



# **Your community, your care: developing Harrogate and Rural District together**

The future for integrated primary and community care in  
Harrogate and Rural District

Harrogate and Rural District Clinical Commissioning Group  
February 2018

# Contents

<b>1 - About this document</b> .....	2
<b>2 - The Case for Change</b> .....	2
2.1 Improving the health and wellbeing of our population .....	3
2.1.1 Our population profile .....	3
2.1.2 Prevention and early intervention .....	3
2.2 Ensuring that our population has a good experience of care and receives good quality care .....	4
2.2.1 Opportunities emerging from accountable care models .....	4
2.2.2 Right care, right place, first time .....	4
2.3 Control of cost and achieving the best health outcomes for every Harrogate pound spent in the health and care system .....	4
2.4 Delivering primary care at scale: the opportunity .....	5
2.5 Simplification of a complex system .....	6
<b>3 - Building on our strengths and challenging the flaws in our system</b> .....	6
<b>4 - The local appetite for change</b> .....	7
<b>5 - The key components of a model of integrated community care</b> .....	8
5.1 Our learning from being a Vanguard site .....	8
<b>6 - The local care model - our future approach to primary and community care</b> .....	11
<b>7 - What good looks like</b> .....	13
7.1 For local people using health and care services and carers: .....	13
7.2 For community and primary care clinicians and practitioners .....	13
7.3 For hospital providers: .....	14
7.4 For commissioners: .....	14
<b>8 - Making the change</b> .....	14
8.1 Leadership and partnership .....	14
8.2 Engagement and involvement of the community .....	15
8.3 Commissioning .....	15
8.4 Primary care support .....	16
8.5 Workforce .....	16
8.6 Technology .....	17
8.7 Finance and payments models .....	18
8.8 Estates .....	18
<b>9 - Governance and conflicts of interest</b> .....	19
9.1 Conflicts of interest .....	19
<b>10 - Final message</b> .....	19
<b>11 - References and links to further information</b> .....	19

# Your community, your care: developing Harrogate and Rural District together

## The future for integrated primary and community care in Harrogate and Rural District

### 1 About this document

The transformation of primary and community care is central to the vision and values of the CCG. Since 2013 we have worked in partnership with our GP practices, primary and community care partners, social care partners, local people and communities, through the Vanguard system, to pilot ways of achieving this transformation. This document sets out the next phase of our ambition to deliver a fully commissioned integrated model of community services.

We describe what local care and support in our communities might look and feel like in the future, as the basis for a continuing dialogue with people and organisations with an interest in the health and wellbeing of their local place. That means everyone who lives here, the people and families who care for them, and the organisations that plan and deliver care.

We are now in a position to build on our vision and plans for local community services by specifying and commissioning improved services that work with and for our local communities.

### 2 The Case for Change

The health and social care needs of our local population are changing. We have a combination of an ageing population, an increase in the number of people with long-term conditions and the changing expectations of our population. Together these increase demand and create pressures on our health and social care system.

As commissioners, we have three overarching objectives, either directly or delivered through the services we commission:

- The population has improved health and wellbeing:
  - a. Better health
  - b. Good quality of life
  - c. Reduced inequalities
- The quality of care is high with:
  - a. Effective care
  - b. Good patient experiences
  - c. Safe care
- The health system is affordable and sustainable by:
  - a. Reducing dependence on health and care services
  - b. Managing demand within resources

## **2.1 Improving the health and wellbeing of our population**

### **2.1.1 Our population profile**

The registered population of Harrogate CCG is 162,246. Life expectancy at birth is 80.9 for males and 84.2 for females, both above the national average. The life expectancy gap at birth in Harrogate (between the most affluent and most deprived areas) is 8.8 years for males and 5.9 years for females.

The CCG has an ageing population 10 years ahead of the national ageing curve with over 1 in 5 people aged over 65. This is set to increase to 1 in 3 over the next two decades. There is also an increase in the number of people who have a limiting long-term illness (53% of people aged over 18 years), including those living with dementia. This population group will require more health and social care and we know that, through early identification and prevention, we can improve health outcomes.

From an audit of bed usage at Harrogate Hospital, we know that 1 in 5 acute admissions could be managed in a less acute setting if suitable alternatives were available in the community; and nearly 2 in 3 hospital beds are occupied by people whose acute medical needs have been met and who could be better cared for out of hospital if appropriate support was available.

We also know that the working age population (15-64) is shrinking as a proportion of the overall local population, with more outward migration of working population than inward migration. This has implications for the health and social care workforce.

### **2.1.2 Prevention and early intervention**

The impact of prevention and early intervention initiatives are often not realised quickly and there is an inherent tension between investing for the longer-term and balancing the books in the short term.

There are however opportunities to work 'upstream' by identifying people at risk earlier and working with them to manage their care better, pre-empting and planning responses to future health crises that could result in an admission to hospital. This is particularly relevant for people with long-term conditions, frailty, mental health problems and at the end of life.

We have tested this on a small scale with a number of practices and want to see this as part of the future care model. This includes the expansion of the Living Well coordinators into GP practices who can signpost people to community assets, and opportunities to be had from working with services not traditionally associated with healthcare: the Fire and Rescue Service for example whose remit now incorporates home safety, particularly for vulnerable people.

