Health in all our hands

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

fit 4 the future

Preparing for an ageing population

Reconfiguring older people's services in Hambleton and Richmondshire: Our Vision - a summary document for discussion

March 2014

Welcome to this summary of our Vision for 'Fit 4 the Future' in Hambleton and Richmondshire. This outlines - and sets the scene for open debate - the priorities for developing health and social care services in the area over the coming years.

Locally, we are responsible for commissioning (buying) the vast majority of the healthcare services received by our population. Ensuring that people receive the best possible care within the resources available is a complex task and we are committed to undertaking this in partnership with patients, their carers, partner organisations and other local stakeholders.

We have identified, through public meetings, some of the main issues and priorities. We now move on to the next stage, which is to present our initial thoughts and commissioning suggestions and open up the debate again to canvass more views and refine the Vision. We have tried to detail the issues and challenges that we face and the opportunities that we have to address them.

We'd like to know what you think about the plans, what else should be in here and what we need to prioritise. You can find our full 24-page “Vision and Case for Change” document on our website.

The growing numbers of elderly people in our area represents one of our biggest challenges and opportunities for improving the design and delivery of care. In this area alone, by 2021 we expect to see the number of people over the age of 65 increase by 30 per cent. Considering that people aged over 65 account for around 70 per cent of all healthcare spend, this will bring new and significant challenges for the local health economy.

The only certainty is that with an ever increasing frail elderly population and their associated health needs, services cannot remain as they are. We have a great opportunity to improve the services that we provide to our population while following our general principles of providing care closer to home wherever possible, allowing people to remain at home as long as possible and putting quality of care, patient safety and patient experience at the heart of what we do.

Once we've spoken to you, we hope to have identified the changes that we need to make to ensure local NHS services are the best they possibly can be to meet future healthcare needs.

Please take the time to read this summary Vision and Case for Change, and let us know your thoughts about the future of your local healthcare services. We are looking forward to hearing from as many people as possible and understanding your ideas and opinions.

Dr Mark Hodgson
GP in Aldbrough St John, Hambleton, Richmondshire and Whitby CCG Governing Body Member

The Case for Change: 'areas we know could be improved'

Many patients already have a very good experience of care and may feel that services are already working effectively. However when we look across the healthcare system as a whole, it becomes apparent that clear problems and gaps in the services provided emerge. This means the system isn't able to care for patients as effectively as it could do, and certainly isn't prepared for the rising numbers of elderly people in the area:

Acute hospital provision

Local acute hospital stays (i.e. in a large hospital) are hugely valued when patients need specialised support. However, such a stay, especially for a prolonged period, is not always in a patient's best interest. We have considerable evidence that locally patients are spending longer than they need to in local hospitals.

Community facilities

The provision of community hospitals with inpatient beds enables care to be delivered closer to a patient's own community and is a fundamental part of our approach to meeting the needs of our local population. Currently, there are three community hospitals, in Richmond, Northallerton (the Rutson ward) and Thirsk. The current model and practice of care is not always ideal. People again stay longer than necessary as there isn't sufficient support for rehabilitation either in the hospital or at home.

Intermediate care

A range of services are provided through both health and social care to help prevent crises escalating to an acute hospital stay or long-stay care home placement, or to step-down patients back to their own homes or communities as quickly as possible. However, there are problems with both the current service model and capacity, so hospitals are unable to return people to their own homes quickly enough and very often people are going into hospital unnecessarily.

Health and social care community teams working together

Vulnerable patients and service users will sometimes need support from community services to maintain their basic health and social function. Our aim is to build services around the patient, in line with national recommendations. However, health and social care teams in the community are not yet working in a sufficiently integrated way.

Continuing health care (CHC)

CHC is a care plan covering the ongoing needs of an individual. Assessments for long term CHC should usually take place in the home or at least a community hospital, where the patient's maximum level of function and properly thought-through long term wishes are understood. However, very often these decisions are taken while the patient is still in an acute hospital, at the point where their long term needs are less clear.

