Item Number: 6

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP **GOVERNING BODY MEETING**	NHS Vale of York Clinical Commissioning Group

Meeting Date: 3 October 2013

Report Sponsor:	**Report Author:**
Rachel Potts Chief Operating Officer	Not applicable

1. Title of Paper: Framework Agreement to Promote the Integration of Health and Care Services in North Yorkshire and the City of York

2. Strategic Objectives supported by this paper

1. Improve healthcare outcomes	Yes
2. Reduce health inequalities	Yes
3. Improve the quality and safety of commissioned services	Yes
4. Improve efficiency	Yes
5. Achieve financial balance	Yes

3. Executive Summary

The attached framework agreement is being presented for adoption by the stakeholders detailed under 'Signatories' at the end of the document. This Agreement reflects the commitment of local government and NHS commissioners in North Yorkshire and the City of York to work together bring services together to significantly improve outcomes and eliminate the fragmentation of services across health, care and support for patients, service users and carers.

4. Evidence Base

Not applicable

5. Risks relating to proposals in this paper

Not applicable

6. Summary of any finance / resource implications Not applicable
7. Any statutory / regulatory / legal / NHS Constitution implications Local partners have a statutory responsibility to integrate health and social care.
8. Equality Impact Assessment Not applicable
9. Any related work with stakeholders or communications plan Through publication of Governing Body meeting papers on the internet.
10. Recommendations / Action Required The Governing Body is asked to adopt the *Framework Agreement to Promote the Integration of Health and Care Services in North Yorkshire and the City of York.*
11. Assurance Health and Wellbeing Boards will review the Agreement annually.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING: 3 OCTOBER 2013

FRAMEWORK AGREEMENT TO PROMOTE THE INTEGRATION OF HEALTH AND CARE SERVICES IN NORTH YORKSHIRE AND THE CITY OF YORK

1. Purpose

This Agreement reflects the commitment of local government and NHS commissioners in North Yorkshire and the City of York to work together bring services together to significantly improve outcomes and eliminate the fragmentation of services across health, care and support for patients, service users and carers. (Parties to this Agreement are listed in Appendix 1). We will also work with neighbouring councils who share a CCG population with us (principally City of Bradford and East Riding of Yorkshire).

We are jointly committed to developing a person-centred and integrated approach to health and social care for the population we serve so that, irrespective of the complexity of our organisations and boundaries, their needs come first. We propose to make the National Voices narrative - "I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" – central to delivering and commissioning care at all levels of our organisations.

This Framework sets out a consistent approach to the key issues of governance, accountability, leadership and resources.

Within this Framework, models for integration of commissioning and services will be developed, appropriate to the group, activities and locality.

Parallel implementation plans will be developed at the appropriate level of commissioning activity (whether whole authority or CCG level), setting out intentions and timescales.

This Agreement commits partners to work together on practical solutions to issues that create fragmentation and hinder progress in integrating services. Wherever possible a single model will be adopted.

2. Governance

This Framework *will be/has been* adopted jointly by North Yorkshire Health and Wellbeing Board and the City of York Health and Wellbeing Board to reflect their commitment to better coordinated health, care and support, centred on the individual and their carer(s). By working within this Framework, they expect to be better able to deliver the outcomes described in their own Joint Strategic Plans.

The Integrated Commissioning Board will have responsibility from the two HWB Boards for turning this intent into reality through joint, aligned and individual commissioning plans and by endorsing practical solutions to key issues identified in this Framework.

The three key Health and Wellbeing Boards of **North Yorkshire, York** and **Bradford** (because of links with Craven) are committed to supporting integration.

3. Why and where an integrated approach is needed

This Framework supports the commitment of partners to the following:

- Better outcomes, quality of care, reducing inequality and securing efficiencies
- Empowerment of patients, users and carers
- Working in a pro-active way with communities, recognising the different needs of communities across North Yorkshire and the City of York
- Professional and political leadership to drive change and promote innovation
- Consistency with partner councils sharing populations with CCGs in North Yorkshire.

Both Health and Wellbeing Boards have identified the main priorities for integrated approaches in their Joint Strategies.

