HARROGATE AND RURAL ALLIANCE

Health & Social care working together with you

BRIEFING DOCUMENT
SUMMER 2019

Introduction

A number of NHS and social care partners have been working together to transform the way community health and social care services are provided for adults in Harrogate District. This joint approach has been developed by five key providers and commissioners, working in collaboration with wider partners, colleagues, service users and the community.

The five organisations who are leading this work are:

- **Harrogate and District NHS Foundation Trust (HDFT)** which provides acute services and a range of community service across Harrogate District;
- **NHS Harrogate and Rural District Clinical Commissioning Group (HaRD CCG)**, the body which buys most healthcare services delivered in Harrogate District;
- **North Yorkshire County Council (NYCC)** who commission and provide social care services;
- **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)**, the local specialist mental health provider; and
- **Yorkshire Health Network (YHN)**, which represents GPs and primary health care services across Harrogate District;

Operating as the Harrogate and Rural Alliance (the Alliance) we are committed to providing joined up health and social care community services for adults across Harrogate District by implementing a new approach to how services are delivered.

This new approach brings colleagues in primary care, HDFT's community service colleagues, social services provided by NYCC and mental health services provided by TEWV together in one place, along with a wider network of NHS, local government, voluntary and independent sector partners and people with lived experience to work together to support and care for our communities.

The Alliance ambition is that together we will create a single service owned by the community and by all of our colleagues which has the person and community at its centre, and delivers good outcomes and value for money.

Ambitions

- ☑ Develop a joined up community health and social care service
- ☑ Ensure the new model is anchored in primary care with prevention as the starting point
- ☑ Place the person and community at the centre of everything we do
- ☑ Ensure successful collaboration, while Alliance partners retain their own organisational identity
- ☑ Be a service that is owned by the community and by all of our colleagues and deliver good outcomes and value for money
- ☑ Be a GP practice / Primary Care Network centred model (a hybrid model between practices and geography)
- ☑ Enable and ensure active involvement from people who use services and carers

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We are one of the first places in England to bring together all of our community services, stretching from the doors to the hospital through people's front doors into their homes. We are different, too, because we bring together the organisations which plan and fund ("commission") services and those that provide them. Together, we spend over £100m in our local community, working with hundreds of different service providers. At the heart of the Alliance are nearly 300 community health and social care colleagues, working with primary care, and responsible for in the region of £50 million of prevention, care and support.

Benefits for local people and delivery partners

In September 2019 GP practices, community health care, mental health and social care services are coming together to provide service users with joined up care which puts them at the centre of a unified health and social care service. In this way we can work together to support service users and their carers and make sure they get the care they need when they need it, that they only have to tell their story once, and that services work together to meet all of their care needs.

We will put early intervention, prevention and sustained wellbeing at the centre of our activities. Services will be delivered at or close to home whenever this is possible, with hospital visits only when it is necessary to deliver the care needed. Unified care will be developed around individuals and their heath and care needs. This approach is what people have told us they want.

Drivers for change

Nationally and locally health and social care systems are facing challenges around quality, sustainability and changing population needs. Integration between health and social care is a central part of both national policy and local strategy and commissioning intentions. The aim is to promote health and wellbeing, deliver better outcomes for the population, make access to services easier and ensure a sustainable system for the future.

National drivers of change

- **The NHS Long Term Plan (2019)** sets out a new service model for the 21st century with a greater emphasis on prevention, tackling health inequalities, improved quality and outcomes, support to staff, becoming digitally enabled and making best use of the public purse
- **Adult Social Care Green Paper** (anticipated) with a key principle to integrate health, housing and care
- **Primary Care Networks** (2019) establish primary care clusters which include GPs and aligned specialist services
- **Sustainability and Transformational Partnerships** (STPs) and the evolution of **Integrated Care Systems** (ICS) pursing the aims to integrate
- **GP Forward View** with an increased investment in primary care, GPs working together at scale, working from a more effective platform with other local health and care providers

