Primary Care Home – a New Model of Care

<table>
<thead>
<tr>
<th>Alliance/Practice Details</th>
<th>Nimbuscare Ltd (Unity Health, Priory Medical Group, Haxby Group, My Health)</th>
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<td>Integrated Care Partners</td>
<td>Vale of York CCG, City of York Council, York CVS, Healthwatch York, York Foundation Trust, Tees, Esk, and Wear Valley NHS Trust, Community Services, Patient Participation Groups</td>
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**What is a Primary Care Home?**

Full details of the National Association of Primary Care (NAPC) Primary Care Home model can be found via [http://www.napc.co.uk/primary-care-home](http://www.napc.co.uk/primary-care-home)

The key attributes of a Primary Care Home (PCH) are:

- Provides care to a defined, registered population of between 30,000 and 50,000
- Shares a focus on personalisation of care with improvements in population health outcomes
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- Aligns clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards

The NAPC regards effective Primary Care as having four central features:

- First point of contact for all new health needs
- Comprehensive care provided for all needs that are common in a population
- Co-ordination and integration of care when a person’s need is sufficiently uncommon so to require special services or provision from another sector (secondary or tertiary care)
- Person-centred (holistic), rather than disease-focused, continuous lifetime care

**Plan**

The Vale of York is currently facing significant financial, organisational, and quality pressures in terms of health and social care provision which must be addressed.

We have identified PCH as a model of care that will help address system wide issues in an integrated effective and sustainable way;

- by identifying aspects of population health that we can improve to reduce inequality
- by implementing new integrated care models to improve health outcomes for PCH populations
- by learning from the 15 first wave PCH sites and with expert support from the NAPC team

We have identified 3 distinct geographical groupings which will be the basis of 3 Primary Care Home communities (West, North East, South)

We have established a PCH steering group with named participants from each
Stakeholder. We will be extending an invite to people using these services to encourage co-production of services provided within the PCH.

We will be performing a demographic and care needs analysis of each PCH population targeting completion by end March 2017. From this analysis the PCH Steering Group will:

- Identify 3 areas of population health that can be improved
- Define a model of capitated budget and risk/reward sharing model
- Facilitate the transformation of our existing “one size fits all” model to a system that delivers continuous lifetime care. Specific services will target people with acute care needs, continuing care needs (including long term conditions) and those with multiple co-morbidities regardless of their place of residence (own home, Residential Home, Nursing Home)
- Embed non-medical solutions that enhance wellbeing
- Support ways to connect people with community resources to reduce long term health needs

Commencing 1st April 2017 each PCH will define and co-produce service provision to meet the 3 areas identified through the analysis.

What do we need?

- Demographic, public health, and social care data at PCH level
- Financial support from commissioners (Vale of York CCG and City of York Council) and Providers (e.g. allocation of PMS monies based on PCH Population)
- Advice and guidance from expert resources wrapped around each PCH (e.g. finance team, business intelligence, public health)
- Re-alignment of “on the ground” workforce to mirror PCH populations
- External evaluation and support of our programme by an established and credible research body.

Sign Off

Approval on behalf of Nimbuscare