fundamental to strong families and communities. Support will be tailored to meet individuals’ needs, allowing carers to maintain a balance between their caring responsibilities and a life outside their caring role, whilst enabling the person they support to be a full and equal citizen. In order to achieve this and support carers as part of our work under ‘Fit 4 the Future’, we think we need:

• Improved access to carer’s assessments working in partnership with NYCC and Carers’ Resource, including supporting hard to reach groups
• Greater sharing of carer information from the Carers’ Resource centres with GP practices (with consent), and , through GP carers champions, raise carer awareness, promote and raise awareness of the use of emergency carer cards, and consider the value of carer health checks
• Improved referral pathways to Carers’ Resource, ensuring hospital discharge planning includes carers, and working in partnership to increase employers’ awareness of carers
• More expert carers, supported by training programmes or other forms of support, in partnership with NYCC and Carers’ Resource

“We want to utilise new information management and technological solutions to enable services and service users to manage their care in new, innovative and more effective ways”

We understand that new technologies are providing us with opportunities to work differently and more effectively. In recent years there have been real changes in how people are kept safe and well through the use of Telecare, with new ideas and solutions emerging across a wide range of issues. The CCG is keen to embrace new technologies and work with service users and services to find ways that improve people’s experience and outcomes. In order to achieve this we think we need:

• To pioneer new technologies that bring service users and professionals together to improve access to services, such as video-links between different locations
• A common approach to sharing information across the integrated team, based on the NHS number as a common patient identifier, supported by safe and secure e-mail addresses and systems, shared consent, and facilitating access to different provider systems at common locations
• Technologies that help people to understand their condition better, keep themselves safe at home, and take more active control of monitoring their outcomes
6. Implementation and way forward

HRW CCG intends to engage with patients, carers, stakeholders and partners in Hambleton and Richmondshire through locality-based engagement events between March and April 2014. The purpose of these events will be to:

- Make and confirm people’s understanding of the case for change
- Present and confirm whether people agree the overall vision
- Discuss the choices that the CCG will need to make in order to implement the vision

Going forward, HRW CCG, with its partners, will need to decide:

- The extent to which a shift of resources is required between acute care into local community services
- The exact set-up of community facilities in each locality, bearing in mind that there are currently two community facilities (the Rutson and Thirsk) in the Hambleton area
- The potential to move to integrated provision through commissioning single providers for intermediate and community care

Once this engagement phase is over, the CCG will then draw up formal commissioning proposals to implement the vision. Depending on the outcomes of the engagement, this work may involve:

- Decommissioning some services that are not fully effective and re-commissioning other services closer to patients’ homes in the community
- Testing the market to see if alternative providers are able to deliver services in new and more integrated ways
- Jointly investing in services with NYCC from 2015 onwards through the new Better Care Fund
- Going out to formal consultation on any of the proposals which constitute significant change

In the meantime, HRW CCG and its partners have the opportunity in 2014/15 to utilise health and social care reserves from pooled budgets created over the previous three years. This investment will be used to address initial pressure points and priorities raised by partners, as well as to test out new ways of working. Whether any of the funding is recurrently allocated will depend on whether it both makes an impact and is consistent with the longer-term proposals and plans.
7. Conclusion

This document is intended to provide information and provoke discussion. It starts to set the scene and the scope of both the challenge and the opportunity relating to commissioning services for Older People in the Hambleton and Richmondshire area. It also confirms the central idea that older people are more likely to remain safe and well in their own homes and communities if we can strengthen the care and support that they receive there. If we do this successfully, then admission to hospital can in some cases be avoided and the overall cost to NHS and social care services reduced.

Perhaps inevitably, the solutions largely lie in the reconfiguration and integration of community services. However, the exact scale and formal proposals for what needs to be developed will require extensive local discussion with service users, their carers, partner organisations and other stakeholders.

A detailed programme of engagement events will be undertaken in 2014 to start to turn this Vision into a reality.

We thank you for reading this document and we look forward to hearing your views.

