Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Introduction & Engagement Events
Continuing Healthcare and Section 117
July 2024

As a way of maximising the time today, and so we all have an equal voice, we encourage your participation in the following;

Slido.com
Event code - #2629035

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Welcome

Victoria Hundleby
Programme Manager

Humber and North Yorkshire
Health and Care Partnership

Housekeeping

- Approach to the session
- Mobile phones
- Breaks
- Fire Alarm or IT considerations
- Slido and FAQ

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Event Tools

As a way of maximising the time today, and so we all have an equal voice, we encourage your participation in the following;

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Agenda

Humber and North Yorkshire

Event 1 Time	Event 2 Time	Ref.	Agenda Item	Lead
9:30	13:30	1	Arrival Tea/Coffee	
10:00	14:00	2	Welcome & Aims of the Event	Victoria Hundleby, Programme Manager
10:15	14:15	3	Setting the scene for the ICB	Denise Nightingale, Director of Nursing Mental Health, Continuing Healthcare & Complex Care Emma Sayner, Interim Director of Finance ICB
10:30	14:30	4	Finance Context	Louise Tilley, Deputy Director of Finance
10:50	14:50		Break	
11:00	15:00	5	Patient Story	Chris Denman, Head of NHS Funded Care
11.15	15.15	6	Out of Area Repatriation	Patrick Bowen, Head of Vulnerable People
11:30	15:30	7	FAQ & Next Steps	Panel
12:00	16:00		Close	

Aims

- **Where are we?**
- **Where do we want to be?**
- **How will we get there?**

Where are we?

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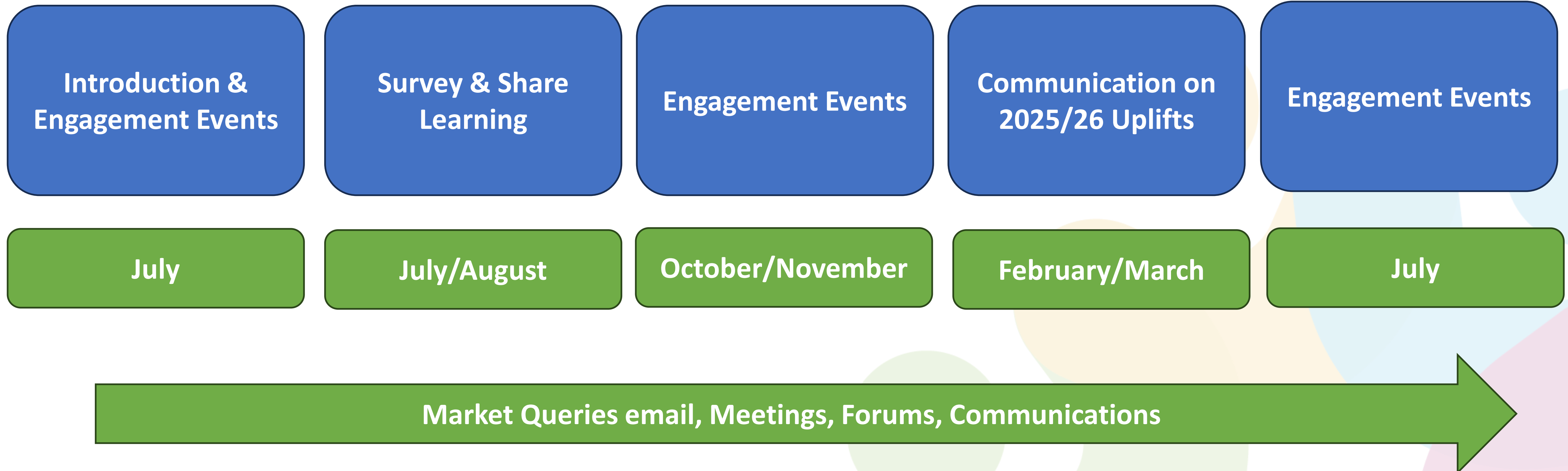
- c.600 providers
- Framework v non-framework
- Multiple teams and approaches
- Inequity in the market
- Reactive v proactive
- Aged Payables

Humber and North Yorkshire
Health and Care Partnership
Frameworks
Stakeholder Engagement
Communication
Inflationary Uplift
Proactive Commissioning
MARKET MANAGEMENT
Financial Planning
Aged Payables
ICB approach to Brokerage
Consistency
Forums, Events, Meetings
Data
Decrease Complaints

Ongoing Engagement Plan

Humber and North Yorkshire
Health and Care Partnership



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Denise Nightingale
Director of Nursing Mental Health, Continuing Healthcare & Complex Care

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What has changed?