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Local drivers of change

- Significant **financial challenges** across the system and need to match demand and affordable supply
- An **ageing population** in Harrogate District
- **Increase** in the number of people with **long term conditions**
- **Increase in length of stay** in hospital and people requiring packages of care or residential/nursing care
- **Strong local partnerships**
- **Learning** from the New Care Models 'Vanguard Programme' (2015–2018)
- HaRD CCG's **commissioning intentions** for the next phase of the ambition to deliver a fully commissioned integrated model of primary and community services (*'Your Community Your Care' Green Paper' February 2018)*

Historically care has been constrained by organisational and professional boundaries. This has often resulted in a person receiving support from teams working reactively and separately, diagnosing people in silos, where diagnoses and other important health and care information is not shared effectively. This sometimes means staff have had additional workload pressures, and little time to give advice and support regarding prevention, wellbeing and self-care. At times the system has prioritised physical health needs, with social care needs being overlooked or seen as divorced for the person's physical needs.

We aim to change the historic ways of working and implement an agile and responsive person-centred service which is at the forefront of delivering health and social care best practice and fully aligned to national and local policy and commissioning ambitions.

Timescales

The new approach has been several years in development. It builds on the integrated community care Vanguard pilot programme which ran from 2015 through March 2018. Drawing on learning from the pilot[1], colleagues have been working together, and with wider partners, to put in place the foundations to support the new joined up approach to service delivery. This has included developing and testing new shared ways of working, putting in place a plan to enable access for colleagues across Alliance partners' buildings and facilities and improving IT systems to enable information sharing.

Mobilisation commenced in May 2019 and the first year of the service will run through 31 March 2020. We will keep the new approach under regular review and identify ways it can be improved. These developments will naturally arise as we work in partnership with colleagues, service users their family and carers, our wider volunteer and community sector partners and policy makers and commissioners.

We fully intend the Alliance approach to be co-designed and co-produced as it evolves – we know we don't have all the answers and it will be better if we do it together. However we will also keep a firm eye on ensuring there is no disruption to service delivery as the changes embed and develop.

[1] *see the 'Sharing the Biscuits' report*

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Leadership and structure

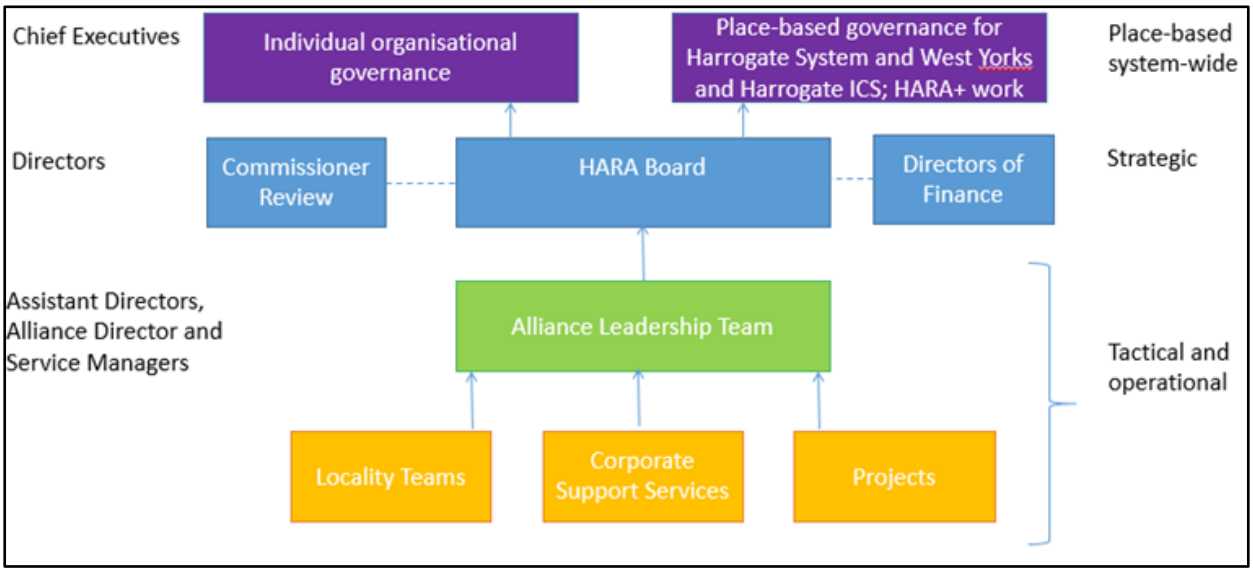
An Alliance Director has been appointed to lead the new integrated community health and social care service. Chris Watson took up this post on 1 August 2019.

