

A Joined Up Vision of Health and Adult Social Care Commissioning and Service Delivery across North Yorkshire

**A statement on integrated working across
adult social care and health**



[2008-2009]



Joint Vision Statement

North Yorkshire County Council (NYCC) and NHS North Yorkshire & York (formerly North Yorkshire and York Primary Care Trust)

Document Purpose: this statement seeks to empower internal staff of both organisations to work in a more integrated way on behalf of people accessing our services and to share with others outside our agencies who may wish to contribute to the collaborative approach.

Title: A Joined Up Vision of Health and Adult Social Care Commissioning and Service Delivery across North Yorkshire

Sponsored by: Derek Law - Corporate Director, Adult and Community Services, NYCC and Jayne Brown, OBE, Interim Chief Executive, NHS North Yorkshire & York.

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Target audience: staff of NYCC Adult and Community Services (ACS), NHS North Yorkshire & York (NHS NY&Y), Practice Based Commissioners across North Yorkshire and key partner agencies in the statutory, independent and third sector in North Yorkshire.

Circulation list: internal staff and external partners

Description: this document is published primarily as a vision statement for the staff of the two organisations in North Yorkshire with the primary responsibility for promoting the health and well-being of the population of North Yorkshire. It gives information on the present areas of joint integrated working and a very strong signal of the intent by both agencies to work in a more integrated way on behalf of the population they jointly serve. The support of other partners will be essential in making the vision a reality. Knowing the direction of travel, staff and partners are encouraged to support the direction and to find practical, innovative and creative solutions to further progress the joined up approach to enable more people to be safeguarded and stay healthy and well.

Cross reference: see also -

The Joint Strategic Needs Assessment for the population of North Yorkshire; the respective commissioning plans from ACS in North Yorkshire and NHS NY&Y and the North Yorkshire Putting People First Concordat.

Superseded Docs: N/A

Action required: all community and primary care staff including Practice Base Commissioners are asked to note the direction of travel and to contribute to more integrated approaches in service commissioning and delivery for the benefit of the people using our services in North Yorkshire.

Timing: this document covers the period Sept 2008 - October 2009

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Foreword

A Vision of Joint Health and Adult Social Care Commissioning & Service Delivery across North Yorkshire

Derek Law, Corporate Director, North Yorkshire County Council, Adult and Community Services



Some two years ago we in North Yorkshire Adult and Community Services recognised that the landscape of social care was about to undergo dramatic change. We planned to get ourselves into a good position as quickly as possible.

We knew we had to reconsider our position of only responding to those with critical need. So we started investing in low level prevention and now our FACS criteria is moderate with responses to people with low level needs where the indications are that these people will be at risk without this intervention. National consultations on 'Independence, Well-being and Choice', 'Our Health Our Care, Our Say' and 'Joint Commissioning Framework For Health and Well-being' confirmed we were on the

right path.

We wanted to give more people greater choice and control, not just of services, but of their own health and well-being. We set out our 15 year vision in 2007. But to deliver this vision we needed support and input of from a range of partners. A robust partnership and integrated approach with our local NHS North Yorkshire and York partner is critical to our success.

We realised that the landscape of the former Primary Care Trusts (PCT) was itself undergoing great change with mergers and financial pressures in many parts of the country. The latter was particularly acute in North Yorkshire.

Throughout as the local NHS has had to make difficult decisions and face significant challenges, there has been a good channel of communication between Janet Soo-Chung, the previous Chief Executive of the PCT, her team and ourselves. We are continuing with Jayne Brown, the new interim Chief Executive of NHS NY&Y, to shape solutions together. The Partnership for Older People's Project (POPPs), in particular, signposted the way forward. We drove hard on a range of joint commissioning boards and eventually arrived at the point where the top teams from both organisations understood the need to progress further with the agenda of integrated working.

This document captures some of the key areas of work we want to push forward on together. Over time other areas will be added. Meanwhile this gives staff of both organisations and our other partners, a strong clear message: 'we can help even more of the people of North Yorkshire to feel safeguarded, stay healthy, be even more independent and well by constantly finding opportunities to work collaboratively, smartly, innovatively and creatively together'.

My thanks to the staff of both organisations for their ongoing work and their readiness to go the extra mile on behalf of the people they serve.

Derek Law



A Vision of Joint Health and Adult Social Care Commissioning & Service Delivery across North Yorkshire

Jayne Brown, OBE, Interim Chief Executive, NHS North Yorkshire & York



North Yorkshire County Council's Adult and Community Services has remained close and supportive throughout the difficult formation period. We are now jointly ready to push forward together. We know we have to make big step changes in order to impact upon the health inequalities in North Yorkshire as highlighted in our Joint Strategic Needs Assessment. We will take up the challenge presented to the NHS by Lord Darzi 'to focus relentlessly on improving the quality of care patients receive' and to move away from cost containment and seek to harness innovation'.

It is simply not possible to transform health care to meet the needs of the 21st century without strong joined-up initiatives. Because of our partnership with North Yorkshire's Adult and Community Services we are now in a stronger position than ever to have a direct impact on the health and well-being of the population by commissioning services in new and innovative ways. World Class Commissioning will deliver better health and well-being for all, better care for all and better value for all; adding life to years and years to life. This is precisely why we are determined to work ever more collaboratively with our key community partner to commission and deliver innovative and integrated community services that optimise health gains and deliver reductions in health inequalities. It is precisely why we wish to encourage our front line primary care staff and colleagues to pursue ever more creative and integrated approaches.

This document is saying clearly to all readers, particularly our staff, that these are the areas where we want to jointly make some early, as well as medium and long term, wins. These are 'strong initiatives'. They contribute to our whole system solutions. Without further progress in these areas our community services, acute and community hospitals will not meet the future growth in demand anticipated across our areas. We must explore every means at our disposal, including the use of assistive technology, telecare and telemedicine, to help people to stay healthy and remain in their communities. By working ever more closely with the Corporate Director of ACS, Derek Law, and his team we increase the potential for greater success in our joint place shaping duties.