Mental health services

Local health services need to be much better at identifying and supporting patients with dementia, and managing significant mental health problems closer to patients' homes and communities. Care should also be delivered more closely with health and social care teams in the community.

GP practices

GP practices in the area have the highest patient satisfaction rating in the country and are working effectively to provide a wide range of services. Nevertheless, practices will need to undergo some significant development in the next few years, including working more closely with local health and social care teams to proactively identify vulnerable people and support them through a multi-agency approach.

Extra Care Housing and the care home sector

There are only 25 nursing and residential homes across Hambleton, Richmondshire and Whitby approved by North Yorkshire County Council. Their locations mean that some rural areas do not have a home particularly close to their local community.

Voluntary sector/local communities

Services provided from the voluntary sector play a vital role in supporting people in their own communities. However, services may often be fragmented, disconnected and dependant on short-term funding.

Information management and technology (IM&T)

Systems and processes for sharing information between agencies and enabling organisations to work together using IM&T in the best interests of patients are not well-established. So staff may spend more time on paperwork and travelling rather than with patients.

Transport

Patient transport services need to be able to take people to hospital more quickly and efficiently when they are referred urgently by a GP. There are also opportunities to better promote the use of voluntary transport schemes and to extend their coverage within the area.

Our Vision for Hambleton and Richmondshire

For older people, we are looking at a wide range of services, including those which respond to and rehabilitate patients when they are in crisis, as well as considering a range of more proactive services, both through statutory services and the voluntary sector, which can promote health and independence and therefore improve wellbeing.

The priorities set out below are drawn from the feedback from our service users and stakeholders, the national and international evidence, and our local commissioning knowledge of how well the current health and social care system is performing.

This Vision has been developed in partnership with North Yorkshire County Council and South Tees Hospitals NHS Foundation Trust. All organisations are committed to working together on the development of this Vision and future plans.

The intention is to make a real impact on population and system health outcomes, including:

- Enabling older people to enjoy the maximum possible good health for as long as possible.
- Reducing avoidable hospital admissions.
- Reducing the average time spent in hospital for emergency admissions in both acute and community hospitals.
- Reducing the number of long term placements in residential and care homes.

"We want to keep older people safe and well in their own homes for as long as possible"

- Access to high quality and responsive services at the Friarage Hospital, Northallerton, including provision of assessment, diagnostics and inpatient treatment, supported by rapid decision-making at the 'front door' (i.e. A&E, Clinical Decisions Unit) and effective discharge arrangements.
- One hospital with community facilities in each of our localities that is able to provide diagnostics, intermediate care beds, geriatric assessment, palliative care support and other services that help meet the needs of older people.
- Effective district nursing teams, working with social care professionals, that are able to provide care for patients in their own home.
- Seven-day geriatric assessment for patients with complex, multiple illness or frailty.
- Round-the-clock integrated nursing and social care services that are able to provide short-term packages of intensive support for patients in a crisis.
- Rehabilitation services that can deliver care in both community settings and the patient's own home, seven days a week, including for those with more specialist needs, such as stroke recovery.
- An effective equipment service, seven days a week, that ensures fast provision for patients in need.
- A viable and high quality care home sector which is able to provide short and long-term stays for people recovering from a crisis or illness from which they can then return home.
- Greater integration with mental health services for older people.
- Assessments for Continuing Health Care and long term placement in nursing or residential homes to be undertaken in the patient's own home or a community setting.
- Access to appropriate palliative care so that those patients who wish to do so are able to die at home.

"We want patients to be empowered and better able to self-care, supported by more information for patients and their carers"

- Integrated health and social care teams within the community which are able to signpost people to all appropriate health and social care services.
- For patients with more complex needs to receive a generic health and social care assessment from community services.
- Extended services within primary care from GPs and pharmacists, which are able to provide a greater range of services closer to the patient's own home.
- Improved management of medicines.
- Identified lead clinicians who are responsible for the care of the most complex vulnerable people.
- A preventative approach specifically supporting people with long term conditions, working on a one-to-one basis to motivate and signpost members of the public to make long term healthy lifestyle choices.
- Better access to online information for patients and professionals.
- Work with North Yorkshire County Council to help it implement its over-arching strategy for prevention.

