The Vale of York CCG

- locality is based on 32 GP practices with a population of 336,330 residents.
- covers York, Selby, Tadcaster, Easingwold, Pocklington and parts of Ryedale
- mainly rural with a number of small market towns and the main urban centre of York.
- comparatively affluent area but with pockets of significant deprivation in York, Selby and around Sherburn-in-Elmet.
- covers three local authorities and Health and Well Being Boards: North Yorkshire County Council, City of York Council and East Riding of Yorkshire Council.
NHS Vale of York CCG area

Demographics

• City of York life expectancy for males is 79.6 and for females is 83.2 (2010-12) which is slightly higher than the national average.

• Current population is 336,360 and over the next 5 years population is expected to grow by 3.9% to 356,360, faster than the national trend.

• A higher proportion of the population is over 50 than the national average. There is also a higher proportion of 20-24 year olds due to the transient population of the two universities in York.

• Over the next 5 years, the percentage of people over 65 is expected to grow by 10% and the percentage over 85 by 18%.

• In 2011 around 16% of people reported that their day to day activities are limited a little or a lot by their health.
Local health profile

- Higher spend and growth on emergency admissions than comparators and National Average.

- Lower spend and number of GP referrals, but higher growth rate than comparators and national average.

- Top 20% of 55 ONS comparators for spend on Circulation, Neurology.

- Higher than average disease prevalence on Depression, Atrial Fibrillation, Dementia, Cancer, Hyperthyroidism, Stroke and Coronary Heart Failure.

### 2014/15 spending*

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Amount (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Services</td>
<td>229,913</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>37,580</td>
</tr>
<tr>
<td>Community Services</td>
<td>28,943</td>
</tr>
<tr>
<td>Other Services</td>
<td>26,930</td>
</tr>
<tr>
<td>Primary Care</td>
<td>55,700</td>
</tr>
</tbody>
</table>
Partners

Commissioners
- Vale of York CCG
- Partnership Commissioning Unit (joint commissioning for multiple CCGs)
- North Yorkshire County Council
- City of York Council
- East Riding of Yorkshire Council
- North Yorkshire & Humber Area Team

Providers
- York Teaching Hospitals NHS Foundation Trust
- GPs (32 practices in Vale of York CCG area)
- Leeds Partnership NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Independent sector provision
- Voluntary and community sector

The community has told us....

I want to feel safe and trust my health / care provider

Co-ordinate my care through a key link person

Give me the right professional support, when I need it.

Locally available

I want fast access to care and support

Provide me with good quality information to help me plan my care
Our Vision To Build A Care Hub

A Care Hub(S) which will:

• Co-ordinate care

• be centred around the individual, with as many services as possible provided in the community.

• provide proactive, community-centred care for populations of at least 50-100,000.

• combine the resources of the public sector, independent sector and community assets to deliver joined-up care and improved outcomes for the population it serves.

• support signposting and delivering a more holistic range of care needs for the population – housing, benefits, personalised budgets, mental health support, ....

Community Hubs

WHAT

A range of health and care professionals working together to meet all of the health and care needs of the population

Actively liaising with professionals where onward referral for specialist support is needed.

HOW

Doctors (family health and medical), Nurses, Social Care, AHPs and Pharmacists

Working from health and care facilities integral to the Hub

Accountable for outcomes and funding across all settings in and outside of the ‘Hub’

Linking into support services e.g. voluntary and third sector, community groups etc.
Bild 10

CT 1  FB/SH to update and redraw
Clare Thomason; 2015-01-21
Impact on the wider system

- General Medicine outreach
- Less emergency admissions
- Less beds used
- Less ED attendances
- Less DTCs

- Joined up adult social care and community health
- Proactive Care for LTCs and frail elderly
- Reduced reliance on Hospital
- Reduced use of care home beds

- Enhanced community mental health services
- Less dementia admissions
- Less beds used
- 95% ED attendances transferred within 1 hour

York Integrated Care Team

Dr Lesley Godfrey
Priory Medical Group, York
The Aims of York Integrated Care Team

- Reduce avoidable hospital admissions
- Expedite safe discharge from hospital
- Enable patients to remain independent longer
- “Person Centred Care”

Progress to Date

- **March 2014**  Focus on the 500 workshop
- **April 2014**  CCG agreed funding
- **May 2014**  GP time secured
- **May 2014**  Agreement with York Foundation Trust
- **June 2014**  Elderly ward observations
- **June 2014**  MDT meetings commence
- **June 2014**  City of York Council Social Care team
- **July 2014**  Social worker input secured
- **August 2014**  “Shared Vision” discussions begin
- **September 2014**  Bid to expand Integrated Care Team
- **October 2014**  National recognition of Care Hub scheme
- **November 2014**  Expanded Bid Approved, OT and physio input
- **Jan – March 2015**  Service Expanded to My Health /Unity /Haxby
- **January 2015**  Carers employed 8am-10pm 7 days a week.
- **Feb 2015**  Voluntary sector and Mental Health
The Integrated Care Team

What is the Integrated Care Team?