We will have more integrated workers. We will commission and contract with partner agencies jointly, seeking the outcomes necessary to keep more people healthy and well. We will have lead provider agreements with clear lines of accountability. Thanks to these initiatives we will deliver more excellent joint packages of care in community settings.

Jayne Brown



A Vision of Joint Health and Adult Social Care Commissioning & Service Delivery across North Yorkshire

Introduction

In July 2008 Derek Law, Corporate Director of ACS, NYCC, and the Chief Executive of NHS NY&Y came together with their respective senior management teams and committed both organisations to ever closer integrated working on behalf of the people of North Yorkshire.

Primary and community care services in North Yorkshire play a central role in helping people live healthy, independent lives with dignity and respect. The promotion of health and well-being and the safeguarding of people will be further embedded in the multiplicity of daily contacts with family doctors, community nurses, pharmacists, social workers, occupational therapists, domiciliary care and other community-based staff, including those based in the independent and third sectors.

We can do more to promote health and well-being at all stages of life and more systematically identify and support those individuals most at risk of ill-health or in need of higher levels of social care support. We can ensure we work together to safeguard the many vulnerable adults in our community in North Yorkshire. There will, in time, be increasing access to more integrated services that help people to maintain and improve their health and well-being. Primary and community professionals will enhance their role in promoting equality of opportunity and equality of health and well-being outcomes.

From listening to people, we know our care and support system in North Yorkshire must:

- give people independence, choice and control, while also ensuring they are safeguarded
- make sure that everyone can get the care and support they need, while prioritising and targeting funding at those most in need
- be affordable and sustainable within our financial resources

We want a society in North Yorkshire where:

- everyone is respected and included as equal members
- everyone has the opportunity to fulfil their potential
- service users and carers inform our judgements about quality and dignity through their personal experience
- public services safeguard and empower people and help them to meet their aspirations
- everyone can understand their role in terms of what they contribute to society and what they are entitled to from NYCC ACS and NHS NY&Y

*David Behan,
Director
General Social
Care, Local
Government
and Care
Partnerships,
Department of
Health*

“Joining up does not just happen – it requires leadership, clarity of purpose and the ability to work collaboratively. Strengthening partnerships between the NHS and local government is crucial to meet the needs of individuals, families and communities and to drive improvements in services for all.”



For care and support services this means that people are supported to:

- live independently
- stay healthy and recover quickly from illness and receive treatment based on clinical need
- have as much control over their own lives as possible and retain maximum dignity and respect
- live with or look after their family
- participate as active and equal citizens
- have the best possible quality of life in their chosen accommodation and community.

We recognise our health and our lifestyle choices are influenced by a wide range of factors rooted in local communities, including how we develop in school, the quality of social care when we need it, access to leisure facilities and our environment.

Our Vision

Our vision is of primary and community care services working ever more closely together, along with voluntary organisations and other independent sector organisations able to forge common goals for improving the health and well-being of local people and communities. We also know that communities themselves may hold many of the answers and solutions to the health and social care challenges we face. Therefore community engagement and community development will become increasingly important in our joined up approaches to health and well-being.

For our Commissioners of Health and Social Care in North Yorkshire we

- see greater clinical freedom and stronger commissioning as two sides of the same coin
- understand the best commissioners will be those who create an environment in which clinical leadership and innovation flourish and
- in which health and social care professionals have a permissions framework to work more flexibly and collaboratively across traditional boundaries to provide more integrated care and
- in which there is a reorientation of commissioning towards health and well-being, preventing the onset of long-term conditions and a life of unnecessary dependency.

Our front line staff

Our front line community services staff are of critical importance in delivering our Joint Service vision for the future of primary and community care in North Yorkshire.

Our organisations will show increased influence by community staff in service transformation, through a commitment to multi-professional engagement in practice based and locality commissioning and in the ongoing development of more integrated workers and clinical collaborations.



Nurses and allied health professionals (AHPs) and locality social care staff will play a key role in integrated care planning for the people in North Yorkshire with long-term conditions. Those at high risk of admission to acute hospital, residential or nursing home care will be assisted to take more control over their health and care, e.g. by the consistent provision of information about a range of local resources, services and health conditions, by the early identification of those who may be at risk of losing their independence, and by the consistent encouragement of self management. Our staff are encouraged to be innovative and creative in finding joined up, cost effective solutions for people. Rather than ask “should we do something together?” they should question “why would we do this alone?”

Practice Based Commissioners

Practice Based Commissioning (PBC) is central to the NHS’s ambition for health improvement and high quality care. PBC puts clinical engagement at the heart of the NHS’ commissioning and strategic planning, allowing groups of GPs and community teams to transform services for their local communities. Closer ties and integrated approaches with social care locality commissioners, known in ACS as the “community service managers”, optimise the local place shaping opportunity and best delivers integrated, streamlined care pathways.

Our Key Guiding Principles

- 1. Our Joint Service provides a service, available to all irrespective of gender, race, disability, age, religion or sexual orientation.** It has a duty to each and every individual whom it serves. At the same time, it has a wider social duty to promote equality through the services it provides, paying particular attention to groups or sections of society where improvements in health, life expectancy, quality of life and well-being are not keeping pace with the rest of the population.
- 2. Access to Our Joint Service is based on clinical or social need, not an individual’s ability to pay.** NHS services are free of charge, except in limited circumstances sanctioned by Parliament. Social Care Services are charged for as sanctioned by Parliament except where the local authority subsidises the cost of services dependent on one’s financial ability to pay or where it offers them for free.
- 3. Our Joint Service aspires to high standards of excellence and professionalism. This is done** in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population. Commissioners in the local authority as well as the local NHS will adhere to the World Class Commissioning standards, benchmarking their performance against these.
- 4. Our Joint Service will reflect the needs and preferences of the people who use our services, of their families and their carers.** The people who use our services, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment and, in social care, will be given choice and direct control wherever possible in service delivery. Our Common Assessment Framework and care planning going forward will help to ensure that people with more complex and long-term care needs receive the best, most appropriately



tailored packages of care to meet their individual requirements and wishes. This involves individuals working with carers, clinicians and social care teams, to agree what their goals are, which services they choose to receive and how and where they want to access them. By 2010 all people (of all ages) with a long-term condition, including people with mental health problems, should be offered their own personalised care plan.