For End of Life patients the introduction of an Electronic Palliative Care Co-ordination System (EPaCCS) aims to help improve the recording of key information about end of life care (EoLC) based on National Information Standards. It allows Advanced Care Plan (ACP) decisions to be updated as persons condition changes and ensure all staff involved in caring for and supporting that person are aware of their wishes.

The National Audit Office estimates that if access to community-based EoLC improved, to meet people's preferences for place of care there would be a reduction in emergency hospital admissions by 10% and the average length of stay following admission by three days.

## **2.2 Ensuring that our population has a good experience of care and receives good quality care**

### **2.2.1 Opportunities emerging from accountable care models**

**Accountable care** is being used to describe a defined set of resources that when planned and deployed collectively can improve health and care outcomes for a defined population, as opposed to providing – and being paid for – more episodic or reactive care.

An accountable care approach supports an integrated system that enables health and care economies to work together and use the funding available to get the right care earlier and to achieve better outcomes for people by working together.

The notion of accountable care is shifting as the thinking emerges both nationally and through the work of STPs. The West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) is emerging as an accountable care system, working together and at scale to:

- Achieve a critical mass beyond local population level to achieve the best outcomes
- Share best practice and reduce unnecessary variation
- Achieve better outcomes for people overall

The Health and Care Partnership works on the principle of subsidiarity – doing the work as close to local populations as possible. As a result, six accountable care partnerships are emerging, all different to reflect local need, but all centred on the ambition and purpose to develop an integrated care offer that simplifies our local health and care services. There is more work to do on this locally, and this paper sets out the beginnings of the commissioning strategy to achieve this for the Harrogate and Rural District local accountable care partnership.

### **2.2.2 Right care, right place, first time**

Our current delivery model has emerged over decades and whilst we have high quality services supporting our population, the model is, in general, one of response rather than proactive and preventative care.

We've set out a desire to emphasise early intervention and prevention but what this also brings is an ethos of getting it right first time, and thinking person not organisation or profession. Time and again, people tell us they want to tell their story once and have a coordinated approach to their care and support. If we get this right, our new approach provides a real opportunity to change practice to achieve this, creating a health and care system that is much more centred on the individual's experience.

## **2.3 Control of cost and achieving the best health outcomes for every Harrogate pound spent in the health and care system**

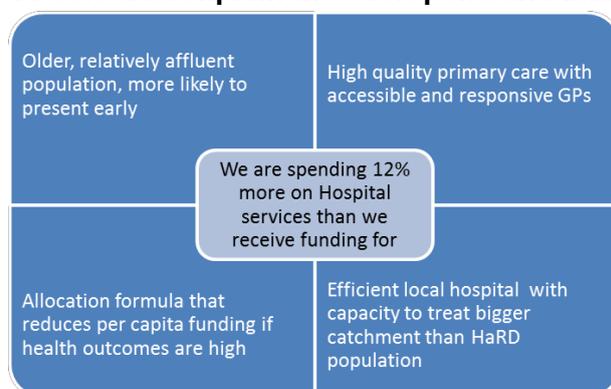
Like most health and care systems in England, Harrogate and Rural District is struggling to match demand with affordable supply. The local health economy is predicting a funding gap of £40.3m by the end of 2020/21 unless services are transformed.

The needs of an ageing population, an increasing number of people with one or more long-term conditions and an increased probability that older people will be living alone mean most NHS systems are overspending and many Local Authorities are struggling to maintain services.

This position is compounded in Harrogate by the high expectations of the public and the fact that the area is well supplied with GPs and has an efficient hospital that treats a larger catchment population than Harrogate and Rural District.

The net result is an overspend and imbalance in the health economy. Analysis by health economists employed by WY&H HCP shows we spend 12% more on hospital services than we receive funding for.

#### Four factors that explain the overspend and imbalance



The solution to the problem is to increase the level of prevention and self-care, to support the population to manage their own (and help manage their neighbours') long term conditions, for GPs to operate at the upper end of their skill set and co-ordinate out of hospital provision, with hospital services reserved for when people need specialist or more complex care.

This approach to rebalancing the health economy and making it sustainable and resilient is not radical but it will be difficult. It requires all partners to work together including the Local Authorities, who, whilst not overspending are both affected by, and can affect, pressures on NHS services.

We need to redesign our community offer, learning from our existing work but using innovative ways to be able to meet challenges head on and support local people and communities to achieve the best outcomes and quality of life through partnership working.

We need to find a mechanism to achieve affordability, sustainability and ensure that contractual levers incentivise making the right choices about health and care.

Changing the pattern of investment to enable growth in primary and community services will be necessary to deliver the vision we have set out in this paper. To do this, we need to collectively bring down the cost base in acute care in line with what is affordable and enable investment in and growth of primary and community services.

Our place based strategy is about sustaining resilient health and care services for our people across the spectrum of primary, community, mental health, social care, hospital care and the voluntary and community sector.

#### 2.4 Delivering primary care at scale: the opportunity

The model we are describing supports the expansion of community-based health and care services, centred on high quality primary care and general practice. This recognises the lynchpin role of the GP and practice in the delivery of healthcare, often acting as the gatekeeper to health services generally.

