Item Number: 7
Name of presenter: Fiona Bell, Deputy Chief Operating Officer

GOVERNING BODY MEETING

7 AUGUST 2014

NHS
Vale of York
Clinical Commissioning Group

Integration Pilots and Better Care Fund

For Information

1. Rationale
Request received from Governing Body for an update on integration pilots and their link to the Better Care Fund and Care Hub model.

2. Actions for the Governing Body
The Governing Body is asked to note the report.

3. Engagement with groups or committees
None. This item has been prepared for Governing Body.

4. Significant issues for consideration
Key issues are that the integration pilots may not deliver at a scale or pace which delivers the required impact on reduction of admissions.

5. Implementation
The integration pilots are being heavily supported by senior members of the innovation and Improvement team. Pilots report to the Joint Delivery Group and are held to account for performance and delivery. The Joint Delivery Group has representation from all the major partner organisations who are also there to help unblock any issues with delivery.

6. Monitoring
Each pilot has its own objectives and key performance indicators. Monitoring will continue through the Joint Delivery Group, and regular updates brought to Governing Body. Exception reporting occurs through the Quality and Performance meetings.

7. Responsible Chief Officer and Title
Mark Hayes, Chief Clinical Officer

8. Report Author and Title
Fiona Bell, Deputy Chief Operating Officer
John Ryan, Programme Lead

9. Annexes
Not applicable

BETTER CARE FUND: FROM INTEGRATION PILOTS TO CARE HUBS

1.0 INTRODUCTION

In April 2014, the CCG, in partnership with City of York Council, North Yorkshire County Council and East Riding of York Council submitted its Better Care Fund (BCF) plans, through respective Health and Wellbeing Boards, to NHS England. These plans were reviewed and accepted by NHS England and the Local Government Association and formal implementation of the plans started in May 2014.

Plans submitted through the BCF were, for Financial Year 14/15, primarily health based with the focus being on developing new services and models of care that reduced the reliance on hospital based services. The main aim of the plans is to reduce the number of unplanned attendances at and admissions to hospitals. Where attendance and admission to hospital is appropriate, the aim is to reduce the amount of time individuals have to spend in hospital. The key enabler to this shift in care delivery is through the development of Care Hubs, where the majority of the health and social care needs of a community can be accessed and delivered. The hubs key focus will be to provide services to assess, diagnose and initiate support services which will enable individuals to remain at home, or return there at the earliest opportunity following a period of exacerbation or crisis.

The journey towards Care Hubs will take some time but the first steps have started with the implementation of several integration pilots. These early models are currently being delivered by:

- **Priory Medical Group**, for a cohort of patients residing within the footprint of City of York Council – initial focus on supporting the care needs of individuals in care homes

- **York Teaching Hospitals Foundation Trust** (YTHFT) in Selby, for patients whose social care needs are provided by North Yorkshire County Council.

- **Pocklington** for patients who reside in the footprint of East Riding of York Council (in development)

- **City and Vale collaborative** group of practices for patients who reside in both City of York Council or North Yorkshire County Council (in development).

The different integration pilots will enable us to test the alternative models of delivery and through the evaluation, identify which elements of each model deliver the most effective services and outcomes. Nationally, the direction of travel is for fewer, larger collaborations of primary care teams and we will be exploring this with practices over the coming months.

2.0 AIMS AND OUTCOMES:

The integration pilots, and their development into a care hub(s) will be assessed and monitored for their impact on both the health and social care system, particularly on unplanned admissions to both hospital and to residential and nursing homes.

Appendix 1 outlines the key measures being monitored.

An early piece of work that is currently being undertaken is to establish a base-line of current activity and expenditure, in both health and social care settings, so that we can clearly measure and report on the impact our new service models are having. We recognise that nationally, much of this work is new, and so the CCG is working with the university of York on the evaluation proposal and baseline. Where there is evidence for different ways of working, and the impact of things such as care co-ordination we are supporting the pilots to build on these approaches.

3.0 CURRENT POSITION

3.1 Priory Medical Group Model

The Priory Medical Group (PMG) model is based around a phased approach of proactively case managing 500 patients in residential and care homes with plans to extend this to include the top 2000 most at risk patients from other practices. The model includes an integrated health and social care team which responds to daily attendance, admission and discharge data from YTHFT supported by regular Multi-Disciplinary Team meetings. A budget of £250K has been identified to support this model with a return on investment target of 1:2 for this year.

