CARE, HEALTH & WELLBEING OVERVIEW AND SCRUTINY COMMITTEE
31st October 2017

TITLE OF REPORT: Integrating Health and Care in Gateshead

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Summary

To update and seek the views of the Care, Health & Wellbeing OSC on the current thinking of health and care system leaders in Gateshead about the opportunities for integrating services with the explicit aim of improving the health and wellbeing outcomes of our population.

The report describes the shared vision and areas for early integration identified by health and care partners.

Background

1. It is difficult to travel far or discuss public sector cuts and reform without hearing the word – or philosophy – '***integration'*** mentioned. The actual meaning of the word in this context is the subject of some debate, and it is clear that it has the potential to exist at many different levels, from the relatively simple step of having a pharmacy co-located with a GP practice (which might also have, for example, a dedicated practice nurse or health visitor), to something much bigger involving the coming together of multiple organisations or stakeholders under an umbrella of 'integration'.

2. Often running hand in hand with talk of integration is the issue of care ***pathways***. The notion of 'pathways' is not, in itself, a complex one. A 'pathway' is simply a single word to describe the patients' journey through the system; but in practice, these can be extremely complex and lengthy, with multiple organisations having an input, often without slick and clear handover processes in place (or appearing not to be).

3. Evidence tells us categorically that the greater the number of points of handover, either within or between organisations, the directly proportionately greater is the degree of risk of something untoward happening to the service user. In addition, fragmentation between organisations can create perverse financial incentives within the system, where money becomes the driving factor, rather than safeguarding the best interests of patients and service users.

4. Current thinking puts the 'Integration' and 'Pathways' agendas together. It is broadly accepted that, if the providers concerned can come together to meet the interests of the service user, by providing seamless pathways of care with the minimum number of points of transfer, this will provide safer, more effective, and more cost efficient delivery of appropriate care. At its ultimate effectiveness, all providers will do only what they need to do before patients are pulled into the next stage of their pathway,

based on careful pre-planning before it begins and throughout, including clear plans for discharge and follow up.

5. Gateshead already enjoys many positive examples of partnership working, sharing resources to achieve common goals and outcomes, underpinned by a common ethos and set of values which put the people we are here to serve at the centre of what we do. Whether we actually call this 'integration' or not, it is without doubt that this strength of relationships and spirit of co-operation provides a perfect platform for formal integration to take place.

6. The organisational system architecture in Gateshead alone lends itself to an accountable care arrangement:
   - Unitary local authority;
   - Single, co-terminus provider of secondary care;
   - Single provider of tertiary care;
   - Single CCG – although covering two LA areas;
   - Single provider of community based services;
   - Multiple, but broadly coordinated, mental health providers.

7. The deliberations of health and care senior leaders in Gateshead have developed in **three parallel pieces of work** over the last year:

   (i) The operation of the Gateshead Care Partnership since October 2016, as the interagency provider vehicle which oversees the implementation of the recently secured community health services contract for the borough. The contract is held by Gateshead Health NHS Foundation Trust but is managed through the Gateshead Care Partnership incorporating Gateshead Health FT, CBC Ltd, NTWFT and Gateshead Council.

   (ii) The informal health and wellbeing board pre meeting of senior officers from the statutory bodies represented at the board, since April 2017. This group has considered and debated the various implications of integrating commissioning across health and care as well as building upon the Gateshead Care Partnership foundations to create a wider provider vehicle. During this period the officers of the organisations represented have also asked GCP to take on responsibility for delivery of the Borough's People, Place and Community (PCC) programme.

   (iii) The Accountable Officer Partnership across Newcastle and Gateshead (comprising the six accountable officers and their most senior directors, the two directors of public health and the system appointed director of integration) published a 'statement of intent' in January 2017 describing its ambition to bring together health and care services. The accountable officers have subsequently described in some detail their respective aspirations for whole system integration. In Gateshead, all four accountable officers described a whole system integration approach as the most likely to reap benefits for the population we serve.