• Primary, Secondary, Social and Voluntary Sector working together:
  – GP
  – Nursing
  – Care Coordinator
  – Administrator
  – Holistic Care workers
  – Carers
  – Social worker
  – Physiotherapist
  – Occupational Therapist
  – Voluntary Sector
  – Mental Health
What does the Integrated Care Team do?

- Review every hospital admission and discharge for Priory Medical Group (PMG) My Health and Unity patients DAILY (Monday – Friday).
- Discuss all “At Risk” patients to see if their admission could have been avoided and if a more appropriate alternative could be used, consider if support may be needed or already in place.
- Phone all “At Risk “ patients to ask how they are and if they require any support, the same day as the MDT meeting.
- Review the Care plan and arrange face to face review if required.
- Give Patients, carers and clinicians direct access to Care Hub team for any future needs.

How we will know what we have achieved- measurements (KPI)

- Number of attendances at A&E over 65
- Number of non elective admissions over 65
- Number of excess bed days avoided
- Number of cost effective alternative clinical pathways identified
- Number of hospital admissions deemed avoidable by Care Hub
- Number of Care Hub interventions resulting in non-admission
- The number of patients contacts for York Care Hub
### Key Performance Indicators (KPI)

#### Hospital data: April 2014 – November 2014

<table>
<thead>
<tr>
<th></th>
<th>PMG</th>
<th>Rest of York</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E activity</td>
<td>-3%</td>
<td>+4%</td>
</tr>
<tr>
<td>A&amp;E Cost</td>
<td>-2%</td>
<td>+2%</td>
</tr>
<tr>
<td>NEL Activity</td>
<td>0.8%</td>
<td>+5%</td>
</tr>
<tr>
<td>NEL Cost</td>
<td>+1.1%</td>
<td>+2%</td>
</tr>
</tbody>
</table>

### Key Performance Indicators (KPI)

#### Integrated Care Team Activity: November 14 – January 15

<table>
<thead>
<tr>
<th>Activity</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early discharges</td>
<td>2</td>
</tr>
<tr>
<td>Hospital admission avoidable</td>
<td>71</td>
</tr>
<tr>
<td>Hospital admissions avoided</td>
<td>33</td>
</tr>
<tr>
<td>Integrated Care team contacts – Telephone</td>
<td>1104</td>
</tr>
<tr>
<td>Integrated Care team contacts – Face 2 Face</td>
<td>920</td>
</tr>
<tr>
<td>Clinical pathways identified</td>
<td>10</td>
</tr>
<tr>
<td>Provided care where service gaps</td>
<td>9</td>
</tr>
</tbody>
</table>
It is enabling patients to remain independent

- By improved communication channels resulting in more timely delivery of care

- Working with Commissioners (CYC/VoYCCG) to develop and implement alternative care pathways that enable people to remain independent longer.

- “Right Care, Right Place, Right Time”

It puts the patient at the centre

- Holistic Care Workers
- Care co-ordinator
- Practice Nurse
- GP’s
- Voluntary sector
- Physiotherapist
- Social Worker
- Occupational Therapist
- Mental Health
- Carers
- Community Nurse

Priory Medical Group
“Person Centred Care”

• Every patient is different

• Care plan is tailored to specific patient needs

• Team providing care spans Secondary, Primary, Community, Social Care and Voluntary sector.

• In plain English this means……..

How does this help the Patient?

• Patients tell us they feel cared for

• Carers tell us they feel supported

• Improved end of life care at home for patients who do not have Cancer

• The Patient’s problem is our problem.

• We have no “criteria” so don’t turn any patients away
What do patients say?

Patient Feedback

- Patient case: Mrs X age 72 had an **unstable back fracture**, sent home from hospital with a **back brace**.