Progress to date includes:

- Identification of individuals currently receiving high levels of both health and social care
- weekly multi disciplinary team meetings with social care to identify and plan for high risk patients.
- Weekly GP visits to care homes to review patients
- Implementation of remote working to enable patient records to be viewed and updated in care homes
- Daily updates from the hospital on any patients admitted from Priory practices.
- Development of a community IV service to include IV antibiotics
- Modelling of the workforce required to deliver a 7 day a week service
- Appointment of a care co-ordinator to oversee packages of care for the initial cohort

3.2 Selby Model

The Integration Pilot at Selby is being delivered by YTHFT, working closely in partnership with GPs from the Selby area practices and colleagues from North Yorkshire County Council. The model is similar, with additional support being provided by a consultant geriatrician to develop remote support and early intervention where necessary. Workstreams are being implemented around 4 key workstreams:

- Admissions avoidance by identifying patients who will benefit from intermediate care/reablement/fast response
- Early discharge to assess patients
- Case management/complex care planning
- Care home support, and GP in reach services

Specific progress has been made around

- Identification of individuals currently receiving high levels of both health and social care
- Development of competencies for a generic worker post who will undertake both health, social care and therapy assistant functions
- Sharing of data and records across health and social care.
- Audit of high risk and vulnerable patients within each of the Selby practices
- Involving the voluntary sector to explore opportunities to deliver elements of support which keep individuals at home.

An initial budget of £550K has been identified for this project through the BCF submission process and to date YTHFT have committed to spend approximately £281K with identified savings of approximately £572K, part year effect.

3.3 Pocklington:

Plans are currently being developed by Pocklington practice in partnership with Humber Foundation Trust, who provide community services to the practice, and East Riding of Yorkshire Local Authority. The overall aim will be to support frail elderly and vulnerable older people to be as healthy, active and independent as possible in their own homes or usual place of care and to develop crisis support teams when needed to avoid admissions where possible. Reablement services will be a key function of the integration project.

3.4 City and Vale

This proposal focusses on collaborative working with the 11 member practices of City and Vale. The alliance has already committed to using the £5 per head funding available to primary care to support the development of their integration project and some of the costs of establishing effective multi-disciplinary teams from all the necessary partners. In a similar way to the other schemes, the project aims to initially support those patients identified as most at risk of unplanned admissions. Supporting patients with self care is a key element of the proposal.

4.0 NEXT STEPS

As described above, the Integration Pilots are at an early stage of delivery and are rapidly developing the services which will support reduced hospital activity.

Once step 3 above (Nov 14 to Mar15) is complete, the next major challenge will be to take these early Integration Pilots and turn them into true Care Hubs. This will involve significant system redesign and much more collaborative working between the CCG, it's partner Local Authorities and its current and future providers. The

developing models are also expected to include a range of diagnostics and direct access services which will need to be delivered at scale across the CCG and supporting workstreams are already underway to develop this work.

Discussions are ongoing in relation to the number and size of consortia or partnerships across primary care, however it is becoming increasingly likely that one care hub will be required in order to deliver services at the scale required to have an impact on the system. An accountable provider model is being explored which may facilitate this.

The CCG has applied for support on the national Accelerate Programme, led by NHS England, Monitor and the Local Government Association. If successful, this will provide national support to develop new data sharing agreements, funding models, and workforce planning.

The Governing Body is asked to note progress to date and to endorse the longer term plan to develop true Care Hubs.

End.

Appendix 1 – metrics for integration pilots and developing care hub.

Measurements to demonstrate:

- reductions in the proportion of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge.
- reductions in demand for emergency placements.
- reductions in the length of stay for residents who do require an emergency placement where no other alternative is available.
- reductions in the proportion of residents being admitted to care homes, from both acute and community settings.
- reductions in the proportion of residents being admitted to care homes from both acute and community settings
- decreases in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge per 100,000 population, per month
- reductions in the number of emergency department attendances
- reductions in the proportion of admissions following an emergency department attendance
- reductions in the proportion of attendances at emergency departments for individuals presenting with mental health problems
- reductions in the number of patients known to the Community Mental Health Team attending emergency departments
- reductions in the number of falls related injuries for residents over the age of 65
- implementation of a shared care record for each individual accessing the Care Hub
- provision of a named single contact point for each individual accessing the Care Hub

To support this we will also expect to see significant improvements re

- Residents only having to tell their story once.
- Faster response times and more joined support to individuals and their carers/families
- Positive feedback and customer satisfaction reports