5. Our Joint Service will work across organisational boundaries and, in partnership with other organisations, in the interest of the people who use our services, our local communities and the wider population. We are committed to working jointly and with a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being. Our Joint Strategic Needs Assessments will have a key role to play in ensuring our shared understanding of local priorities and will be fed into the Local Area Agreement and converted into joint commissioning plans.

6. Our Joint Service is committed to providing best value for taxpayers' money and the most effective and fair use of finite resources. In considering our investment portfolio we will invest more in 'upstream' interventions knowing this will help to keep people healthier for longer. This will be increasingly reflected and embedded in action on joint working across our shared plans and shared priorities. With our general practice colleagues we will be proactive in seeking to identify at risk groups and individuals via active case management and signposting. In the implementation of our commissioning strategy we will reflect our support for the 'Putting People First' Concordat, which emphasises the shared responsibility of health, social care and wider community services in helping people live independently, stay healthy and participate as active and equal citizens, irrespective of illness or disability.

7. Our Joint Service is accountable to the public, communities and people that it serves. Our system of responsibility and accountability for taking decisions in our joint service will be transparent and clear to public, the people we support and to our staff. We will give the people who use our services, their carers and the public the opportunity to influence and scrutinise our performance and priorities; and people, public and staff will be involved in relevant decisions about our joint service which affects them, either directly or through their elected representatives.

Our Model of Integrated Working

The model aims to provide services for people at all levels of need and supports the implementation of national guidance including:

Our Health Our Care Our Say: this lists seven positive outcomes for people using health and social care services.

- Improved health and emotional well-being
- Improved quality of life
- Making a positive contribution
- Choice and control
- Freedom from discrimination
- Economic well-being
- Personal dignity



Putting People First: this National Concordat emphasises the need for a personalised adult social care system, which ensures that prevention, early intervention and enablement become the norm.

Transforming social care this Local Authority circular states that “local commissioners working with local partners, in particular the NHS, should consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need”.

Our NHS Our Future: NHS Next Stage Review - Leading Local Change: this sets out five pledges to delivering change

- Change will always be to the benefit of the patient
- Change will be clinically driven
- Change will be locally led
- Patients, carers, the public and other key partners will be involved
- Patients/carers will see the difference when new and better services are introduced before existing services are withdrawn.



Service Description – Integrated Health and Community Whole System Approach

Both NYCC and NHS NY&Y recognise the need to have in place critical service elements in each of its four major localities in North Yorkshire: 1) Hambleton and Richmondshire, 2) Scarborough, Whitby and Ryedale 3) Harrogate and Craven and 4) Selby. (Similar arrangements may evolve in the fifth area with the City of York). Like a jigsaw the four major local community areas in North Yorkshire must have all the critical elements to deliver a complete local picture. The elements are deemed ‘critical’ as they are essential to keep the whole system moving freely thus avoiding unnecessary blockages. The top twenty critical elements are deemed to be:

1. Access to an excellent General Practice service which, along with the range of community services, proactively seeks to keep people well and healthy in the community but, when appropriately required, can access secondary care services.
2. Access to an acute hospital offering the appropriate range of services delivered by highly skilled clinicians in a safe environment.
3. Front facing triage services delivered by senior experienced, competent health and social care staff operating as trusted assessors who seek to divert people from hospital admissions where these are avoidable.
4. When admission to hospital is required access to a good integrated care pathway team who plan for discharges before or on admission of patients to a hospital setting.
5. A rapid response integrated team whose task is to respond to people at risk of admission to hospital or residential or nursing home care where indications are that, with some immediate intensive input and support, such admissions can be avoided. This is like the critical virtual ward in the community. Crises response 24/7 will need to be built into this element.
6. This is complemented by an excellent intermediate care and re-ablement service which may have both a building based element as well as a home based element. Staff should be sufficiently skilled to offer support to those with dementia or a mental illness as well as to those who are disabled or frail.
7. Access to a wide range of assistive technology, telecare and telemedicine to complement person based support, offer reassurance and protection and support independence.
8. Access to a range of health services such as dermatology which do not need to be based in an acute hospital. This may be a community hospital, an extended access or practice based linked service offering a range of inputs.
9. Support to those who are frail and recovering who no longer need to be in an acute hospital setting but who are not yet well enough to be supported at home. Likewise this could be linked to a community hospital setting or provided by an excellent independent nursing home provider.
10. An appropriate range of accommodation with care for vulnerable adults needing accommodation and care input, including those with dementia, learning or other disability or with mental health needs unable to remain in their home. Extra care provides the security of having your own home as well as the availability of having care on site.
11. For those still unable to access extra care with nursing and social care input there should be access to a range of good quality, goal orientated nursing and therapy care in other settings.
12. A wide range of allied health professional and therapy staff who, with specialist skills to help maintain, restore, strengthen, and rehabilitate people physically and mentally in a range of clinics, coupled with advice services to support people to remain long term in their homes.