These are personalised models of care for:

- Frail older people
- Dementia
- Long term care (including access to urgent social care and mental health and physical health interface with long term conditions)
- Mental health and dual diagnosis; learning disability
- Child and adolescent mental health.

Improving our arrangements for:

- Continuing health care
- Transition between children's and adults services
- Working with voluntary sector on prevention
- Addressing health inequalities and poor outcomes.

Developing new approaches for:

- Getting the model of primary care right and its interface with hospitals and social care
- Shifting activity and spend from hospital to community settings
- Advice and information
- Aligning personal health budgets with personal social care budgets and direct payments

4. Intended benefits

This Framework is based on a shared philosophy and approach: if we can get it right for most vulnerable, we can get it right for everyone. It seeks to achieve benefits from the following activities:

Productivity

- Better use of resources – though may cost more in short term
- Getting it right first time for the person should cut out waste, reduce duplication and swing door practices, repeats of services
- Allows resources to be put at best points of pathway to avoid spend on expensive parts of the system (i.e. secondary care and care homes)
- Reduce lengths of stay in hospital
- Promotes trust of other professional judgments.

Coordination and continuity of care

- Ability to meet complex needs through coordination of services
- Coordinated services can help integrate the carer and user as part of the team deciding care

- Highlights roles/responsibilities on carers/users in additional to professional care plan
- In our person-centred approach people will have a share in shaping their solution and be empowered to share the task of health and well-being
- Continuity of care
- Receiving a service from an integrated team may mean I don't have to have the stigma of receiving social care
- Easier access: one stop, no wrong door
- Pick up gaps and tensions in the system
- Less diversion of efforts on process and procedures.

Person-centred approach
- Promotes personalisation
- Enabling, not disabling: enabling patients to take control of their own care
- Person-centred rather than organisational or professional silos
- Enabling patients to take control of their own care
- Allows more mature discussions about choices and expectations
- Reduces duplication through multiple assessments – collecting information once
- Can focus on assessment for outcomes rather than specific services
- Reduces confusion, simpler, plain language.

Safeguarding
- Collaboration in developing effective safeguarding protocols and interventions.

Prevention
- Promotes prevention and planning in advance of a crisis
- Stops passing the buck.

Workforce
- Workforce benefits – staff are empowered and motivated to find solutions for people
- Key worker approaches.

5. Existing arrangements to build on

There is firmly established commitment to delivering integration across all organisations. There is programme management support already established across the region for implementation, and a range of section 75 agreements in place.

A number of projects have already started to bloom across the area with sharing of experience, and lessons learnt. In addition to working on specific Local Integrated Teams, there has also been extensive evidence of co-operation and co-ordination across organisations to develop solutions for specific communities.

These include the previously detailed work around dementia and substance misuse, as well as work looking at one of our local community hospitals. This work in Ripon for example, has involved the public, schools, churches; city, district and county councils and councillors, leisure services, the local hospital and community health provider, mental health services and the CCG looking at how to work together to offer a variety of services to the community. It demonstrates a level of engagement with service users and carers, which will need to be carried across to all of our integration work, if it is to succeed.

We also have experience of the use of enabling technology (both telecare and telemedicine) to aid clinical decision making, support people with long term conditions, support carers, end of life care, advice and support into nursing homes, as well as primary/secondary care IT interface e.g. Systmone available in Airedale, Wharfedale and Craven.

Work is already underway at a local level in different parts of North Yorkshire and York to experiment and learn how integration can be developed and sustained within local teams. This includes local programmes of organisational development where staff from different organisations have been brought together to build a shared sense of identity and the agreement of common priorities and solutions. Taking forward and properly embedding such large-scale organisational development and change will require continued commitment and energy over an extended period and is one of the areas that would benefit from North Yorkshire and York being a pilot site.

New joint approaches to commissioning are being tested in the area of substance misuse where an outcome based model is been specified and consulted upon. An initial joint commissioning involving four of the CCGs, North Yorkshire Council and Public Health together with two Mental Health Trusts has initiated the process of agreeing a similar approach in mental health.

In some areas, we have operational integrated protocols with the plan to role these out further. We have a range of examples from each CCG area of success already being achieved.