This will include opportunities for practices themselves to reduce costs, share resources and expertise, but additionally opportunities for population health and the health economy:

- To reduce overtreatment and bring activity into line with our comparators
- To shift diagnostics and treatment into the community where appropriate
- To deliver more care at home and prevent avoidable admissions, particularly associated with frailty
- To manage demand effectively through more proactive and planned care that is coordinated across close working with integrated community teams and practices
- To renegotiate the relationship between general practice and hospitals - for example if the GP is responsible for more of the pathway, the hospital team may be able to be more responsive and work more closely with general practice to achieve more timely diagnosis and specialist treatment
- The opportunity to test and actively deploy technology, apps and telehealth

## **2.5 Simplification of a complex system**

The emergence of directives around '*integrated urgent care*' and also '*integrated community services*' from the Five Year Forward View enables us to simplify a very complex system to something more intuitive that will help people make the right choices about accessing care.

## **3 Building on our strengths and challenging the flaws in our system**

In Harrogate, we are proud of the care and support we deliver to our local people. As we take the next step in transforming the system, we will continue to value the assets and strengths we have already, including:

- ✓ A location that is attractive to live and work in
- ✓ Relatively low deprivation and a relatively healthy population
- ✓ Informed, engaged people with an interest in maintaining their own good health and maximising their independence
- ✓ Accessible and responsive primary care
- ✓ Good relationships between primary and community care clinicians and local people
- ✓ A high quality, committed primary and community care workforce
- ✓ High quality general practice
- ✓ High quality mental health services
- ✓ A high quality local hospital
- ✓ A constructive approach towards partnership and joint working between health and social care professionals and organisations and working closely with the voluntary sector
- ✓ A record of innovation and flexibility in developing new services

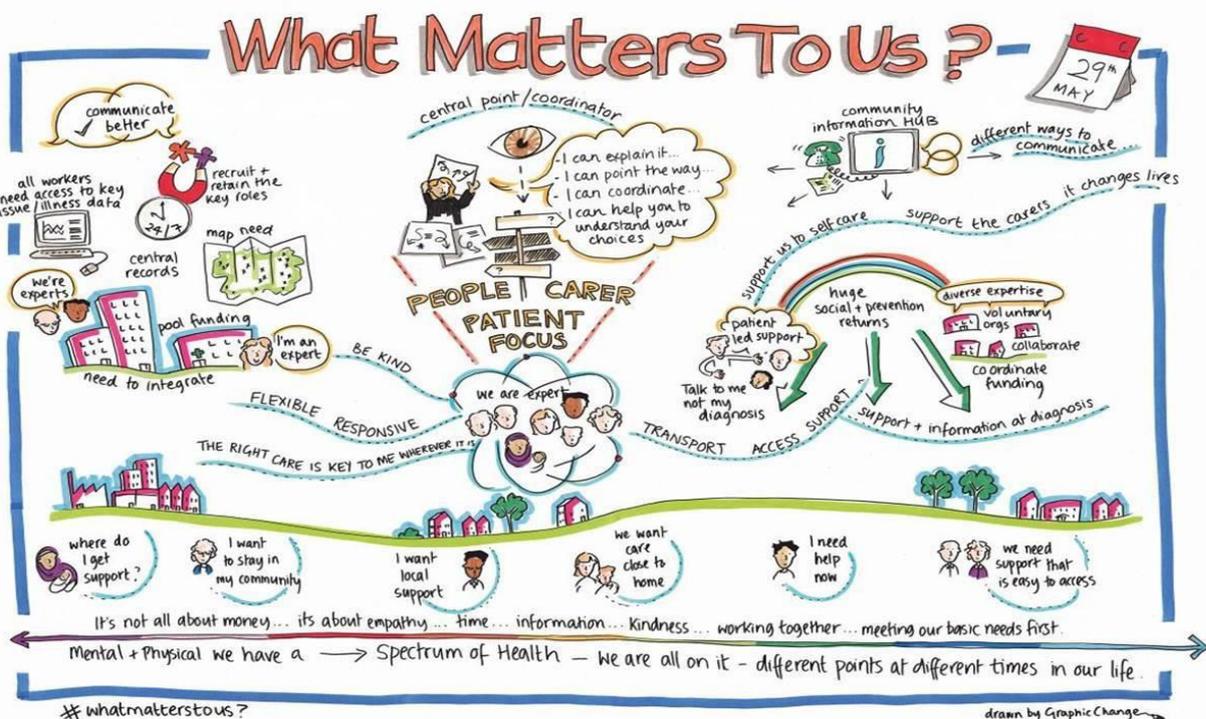
However, the imperative of balancing demand with the resources available together with a drive for continuously improving the health and care offer available to the local population, leads us to the need to address the flaws within the current health and care system. Our assessment indicates that these are:

- ✗ Demand outstripping the resources available
- ✗ Supply driven demand
- ✗ A payment model incentivising acute sector growth
- ✗ A lack of an integrated focus and approach to prevention and early intervention
- ✗ A paternalistic model that doesn't adequately enable self-care
- ✗ A contractual model that doesn't support a partnership or whole system approach
- ✗ We do not currently plan and develop our workforce as a whole system

## 4 The local appetite for change

Our participation in the Vanguard programme was driven by a collective desire across partners to build on our strengths and address our system's flaws. From the outset we wanted to engage local people in the design of the new care model. In May 2015 an Open Space event was held to shape the new model and to hear from local people 'what matters to us'. This became the title of the Vanguard programme locally, helping to keep a person-centred ethos central to developments.

The picture below came out of the event in May 2015, and we believe still represents the best overview of the local priorities for care and our agenda for change in the next few years.



The Open Space event involved 80 people including service users and staff. It was facilitated to ensure that everyone's voice was equal and the topics of conversation were generated by the attendees.