13. Highly skilled and dedicated domiciliary care and healthcare support in sufficient quantities is critical to maintaining people in their own homes and supporting those returning from an episode of hospital based care. All home based support to be delivered on a re-ablement model, promoting self management wherever possible.
14. Assistance to family and carers who support family members who are either frail or ill or in need of personal attention and support in their home settings. This support may be in the form of information, training, respite and short breaks or a range of delivered services including equipment for the home, aids to daily living and adaptations.
15. Input, support and services from the third sector aimed at keeping people healthy and well and supported in their community settings with a particular focus on early intervention and developing creative and innovative cost effective solutions.
16. Front line staff skilled at assessing need (trusted assessors) are vital. These staff will be excellent in supporting people in solution finding, designing care packages shaped by the people who will use them and signposting people for additional or alternative support if required. These staff will be trained and equipped to provide an immediate clinical or service input thus avoiding multiple unnecessary handovers.
17. Library and other information services which offer people opportunities to gain knowledge about their rights, their condition and sign-post people to information on the wide range of community services available in their locality.
18. Access to good transport services is important. Some transport, such as the ambulance service, carries specialist medical assistance and life saving support to people in medical crises. In partnership with others these services may divert inappropriate admissions to hospital or speedily get those into hospital who need to be there urgently. Other community transport is necessary for access to a whole range of community services.
19. Community facilities such as leisure, gyms, employment and occupation opportunities, good housing and healthy environments are essential to good health and well-being.
20. Good leadership, excellent local management and access to skills development are essential to develop an open flexible and responsive whole system. Reducing professional and organisational barriers are essential to effective service.

None of the top twenty critical service elements can stand alone. All are inter-dependent and necessary if the local health and social care economy is to function well and offer the right service in the right place at the right time for people needing the service. This 'list' becomes the focus of our locality mapping exercises where gaps are noted and drives future commissioning intentions.

Accountability

In each area of service there will be clarity about governance arrangements. We will seek, wherever possible, to have one lead agency with management accountability for the named service provision area with the joint commissioners having specified the outcomes required of that service area.



Service Description – Integrated Working Approach

The service will take a whole systems approach to promoting independence, health and well-being. It will involve:

- One point of access for people seeking support – whichever door they choose gains access to all the system.
- Proactive case finding of individuals who may need support and effective sign posting to appropriate services including low level prevention initiatives.
- An integrated team approach of health and social care staff to proactively assess, develop and implement an appropriate care plan, support and monitor people with health and social care needs.
- Each person receiving support having one named worker to maintain case responsibility ensuring relevant input from others as required.
- Community Assistant Practitioners (CAPs) providing all support currently given by a range of non professionally qualified support staff.
- Low level monitoring of those at risk by third sector organisations.
- Universal access to a web-based information database to be used to signpost people to services aimed at promoting independence, health and well-being.
- Practice-centred systems for identifying vulnerable patients and creating jointly agreed priority lists between health and social care professionals within integrated teams
- Effective communication with local community pharmacies and more active inclusion of the results of medicine use reviews in the case management process
- Availability of beds for the management of particularly vulnerable patients, supported by dynamic “goal oriented” nursing, therapy and medical workforces.

THE NHS NEXT STAGE REVIEW

Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations.

“In previous reviews of the NHS, frontline staff have been on the fringes or bystanders. This Review has been different. We and our colleagues in the NHS have been at its core. There has been an unprecedented opportunity for health and social care professionals to review the best available evidence, to discuss priorities with patients and the public, and develop compelling shared visions for our local NHS. Through this Review, the NHS has created its own ambitious visions for the future of health and healthcare. This marks a real change in the relationship between the frontline NHS and the centre. Lord Darzi and the Department of Health have focused on supporting the improvements we want to make. This report will enable the local NHS to achieve what matters to us, to patients and to the public – improved health and high quality care for all.”



Expected Outcomes:

- To provide integrated support that is responsive to the needs of people needing support.
- To enable / empower people to maintain good health and independence as far as possible.
- To empower people to self manage their condition and have control over the decision made regarding their health and well-being.
- To reduce admissions to residential and nursing homes.
- To reduce unnecessary admissions to hospital.
- To improve operational working between partner organisations to enable services to be more flexible, proactive and responsive to individual needs.
- To improve knowledge and skills within the local support team.
- To improve strategic working to improve cost effectiveness and efficiency.
- To develop more effective commissioning processes by and between partner organisations
- To deliver efficiencies in the whole system deploying staff equipped to deliver all components of a care plan.

The Integrated approach requires localities to:

- define and develop an integrated multi disciplinary team to address the physical, mental and social care needs
- develop a formal partnership agreement and governance arrangements between key partners.
- develop a joint service level agreement for the integrated team/model agreed between providers and commissioners.
- develop the role of Community Assistant Practitioners to undertake appropriate tasks undertaken by domiciliary care staff, health care assistants, physiotherapist's assistants and OT assistants.
- enable CAPs and other non-professionally qualified staff to provide an expanded range of health and social care tasks.
- implement low level primary prevention initiatives for the general population and secondary prevention initiatives for those who have developed health or social care needs to prevent further deterioration.
- develop the role of the third sector in the provision of mainstream services.
- involve people and their carers in the planning, implementation and evaluation of the services they receive.
- involve other relevant services in the delivery of the locality model including: GP practices and PBC groups, Acute Trusts, ambulance services, housing and housing support, library services, NYCC Customer Service Centre.



Intermediate Care

Intermediate care is a range of needs led, transitional and integrated services that are intended to maximise health gain and:

- prevent unnecessary admission to an acute hospital bed
- support timely discharge
- reduce avoidable use of long-term care
- maximise independent living.

People in North Yorkshire will have access to a range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from NHS NY&Y and NYCC. The aim of such a service is to prevent unnecessary hospital admission and to provide effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

The *Community Care (Delayed Discharge etc) Act 2003* removes social services' ability to charge for community equipment (up to a given price) and intermediate care services. This means that these services will be free of charge to users and removes a barrier to NYCC providing these services jointly with NHS NY&Y, which does not charge and will help make access to services easier.

The intention is to build on existing best practice across North Yorkshire and elsewhere in the Country. Over time it will mean the transformation of some of North Yorkshire in house domiciliary care services as more staff time is dedicated to promoting independence. The cost implications of this proposed direction of travel will need to be considered.

Intermediate care services are delivered in partnership between our local primary and secondary health care, local authority services and the independent sector. Indications from elsewhere suggests that maybe 40% of patients in acute and community hospital setting could benefit from intermediate care.