We would like support understanding the framework of rules on choice, competition and procurement as a means of driving and embedding integration. There has been initial discussion on moving from Payment by Results to per capita funding model with one acute partner.

North Yorkshire County Council's finance officer, CCG and acute provider finance colleagues have begun to explore open book accounting as we consider a whole community funding approach in Craven.

6. Statutory requirements

This Framework Agreement gives practical expression to the statutory responsibilities of local partners to integrate health and social care. In its application, partners will also have regard to their duties to innovate and have regard to relevant NICE/SCIE guidance, clinical and professional standards.

Current legislation requires councils to adopt a single, consistent approach to assessment of need and means, eligibility and charging within their boundaries.

NHS bodies must follow the requirements of the NHS Constitution.

NHS England and Monitor have statutory duties, respectively, to promote and enable integrated care. Local authorities have statutory duty to improve the public's health. CCGs and HWBs also have statutory duties, respectively, to promote and encourage the delivery and advancement of integration within their local areas at scale and pace. NHS England's planning guidance to CCGs requires integration, including the pooling of budgets to reflect local need to be given explicit consideration in local area planning. It also requires CCGs to work with councils to agree the allocation of funds to benefit health outcomes in their local population.

There will be a duty for councils and CCGs to jointly commission health services for children with special needs.

All parties have duties in relation to safeguarding, which will be incorporated into integrated services.

Legally, health and social care can be integrated in a health body but not vice versa, unless a special purpose joint vehicle is created. Health functions (other than public health) cannot be transferred to a council, only resources. Councils must demonstrate that the transfer of resources to NHS is best use of them.

We will adhere to the principles of the Caldicott report and the NHS Constitution on data sharing.

7. Principles

All parties have to work within their allocated resources. There will be a clear understanding of the money in the system and its usage as a first step to consider what shift might be required.

There will be an appropriate balance, tested and reviewed, between our investment in prevention, reablement and acute responses. We recognise that sharing early information with people can in itself be preventative.

We will take steps to ensure that we assess and manage the potential, or unintended, risks of change, with particular attention on issues of safety and safeguarding.

We will develop a more *personalised approach* to health and social care through:

- recognition and support of the person, carer and family context
- simple information and assessment, with good communication with the person and between those working with them
- Involvement in all decisions about health treatment, care and support
- understanding of the amount of money available to them for care and support and how they can exercise choice and control in determining how it is spent – whether from their own, council or personal health budgets
- good contact and care planning, whether new to services, changing them, moving to a new address in the area, or moving to another authority.

In our approach, we will be clear about the critical success factors expected of integration projects so that we include a *test of change – (*can we answer the question ‘how will we know it work?’ and do this from a number of perspectives. So why are we doing it? Is it reasonable or fanciful thinking? Is the proposal meaningful in a way that helps move the culture in the expected direction and motivate staff?)

The test in our transformed system is one where it must work for people we presently consider ‘hard to reach’ and for the most vulnerable e.g. person who is frail with dementia and with little support.

We need to test this regularly with people, focus groups and communities on how things have changed for them [a key role for HealthWatch] and to combine this with data. i.e. the experience if the patient will be a critical element of the performance framework.

The system, given the nature of health and social care issues may always have a level of complexity in it. However, as a guiding principle the system will seek to hide some of that complexity from its customers and where it cannot, we will use a range of means, tools, maps and communication approaches to help people understand how to navigate their person pathways.

We wish to ensure change happens in a structured way giving providers time to adjust their business model. However the key is to deliver the outcomes desired at pace and while there is a need to have services there is not a desire to sustain providers who cannot deliver on the outcomes in a cost effective manner.

As well as identifying leaders and champions for this transformational integration agenda, we will seek to identify and add to the dedicate resource of implementation project officers who can assist make this happen.

We will have in an information sharing protocol in place quickly.

We will be learning/sharing organisations and take practical steps to making this happen.

8. Approaches to key supporting issues and challenges

All parties are committed to the principle of integration to improve outcomes for patients, users and carers and care closer to home. In pursuing this there will be *integration models at the level that best achieves this*. This could be at whole council, CCG, district, or locality. For the councils this means that integration may proceed at a different pace and approach within their boundaries, to achieve the overall ambition.