We also used the work of **National Voices**<sup>ii</sup> who developed a narrative for integrated care, setting out what people expected from their care. This was expressed as ‘I’ statements and these became our touchstone:

- ✓ ‘I feel safe receiving preventative, long-term condition management, crisis and end of life care closer to home’
- ✓ ‘I have easy to understand information about care and support which is consistent, accurate, accessible and up to date, in order to prevent illness, remain as independent as possible and in times of need’
- ✓ ‘I am in control of planning my care and support and respected as understanding my own health and conditions’
- ✓ ‘I am supported by a team of people who are confident, happy, coordinated, know what they are doing and trust each other so I don’t need to tell my story again and again’
- ✓ ‘I know who to contact to get things changed’

The person-centred, locally focused vision expressed here continues to be the basis for our work together to create primary and community services that from the patient’s perspective are able to deliver **‘Your community, your care, developing Harrogate and Rural District together’**.

## **5 The key components of a model of integrated community care**

### **5.1 Our learning from being a Vanguard site**

In the past three years we have been able to evaluate and test out a range of new ways of working and we have benefited from national support, as part of our participation in the Vanguard programme from 2015-18.

The new model will be underpinned by learning from the best elements of our Vanguard programme and the current pop up work, as well as national evidence from other systems who like us have wrestled with, and found solutions to local health and care challenges.

The experience of the Integrated Response Service (IRS) has shown that it is possible for mental health, social care, pharmacy, community nursing, therapy and practices to work together with no need for internal boundaries or referrals. Feedback from people using the service consistently commends the approach and this integrated approach will continue to be the bedrock of the model with the following;

- **A focus on population health rather than organisations**
  - Our current health and care system is one built around the needs and priorities of organisations rather than one oriented around improving the health of the population.
- **Care delivered at home as part of our community assets**
  - We should see local care as the norm. Our ambition is to provide more care and support for people in their homes, or in a local community setting, and only expect people to visit a hospital when there is no alternative way to deliver the service they need.
  - We should see local care as a local asset. The organisations that deliver care and support services should play a real part in their local community, as employers as well as providers.

- We are surrounded by assets that can support health and wellbeing, particularly prevention and early intervention, from universal services such as Harrogate Borough council's leisure and sports facilities, the parks and gardens, voluntary sector activities and mainstream public activities such as parkruns.
- Statutory health and care services have an opportunity to capitalise on these assets, weaving them into a wider model of health and wellbeing.
- **Joined up, or integrated care**
  - A simplified system of health and care services that are joined up and delivered and experienced as a single entity. The ambition is that the boundaries are dissolved between organisations and the person and their family experience a single service across all aspects of care and support.
  - Care that is delivered in the community as a single system, which spans the traditional boundaries between self-care, social care, primary care, community care, mental health, intermediate care and secondary care.
  - A single assessment and care planning process, based on the goals of the person with delivery coordinated across the health and care organisations are essential to underpinning good care.
- **A GP-centred model**
  - GPs need to be at the heart of the model with care arranged around practice populations.
  - The experience of the IRS pilot has shown that it is possible for GPs to work really closely with community health and care services to mutual benefit. There are indications that this could release GP time by identifying people who could be assessed by the team rather than directly by a GP and also in finding cases to intervene earlier more proactively and in a multi-disciplinary way.
  - GPs have engaged daily with team huddles and are able to both support and challenge practice to get better outcomes for people.
- **A system that puts people in control of their care and health**
  - Involving local people in service design helps to get it right.
  - We expect people to be in control of their own care, with a real say in how services work for them, in an equal partnership with the people who deliver them.
  - We expect self-care to be part of everyday life for local people and for people to play an active role in taking responsibility for staying well and delaying the need for care.
  - We will ensure that there are trusted sources of support to give confidence to the patient to take more responsibility for their continuing health, and to clinicians and professionals to enable them to 'let go', releasing time and resources that can be focused on the work that only they can do.

