Item Number: 7
Name of Presenter: Dr Tim Maycock

Meeting of the Governing Body

4 June 2015

NHS
Vale of York
Clinical Commissioning Group

General Practice '£5 per Head' Funding 2014/15

Purpose of Report
For Information

1. Rationale
To summarise NHS Vale of York CCG's spending against NHS England's '£5 per Head' guidance for the 2014/15 financial year.

2. Strategic Initiative *(double click and select 'checked' for all relevant initiatives)*

- ☒ Integration of care
- ☒ Person centred care
- ☒ Primary care reform
- ☒ Urgent care reform
- ☐ Planned care
- ☐ Transforming MH and LD services
- ☐ Children and maternity
- ☐ Cancer, palliative care and end of life care
- ☒ System resilience

3. Actions / Recommendations
The Governing Body is asked to receive the contents of this report.

4. Engagement with groups or committees
NHS Vale of York CCG Senior Management Team, Council of Representatives and Quality and Finance Committee.

5. Significant issues for consideration
1) All of the General Practice schemes/projects that are summarised in this paper were initially reviewed at the CCG's Senior Management Team meeting and align with NHS England's national guidance 'Everyone Counts: Planning for Patients 2014/15 to 2018/19'.
2) During 2014/15 this funding was offered to Vale of York Practices at a maximum of £5 x their registered patient population. Bids were invited from individual Practices, or through Practice collaborations.
3) NHS Vale of York CCG's investment into General Practice to support these schemes during the 2014/15 financial year was circa. £1.3 million.
4) To promote the overarching theme of innovation in General Practice, for 2015/16 this programme will be branded as NHS Vale of York CCG 'General Practice Innovation Fund'.

6. Implementation
Dr Tim Maycock (Clinical Lead) and Shaun Macey (Senior Innovation and Improvement Manager) for NHS Vale of York CCG's Primary Care Programme have been responsible for the rollout of schemes to Practices, monitoring spend and reviewing schemes at end of year.

7. Monitoring
N/a

8. Responsible Chief Officer and Title Dr Tim Maycock Clinical Lead	**9. Report Author and Title** Shaun Macey Senior Innovation and Improvement Manager
10. Annexes Appendix 1 is provided for Governing Body members and available at http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/	

1. Background to the 2014/15 General Practice '£5 per Head' Schemes

NHS England's 'Everyone Counts: Planning for Patients 2014/15 to 2018/19[1]' which was first published at the end of December 2013 states:

CCGs will be expected to support Practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for Practice plans to do so. They will be expected to provide additional funding to commission additional services which Practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each Practice, which broadly equates to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund.

In accordance with this national guidance, during the 2014/15 financial year NHS Vale of York CCG offered the £5 per head funding to its member Practices.

In order to ensure that Practice schemes were appropriately aligned with the CCG's integration and Better Care fund initiatives, the CCG wrote to Practices suggesting that they should use the funding in the following areas:

- Development of Care Hubs or the provision of more community based services
- Supporting the accountable GP in improving quality of care for older people
- Avoiding unplanned admissions
- Reducing A&E attendances
- Proactive Case Management and Multi Disciplinary Team reviews
- Discharge planning
- Improved demand management and/or improved patient access
- Practice education/training to up-skill staff
- Systems development to improve sharing of information between services
- Cross-agency working
- Development and review of Personalised Care Plans
- Promotion of self-management for patients

Practices submitted a variety of proposals (both individually and as Alliances) that were reviewed/approved at the CCG's Senior Management Team meeting. Different schemes moved into their delivery phases at various points throughout the year. Only one of the CCG's smaller Practices did not apply for this funding.

[1] http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Practices/Alliances were asked to provide a monthly expenditure plan for their schemes, and the overall spend that was requested for 2014/15 was circa £1.3 million.