8. In summary, we have whole system support for an integrated approach to health and care in Gateshead, shared by accountable officers, their commissioners and their providers.

9. It is of note that the solutions proposed in this paper relate to the Gateshead geography only. We recognise, however, the continued need to work collaboratively with our geographical neighbours (particularly Newcastle) for issues such as cross

boundary flow and acute care collaboration; this work is not described any further in this paper.

The Purpose of Integration in Gateshead

10. The NHS and Local Authority leaderships' considerations are about how best to secure and arrange the services for the resident population to meet the following three objectives:

    (i) To shift the balance of services from acute hospital care and crisis interventions to community support with a focus on prevention and early help.

    (ii) To support the development of integrated care and treatment for people with complicated long term health conditions, social problems or disabilities.

    (iii) To create a better framework for managing the difficult decisions required to ensure effective, efficient and economically secure services during a period of continued public sector financial austerity.

11. The following table describes the headline parameters of 'logic' of our thinking to date.

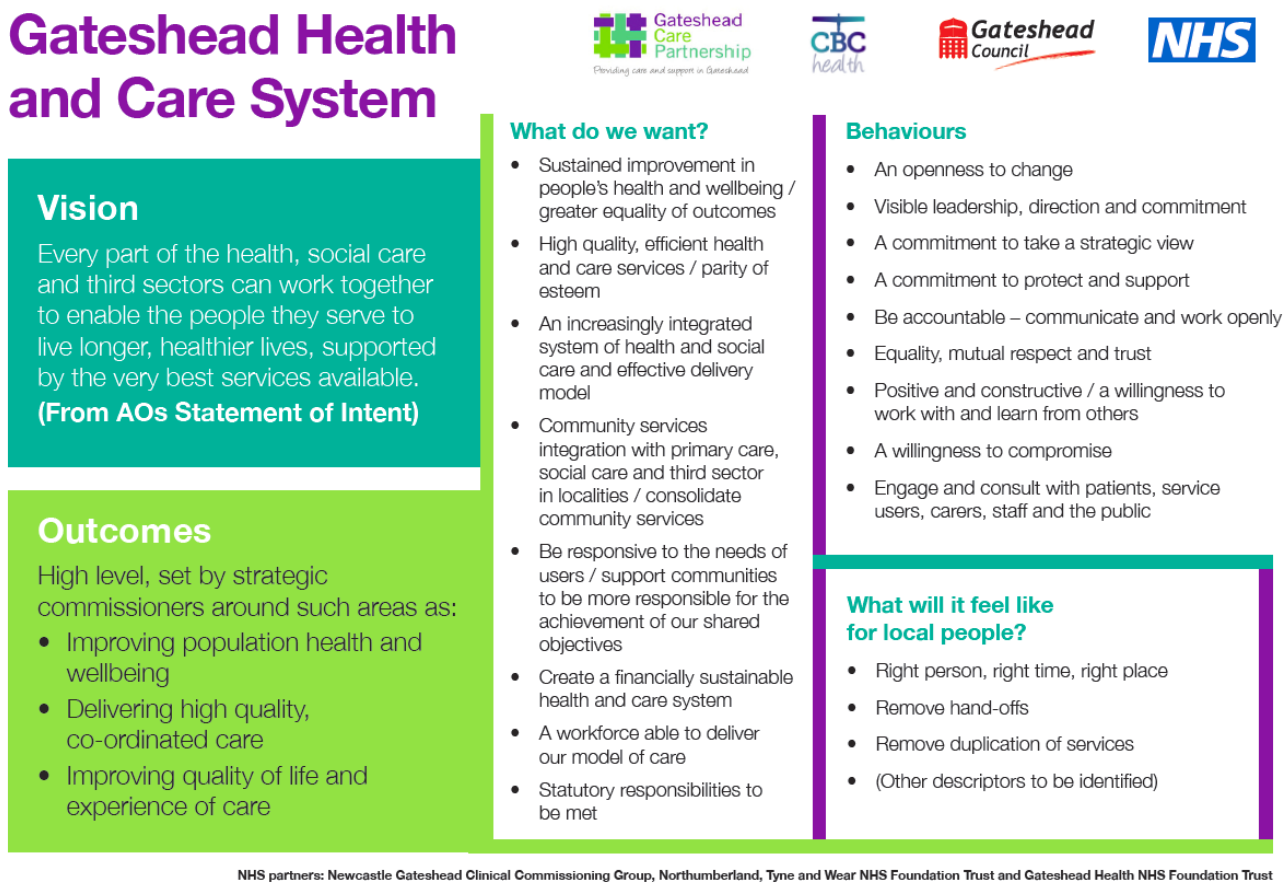
Language	We need to make sure we share a common language – "Gateshead Care Partnership" is the term that describes provider collaboration; "Gateshead health and care system" is a term that describes provider and commissioner collaboration. In other words, we are not using 'accountable care' in any language.
Outcomes	We want the care and health commissioners to describe the population outcomes that must be delivered and liberate the Gateshead Care Partnership to determine how best those outcomes should be achieved.
Gateshead	We want to work at a Gateshead footprint to deliver community based services, recognising the need to collaborate with geographical neighbours (like Newcastle) for services that operate at a broader footprint, such as acute care and mental health inpatient care.
Idiom	We believe that 'form follows function', so our focus is on the model of care we want to deliver rather than the organisational structures that could deliver them.
Collegiate	Our delivery model is best served by us all working together and with an 'enabling' mind-set in how we arrange and deliver services.