- 6 CCGs with statutory duties now 1 Integrated Care Board with a single accountability for statutory duties.
- Responsibility to work across and join up health and care services and ensure we have equity of access and improve individual's outcomes ensuring we tackle inequalities.
- Enhancing productivity and value for money across the ICB

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Complex Care within the ICB

- Moving to one clinical team whereby communication around individuals receiving care will still be through local teams
- Moving to one complex care finance team
- Reporting and outcomes will be done once but will reflect spend, eligibility and performance by place

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Quality, Safety and Legal compliance

- **We want all our residents to be in receipt of excellent care wherever it is delivered**
- **We have hugely varying rates by place of who is in receipt of Funded Nursing Care**
- **We have increasing rates of additional restrictive 1-1 care for long periods and in particular for people with a dementia diagnosis and those with an autism and or learning disability diagnosis.**

Quality, Safety and Legal compliance (cont.)

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- **We have far too many Friday afternoon crises.**
- **We seem to have an increase in providers giving notice when a person's disease progression is evident, and this is different by local area.**
- **We do have amazing care and support that should be shouted from the roof tops and championed**

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Louise Tilley,
Place Deputy Director of Finance

Humber and North Yorkshire
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Finance Context

- The 24/25 ICB budget for all age continuing care is £223,220k (5.7% of total ICB budget)
- This represents an increase of 40.9% c.f. the 19/20 spend of £163,866k
- The ICB is operating within an extremely challenging financial environment, with cost pressures outstripping allocation growth.
- Efficiency requirement of 6.6%

Finance Context (continued)

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We need to

- Recognise the different markets across the ICB e.g. York c.f. Hull
- Understand the cost drivers within the providers & work with you
- Ensure Value For Money
- Be consistent / equitable in our decision making

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Chris Denman
Head of NHS Funded Care

Continuing Health care (CHC)

- Individual with Dementia – who is regularly distressed and dysregulated
- Living within a Residential Care Home – registered for people with Dementia
- Provider requested 24hrs 2:1 or will serve 28 days-notice

What did we need to know

- When was the last review of the placement
- When was the last GP consultation/medication review
- When was the last time the providers care plans had been updated
- What where the daily diary records and incident logs telling us

What we found

- The last review was 3 months ago – records identified no change in presentation – no additional resources or intervention requested /required
- The Last GP consultation was 6 months ago – records showed that no recent contact had been made with the GP to request a review.
- The Care plans needed reviewing - they were updated in the home following the review 3 months ago - no further amendments had been made to accommodate any new presentations – light in personalised detail
- The Daily Diary records and incident reports were light in detail – no detail of triggers, times of day, duration, descriptors, methods of intervention, what worked or what didn't work.

What we did

- Full review - of the individual and their circumstances – providing co-ordination and support to bring the right people together to better understand the individual and their situation and ensure decision making is compliant with the MCA.
- Contact with the GP - organised medical screening and medication review – made sure the care home had good links with their local PCN and registered practice.
- Referral to the Dementia Mapping team – full review of the care plans, environment and routines – reports and recommendations personalised – bespoke care planning and training for staff.
- Referral to LA Contract Quality and Performance Team – full review of the providers recording systems and approach, offer tools and training - improve the quality of information being captured – improve evidenced based communication to other stakeholders.

What Happened

- Clear understanding of the individuals need and circumstances – tweaks to the care provision – 14hrs of additional staff time across the week to support with activity and routine which have been identified as trigger points.
- GP medical screening identified UTI - medication review altered balance and timing of regular medication. Next review booked in.
- New care plans - aspects of the routine and environmental structure have been changed which has reduced triggers and anxiety for the individual.
- Recording has improved – more personalised to the individual, capturing activity, wellbeing, incidents are described, triggers and de-escalation included. What works and what doesn't work.

The Outcome

- Individual remains in their home
- Provider no longer burdened with having to full fill 2:1 staff rota
- Health has been reviewed and changes made
- Family are reassured and feel less concern for their loved one
- Provider has attained new understanding, training and approaches to the delivery of care for people with Dementia and has made changes to their usual delivery and administration of the care they provide.
- Statutory responsibility has been fulfilled:

I. Individual and situation of how their needs are being met is **<u>Safe</u>**

II. the level of resource and intervention to meet those needs including the application of Public Funding is **<u>Proportionate</u>**

III. Care and support is least restrictive, decision making has been appropriately managed under the MCA, the arrangements and application of statutory intervention is **<u>Legally Defensible</u>**

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Patrick Bowen
Head of Vulnerable People
North Lincolnshire Health and Care Partnership

North Lincolnshire Place Partnership
Out of Area Repatriation Programme

North Lincolnshire Partnership commenced a programme of work to repatriate individuals to North Lincolnshire. Our practice is in line with individual's human rights and legal frameworks.