All parties commit to developing consistent, practical and simple solutions to the issues that have caused fragmentation of services and hinder integrated approaches. We recognise this will take time so propose a two stage approach:

Stage 1: addressing fragmentation; clarifying how decisions can be speeded up by partners; encouraging innovation;
Stage 2: consolidate learning and evaluate whether outcomes have been achieved;
Stage 3: scale up to achieve step changes;
Stage 4: steps toward fuller integration.

We commit to develop a streamlined approach to securing agreeing to local developments within this Framework.

We will jointly develop a resource bank of contacts, information, national and local solutions in the following areas:

(a) *IT and information sharing* arrangements and protocols to support integration, (within the principles of Caldicott and the NHS Constitution) at three levels: technical and IT solutions for records; information governance; how staff from different organisations in one location can find relevant information.

(b) Patient and public engagement, covering the four key dimensions of involvement, engagement, consultation and patient experience.

(c) Consistent approaches to the issues of *competition and procurement*. Within relevant legislation and guidance, we will adopt the most appropriate *commissioning and provider model*s for the achieving the right outcomes. This may be one or more of the following: aligned, joint, lead commissioning; or prime contractor.

(d) A *shared approach with NHS Engla*nd to its commissioning responsibilities in North Yorkshire and York.

(e) Developing *future models of primary care*.

(f) The development of a *shared performance framework* that reflects transformation of the system and positive experiences for patients, users and carers.

(g) *Evaluation* arrangements to confirm the intended outcomes and better patient, user and carer experience.

(h) A shared approach to the *use of resources* that ensures continuing budget control and management, manages and shares risk, and addresses issues of redirection. We wish to support innovation in service delivery, integration of services and unbundling of services to enable components of care to be delivered and paid for separately, where this is in patients' best interests.

(i) A position on the contribution of *risk stratification* and how health and social care data can assist with prioritising.

(j) A review of *physical assets* (land, property, and offices) to achieve the goals set out in this Framework and how they can best be used to promote integration.

(k) A *workforce strategy* that promotes flexibility in support of less fragmented approaches and develops people to take advantage of the opportunities this Framework provides.

(l) The necessary *legal agreements* for resource transfer, delegation and governance in as simple and consistent a manner as possible, when and where appropriate.

(m) Arrangements for *points of access* to services based on the principle of no wrong way in.

(n) How best to bring staff together in *integrated community teams*.

(o) C*ommunications*– to ensure consistency of messages and information by partners.

9. Identification and resolution of differences

This Agreement seeks to promote commitment, confidence, transparency and trust in the relationship between health and social care at all levels, by addressing poor outcomes, inequalities, fragmentation, inconsistencies, inefficiency and ineffectiveness.

To this end we will develop a shared approach to commissioning, budget and performance issues based on the following: early discussion and no surprises; transparency in budget and performance matters; and anticipation of unintended consequences in relation to possible shifts in demand and costs between partners.

Concerns about, or possible breaches of this shared approach will be addressed and remedied wherever possible, through the Integrated Commissioning Board.

10. Review arrangements

Both Health and Wellbeing Boards will review this Agreement annually through the publication of a progress report. This will include proposals to add to or modify it.

Signatories

Health and Wellbeing Board – City of York	
Health and Wellbeing Board – North Yorkshire	
City of York Council	
North Yorkshire County Council	
NHS Vale of York Clinical Commissioning Group	
NHS Hambleton, Richmond and Whitby Commissioning Group	
NHS Airedale, Wharfedale and Craven Clinical Commissioning Group	
NHS Scarborough and Ryedale Clinical Commissioning Group	
NHS Harrogate and Rural District Clinical Commissioning Group	
NHS England – North Yorkshire and Humber Area Team	
NHS England – West Yorkshire Area Team	

Dated:
This Framework was adopted by North Yorkshire Health and Wellbeing Board on 25th September 2013; and is expected to be adopted by
City of York Health and Wellbeing Board on 2nd October 2013