“We want improved transport options for patients to enable older people to access services, so they are not disadvantaged by the rural nature of the area”

- Continue working with North Yorkshire County Council around supporting and empowering communities, including transport issues.
- A responsive patient transport service that helps people to access the care they need in a timely manner, which recognises people’s clinical and mobility constraints and that applies the national criteria for both patients and their escorts correctly to help achieve this.
- Further transport options to be available within the voluntary sector to enhance existing public and private transport options.

“We want to better equip local communities with the skills and resources they need to care for their older population and facilitate greater social interaction”

- A range of services commissioned from the voluntary sector, such as befriending schemes, village agents and volunteering 'time banks'.
- Voluntary sector 'hubs' for older people in each area that can be a focal point for patients to contact and partner organisations to refer to.
- Ensure that people have easy and early access to information and advice.

“We want to ensure carers are better supported so that they are better able to look after those they are caring for as well as maintaining their own health and wellbeing”

- Improved access to carers' assessments working in partnership with North Yorkshire County Council and Carers' Resource.
- Greater sharing of carer information from the Carers' Resource centres with GP practices (with consent).
- Improved ways to refer people to Carers' Resource, including ensuring hospital discharge planning includes carers.
- More expert carers, supported by training programmes.

“We want to utilise new information management and technological solutions to enable services and service users to manage their care in new, innovative and more effective ways”

- New technologies that bring service users and professionals together to improve access to services, such as video-links between different locations.
- A common and secure approach to sharing information among professionals.
- Technologies that help people to understand their condition better, keep themselves safe at home, and take more active control of monitoring their outcomes.

The National Impact

We can't ignore what's happening nationally when planning what we need to do locally. There is a wide range of policy, evidence, good practice and other factors which we need to consider:

Prioritise prevention and early intervention

- a range of current national policies have given renewed emphasis on the promotion of wellbeing, the prevention of ill health and early intervention.

Extend access to GP surgeries and provide a named GP

- work underway includes giving older patients a single 'named clinician' who is accountable for their care at all times when they are out of hospital, and a new service for patients with complex care needs who may be at risk of unplanned admission to hospital.

Ensure Integrated Care and Support

From 2015/16, each CCG will need to create a 'Better Care Fund' which will support investment in the integration of health and social care and the shift to community provision away from acute (large) hospital care.

High quality care for all

In recent months the NHS has had to address the outcomes of recent reviews into significant failures of the health and care system. Nationally, the aim is to foster a culture of compassionate care in which patients are genuinely and consistently at the centre of everything the service provides.

Provide more personalised care

- a personal health budgets policy is being rolled out nationally in the NHS, which is an amount of money to support a patient with identified healthcare and wellbeing needs agreed between the patient and their local NHS/social care team.