People need rehabilitation and therapy, social, personal and nursing care. There will be some need for medical support, perhaps through development of the role of the community geriatrician. Some people may benefit from short focused inpatient stays in an acute setting. Most rehabilitation need is for physiotherapy or occupational therapy and these staff are a critical component.

Access to our intermediate care services in each locality will continue to be based on need and will not be driven by demand on beds in hospital settings or reduced access to residential or other community services. People should be able to benefit from the intense input offered by the service and success will be measured by people's improved health and independence and well-being. The ideal setting for most people accessing intermediate care support will be that they receive this support in their own homes. It should be noted that intermediate care is finite and is not ongoing like long term care.



Integrated Care Pathways (ICPs)

We are indebted to the NHS National Library for Health for the following extracts:

Integrated Care Pathways - what are they?

“ICPs are both a tool and a concept that embed guidelines, protocols and locally agreed, evidence-based, patient-centred, best practice, into everyday use for the individual patient/person receiving services. In addition, and uniquely to ICPs, they record deviations from planned care in the form of variances.

An ICP aims to have...

- the right people
- doing the right things
- in the right order
- at the right time
- in the right place
- with the right outcome
- all with attention to the patient/service user experience

and to compare planned care with care actually given.

It is this last point that sets ICPs apart from the myriad of other tools supporting best practice.

An ICP is a document that describes the process for a discreet element of service. It sets out anticipated, evidence-based, best practice and outcomes that are locally agreed and that reflect a patient-centred, multi-disciplinary, multi-agency approach.”

The protocols and care pathways library aims to provide information relating to the development and implementation of care pathways and protocols. Over time these will provide an extensive database of examples.

In North Yorkshire we have many agreed integrated care pathways and the intention is to have our set of pathways readily available in accessible format for our multi-disciplinary teams and integrated services and staff. We will encourage both social care and health clinicians to work closely with people using services to constantly improve pathways and contribute to local, regional and national best practice.

There is a clear link here with personalised care planning. The individual client or service user should be made aware of what excellence looks like based on national and local best practice. Adjustments can be made to take account of individual circumstances.

“The genuine ICP is characterised by:

- systematic action for consistent best practice, continuous improvements in patient/person care, all with attention to the patient/person experience
- person centred - built into packages of care for identified groupings
- provides continuous feedback via variance tracking and analysis
- multidisciplinary - based on roles, competence & responsibility rather than discipline alone
- maps and models clinical and non-clinical care processes
- incorporates order and priorities including guidelines and protocols
- includes standards and outcomes

<http://www.library.nhs.uk/pathways/page.aspx?pagename=ICPS>



Integrated Community Equipment Services including self assessment

At this time we have a range of integrated and separate approaches with some working less well than others in giving people the choice of equipment they need to get on with their lives. We recognise our common duty of care in this service not only to those who come to the state for their equipment and advice but also to the many self-funders who purchase aids to daily living from a variety of commercial sources.

As well as improving the standard of present service delivery it is our intention to jointly explore the retail model of aids to daily living service delivery.

We also wish to explore greater access and support for self-assessment for some equipment and greater ease of access at our respective points of delivery. Our joint intention is to:

- Have a more integrated service.
- Improve quality and put users and carers at the heart of the service
- Empower local services to focus on users with more complex conditions
- Maximise the skills of professionally qualified staff giving them more time to focus on their core skills of delivering therapy support to those in greater need.
- Find a way of offering personalised services, whether provided by the state or privately (self-funders).

We will consider jointly:

- Moving to a prescription rather than requisition model of service delivery
- Increasing the information available to support people to understand options
- Increasing availability of self assessment tools
- Developing a market to access independent needs assessors – advice and treatments

World class commissioning

Competency 2. Work with community partners Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.

Why? “..... Partners include local government, PCTs, healthcare providers, third sector organisations and clinical partners such as practice based commissioners and specialist consortia. Working collaboratively with partners, we will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission”

Processes and knowledge requirements

“..... Has up-to-date knowledge of the strengths and weaknesses of the commissioning community in which it operates, identifying key local participants and potential to optimise improvements in outcomes. Advises and develops local partner commissioning capabilities where there will be a direct impact on joint commissioning goals. Shares across the local community its ambition for health improvement, innovation, and preventative measures to improve well-being and tackle inequalities. Uses the skills and knowledge of partners, including clinicians, to inform commissioning intentions in all areas of activity. Actively shares relevant information so that informed decisions can be made across the commissioning community. Monitors and evaluates the effectiveness of partnerships.

Example Outputs

Robust and aligned local area agreements informed by JSNAs.
Evidence of collaboration with other commissioning agencies, optimising cost efficiency through shared service arrangements, such as joint commissioning plans, shared and single audit systems.
Open and effective shared knowledge and information processes which maximise use of local community intelligence and engagement.”



- How to make available more knowledgeable and competent staff in the marketplace
- Working with the DH and CSED to acquire retailers identified by a quality mark as distribution points
- How to give more access to products
- How to further the normalisation of products – moving away from institutionalised equipment
- How to increase product choice and innovation
- Empowering more people to self help
- How to give people more control over their independence

Locality and Practice Based Commissioning (PBC) and local place shaping

North Yorkshire Adult and Community Services has divided the county into 23 locality communities. Each locality has a Community Service Manager (CSM) who is the delegated budget holder for that locality. They also have the management overview of assessment and commissioning teams in that locality, as well as the Council's ACS service provision. They are, in effect, key locality commissioners, assessors of local need and place shapers in respect of social care services.

NHS NY&Y has delegated indicative budgets to the General Practices in all localities across North Yorkshire. Practice based commissioning (PBC) is about GP practices taking on delegated indicative budgets from their PCT to become more involved in commissioning decisions for their patients. Through PBC, front-line clinicians are being provided with the resources and support to become more involved in commissioning decisions. Practice based commissioning will lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want.

