NHS
Vale of York
Clinical Commissioning Group

Primary Care Home – a New Model of Care

Alliance/Practice Details	Nimbuscare Ltd (Unity Health, Priory Medical Group, Haxby Group, My Health)
Integrated Care Partners	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
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 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 heath 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 creditable research body.
Sign Off	Approval on behalf of Nimbuscare