North Yorkshire County Council

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Report Title	Integrated Commissioning Approach across Hambleton, Richmondshire and Whitby – Year One Evaluation
Report For	Hambleton, Richmondshire & Whitby CCG Governing Body
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Introduction

NHS Hambleton, Richmondshire and Whitby CCG and North Yorkshire County Council (NYCC) have agreed to a joint commissioning approach with the aim of facilitating further integration of adult health and social care services to enable the development of a joint commissioning strategy to support the integration of services.

The key enabler to this vision is a Section 75 agreement which has formalised the commitment by both the CCG and local authority to work more closely aligned. The agreement has not overridden sovereignty of decision making from either organisation but is simply a legal mechanism to enable the provision of a pooled budget and for consideration of a future move towards pooled services.

The agreement also provides a governance arrangement to deliver on the shared vision of providing a timely transformation towards an integration approach to the provision of health care, public health and social care services in Hambleton, Richmondshire and Whitby.

Both NYCC and the CCG believe that this approach helps to facilitate the best use of resources to support the local resident and patient population and the two organisations have established the Hambleton, Richmondshire & Whitby Health and Care Integrated Commissioning Board (HRWHCICB) as the vehicle through which both parties discharge their shared planning and commissioning responsibilities in respect of the pooled funds.

The purpose of this paper is to provide an evaluation of the first 12 months of this agreement recognising key successes and service transformation.

2017-18 Integrated Commissioning Achievements

The Transforming our Communities and Transforming Mental Health Services public consultations throughout 2016 and 2017 have paved the way for a collective vision for out of hospital transformation to be implemented with new models of care supporting care closer to home in a more integrated and timely manner.

Both organisations have an ongoing commitment to the proactive management of frailty; this has been a priority area for the HRWHCICB in its first year. Both organisations made an early assessment of commissioned services for the frail population with a mapping exercise to determine the spread of services and this has helped to inform decisions throughout the

year. The Consultant in Public Health Annual Report for 2018 focussed on frailty and the ageing population, this was jointly presented to the CCG Governing Body to demonstrate the integrated approach to the management of frailty across HRW.

Examples of successful integrated projects include:

- **Step Up/Step Down Care in Extra Care Housing Schemes**
  9 Step Up/Down Beds across Hambleton, Richmondshire have been commissioned to actively support discharge out of acute care and prevent avoidable admissions through providing a flexible community bed base within a patient's home community, supported by an Integrated Locality Team. An evaluation of the beds has been completed and action plan in place to increase occupancy levels and ongoing work to extend the scope of this bed base to support the wider health and social care system.

- **Integrated End of Life Service**
  An integrated end of life care pathway has been established in Hambleton and Richmondshire to replace the fast track system. This service, working with the integrated locality teams allows patients who wish to die at home to do so knowing they will receive the best possible care and support. The service is also preventing unnecessary hospital admissions for patients at end of life.

- **Integrated Locality Teams (ILT)**
  The establishment of a concept of integrated locality teams has facilitated new ways of working with specialist services; both community and hospital based, to offer patients and much more complete and less fragmented care and support. This aims to develop further integrated care by creating a simple pattern of services based around primary care and natural geographies and with a multi-disciplinary team. This concept is a natural extension to the Multi Agency Meetings (MAMs) which provide a forum for collective decision making in relation to our most complex residents.

- **Integrated Discharge Pathways**

  HRW CCG and NYCC have worked together to redesign processes to deliver integrated discharge pathways focussed on safe discharge of patients from hospital to the most appropriate setting at the earliest opportunity.

  Three Discharge to Assess pathways have been developed which include trusted assessment, joint assessment documentation to provide greater clarity and avoid duplication and increased communication between health and social care:

  - Pathway 1 - Focus on home first principle, delivered through trusted assessment and embedding the restart process and home from hospital service;
  - Pathway 2 - Delivered through trusted assessment, integrated step up step down beds, palliative care, reduced assessments in acute setting, dedicated discharge to assess beds in residential care; and
  - Pathway 3 - Most complex patient group likely to need long term 24/7 care, integrated brokerage delivered by NYCC on behalf of Health, assessments for long term care undertaken outside of acute hospital setting

  We have seen an improving Delayed Transfers of care (DTOC) position due to a reduction in funding assessments being undertaken in the Acute setting (from 46% to 0%). Local escalation pathways and daily reporting has been reviewed against the requirements of the High Impact Change Model to inform our local DTOC Action Plan.