- After a difficult weekend Mr X phoned his GP, his wife was **distressed and in constant pain** especially when taking the brace on and off. A **Holistic Carer visited the same day** from the team and attended to assist once a day which **improved Mr X’s confidence**.

- The social worker from the care hub arranged for the re-enablement team to access training in changing the brace, they **took over support** after 2 weeks.

- Mr & Mrs X were **delighted** with the care hub service and would have been **previously reliant on admission to hospital**.
Dear Liz Allen,

May we let you know how well the after care service is working for us since ’s recent discharge from York Hospital.

**City of York Council are providing excellent care** for us through home care support, coordinated by your good self and staff.

**However the early, direct care afforded to us, truly was magnificent by any standards, and we were lifted from a quite desperate situation, to one of relief and hope.**

Thank you very much for the kind and efficient manner in which you set this in motion, as the difficult times for us have been greatly eased and we are most grateful.

---

**Team Feedback**

- “The team supported her and her mother during a challenging, upsetting time and cared for the health and social needs for them as a whole unit.”

- “As a team we were regularly challenged, her needs were both complex medical with social issues. She bounced in/ out of YH, calling urgent care regularly. Now her needs are being met and she feels enabled to make decisions about her care. She rarely calls for visits now and has not been admitted for over 6 months now. On my last visit, she thanked me for the “Priory Team” who had made all the difference.”

- An excellent team that provides both responsive and integrated care. Valued by patients, family and clinicians. **Nothing but praise** for this team that appears to be making a real difference to our patients care in both avoiding admissions and re admissions and General care to high risk/need patients.
Achievements

• Providers of care are now working together

• Creation of an individual “Care Plan” owned by the patient or their carer

• Work to create a “Shared Care Record” is underway

• Gaps in care identified....

Progress February 2015

• Less fragmentation of service provision

• MDT team working well

• Team education

• Engagement of voluntary sector is now really happening

• Mental Health input to start

• Patient population covered by team 90,000 and will expand to 110,000 in March
Next Phase

- Refocus attention on Care Homes. Learning from the Selby model
- Develop links with other teams
- Implement more near patient testing
- Develop or implement new clinical pathways in response to gaps identified that will reduce avoidable hospital admission
  - e.g. Urinary infections, intravenous antibiotics at home, Potassium and sodium guidance for clinicians

Challenges Overcome

- Communication with individuals and teams that feel threatened by change
- Finding time in a system at capacity to see the efficiencies that can be made
- Bureaucracy
- IT access to 4 practices systems and 2 system providers in the MDT
- Governance required to work with other practices
We will continue....

• To make small incremental changes

• **Empower staff** to do their job safely using a **common sense** approach

• To do more if it works, if it doesn’t, we stop

• To keep focussed and not get distracted

What are the risks?

• Politics – UK General Election in May 2015

• Finance - Activity is reduced but financial pressures will continue

• Data sharing is essential to success

• Bureaucracy
Foundations for Success

• Communication

• Co-operation

• Co-ordination

• Control

Lessons Learnt

• **Communication** only effective if you have engagement and trust, **cooperation** then follows

• **Coordination** is **key** to success

• You are **NOT in control** of everything! Don’t expect to be especially when working with many agencies

• **Engaging** with the **leaders** of ALL organisations

• Expansion will require more leaders / champions

• Leadership **training, support and mentorship**
The Future

• Integrated Health and Social Care across the whole of the VoYCCG

• With full commitment from:
  – York Teaching Hospital Foundation Trust
  – Vale of York Clinical Commissioning Group
  – All Primary Care Providers
  – City of York Council, North Yorkshire County Council and East Riding Council
  – Voluntary sector

How it all comes together....

2013/14 Identifying the fibre
- Support our member practices to manage variation
- Build new relationships across multi agency teams
- Dedicated project and programme management

2014/15 Our fibres become yarns
- Practices coming together as Federations / Collaboratives
- Joint health and social care MDTs
- Early implementation – Selby and Priory Medical Group

2015/16 All the strands of our vision are in place
- New contracting / payment models in place
- Shared care records and data flows between providers
- Fully integrated health and social care workforce

2016 Onwards Our rope is formed
- Strength and resilience through collaboration
- Our rope helps pull the system through innovation
- Care hubs become the default position for health and social care provision
• Fiona Bell, Deputy Chief Operating Officer
  fiona.bell8@nhs.net

• Dr Lesley Godfrey
  lesley.godfrey@nhs.net