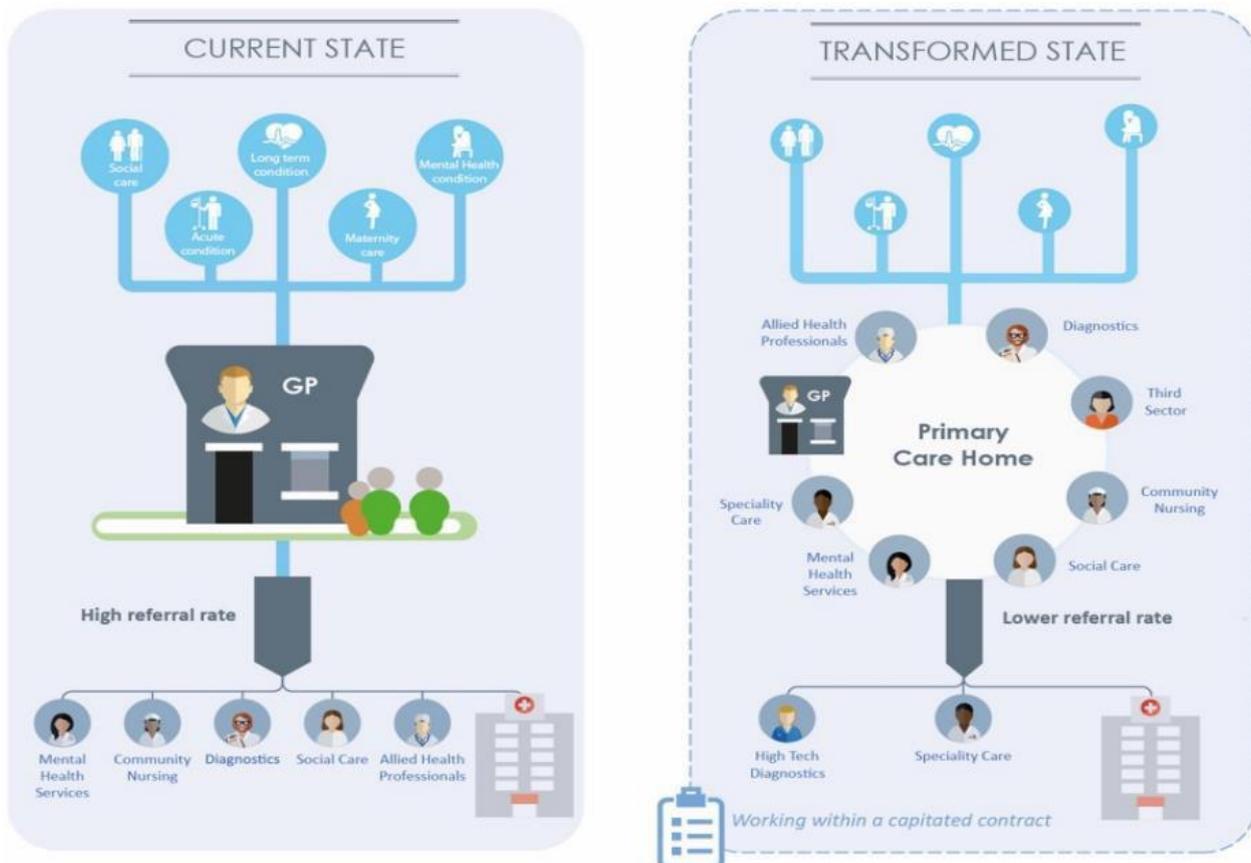
- **A workforce skilled at delivering coordinated, proactive, preventative care, working as a single entity**
  - The workforce is our greatest asset and they need to be involved in the design and delivery of the care model. They will need new and different skills and need to be supported to achieve and embed these.
  - Co-location of staff is significantly important to creating a joined up culture and shared values and resolving the practical issues associated with this should be a priority.
  - For the first time we now have NHS mental health, community nursing, therapy and pharmacy staff co-located in a local authority building, benefitting from learning from each other on a daily basis.
  - A workforce that is planned and developed as a whole system rather than by individual organisations.
- **A focus on prevention and early intervention**
  - Good case finding and early intervention can help delay or avoid crises that can lead to admission to hospital or long-term care. Working with people to support them to manage their long-term conditions more independently and to have a crisis plan to use when they need it can help people to stay at home longer.
  - End of life care is care that affects us all, at all ages; the living, the dying and the bereaved. Nobody likes talking about death and dying, and death is often seen as a failure of treatment. If we can start to help people have these conversations we can start to improve how individuals are supported and encouraged to prepare for and plan for their last days. This can ensure that all individuals, their carers and families' experience good end of life care.
- **The right leadership and support**
  - Implementing a new care model needs a lot of investment in leadership at all levels. A new type of system leadership is needed which requires different skills for partnership working, including being able to get things done without direct authority over staff from other organisations.
  - Change takes time, effort and resilience: focus is required on organisational development, project management, quality improvement and change management resources.
- **A focus on continuous improvement**
  - A quality improvement methodology is really important to ensure a focus on the quality of care and continuous improvement. It exposes waste and helps to remove it from the care model, freeing up precious resources to be targeted more effectively.
  - Data underpins everything and enables the teams on the ground and the managers to make the right decisions. Access to day-to-day data helps the teams understand their impact and helps them to continually improve.

## 6 The local care model - our future approach to primary and community care

6.1 Learning from Vanguard and other national models including 'Primary Care Home' sites we have set out our commissioning ambitions for the future local model;

- Care delivered in practice-centred around populations of 30-50,000 registered patients.
- General practices supported to develop to operate at scale across the district in a federated model, whilst preserving high quality list based personal care.
- Being ambitious about what services could be delivered in the community rather than in a hospital setting, to fundamentally shift the traditional access points and expectations of people who use services.
- A community of clinicians and practitioners from across health and social care services, including mental health, working together to meet the needs of the local population.
- Tactical commissioning enabled through effective local expertise, knowledge and skills available in the community.
- Preservation of acute hospital capacity for those who are critically ill or who need diagnostics and speciality interventions that can only be delivered in a hospital setting.