Our Compiled Vision Statement

12. Avoiding duplication of effort, maximising our collective impact and getting on with the job in hand are three important principles that have driven the thinking in Gateshead so far. In line with that approach, the health and care system has agreed a one page summary of all the various vision statements, memoranda of

understanding, compacts and behavioural charters that have existed in the borough for some time.

13. This one page summary doesn't replace any vision statement that may exist in individual organisations – it simply shows that however we choose to construct the various sentences in our own organisational documents; we all share a common goal and ways of working. We therefore don't need to create a new vision document for this work.



Strategic Commissioning Arrangements

14. The health and care leaders in the borough have described effective strategic commissioning around three components:

- A whole system vision, described on a long term basis and enacted through a corresponding contracting arrangement. (see paragraph 12 and 13 above)
- An outcomes based commissioning model so providers are free to innovate and work differently, accepting they must deliver the commissioner set outcomes and the NHS constitution and associated metrics.
- Minimal transactions between commissioner and provider, accepting the principle that the outcomes will drive transformational change. Central to this is the need for system wide data sharing arrangements/ protocols.

Outcomes based commissioning

15. The Gateshead Care Partnership could be commissioned, jointly by the CCG and Local Authority, to deliver a range of care and health outcomes and be measured simply on the achievement of the associated outcome metrics. Any contract would of course require compliance with the NHS constitution and all other statutory obligations and delivering these would be the responsibility of the providers (as is the case at present) and overseen by their regulators.

16. Focusing on outcomes would mean that the providers, through Gateshead Care Partnership, are free to innovate and work differently as commissioners would no longer have a transactional focus, but would focus on the transformation of services measured through the impact of provision. There are many outcomes frameworks available from other areas that could appropriately be adapted for use locally, and a sample of one framework is set out below simply for reference:

Commissioners identify the outcome statement

And set metrics to measure their achievement.
First order metrics: 1 – 3 year period
Second order metrics: 3 – 10 year period