Provide sustainable housing for local communities

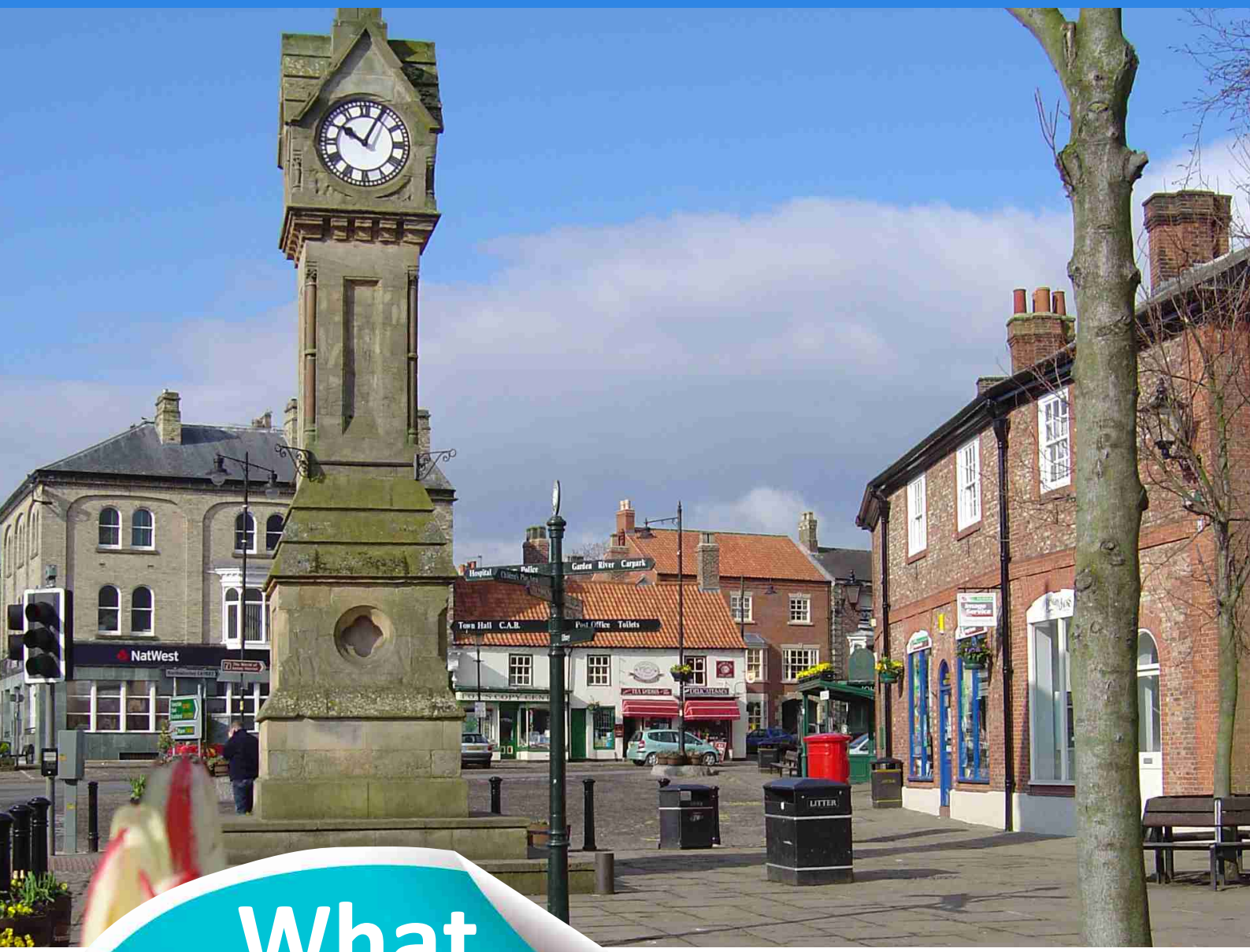
The needs of older and vulnerable people can be met in a variety of settings, such as shared specialist supported housing, extra care housing, care settings, as well as through general housing.

Financial efficiency of services

Nationally, the NHS faces pressure on budgets and the need to make continued efficiencies if it is to remain in the black. The emphasis is on reducing inappropriate care in hospitals.

Good practice from elsewhere

We will develop proposals in line with the latest thinking from leading health research organisations, such as the King's Fund.



What do YOU think?

This leaflet is a summary of our overall Fit 4 the Future Vision for Hambleton and Richmondshire. It is 24 pages long, and is available on our website or by request. If you'd like to see it, please get in touch.

Despite the level of detail presented in the Vision, we recognise that work is still required in order to refine it and identify how we can work together to deliver it.

So, we'd like to know what you think. We have a series of engagement events running up to the middle of April 2014, which are open to everyone. There is opportunity at these to ask questions and let us know your views, as well as to complete our survey. Please see our website for details or look out for posters in places such as GP surgeries or pharmacies.

You can also visit:
www.hambletonrichmondshire andwhitbyccg.nhs.uk
and complete our online survey.

email us @:
p.widdowfield@nhs.net

or talk to us on:
01609 767 636

@HRW_CCG

www.facebook.com/HRWCCG

www.hambletonrichmondshireandwhitbyccg.nhs.uk