A joint leadership team is in place, drawing skills, experience and talent from across the Alliance partners.

Oversight is provided by the Harrogate and Rural Alliance Board (HARAB) which is comprised of senior leadership from each member of the Alliance. HARAB will provide strategic direction to the Alliance, governance and oversight of risk and hold the Alliance Leadership Team (ALT) to account for delivery. HARAB will function as a forum to discuss issues with the aim of reaching consensus among Alliance partners.

The ALT has been established to manage the core operational services and to ensure that they remain safe, effective and high quality. The ALT also has the leadership role in the shaping delivery plans to achieve the objectives and strategies agreed by the HARAB. The ALT team includes four dedicated Service Managers who will manage day to day delivery of the service. Together this team is responsible and accountable for delivery in the new aligned structure.

Overview of the Alliance Governance



The Alliance has been established by five health and social care organisations to provide a financial and governance framework for the combined service. It is not a separate legal entity. The formal relationship between commissioners (who are responsible for funding decisions) is set out in the Alliance Agreement which is currently out for consultation (closing September 2019)[2].

[2] The consultation can be found here https://www.northyorks.gov.uk/section-75-hara-consultation.

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The approach to delivering community care for adults

The new approach will be look at the whole case load with general practice, community health and social care professionals working together as one team.

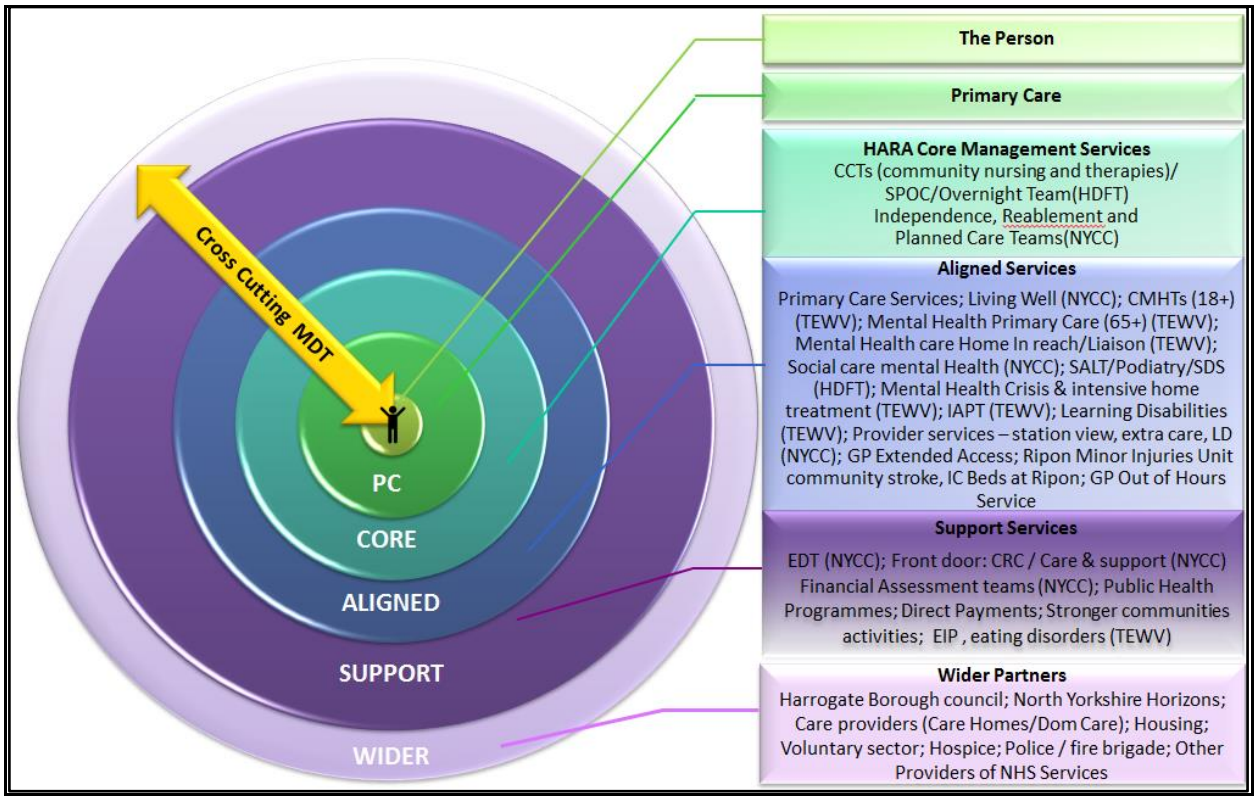
Health and care professionals will together assess the needs of the 'whole person' with daily and weekly collaborative meetings which look at current 'hot' and complex cases.