2. Delivery of Schemes for 2014/15

In summary, the CCG funded a total of 14 schemes across Vale of York Practices/Alliances during 2014/15 at an overall cost of £1.3 million. These schemes include funding additional resource to develop Personalised Care Plans, promoting Multi Disciplinary Team reviews of Personalised Care Plans across Practices (with input from Community and Social Care teams), Care Home in-reach services, urgent care clinics, patient self-care and patient demand management schemes, and projects to use Information Technology to deliver e-consultations and promote new methods of patient access. All schemes were felt to be aligned with the CCG's system-wide strategic objectives.

Feedback from Practices has been very positive and enthusiastic, with several commenting that this funding has given them the opportunity to think about how they can start to work differently.

Practices/Alliances were asked to share learning from their respective schemes at a Forum event on 14 May 2015, and were asked to present a 'poster' which:

- described the scheme itself
- explained what impact the scheme was planned to have
- shared any lessons learned from implementation
- described any headline figures (if available) around impact to date

The Forum was well attended with enthusiastic representation from both GP's and Practice Managers across the various schemes and provided an opportunity for Practices to exchange ideas and ask questions.

The poster presentations from each scheme are included in Appendix 1.

The Governing Body is asked to receive the contents of this report, and we look forward to presenting the outcomes and learning from the 2015/16 General Practice Innovation Fund schemes in May next year.

Appendix 1

General Practice '£5 per Head' Funding 2014/15

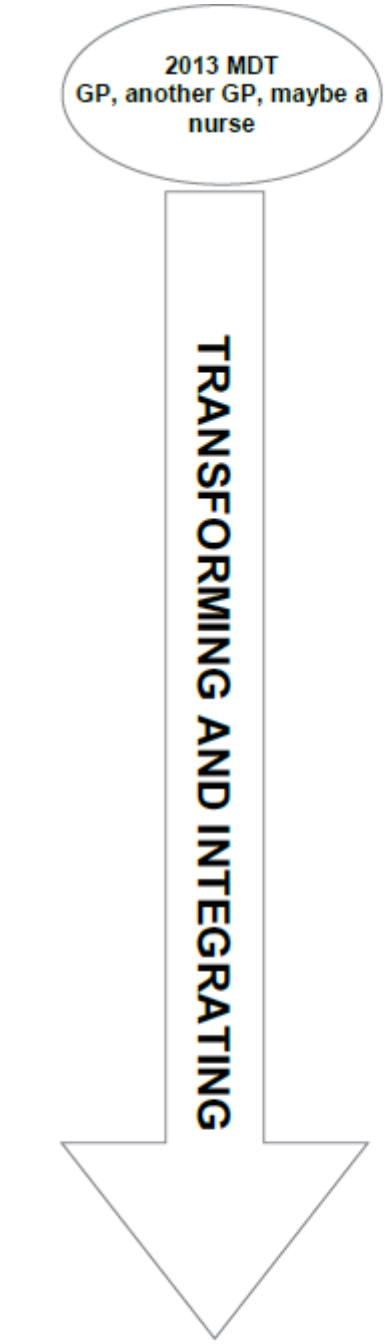
Posters from Forum event on 14 May 2015

EVERYONE COUNTS PLANNING

IMPROVED ACCESS TO PRIMARY CARE

- Named GP >75
- Register identified
- Care plans instituted for patients in "At Risk" group
- Improved communication pathway Encourage patients' to contact the Practice (when appropriate) rather than Ambulance/OOH
- Contact patients on the register within 3 days of discharge following hospital admission
- Better understanding & management of patients' condition by both the patients' and their carers
- Patients and Carers feel better supported and informed regarding how and when to use various services

BEECH GROVE MEDICAL PRACTICE



CAVA Community MDTs

Aims

- to support the coordinated care of the frail elderly in primary care
- to re establish working relationships across the disciplines
- to enable sharing of information
- to support and strengthen locality teams
- to enable personalised patient centred care delivered by a small number of known professionals
- to minimise duplication of effort