It is crucial that we do not lose sight of the individual. Our goal is to ensure that they live their best possible life and have the opportunity to become integrated within their local community.

We will look to reinvest existing monies, currently used to commission out of area placements, to grow the North Lincolnshire economy, benefitting vulnerable people and the wider population.

This will be achieved by positive partnerships, fostering innovation, market intelligence, skilled workforce, quality, commissioning better outcomes, better use of the North Lincolnshire £, sustainable change.

Community First Strategy
North Lincolnshire Place Plan for Health and Care Integration

Our shared ambition

Our ambition is for North Lincolnshire to be the best place for all our residents to be safe, well, prosperous and connected; experiencing better health and wellbeing.

This means that people will:

- Enjoy good health and wellbeing at any age and for their lifetime
- Live fulfilled lives in a secure place they can call home
- Have equality of opportunity to improve their health, play an active part in their community and enjoy purpose within their lives

Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust
North Lincolnshire Council
North Lincolnshire Health and Care Partnership
Community First Approach
NHS Humber and North Yorkshire Integrated Care Board (ICB)

Out of Area Repatriation

Objectives

North Lincolnshire Partnership commenced a programme of work to repatriate individuals to North Lincolnshire. Our practice is in line with individual's human rights and legal frameworks.

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This will be achieved by positive partnerships, fostering innovation, market intelligence, skilled workforce, quality, commissioning better outcomes, better use of the North Lincolnshire £, sustainable change.

Goals

Understand current OOA needs and anticipate future needs to inform the programme of work.

Utilise data and outcomes to inform market development and consultation with providers.

Set ambitious targets for reducing the number and duration of out-of-area placements.

Work with a diverse group of individuals to provide valuable learning opportunities, informing future interventions and improving the effectiveness of services.

Support a significant impact on reducing out-of-area placements and improving overall outcomes for the community.

Implement governance and oversight arrangements.

Strategies / Policies

Community First Strategy
All-Age Carers Strategy 2022 –2026

NL Integrated Strategic Adults commissioning strategy

North Lincolnshire Strategic Intent

Integrated Neighbourhood Plan

North Lincolnshire Housing Strategy

North Lincolnshire Joint forward plan

Joint Health and Wellbeing Strategy 2021-26

Joint Forward Plan

Integrated Care Partnership Health and Care Strategy

Measures

Improvement in peoples personalised outcomes.

Reduced number of people being placed OOA for care and support.

Number of people repatriated to North Lincolnshire to receive care and support.

Growth of specialist housing.

Growth of specialist skilled providers.

Reduction of standard residential services.

What difference will this make....

Programme of Work
Out of Area Repatriation

Project 1 (July 2023 – April 2024)
OOA Diagnostic Review

- Placements information
- Individualised commissioning
- Financial analysis
- Historical data/information

The information formed a comprehensive report, enabling the project team to make informed recommendations around the next steps.

Project 2 (June 2024)
Market Development

To update the Market Position Statement alongside a plan for provider consultation.

The programme will include a broad range of interventions aimed at preventing out-of-area placements and improving support for individuals with complex needs. This will involve collaborating with community organisations, providers, and housing agencies to develop comprehensive solutions leading to an enhanced community model.

Project 3 (June 2024)
Pilot Phase – Individual Repatriation

Person centred, Governance & Risk, Case Management, Information Sharing, Legal Frameworks, Communication.

We will identify measurable benefits to determine the success of the pilot.

Project One , Diagnostic Review

The objectives were to complete a diagnostic review of in scope OOA placements, and to analyse historical placements and financial data. This piece of work identified those in scope (45 individuals supported through mental health services, 22 individuals in receipt of continuing healthcare and 14 individuals in receipt of local authority funding – *August 2023*).

Findings and Considerations

- Individuals placed out of area due to insufficient local specialist provision or capacity.
- Shortage of suitable accommodation and specialist services, particularly for individuals with behaviour that challenges.
- A number of individuals are placed within locked rehabilitation and specialist mental health units.
- The role of multi-disciplinary teams in out of area placements.
- The report identifies barriers to repatriation, the duration of hospital stays and transition between care settings.
- Many OOA placements are a result of the use of the Mental Health Act Section 3 (117 Aftercare).