Ends
Appendix 1

Examples and evidence of good practice

King’s Fund
Their research shows that there is considerable evidence, both from the NHS and systems world-wide, that suggests more integrated care can deliver improved user experience; better quality of life; reduced carer burden; greater efficiency; and controlled / reduced costs. However, the evidence also suggests that often there is a very poor ‘fit’ between the needs of frail older people and the existing infrastructure of health care and social care, with access, continuity and co-ordination problems the most serious barriers to integrating health care. The main ingredients of successful integration include person-centred focus on frail older people with relatively high care needs, including careful targeting; responsibility for identified population and/or geographic area, including single entry point into system; case managed, inter-professional, evidence-based team care; and a heavy emphasis on care co-ordination.

National Voices
National Voices is a national coalition of health and social care charities in England that is working together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them. It has provided a narrative for person-centred, co-ordinated care that describes what integrated care and support looks like from an individual’s perspective.

NYH CSU literature review
North Yorkshire and Humber Commissioning Support Unit has analysed the literature and identified a range of published models of good practice from across the UK. These include Sheffield, Warwickshire, Poole, Torbay, Guy’s and St Thomas’ NHS Foundation Trust in the London Boroughs (LBs) of Lambeth and Southwark, Cambridge/Addenbrookes, Hull, Birmingham, Pan Gwent and Poole. The messages that are emerging from these models include:

**Torbay**
- Focus on the most vulnerable patients
- Integrated Commissioning function across acute / primary / community and social care
- Single Management.
- Introduction of locality teams including health and social care professionals in the same location.
- Single point of access, with a co-ordinator to arrange care packages and modify them in accordance with patient changing circumstances.
- Shared electronic health and social care records.
- Significant investment in community Health and Social Care Services.

**Guy’s and St Thomas’ NHS Foundation Trust LBs Lambeth and Southwark – Integrated Care**
- A whole-person approach, taking into account physical, mental and social care needs.
• Joining up services across different organisations
• Stream-lined, integrated discharge process

**Birmingham Community Healthcare NHS Trust**
• The multi-disciplinary team have access to a community geriatrician and mental health specialist

**Pan Gwent Frailty Programme**
• People are now treated holistically rather than simply defined by their illness
• People stay longer in their own homes
• Every patient is treated as an individual

**Sheffield ‘Right First Time’ Programme**
• Care homes aligned to one practice, which accepts all patients who choose to register, and one or two named GPs provide the service
• Community integrated teams to be reshaped round groups of GP practices
• ‘Redesigning the Front Door of the Hospital’ for example, through a ‘Frailty Unit’, by reducing the number of elderly admissions and by completing comprehensive assessments at the point of referral and developing consistent thresholds for admission

**Warwickshire ‘Cutting the cost of frailty programme’**
• ‘Choose to admit’ only frail older people who have evidence of an underlying life threatening illness or need surgery
• Early access to an old age acute care specialist
• ‘Discharge to assess’ as soon as the acute episode is complete, in order to plan post-acute in the person’s own home, and to provide comprehensive assessment and reablement during post-acute care to determine and reduce long term care needs
• Reduce the number of beds in community hospitals so that more focused attention is given to a smaller number of patients and releasing resources to invest in home-based community services
• Rapid (two-hour) response to frailty crisis with an older person and meet the needs of patients who would benefit from early supported discharge from hospital
• Change model of community hospital provision to one that gives greater emphasis to step-up, short stay care for patients not requiring the full diagnostic and treatment services of the acute hospital

**Poole Rapid Assessment & Consultant Evaluation Programme**
• Rapid comprehensive assessment of older patients with complex needs. Facilitates early supported discharge and avoids unnecessary hospital stays
• Admissions unit where medical patients with geriatric needs referred to hospital as emergencies are assessed and cared for by a consultant-led multi-disciplinary team (MDT).
• All patients receive comprehensive geriatric assessment (CGA) within 24 hours of admission and there is a daily MDT meeting to facilitate discharge planning.
• GPs can refer patients to the daily emergency clinic held on the ward to access rapid diagnostics and CGA without admission to hospital
If you would like this document in a different format such as audio CD, Braille or in another language, please call 01609 767600.