Method

- released clinician time to enable engagement with key stakeholders and enablers
- clinicians and mangers worked together to agree a shared working model
- created a Proactive Care Plan for use by all Practices
- set up weekly CMDT in each practice across CAVA footprint
- set up monthly Proactive Care Meetings in each practice
- encouraged participation of a wide range of disciplines by guaranteeing multiple GP presence and regular email invitation to attend or contribute remotely
- develop shared CMDT portal via Intradoc
- nurtured the concept of the ' trusted colleague' to enable other disciplines to access the CMDT portal

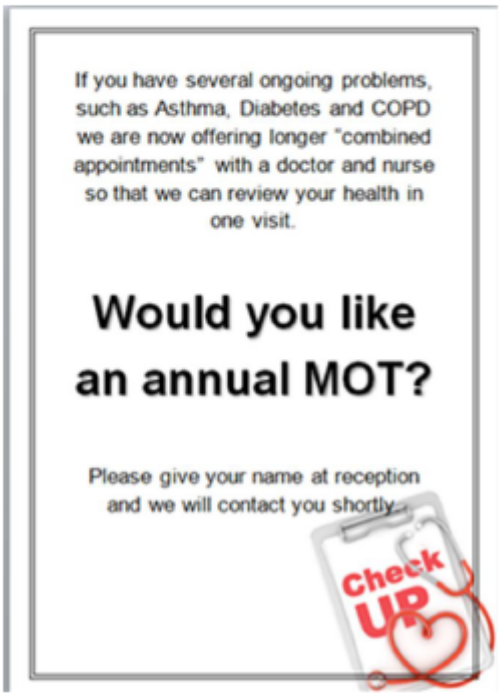
Achieved

- Proactive Care Plan template in use across CAVA practices
- 11 CMDT meetings have taken place each week since July 2014
- Up to 20 patients are subject subject to multidisciplinary team discussion in each meeting. Average of 10 resulting in approx 110 a week
- 16 different disciplines have attended meetings
- communication across CMDTs have improved
- evidence emerging of unplanned admissions avoided

In Progress

- CMDT portal development to improve communication within teams and across teams
- CMDT portal development to enable activity tracking and performance review
- development of library of shared condition protocols for ease of upload into care plans and consistency of approach
- continued effort to encourage and grow participation of other disciplines in CMDTs

Clifton Medical Practice – £5 per Head



"The surgery has been updated which makes it more welcoming. Reception staff are very helpful, and had a good and helpful consultation with my GP and Nurse."

"They are a great opportunity to have all my reviews done at one time rather than me having to come back several times."

"Great idea and saves me coming back more than once"

"I have diabetes, COPD and Hypertension and usually have to come in multiple times just for reviews; this is a good way to get it all done at once"

- ***Aim;*** *To improve holistic care of patients with several comorbidities to reduce admission rates, GP consultation rates, polypharmacy improve social circumstances and reduce social isolation.*
- ***Method;*** *We reviewed our current practice of reviews for chronic disease and medication reviews and sought patient feedback in this area. After liaising with community pharmacist, local care agencies and charities including MIND and Age UK we set up "combined surgeries" to provide review by GP, chronic disease nurse, community pharmacist and link with MIND/Age UK*
- ***Outcomes;*** *These clinics have been well received by patients, we plan to audit admission and consultation rates for the 12m preceding their first combined appointment and the 12m after.*
- ***Further work;*** *Our plan is to extend these appointments to a greater number of patients with >1 morbidity, look at working with more agencies including those supporting patients living with demetia*

Everyone Counts £5 per head Forum - Dalton Terrace Surgery

Description of Scheme

Our scheme aimed to improve the quality of care for older people by

1) Reducing A&E attendances & emergency admissions by:
   - -Monthly case seeking of high A&E attendees & educating them on accessing health care
   - -End-of-life plans and sharing with OOH providers so inappropriate admissions avoided
   - -Directed MDT medication reviews to avoid polypharmacy
   - -Internal reviews of all unplanned hospital admissions

2) Improving patient access by:
   - -Effective management of demand (upskilling nurse to Nurse Prescriber/Minor Illness Management to give better access to GP appointments)
   - -Additional embargoed slots to enable nominated doctors to triage and see their own patients
   - -Same day telephone consultations with nominated GP for those at high risk
   - -Longer appointments to those with complex care needs