The National Association for Primary Care demonstrates the difference between the current model and a future state bringing GP and community health and care services together around a practice population:



We can now take the learning from the new care model programme and begin to describe the future state:

- **Home first:** The assumption is that care will be delivered locally - in the person's home wherever possible, or in a community setting.
- **Accessing local care:** Currently, all demand is channelled through GP practices, with primary care clinicians acting as gatekeepers to other community-based services. In the future, people will be able to access the whole range of community based care and support services, including GP services, more directly, through co located teams.
- **Integrated local teams:** Within each locality (which will reflect the size and shape of the local communities in our area) a single, co-located, integrated team will work together to assess people, plan and deliver the most appropriate response to need. This will include people currently working within primary care, community health (therapists, nurses, pharmacists), mental health services, and social care. They will work closely with local third sector and independent sector providers.
- **Person-centred care and support:** The integrated team will work with the person and their carers to agree their goals and how these can be met. This will be personalised, coordinated, anticipatory and comprehensive. It will be coordinated by a key worker who both enables the person to manage their care and also orchestrate the support needed.
- **Support to self-care:** The approach assumes the person has a role in managing their health care needs and support. It will also anticipate and plan for future crises wherever possible and plan for managing the end of life more proactively so that health and care needs are met in a more planned and coordinated way, avoiding crises wherever possible.
- **A real round-the-clock response.** Although not all functions will be available 24/7, the integrated team will have a presence around the clock so that people and their carers have a known and trusted source of support and advice out of hours.
  - There will be continuity between in-hours and out-of hours support based around the person's care plan. Providers will use evidence on demand to plan and deliver services when they are needed.
- **More community-based resources.** To enable local delivery to become the norm, some functions currently delivered in hospital will be relocated to community settings. This will include a wide range of diagnostics and therapies, although those functions requiring very specialist inputs will still need to be delivered in hospital.
- **A new local approach to bed based care.** Although emergency and acute secondary care will still be delivered in hospital, the needs of people requiring non-acute treatment in a bed (such as slow stream rehabilitation, or intermediate care) will be managed by the integrated team, working into community based beds in extra care housing or care homes with hotel services delivered by the housing provider.
- **A different relationship between clinicians.** As more care is delivered in the community, centred around primary care, there will be a need to negotiate a different relationship between GPs and hospital-based doctors and an understanding of their respective roles within care pathways.

- **Using community-based assets and universal services.** Harrogate District has a wealth of universal services that can support the health and wellbeing of the population. As we move to a community-focused approach, we would expect further connections to be made and opportunities exploited, for example the Fire and Rescue Service supporting home safety and the Police and Borough Council working together to better meet the needs of vulnerable people in the District we have significant numbers of services provided by the voluntary and community sector and we need to join these up and ensure accurate sign-posting to make the most of this valuable asset.
- **Deploying technology and innovation.** Our ambition is that technology is core to the delivery model, harnessing opportunities to support mobile/agile working, access to services, communication, information sharing and engagement and self-care. We want to really exploit the opportunities and benefits that technology can offer, including virtual consultations, remote condition monitoring, 24/7 access to real time advice and guidance.

## 7 What good looks like

This vision will be recognised by many as a direction of travel that has been discussed by partners over several years, but it will take real effort, significant leadership and commitment to make it happen. By creating a new way of caring for local people in their own communities the following benefits can be realised.

### 7.1 For local people using health and care services and carers:

- ✓ A single, joined-up response for all day to day care and support needs
- ✓ More say in what care is received, and more control over how things are done
- ✓ The ability to take responsibility for self-care, to maximise people's independence
- ✓ More continuity in the people who work to deliver care and support
- ✓ Less need to travel for care and support
- ✓ More diagnostic and assessment services available locally
- ✓ A hospital bed only when it is needed
- ✓ A bed in your local community when intensive support without full hospital care is needed
- ✓ Simplified access to urgent and routine care services from a local team that you know and trust
- ✓ Care at the end of life that is co-ordinated, skilled and supports peoples choices

### 7.2 For community and primary care clinicians and practitioners:

- ✓ The ability to work as part of a recognised local asset at the heart of a local community
- ✓ Appropriate workload for primary care and general practice – patients seen in the right place, at the right time, by the right practitioner
- ✓ Improved local control over out of hours service response and co-ordination
- ✓ Streamlined pathways to direct people to an expanded range of community based care functions

- ✓ Working as part of an integrated team with a common way of working and no barriers between different organisations or roles within the team
- ✓ More flexible and autonomous roles based on the principle of co-developing personalised care for individuals
- ✓ The opportunity to develop and share skills

### **7.3 For hospital providers:**

- ✓ Reduced pressures on hospital admissions
- ✓ Improved community-based resources for non-acute inpatient care, reducing delayed discharges
- ✓ A single, integrated community team working to a single set of protocols, reducing duplication and delays in handling referrals and transfers of care
- ✓ Opportunity to reduce cost base to improve efficiency and delivery of financial plans

### **7.4 For commissioners:**

- ✓ Improved population health
- ✓ Improved value for tax payers money and ensure management within the allocation cost
- ✓ Improved experience and quality of care for people using services
- ✓ Reduced demand on secondary care
- ✓ Improved efficiency in community based care
- ✓ A single set of quality standards
- ✓ Improved consistency in information management for locally based services

## **8 Making the change**

We will be working through 2018 and 2019 to put the changes in place to make this model of care a reality for our local population. There are a significant number of areas that need to be worked through on this journey. A summary of the task in hand is set out below.

### **8.1 Leadership and partnership**

The CCG will lead commissioning of the new primary and community care model, working in partnership with NYCC as commissioners of social care services in the district to deliver our ambition of an integrated commissioning model. This is complex and more work needs to be done to understand the various tiers of commissioning emerging at West Yorkshire, pan-North Yorkshire and Harrogate place levels.