Together the locality Community Service Managers and the local PBC group will know the people at risk in their community. They will often have responsibility for shaping joint care packages. They will know the people in their locality with long term conditions, those at risk of frequent admissions to hospitals, those who have frequent falls and those at the edge of needing long term care and support.

Closer linkages between PBC and social care Community Service Managers and Commissioners will be encouraged and supported across North Yorkshire. It is they who shape the direction of travel along a care pathway. Together they impact on the shape of budget expenditure. They are major influencers in the supporting the health and well-being agenda of many in their community. They command access to many of the resources in that community.

We will support better integrated working between ACS Community Service Managers by:

- Sharing information and data from the JSNA process for the district populations
- Service mapping the local community i.e. what is available and where for this local population
- Supporting integrated long term care approaches
- Facilitating data sharing on people at risk of admission to hospital and with long term care needs
- Considering how best to support local integrated prevention approaches and solutions.



Assistive Technology (Telecare and Telehealth)

Assistive Technology (Telecare) is the remote or enhanced delivery of services to people in their own home by means of telecommunications and computerised systems. It offers the prospect of preventative care services that maintain vulnerable people in the community with increased independence and at lower overall service cost, although these outcomes are dependent on sensitive design of service provision for specific users.

Assistive Technology uses a range of sensors, matched to individual needs, linked to a lifeline (a kind of telephone). They can support people when living with any care or health issues that they may have. Different sensors can be selected to safeguard people when going about their normal daily routine safe in the knowledge that if help is needed then it will be automatically called. Then a personal response can be organised. It gives people the freedom and dignity to live the lifestyle they wish.

Assistive Technology can support people with ordinary every day things they might find difficult like answering the door or remembering to take medication. Assistive Technology can sense and react using detectors for gas as an example or people using panic buttons/pendants to call for assistance. Assistive Technology can also help manage dangerous situations e.g. a person lying for periods on the floor due to falls; detecting floods from overflowing taps or epilepsy sensors or notification systems for someone if a person needing support has left their home at an inappropriate time of the day such as early hours of the morning putting themselves at risk.

If Assistive Technology senses a problem then it will send a signal to the lifeline where an alarm can be raised 24hrs a day. People using the service in North Yorkshire (and there are nearly 10,000 doing so!) use a specialist centre where trained operators, speak to them over a speaker on the lifeline and as they already have people's details with their agreement they know who to call in an emergency i.e. family, friends, carers or the emergency services. Alternatively people can choose to have calls made directly to their chosen emergency contact.

In North Yorkshire we have used Assistive Technology for a lot of different people and whilst it is not suitable for everyone, the feedback we have had from people who have used Assistive Technology is very positive. 85% people said that Assistive Technology had helped them to continue to live at home and 91% of people said that Telecare equipment had given them more confidence/peace of mind. Assistive Technology is available to anyone, who wants to feel more confident and safer in their home. This equipment does not replace family or other carers who visit but it can give people and their family confidence that should help be needed it will be called.

County Councillor Chris Metcalfe, Executive Member and Portfolio Holder for Adult and Community Services

“Assistive Technology (Telecare) is the most radical change to the way vulnerable and older people receive support in recent years and will allow record numbers of people receiving care to keep their independence and remain living in their own homes rather than moving into residential or nursing homes.”



The areas most likely to benefit from a telehealth service are those dealing with Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF) and diabetes. We will, in our joint services, therefore:

- Seek to keep our staff and commissioners up-to-date on the latest developments and opportunities to use assistive technology to support people at home
- Keep them informed of the research and the evidence base for the use of assistive technology
- Work together to ensure this becomes part of our mainstream approach to supporting people in community settings
- Continue to invest in assistive technology as a core activity.

Joint Strategic Needs Assessment (JSNA)

Through the leadership of the Corporate Director, ACS, NYCC and NHS NY&Y have together been looking at the needs of the population of North Yorkshire so that we can coordinate our efforts and those of others in meeting those needs from the resources available.

There is a great deal that we already know, so this document refers to other work that is already available, for example, the local authority profiles issued annually by the Department of Health and Association of Public Health Authorities; the current NYCC Children and Young People's Plan; the NYCC, ACS' Strategy for Independence, Well-being and Choice; and the NHS NY&Y "Investing in Health" report. As well as lots of data the JSNA pays attention to the voice of people and what they say will help keep them healthy and well. The level of 'voice' represented in North Yorkshire's JSNA may place it among national exemplar models of best practice.

Needs assessment is a continual process of asking people what they think, looking at the routine information we collect, appraising the effectiveness of what we have done before and using all of that intelligence to constantly readjust the resources at our disposal to get a better fit with the needs that are unmet. Any report on the Joint Strategic Needs of North Yorkshire deserves a wide audience and a summary will be made available through a wide range of local media.

The full version of the document, with its technical annexes, is addressed primarily towards those who have a statutory duty to commission or provide services according to population needs. Summaries of this assessment will be compiled for each local district authority and made available on the NYCC website. We hope it will be widely read and prompt further discussion, further avenues of inquiry and, above all, new solutions.

The six themes around which the 2008-09 JSNA is structured have emerged from years of joint working at the North Yorkshire Strategic Partnership, and feature in the current Local Area Agreement.

The six themes:

- Being healthy
- Access to services
- Being safe
- Quality of life
- Making a positive contribution
- Economic well-being



The report acts as the basis of a dialogue between NYCC and NHS NY&Y on future commissioning intentions. Here we will agree the joint priority areas we need to plan for and address together over the coming year. Together with national requirements and these local priorities our commissioning and service provision receives its direction of travel and we make our adjustments to the previous years activities.

Place Shaping and Extra Care

Older People and members of the wider community have responded positively to the extra care developments that NYCC and its partners have delivered in the county over recent years. They are seen as providing quality accommodation, security and promoting greater independence and well-being, preventing the need for residential care by the occupants themselves. They are, as well, the basis of a modernised care and support service for people in the surrounding communities. Bringing young and old together the schemes are being used as true community resources.