Outcome		First order metric	Second order metric
Improving population health and well being			
A1	The health and care system to improve the overall health of the population	Excess winter deaths (persons)	Mortality rate from causes considered preventable.
A2	People are supported to lead healthy lifestyles and are protected from illness	Smoking prevalence (adults)	Alcohol – related hospital admissions (persons)
A3	The health and care system works with others	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Proportion of people who use services who reported that they had as much social contact as they would like.
Delivering high quality, coordinated care			
B4	People have access to services when they need them	The ability to get an appointment or speak to someone in primary care.	Common surgical procedure rates
B5	The health and care system works to reduce unplanned hospital admissions and the time people spend in hospital	Inequality in avoidable admissions/for urgent care sensitive conditions	Emergency admissions for acute conditions that should not usually require hospital admissions (persons)
B6	People are supported to recover from illness or injury and stay healthy after treatment	One year survival from all cancers (persons)	create new measure: other long term condition
B7	People receive services which are coordinated and person centred	Were you involved as much as you wanted to be in decisions about your care and treatment?	Delayed transfers of care
B8/9	People are supported to maintain their independence and manage their own health	Long term support needs met by admission to residential and nursing care homes (aged 65 and over)	Proportion of people who use service who have control over their daily life.
B10	People are cared for in a safe environment and protected from avoidable harm	NHS Safety thermometer (VTE, pressure ulcers, catheter UTIs, falls)	Incidence of healthcare associated infection: C Difficile

Minimising transactions, maximising transformation

17. If commissioners are to concentrate primarily on setting health and wellbeing outcomes for the providers to deliver, their behaviours will also need to fundamentally change so the transaction dominated contracting arrangements between commissioner and provider are replaced with outcomes based contracts that demand the transformation of services – however the provider chooses to do that.

18. Coupled with that change in behaviour, we will need to create a health and care system based on a transformed payment mechanism to address the following four points:

- **The balance of spend….** The unintended consequences of the 'payment by results' financial mechanism in the NHS is that funding for most services provided in acute hospitals is demand led, whilst community services and mental health services have fixed budgets. The result, particularly in the current climate of public sector austerity, is a tendency for funding to be directed into crisis services and away from lower level community based services.

- **The rules about spend….** which differ between the health and care system as the NHS is free at the point of delivery; social care is means tested and dependent on eligibility criteria. Whilst these are of course statutory requirements, we must be mindful of their impact in any integrated system.

- **The patients / citizens on whom we spend….** The current funding mechanisms are based on the implicit assumption that most NHS activity comes in the form of one off episodes of treatment for people who are otherwise healthy. In reality, the bulk of NHS spending is supporting people with complicated long term needs, who are best served by coordinated long term support rather than multiple disconnected episodes of treatment.

- **The financial stability of organisations….** The infrastructure costs, particularly of hospital based care, are generally fixed (or marginally variable); any shifts of resource to community settings will need to be mindful of the continued need for hospital services and therefore the financial stability of organisations across the system.

19. The Gateshead Health and Care system leaders have recognised the need to develop this line of thinking further. Creating a financial mechanism that addresses the above four points and creates a system in which money flows easily and effectively between organisations, is of course challenging. Dedicated work will be required to undertake this work.

20. The way in which money can flow in a newly designed system is a critical consideration and further work is required on this point.

Integrated Provision Arrangements

21. We believe Gateshead Care Partnership should be seen as:

- A group of system enablers who are charged with making changes together. Adopting a 'wellness and recovery planning' model which focusses on the whole person/ family and what we can do together.