Commissioners will continue to work together with key stakeholders, people and communities, who have invested time, energy and resources in getting us this far. Our priorities will be:

- To continue to work with GP practices to realise the local ambition of an at scale primary care provider which supports a high quality and sustainable model of General Practice in the district
- Develop opportunities for GPs and other practitioners to work in different ways, providing alternative pathways and service offers within primary care and to identify, develop and support GP leadership necessary for this work

- To explore options for integrated commissioning with social care to achieve best value in use of resources across a population
- To build on our conversation with our local Trusts and other providers, to share and refine the model and specification
- To talk to the local population, sharing this strategy and testing our thinking.

## **8.2 Engagement and involvement of the community**

Early engagement with local people at the beginning of the Vanguard programme provided our overarching brief for building and testing a new model of care.

As the commissioning model develops, we will work with local people to get it right and we know that we need to refresh the conversation.

We expect the provider response to be closely informed by local engagement.

## **8.3 Commissioning**

We will develop a detailed outcomes-based specification for the local care model by April 2018 and put in place contractual mechanisms to achieve the delivery of a new model by April 2019. We will prioritise the delivery of flexible, responsive services that meet the principles we have set out above.

We are reviewing procurement and contractual models that will enable the delivery of services to be experienced by users as a single entity and will support providers to achieve this. We recognise that the current contracting landscape may not enable this, with binary contracts between the CCG and various providers.

The clear expectation is that the commissioned model achieves the vision set out in this document and fundamentally shifts the care model out of hospital to the community, centred around general practice.

Whilst our clear ambition is to find a coherent model of commissioning across the CCG and North Yorkshire Health and Adult Services that can deliver the ambitions we have set out here, there is a complexity around integrated commissioning with the local authority that needs to be worked through.

The role of the Health and Care Partnership (HCP) in commissioning services on a West Yorkshire and Harrogate footprint is also emerging, however it is not anticipated that it will have an impact on the commissioning of community-based health and care services for the Harrogate place.

We will also explore the potential for joint commissioning with the County Council which would bring together community based healthcare and social care into a single commissioning space.

We expect a novel response from providers to deliver the vision. This is likely to require an equally novel approach to commissioning, procurement, contracts and payments models. This is an emerging science nationally and we will learn from other health and care economies. We will also be supported in this journey by NHS England's New Business Model teams and potentially follow the Integrated Support and Assurance Process (ISAP) which provides a series of checkpoints throughout the commissioning process intended to support, work through and fix problems.

## 8.4 Primary care support

The local care model responds to the needs of our local practices, but at the same time we recognise that it will involve some challenging changes in the ways that primary care professionals work:

- within the practice (for example, in supporting people to take on more responsibility for self-care and self-management of their health, or in expanding the practice team to include a wider range of professional inputs)
- as part of the wider local system (for example, in how they access other community services, local diagnostics, etc. on behalf of their patients)
- we will work with our practices to agree new ways of working and provide training and support for clinicians and staff as the local care model is introduced

## 8.5 Workforce

The model anticipates that there will be an increased number and range of staff working in community settings to deliver care. This is likely to mean that many existing community based staff will take on new roles and responsibilities, alongside some jobs transferring for all or part of their time from hospital to community settings.

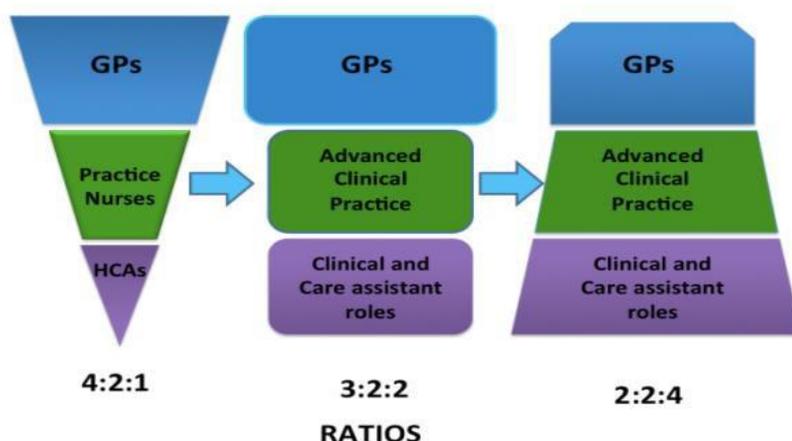
We will work with our partners to encourage the development of a workforce that is confident to deliver in their new roles and able to respond to the changing needs of our local population.

There are significant challenges in maintaining and developing the right skill mix to achieve our vision. Analysis has been undertaken at a West Yorkshire and Harrogate (HCP) level to understand workforce needs, however we need to understand the profile for Harrogate:

### **Each year for 2017 to 2021 across West Yorkshire & Harrogate Sustainability and Transformation Partnership area**

- 150 new general practitioners (GPs) per year
- 50 new nurses per year
- 50 new clinical pharmacists
- 50 new advanced Allied Health Practitioners per year (paramedics/emergency care practitioners, physiotherapists and occupational therapists)
- 50 physician associates per year
- 70 new clinical support workers (health care assistants) per year
- Conversion of 70 practice clerical support workers per year into clinical support (patient facing) roles such as a care navigators
- Expansion of mental health therapists (70)
- Training of existing and new volunteers as community champions, wellbeing experts and experts by experience. (70)

There is also the balance of skills with practices themselves and a shift from a traditional top-heavy GP model to one that utilises the skills of other clinicians and assistants, reducing pressure on GPs themselves:



## 8.6 Technology

The local care model will need to be supported by a range of technologies to allow people to optimise their contribution to care and to encourage innovative solutions. That means being able to share information across functions through shared systems, but will need to go further, for example in equipping people with the technology they need to self-manage long term conditions safely and confidently.