However there is so much more that extra care housing can deliver with further investment. The original intention of NYCC ACS was to decommission the Council's residential care homes and replace services through partnerships with housing providers of extra care housing and domiciliary care. Shifting the emphasis away from the replacement of EPHs as the central drivers for the extra care programme to an enabling structure for locality commissioning is now seen as desirable. An extra care scheme in a community is a once in a lifetime opportunity. It can provide a vehicle that will support the delivery of a number of commissioning intentions that otherwise would be difficult to deliver and these need not be limited to the aspirations of NYCC ACS. There is scope for the involvement of partner commissioning organisations and third sector providers. To date the potential added value benefits of extra care has not been fully exploited. There are a number of public services and facilities with associated benefits that could be realised and these include:

1. Community libraries
2. Social clubs
3. Well-being suites
4. One stop shops
5. Locality satellite hot desk offices
6. Health centre/clinics
7. GP surgeries
8. Intermediate care/rehabilitation
9. Children's activity areas

NHS NY&Y recognises the opportunities within this model and has initiated and supported, for example, discussions with GPs in one locality about maximising the use of such a building to meet local health as well as social care needs. Therapy rooms and other facilities will allow nurses and other health professionals to deliver a range of local clinics to local communities.

We will be jointly exploring how we can utilise such resources to support people with dementia in need of support and this will be reflected in our joint dementia commissioning plan due out shortly for consultation.



Other Integrated Commissioning and Partnership Approaches in North Yorkshire

By now it will be clear that there is a lot of integrated working already under way between NYCC ACS and NHS NY&Y. This is part of an ongoing strategic approach which has evolved since NHS NY&Y put in place the essential elements of the new organisation. This has gathered pace since April 2008 and, as indicated in the introduction, culminated in the agreement in early July by the top teams of the two organisations.

Mental Health

There is a Joint Commissioning and Partnership Board involving NYCC ACS and NHS NY&Y commissioners and our Mental Health Trust Provider partners. There are a lot of networks including front line integrated teams who feed into this. Senior Management Teams from both organisations are seeking to deliver a model of integrated care with NHS NY&Y as the lead commissioner and have integrated working approaches with ever clearer lines of accountability from the named provider(s). Staff and services will be managed by a named organisation. The joint Mental Health commissioning plan is available from our web sites.

Learning Disability

There is also a Joint Strategic Learning Disability Partnership Board where both NHS NY&Y and NYCC work closely together to deliver the agenda laid out in Valuing People Now. Likewise locally there are Partnership Boards and teams working in an integrated approach. Some of the Partnership Boards themselves have even wider partnerships involving a range of other agencies.

Both organisations are on track to have a clear statement for the Department of Health about the local authority taking the lead in commissioning and service delivery, building on the many existing agreements. The teams negotiating the way forward on this have been identified and dates for discussions are set. This will build on the work of previous years where for a long time there have been Section 28A agreements and joint commissioning posts. As with Mental Health the aim this time is for the local authority to act as the Lead Commissioner, have in place more integrated working approaches, ever clearer lines of accountability and provider services managed by a single named organisation.

Market Development Board

Both the local authority and NHS NY&Y rely heavily on providers in the independent sector to support people with a range of needs in community settings including those in residential and nursing home care. We recognise that hospitals would soon get blocked if we had insufficient domiciliary care support. Working with providers in the market place is critical to our success. Thus North Yorkshire has established a 'Market Development Board' where, together with representatives of the independent sector, e.g. Independent Care Group (ICG) and others, we work in partnership to ensure the market continually develops to meet the needs of the people. ICG and the third sector are co-signatories of our Concordat on Putting People First in North Yorkshire

Dementia Commissioning Plan

NYCC and NHS NY&Y have recently held a 'think tank' on commissioning for dementia services. Many organisations and representative groups attended with representation also from the Department of Health. The idea is to build on the existing networks and reshape services to meet the needs of people now while also paying attention to future demand. Agencies and partners with



an interest in dementia services are presently helping us to complete an audit and also to highlight the current gaps and pressures in services. We developed a framework questionnaire and asked stakeholders to contribute to our joint future commissioning framework.

The Scrutiny Committee of the Council, together with representatives of NHS NY&Y invited and listened to stakeholders from across the county as we together agreed some outlines of the commissioning strategy. From this we will draft a dementia commissioning plan which will then have a three month consultation period. This will coincide with the national policy framework in late autumn.

Contracting and Commissioning third sector partners

The local authority and the local NHS often commission from the same organisations and often do so jointly. We are presently reviewing how we can do this in a much more systematic way. We also recognise the need to make a joint shift towards being clearer about the outcomes we want following the JSNA. We also must secure the future of the sector and look afresh at the different models of commission. We must also encourage the sector to consider how it too will work in a more integrated and collaborative cost effective manner. We have a series of workshops planned over the next two months to begin this dialogue with the sector following the initial joint event with the Local Infrastructure Organisations (LIOs) in April.

We clearly want to move in time to a more outcomes based commissioning and contracting approach with the sector. The focus will, not surprisingly be on the health and well being of people with a particular emphasis on safeguarding the most vulnerable in our communities.

The Regional Public Health Group at Government Office focuses on two main areas: improving public health and improving social care services for people in Yorkshire and The Humber.

Public health works across communities and populations rather than at the level of the individual. It emphasises collective responsibility for health, its protection and disease prevention. Key to this is the recognition of the key role of the state, linked to a concern for the underlying socio-economic and wider determinants of health, as well as disease. Partnership working with all those who contribute to the health of the population is a main aim of public health action at all levels – nationally, regionally and locally.



Contracting and Commissioning Independent Sector Partners

The Market Development Board (MDB) is a partnership between NYCC's ACS, NHS NY&Y and the ICG and others representing the wide range of providers of support across North Yorkshire.