Local Provision

- Existing vacancies may not be able to support the needs of individuals that may challenge currently placed out of area.
- Commissioners have not consulted with the provider market about the necessary skills to support individuals with behaviours that may challenge.
- Understand the need of specialist housing provision.
- Evaluate the current infrastructure.

Next Steps

- Repatriation:
  - Set ambitious targets for reducing the number and duration of out-of-area placements within a specific timeframe. These targets should be based on a thorough analysis of current trends and projected future needs, considering factors such as population growth, demographic changes, and service demand within North Lincolnshire.
  - Progression of repatriation pilot for 7 individuals.
  - To widen the scope of the project to include oversight of Inpatient mental health rehabilitation particularly for those individuals with behaviours that may challenge.
  - Equity and Fairness. An inclusive approach will be taken to ensure that support is provided based on need.
  - Broader Impact: By addressing the needs of a larger number of individuals, the programme can have a more significant impact on reducing out-of-area placements and improving overall outcomes for the community.
  - Learning Opportunities: Working with a diverse group of individuals with varying needs and circumstances provides valuable learning opportunities that can inform future interventions and improve the effectiveness of services.
  - Ensure individuals placed out of area, are registered on the Home Choice Lincs register, when and if appropriate, to ensure that the strategic housing plan identifies specialist housing need, namely that capacity meets demand.

- Consultation with Providers:
  - Engage with our provider market, be clear on what is required
  - To provide current and trajectory data to support the longer-term strategic housing plan
  - Ensure a system approach
  - Transition Planning, scoping future need

Next Steps

- Models of Care
  - Care at home framework (specialist provision)
  - Alternative to small supports (complex care at home).
  - Capitalise on opportunities for specialist housing and workforce development

- Implement the Protocol to prevent commissioning of OOA specialist residential placements. This will support the ongoing monitoring of OOA numbers, themes and trends, which will feed into market shaping

- Explore innovative approaches and best practices from other regions that have successfully reduced out-of-area placements. This could involve implementing new care models, leveraging technology to improve service delivery, or adopting alternative funding mechanisms to incentivise positive outcomes.

- Establish a shared risk protocol and system process.

- Addressing Root Causes: Ensure the programme targets the underlying factors contributing to out-of-area placements, such as gaps in local service provision, inadequate accommodation options, and limited access to specialised support services. Developing strategies to address these root causes will be essential for long-term success.

- Preventative Approach: By identifying and addressing the underlying factors contributing to out-of-area placements for a broader population, the programme can help prevent future placements and support individuals at risk of placement in a proactive manner.

Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust

North Lincolnshire Council

North Lincolnshire Health and Care Partnership

1st Community First Approach

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Planned	Complete	On track	Some risk	Off track	Closed

Core Delivery Phases:	Action:		2023 J	A	S	O	N	D	2024 J	F	M	A	M	J	J	A	S	O	N	D	2025 J	F	M	A
1. OOA Diagnostic Review	Collate all OOA data. Analyse individual data.	Complete																						
	Collate and analyse placement and financial OOA data	Complete																						
	Analyse all data, recommending pilot cohorts, submit within report to ISPACE	Complete																						
2. Market Development	Establish a Project Team (Project 2 oversight, reporting, ToR, objectives)	May 2024																						
	NLC - Update the North Lincolnshire Market Position Statement , to inform the provider consultation meetings	TBC																						
	NLC - Provider consultation meetings	TBC																						
	2.1 Strategic Housing / Specialist provision - Understand the current and future need	Oct 2024																						
	2.2 NHSE Capital Grants. (To explore capital grant monies available, to support with housing)	July 2024																						
	2.3 To understand the local offer in each of the 6 Places (To identify why NL are an outlier)	July 2024																						
	2.4 Understand what we mean by an individual in receipt of MDT (Frequency and professional input)	Aug 2024																						
	2.5 Application of the care@home criteria framework, to understand if this framework will meet their needs.																							
3. Repatriation	Establish a Project Team (Project 3 oversight, reporting, ToR, objectives)	May 2024																						
	3.1 Matrix for outcome measures - 'so what'	Sept 2024																						
	3.2 Data set - current position. Select individuals for Pilot	June 2024																						
	3.3 Explore the opportunity around a research project	March 2025																						
	3.4 Pilot Repatriation ; 7 individuals	Dec 2024																						
	3.5 Repatriation of Individuals ; Personality Disorder (Numbers to be confirmed, trajectory 4)	Jan 2025																						
	3.6 Repatriation of Individuals ; Inpatient rehabilitation (Numbers to be confirmed, trajectory 4)	Feb 2025																						
	3.7 Repatriation of Individuals ; Learning Disability/Challenging Communication/Autism (Numbers to be confirmed, trajectory 4)	March 2025																						
4. Additional Workstreams	Development & Implementation of an OOA Prevention Protocol	June 2024																						
	Development & Implementation of an OOA Inpatient Rehabilitation Protocol	June 2024																						
	Place oversight and assurance meeting for OOA Inpatient Rehabilitation	August 2024																						