There will be four teams delivering services from two localities in Harrogate District. Each of these teams will be aligned to a Primary Care Network.

Teams will work together across organisational boundaries to put the person at the centre of care delivery. There is more detail on what the service includes and how it will be delivered below.

Services

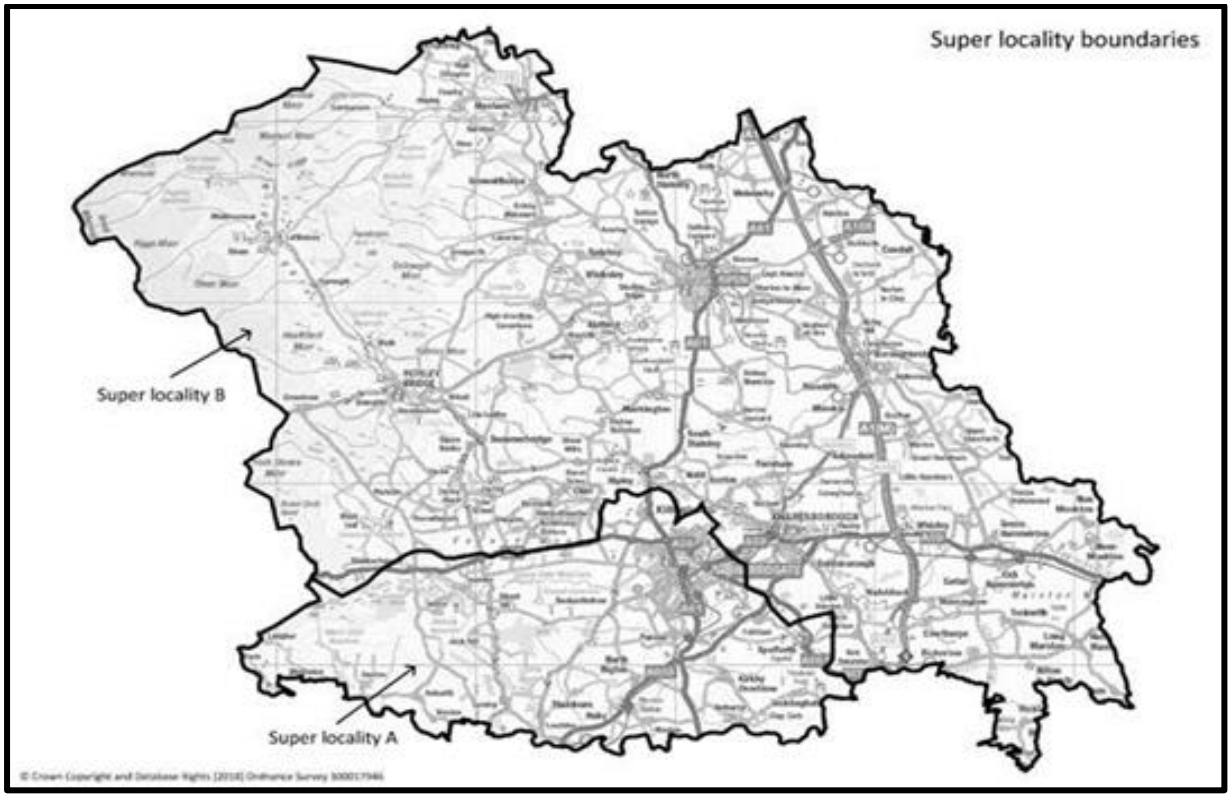
The Alliance is a true collaboration of health and care providers. The diagram below sets out the services which are included in the new model.