Smartphones, apps and web-based resources and solutions are now part of daily life for people and the expectation that the health and care system has some way to go to embed this in that way we deliver care. We would expect the new model to harness these opportunities which support control of their care to be shifted increasingly to the person.

The STP 'aide-memoire'<sup>iii</sup> summarises the expectations driven by technology by 2020:

- i. Digital maturity in secondary care providers is significantly increased**
  - Patient information is recorded once, digitally, at or close to the point of care.
  - Clinicians alerted promptly to key patient events and changes in status, supported by knowledge management and decision support tools.
  - Improved management, administration and optimisation of medicines, availability of assets and effective staff- rostering.
- ii. Information is digital (paper-free) and flows between primary, secondary and social care providers seamlessly**
  - Patient information at the point of care is available digitally (irrespective of where it was recorded), on a secure, timely and accessible basis.
  - Transfers, referrals, bookings, orders, results, alerts, notices and clinical communications are passed digitally between organisations.
  - Telehealth and collaborative technologies being used to deliver care in new ways.
- iii. Patients, carers and citizens use digital technologies to manage their health and wellbeing**
  - Patients digitally book and manage their appointments, request and manage their prescriptions and consent to share personal information.
  - Patients can view, understand and contribute to their digital record, and manage how this is made available to family and carers.
  - Approved digital tools and applications used across care settings to facilitate: care planning and shared decision making; education and access to resources; monitoring and feedback on health and wellbeing; and administration of personal budgets.

## **8.7 Finance and payments models**

Fundamentally, we must ensure that the service we commission can be delivered within the available resources, and our commissioning approach will prioritise both cost-effectiveness and transparency, so that we can be assured we are getting value for money.

As we progress with integration, for example with social care, we will need to consider the options for bringing together the available funding from across the whole system and using this as a joint resource from which to commission a fully integrated model effectively meeting population needs. The concept of a *whole population budget* enables the totality of resource to be deployed where the need is to have the greatest impact. It is however highly complex and a significant shift from current arrangements.

We need to review the impact of current payment models such as Payment by Results for acute care and block contracts for community services (including mental health and community health services) and understand and appraise the alternatives available to us.

## **8.8 Estates**

The CCG recognise that in order to deliver the changes to the way it commissions services, we need to understand how and where services are currently delivered. A high level estates strategy was produced in 2015 and this reviewed all the community property to assess ownership, size and condition and on the whole there is good quality property being used well. However, that is not the case in all areas and the way in which we currently use property reflects current models of care.

The CCG is working with providers to assess areas where there needs to be significant change and investment in the properties as an enabler to deliver the new care model, recognising that there is a long lead in time to deliver new estate. This change in the estates will not prevent all aspects of the new care model from being implemented, but we know that accommodation is likely to be a barrier to achieving co-locating of services and the full benefits if the property is too small, is of poor quality and is sited where access is more difficult than it could be.

The concept of local hubs will shape the way in which the estates assessment will be undertaken, prioritising opportunities that will allow the co-location of services and capacity to facilitate more community based services. Where physical hubs are not achievable, services will be clustered around a number of properties/providers to create a virtual hub, where services are accessed and delivered closer to the patient.

The CCG is currently working with a number of providers to understand where the local hubs could be sited, taking into consideration deliverability and affordability. This work will run alongside the service development aspects, both influencing each other to ensure that new services and new premises are aligned to offer the best solution.

## 9 Governance and conflicts of interest

Decisions will need to be made about the most appropriate way to deliver the change in services. These decisions will need to incorporate clinical advice and guidance. The Governance on the CCG's decision making process is set out in the CCG Constitution and this process will need to be adhered to. The types of decisions to be made include:

- What services are we going to commission?
- How are we going to commission these services?
- Do we need to commit to a procurement exercise?
- What form will that take?
- What is the specification for those services?

### 9.1 Conflicts of interest

The inherent conflict in GPs making decisions about services which will have an impact on primary care will need to be managed. This can be done in a number of ways including involving them in discussions but not in decisions; excluding those conflicted GP members completely or asking GP partners from other areas to act on behalf of the Harrogate Primary Care community. In all likelihood this will need to be managed in different ways at various stages of the process. We will agree this through the CCG Governing Body in more detail moving forward.

## 10 Final message

We have developed this vision together based on our work with our partners in primary care, acute care, community care, social care, mental health, local users of our services and their carers in the past 2 years. Latterly, in the last year of the Vanguard programme, we have worked very closely with three practices who have had a major influence on the development of the new model which has been tested as the Integrated Response Service.

The challenge now is to move from a programme, testing and trying out ideas, to the future state, making the changes in our own work that will build a confident, innovative and effective system of primary and community care for our local population.

If there are opportunities we have missed, or if you have additional or different ambitions for the future, we want to hear from you.

Please contact Jane Baxter, Interim Head of Integration who will coordinate your responses: [jane.baxter1@nhs.net](mailto:jane.baxter1@nhs.net)

We look forward to hearing from you.

## 11 References and links to further information

<sup>i</sup>End of Life Care:

National Audit Office (2008) End of Life Care. National Audit Office:  
<https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf>

<sup>ii</sup> National Voices:

<https://www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf>

<sup>iii</sup> STP Aide-memoire: digital:

<https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-aide-memoire-digital.pdf>