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A different way of working to provide support

John's Story

An alternative to 'Small Supports'

About John

John is a 58-year-old autistic man who lives along in the community. In addition to his autism diagnosis, he lives with a personality disorder and a sensory possessing disorder.

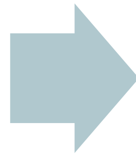
John is educated to master's level, has lived independently most of his adult life and was previously married.

John's family have been a natural support network and continue to be supportive.

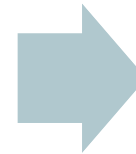
John has been known to services for most of his adult life, he's previously been distrusting of professionals who he describes as transient and those who 'do too' nor 'do with'

Detention & Hospital

Following a gradual decline in his mental health, John found himself living in conditions which placed his health, both mental and physical, at risk.



During this time, John was unable to engage with services, was at risk others and made a number of attempts on his own life, this resulted in his detention under the Mental Health Act.



John spent 3.5 years in hospitals across the country. Initially very combative, destructive and aggressive towards others. John was moved to a specialist Adult Autism ward within a private hospital setting where his recovery commenced.

Returning Home

Due to Johns distrusting nature, a discharge from hospital was always going to be a challenge.

Medications, along with MDT therapy provided John with a platform to begin his return home.

Commissioners and Providers had to establish a new way of working with a focus on outcomes whilst seeking to address current system restraints

Johns support team needed to robust, highly skilled but small.

Having being approached by Mental Health Case Management, we agreed to work with partners to deliver a bespoke package of support

Having identified the team, they began to visit John in hospital to build trust and start to make plans for his discharge into his own home

Having identified the team, they began to visit John in hospital to build trust and start to make plans for his discharge into his own home

North Lincolnshire Health and Care Partnership
NHS Humber and North Yorkshire Integrated Care Board (ICB)
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A whole new way of commissioning services was needed to make this a success

The Multidisciplinary Team approach to this package was essential, the challenge of ensuring many system partners were able to deliver services as part of a single, coordinated package of support was significant and required much planning

The package of support required input from specialist services, some not ordinarily available in North Lincolnshire. It was agreed that a **single budget** would be allocated to ensure such services could be externally commissioned. As the provider we took the lead on case management and worked closely with colleagues to utilise the budget to best meet John's needs.

Significant environmental changes to his bungalow, including soundproofing, low stim décor and specific floor coverings were installed. **This was funded by a Disabled Facilities Grant**

John was instrumental in creating a support plan that met his needs. The idea of co-production was not lost during the whole process, this included decisions around his PA support, his medication, his environment and his therapy timetable.

Supporting John in this way is a challenge and requires the system to be resilient, as part of the package of support, commissioning 'support the supporter' sessions from a system partner helps to ensure that those providing 1:1 support to John are supported too.

Amber Adult Social Care

The Current Situation

- John is living back in his home with some support from his PA's
- From living in the hospital environment with 24hr care, he now can live independently with 30hrs a week support. He decides how this looks each week.
- John is able to self-moderate his behaviours, Even when this is not possible, he is able to keep himself, and others safe.
- His new way of living has allowed for a significant reduction is both psychotropic and physical health medicines.
- John is happy, he is in control of his life
- The impact on 'The System' both operationally and financially is significantly reduced.

Summary

Providing support to those with **'Hefty Reputations'** is far from easy; it requires deviation from the norm which can leave organisations feeling vulnerable

Working collaboratively is challenging, especially when providers are from multiple different organisations, the role of the case manager/care co-ordinator is not to be underestimated.

Risk is inevitable and cannot be eliminated, 'The System' must learn to be able to take risks at an individual level without providing system wide mitigations which often only protect the system not the person being supported.

The benefits of co-producing care are enormous, not only for the person being supported but also for the wider health and care systems and economy.

Building in a robust '**Support the Supporter**' plan into complex packages is essential to ensure their long-term success, this is more than just providing supervision.

Slido & FAQ

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A big thank you for attending today and contributing to the market engagement events.

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End of Slides