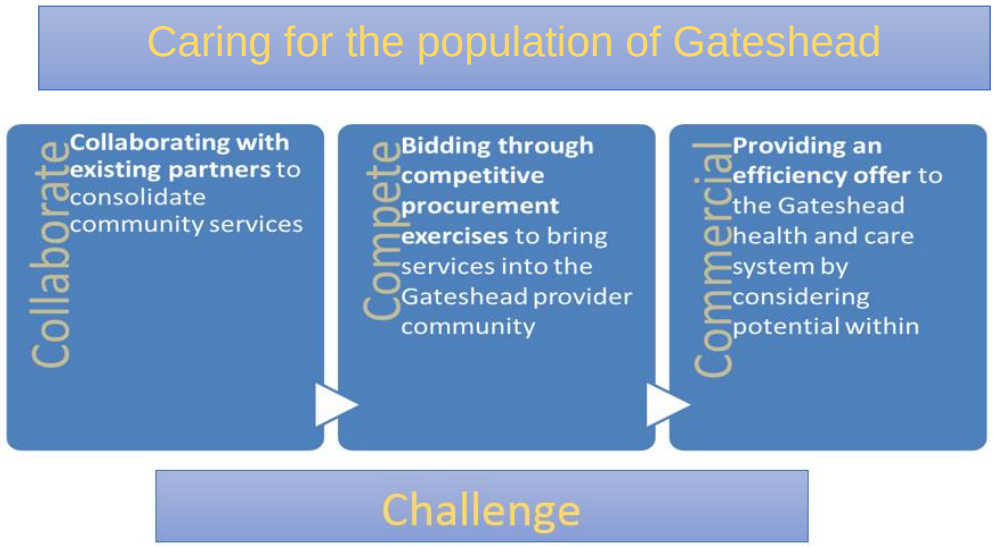
- Operating on a system wide basis (i.e. across all care and health partners) and delivering universal services, whilst also focusing on agreed priority groups for whom we take a multi-disciplinary approach to planning and securing care. We will develop services that generate truly 'owned' and comprehensive care plans that deliver the outcomes with the patient.

- Challenging each other where professional boundaries get in the way of doing what's right, stopping services that are not working and testing new ways of working. Supported by a shared improvement method and shared data sharing/ information governance arrangements (both require development locally).

22. General practices provide the cornerstone of any new health and care arrangement – providing services to all those who are unwell or think they are unwell, in settings very close to people's homes. Practices in Gateshead are committed to integration and are thinking about how they can operate at scale, with neighbouring practices, to offer a wider range and more sustainable primary care offer within its unique NHS business model and delivered through a nationally negotiated contract (known as GMS or PMS). The nationally negotiated contracts are not within the remit of the Gateshead commissioning system and this will not change without practice consent or a change in national policy.

Extending the provider collaboration

23. The Gateshead Care Partnership believes patient/ population care is a shared priority and that working together across our organisational boundaries will deliver better patient care than working individually. The partnership board has identified its areas for future focus as shown in the graphic below and explained in more detail in the subsequent paragraphs. The priorities require formal approval by the board in time.



24. **Collaborating with existing partners** to consolidate community services
    - A 'care closer to home' model of collaboration between the in-house council domiciliary care provision (which caters for the highest 20% need group), community nursing, community psychiatric nursing, care call etc.
    - A combined and integrated approach to urgent and same day response services, bringing together existing GP walk in centres, ambulatory care, extra care, same day appointments, rapid response, psychiatric liaison services
    - A community based allied health professional base, bringing together the various funded and provided occupational health and equipment services in the first instance and then potentially expanding to a wider range of services.
    - Coordinated care planning across all patient groups but beginning with a specific focus on old age/ frailty, older people's mental health, diabetes, respiratory, and rheumatology

25. **Bidding through competitive procurement exercises** to bring services into the Gateshead provider community.

26. **Providing an efficiency offer** to the Gateshead health and care system by considering potential within:

- The existing infrastructure configurations
- The training and education of the workforce and in collaboration with the third sector.
- Opportunities to support and develop local commercial companies (be they in domiciliary care or other fields) could also be explored.
- Bringing together community and hospital based services (paediatrics, long term conditions, drug and alcohol, care of the elderly (physical and mental health) etc.