Geography

Services will be delivered from two localities, each with two teams.

The map below sets out the locality boundaries.



Delivery

Each locality has two integrated teams which work directly to the footprint of the Primary Care Networks (groups of primary care practices). The integrated teams will include GPs and GP practice staff, representation from the linked HDFT and NYCC teams and aligned partners when needed.

To manage the activity of HDFT and NYCC teams within each of the two localities there will be two operational teams based around a specific geography, each managed by a service manager. The operational teams are based on a footprint which supports the management of activity within a specific geographical area. These operational teams will be linked to the integrated team footprint of the Primary Care Networks.

It is proposed that during Year 1 (which runs through 31 March 2019) there will be one NYCC and one HDFT service manager allocated to each locality, with four service managers in total for the new service. Each service manager will be allocated to one of the four Primary Care Networks, and will ensure the co-ordination of multi-disciplinary team meetings with primary care colleagues.

The new approach will include both daily huddles and weekly Multi-disciplinary team meetings.

Daily Huddles

Daily huddles are intended to be short and concise meetings, focusing on the delegation of work and a review of any required actions within team caseloads. They will be held daily within the defined geographic area of each of the four operational teams.

The goals of a daily huddle are to:

- Discuss 'hot' cases who are new or of concern
- Provide regular interaction with colleagues across NYCC & HDFT
- Reinforce the sense of team
- Provide a more joined up approach to a person's health and care
- Review system resilience and capacity across teams
- Reinforce the sense of team
- Communicate what is going on

These huddles will be based in a set location within each operational area, at a stated time so that GP practices and any other partners can and may join. There will be the capability for any colleague or partner to join the meeting virtually.

Daily huddles will also provide more regular interaction of the team members and access to the leadership team for guidance and support.

Multi-Disciplinary Team Meetings

Each of the four integrated teams will hold a weekly Multi-Disciplinary Team (MDT) meeting, within one of the four Primary Care Networks. MDT meetings will provide the opportunity for more complex case discussions within the integrated teams. They will also allow colleagues within the integrated teams to share soft intelligence regarding those who may yet be unknown to services, but who may benefit from some preventative support.

There will be agreed criteria for which cases should be supported through an MDT approach. It is expected this will focus on those who are at immediate risk, where the case is complex and requires an integrated approach, or where there is a risk of hospital admission. In time this criteria will extend to include not just those cases at immediate risk, but also those where early intervention would prevent, reduce and delay the need for long term health and care support.

There will be one MDT per week per Primary Care Network, each will be held on a different day to ensure partners and colleagues who may need to talk about cases in different integrated team areas can join the meeting. The duration of the meeting is expected to be 90 minutes. MDT's will have a structured and coordinated agenda, so that colleagues can join at their planned time.

It is anticipated that the following roles or their nominated deputies will be included in the weekly MDT:

- Primary care lead
- Service manager
- NYCC and HDFT team manager of linked team

- Any other required colleague, e.g. social worker, mental health social worker, district nurse, occupational therapist

There may also be the requirement to include the following roles as and when needed:

- GP/practice staff
- Tees, Esk and Wear Valley representatives
- Living Well
- Wider partners
- Voluntary and community services groups

The future

Our goal is an agile and responsive service which is continually evolving. We will actively work across the partnership and with service users and their carers and families, partners in the volunteer and community services sectors, commissioners and policy makers to further develop the services in year one and beyond.