- **Personal Health Budgets**
  An agreement has been put in place for NYCC to administer personal health budgets on behalf of the CCGs with increased monitoring and a more robust service to ensure better outcomes for individuals and value for money. This was previously contracted to the private sector.

- **Telemedicine in Care Homes (Immedicare)**
  The CCG has invested in Immedicare which is a telemedicine system enabling 24/7 access to skilled multi-disciplinary health care teams. The CCG has worked with NYCC to implement this technology into care homes and extra care housing facilities throughout Hambleton, Richmondshire and Whitby. 26 units have been fully implemented across 25 sites. The service is in place across 8 Nursing Homes, 12 Residential Homes and 5 Extra Care Housing Facilities.

  The service is currently assessing an average of 37 patients a month in their place of residence, as an alternative to patients being assessed by their GP, or in an acute setting via ambulance conveyance.

  A review of caller intentions (if Immedicare was not available) identified that 72% of homes would have called the patients' GP or an ambulance and 66% of Immedicare calls resulted in no onward referral required to other services. Care home staff reported feeling more confident and supported in managing their residents' needs. We are seeing a downward trend on hospital admissions from care homes.

- **Improved Better Care Fund (iBCF)**

  The iBCF has supported the collaborative development of a range of important priorities for the locality including joint funding towards step up step down beds, frailty training for care home staff and healthcare professionals and Discharge to Assess implementation materials.

- **Continuing Healthcare and Section 117**
  These are important workstreams in terms of quality and finance for both organisations and support some of our most complex patients. We have established a joint board across North Yorkshire CCGs and Local Authority to ensure system-wide approach. A working group to review Section 117 pathway has been established with a pilot underway. Escalation processes between both organisations are embedded to reduce delays and ensure a person focussed service.

- **Living Well Pilot**
  We have agreed a joint pilot with the NYCC Living Well Team to proactively support vulnerable individuals whom are frequent attenders at Accident & Emergency and GP Practices. The aim of the pilot is to put targeted interventions in place as a preventative method for greater support and to reduce the impact on future statutory health and social care services. An evaluation has been designed to measure the success of the pilot with a view to further roll out if deemed to be successful.

- **Safe and Well pilot – North Yorkshire Fire and Rescue Service**
  We have established a pilot to work with partners to better support our vulnerable residents in the Dales through proactive safe and well visits conducted by North Yorkshire Fire and Rescue with a widened scope and information sharing agreement.

  Agencies involved include: GP Practice, Rural Task Force, Richmondshire District Council, CCG, NYCC and Voluntary Sector agencies.

- **Managing Frailty**
  Following a number of dedicated multi-agency workshops a local action plan is ongoing focusing on the implementation of the frailty pathway to address issues by ensuring resilient services which are joined up and based in the community and primary care to prevent the instances of non-elective hospital admissions and the need for social care packages.

- **Mental Health**
  New Models of care are in development including enhanced and integrated community mental health provision and a social care mental health team restructure to enhance the social care offer. Options for future joint commissioning in relation to community provision for mental health are being explored.

- **Dementia**
  Local action plans to deliver the North Yorkshire strategy are in place and include areas such as improved dementia diagnosis rates in primary care, shared care processes, better support post diagnosis with greater signposting and navigation to support services for patients and carers. Work with the dementia collaboratives continues with both HRW CCG and NYCC making a commitment to support these local groups.

  A review of dementia diagnosis coding in primary care has been undertaken and key actions identified, it is envisaged the outcome of the work will show a significant increase in dementia diagnosis. A pilot Dementia Navigation Service in the Richmond locality with a dedicated post working as part of the GP locality cluster has commenced in January 2018.

Conclusion

The new models of care and service transformations detailed within this report have demonstrated some key successes brought about by the commitment of the two organisations to work collectively in the best interests of the population of Hambleton, Richmondshire and Whitby. The HRWHCICB look forward to establishing priorities for the coming year and continuing to evaluate the successful projects to date.