Priorities for action

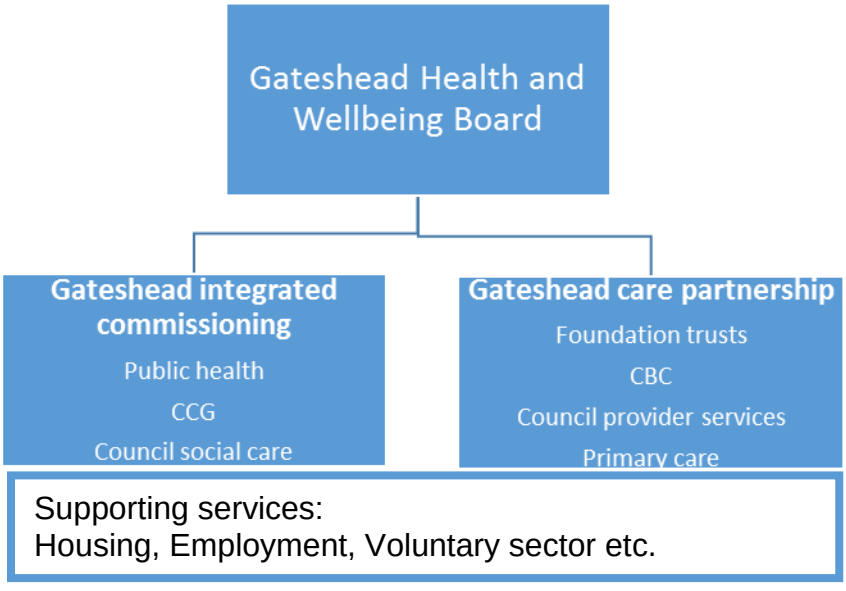
27. The Gateshead People, Care and Communities Model provides the overarching direction for the Gateshead Care Partnership and aims to develop: *"A place based system where everyone, young and old will be supported to live, work and age well as individuals and as part of their community. If needed, care and support, supporting physical, mental and social needs, will be easily accessible and coordinated close to or at a person's home."*

28. The Gateshead care Partnership was tasked to take forward the progression of the People, Care and Communities Model in Gateshead. From initial discussion the following priority areas have been identified:
    - People with complex needs;
    - Frailty;
    - End of life care;
    - Medically unexplained conditions;
    - Children's services.

29. Other areas to be considered include:
    - SEND;
    - Transitions (from children's services to adult services)
    - CAMHS;
    - Learning Disabilities

Governing a New Health and Care System Arrangement

30. Under the auspices of the Health and Wellbeing board, the arrangement of commissioning and provision across care and health services could be reconfigured to deliver the integrated system.



31. This diagram shows both the commissioner and provider partnership reporting into the Health and Wellbeing Board. This is consistent with its statutory obligations relating to health and wellbeing arrangements – as the Board is required to have oversight of the health and care system as well as providing direction about the priorities for the resident population.

32. The structure avoids the traditionally hierarchical reporting arrangements between commissioners and providers – reflecting the different but complementary roles of each within the new way of working:

    - The strategic commissioner, in understanding the overall population needs, sets the health and wellbeing outcomes to be achieved within an identified financial envelope.
    - The collaborative provider arrangement delivers those outcomes across all the organisations within its parameters and undertakes much of the transactional/ contract management work traditionally associated with commissioners.
    - The proposed commissioning and provider structures both recognise that the third sector and HealthWatch can offer valuable additions to the arrangements and discussions are underway with these bodies to work out the best way to capitalise on the services they provide.

33. The Health & Wellbeing Board at its meeting on 8th September agreed that Gateshead health and care system leaders come together in a formal group under the auspices of the Board, in order to further develop the proposals for the integration of health and care services in the borough. Further proposals will be brought back to the Board over the coming months for consideration.

Recommendations

34. The views of OSC are sought on the content of this paper and, in particular, the potential for integrating health and care services as part of an incremental approach to the overall integration of services in the borough.

35. OSC is also asked to note the creation of a time limited health and care system leader group to develop comprehensive and costed proposals, which will report regularly to the Health and Wellbeing Board.

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