The purpose of the partnership is to:

1. Develop approaches to create a broad understanding of the importance of the care industry to the economy and welfare of North Yorkshire.
2. Explore ways and means of maintaining a modern, relevant, quality range of support provision accessible to the people of North Yorkshire.
3. Work in partnership, accessing all available resources, to transform care services in all sectors as outlined in 'Putting People First' Concordat.
4. While the MDB does not have a responsibility to maintain any one provider or type of provision it will seek to secure a balanced market place in North Yorkshire offering wide choice, personalised support and high quality support to the people of North Yorkshire by
 - i. Working to ensure an excellent pool of skills across the sector
 - ii. Finding ways of encouraging excellence in provision
 - iii. Noting feedback from inspector and audit organisations and trends and using this to work together to ensure North Yorkshire has the best reputation in care provision
 - iv. Undertaking regular market analysis to understand and respond in a cohesive and sustainable manner to the widening knowledge about best practice, the ever shifting economic climate, the rising and changing expectations of people seeking support and demographic changes.
 - v. Seeking to maintain, expand and not to de-stabilise capacity in the sector and ensuring equality of opportunity to all types of providers, including the third and fourth sectors.
5. Provide a forum for expressions of any concerns arising in the sector with a view to creating joint solutions if required, in particular work on the economic development solutions for the sector.
6. Allow opportunities for creative thinking and the exploration of innovative approaches giving opportunities for individuals and groups to present tomorrow's possible solutions to support need.
7. Maintain good open communication across the sector utilising the web, communication briefs and conference opportunities.
8. Sharing financial and commissioning data to enable all parties to understand the current and future climate and plan accordingly.
9. Develop stronger links with other parts of the statutory sector, i.e. Skills for Care and Business, CSCI/CQC, Acute Trusts, Strategic Health Authorities and the RDA.
10. Help the market adapt and change in a planned manner.
11. Put forward solutions to Government.
12. Communicate issues on developments to a wide audience.
13. Seek to tackle joint recruitment and retentions issues.



Executive Overview Group

Managing this very full agenda is both challenging and exciting. The Corporate Director of ACS, Derek Law and the Interim Chief Executive of NHS NY&Y, Jayne Brown, have agreed to meet every four weeks to monitor progress on this integrated agenda and, where any difficulties arise, will seek to address these. The Director of Commissioning and Development in NHS NY&Y and the Assistant Director, Commissioning & Partnerships, are required to attend to report on activity, development and progress on an integrated agenda. There is also an opportunity for a heads up on new challenges coming across the horizon which in turn may require new strategic approaches. This Group signed off this draft outline joint strategic statement in the September 2008 meeting, tasking key staff to build on the work and engage others to add and further the proposals in time for a major launch in November 2008.

Executive Implementation Group

The Commissioners from NHS NY&Y and NYCC ACS, as well as the Assistant Director of Operations, with a range of commissioning and provider staff, form the Executive Implementation Group. From this a variety of work streams and communications will be implemented within agreed timetables to further the vision and make it a reality. This group was key in shaping much of the agenda between April and August 2008, laying the foundations for this statement and communicating it to the Corporate Director ACS and Chief Executive of NHS NY&Y.

In its follow up meeting to the September Executive Overview Group it agreed to

- do further work on the statement
- explore how best to engage PBCs in owning and shaping the statement further
- develop short briefing notes for staff and key others
- prepare for a November launch
- complete the draft table of named links in each organisation
- begin the process of developing action plans for named work areas.

The Executive Implementation Group will meet on a four weekly basis in the week prior to the Executive Overview Group. It will support and drive implementation of agreed project areas and receive updates from localities.

Healthy Ambitions is a vision of a world class NHS for the Yorkshire and Humber SHA region

The 8 clinical groups recommendations pulled together to form the report covering birth to end of life care. In asking how quickly improvements can be made the report states:

“Some of this work is already being implemented and a great deal of effort will be made to make these improvements to your NHS as quickly as is practical. However, many of these changes cannot be made overnight and the ambition for the kind of NHS we want to provide means that elements of Healthy Ambitions will take time to implement fully.

The NHS cannot do it alone.

Strong and focussed partnerships with a whole range of agencies like local government, schools and charities will be essential to realise our ambitions.”



Key messages to Staff from NYCC ACS and NHS NY&Y.

- Adult Social Care and NHS NY&Y are partners in supporting the health and well-being of the population of North Yorkshire.
- Integrated working and integrated approaches are seen as essential and not optional to the delivery of joined up approaches, particularly for the people who have both health and social care needs and for their carers.
- Integrated working and collaboration is expected at all levels of the organisations.
- Front line workers should understand they are encouraged to be innovative and creative in developing joined up solutions for patients and people who use services.
- If the perception is that 'the mythical system' is getting in the way of delivering an even better service to people or 'them up there' would never allow it then ask and challenge the blockages, real or imaginary.
- Front line assessors and commissioners should familiarise themselves with the many options of service delivery available in their locality, including assistive technology and extra care resources.

Key Messages to Practice Based Commissioners and Locality Community Service Managers

- Both NYCC and NHS NY&Y see you as local 'place shapers'.
- Your commissioning decisions often determine the care pathway the person using services has available to them.
- Your focus on joined up approaches to early intervention can prevent people entering acute pathways unnecessarily.
- We are interested in hearing about your creative, cost effective solutions which allow more people to be supported safely and with dignity in community settings of their choice.
- You have knowledge of your local market and what works well and what works less well for people. Your joint intelligence is critical in shaping the strategic commissioning agenda of both partners.

Key Messages to Partners

- Note agenda and direction of travel of the health and social care partnership and the key measures of success: people are safeguarded whatever the service; more people are supported to be healthy and well and the need to avoid unnecessary admission to acute care by having a greater focus on early intervention and prevention.
- Take account of the desire to find creative, cost effective solutions for people gives partners opportunities to contribute to shaping commissioning strategies and input from the third and independent sector is welcome.
- The preference is for solutions that are localised and community based.
- Just as NYCC ACS and NHS NY&Y are seeking to work more effectively on behalf of those needing services in more integrated and collaborative way, there will be an increasing expectation of more integrated approaches among providers in the independent and third sector.