3) Supporting patients after discharge
   - -Nominated GP reviewing discharge information and reviewing patient
   - -Carer support where necessary

Planned impact

- -Reduce unplanned admissions / inappropriate use of A&E
- -Improving health related quality of life for those >75 years with chronic diseases
- -Improving proportion of older people living independently at home after hospital discharge
- -Economic benefit for CCG/NHS

Lessons learned from implementation

Positive:
- -Focuses attention on identifying precipitating factors that lead to admissions and modifying these risks/behaviours
- -Upskilling of nursing staff to free GP time for patients with more complex needs, with prospect of employing other health care professionals (eg pharmacist, primary care navigator)
- -Helpful group approach to reviewing polypharmacy problems

Negative:
- -Embargoing of slots/double appointments for complex cases reduces availability to other patients
- More administrative load for GPs, with definite measurable outcomes of the project difficult to define
- Potential loss in continuity of care for those not >75yrs (locum GP / bank nurses used as backfill)
- MDT approach not easily feasible given demands on community nursing staff
- Future economic planning – dilemma of employing extra staff if funding not certain for coming years

Headline figures to date

Reducing Unplanned Admissions in Residential Care Homes

Elvington Medical Practice has established a proactive care management programme with three local residential care homes. This comprises a scheduled weekly visit from a named GP and the supply of dosetted medication. The £5 per head funding was allocated to introducing this service to the Grimston Court home and covered 2 sessions per week of GP time, increased dispenser time, and procuring EMIS mobile to improve efficiency.

This is the first year the Practice has provided this service to Grimston Court so no comparative data is available. The level of GP activity and frequency of unplanned admissions, along with anecdotal evidence from both the home and YTHFT indicates it has been successful in achieving its aim of reducing admissions in this high risk cohort.

The project in numbers

468 patient consultations over 12 months — average 9 per week. Not including telephone consultations.

59 patients seen—average 8 consultations per patient in 12 months

16 admissions (13 patients)

All unplanned

15 Unavoidable

1 Avoidable admission– OOH fall, soft tissue injury

Elvington Medical Practice

LISTENING, HELPING, LEARNING

Key Outcomes

Communication– Regular visits have improved doctor-carer communication as relationships develop and understanding about patients and care provision improves.

Continuity of care– Named GP visiting each week ensures patients' care needs are met and that visits are maximally effective, through reduced repetition of histories etc.

Patient confidence- Patients are elderly and cognitively impaired so seeing the same GP each week allows them to recognise and trust those providing their care.

Annual reviews– Patients' care plans are reviewed annually in their birth month by their named GP, as the minimum level of care.

Acute problems– Scheduled visits allow home staff to assess acute problems to avoid out of hours callouts where it is felt the problem can wait.

Medicines management– Weekly visits allow the GP to monitor all medication on a weekly basis. Integrating this with the medication provision allows for changes to be made quickly and with minimal waste.

Transfer of knowledge– The care home staff work more closely with the Practice through increased contact, so clinical and medication information is relayed quicker and more effectively.

£5 PER HEAD – ESCRICK SURGERY

CARE PLANNING

A

WORK AS A TEAM

5 Doctors
1 Practice Manager
1 Administator

B

ORGANISATIONAL/ PLANNING

94 Patients allocated
Reserve list created
Documentation prepared
Read codes/templates available
Time allocation/Appointments booked

C

THE CONSULTATION

Face to face contact
Comprehensive review
Plans discussed
Advice given
Forms completed
Opportunistic review done

D

NURSING HOMES

Sessions allocated
Comprehensive Reviews
Care Planning
Chronic Disease Management
Advice offered

E

ADMINISTRATIVE PROCESS

Template completion
Follow ups at 3/12 (or appointments)
Monthly meetings
Changes made

F

OUTCOMES

1. Awareness of patients
2. Medication review
3. DNACPR in place
4. Use of community matron
5. Increased time dedicated to patients in nursing homes

COMMUNITY CARE PLUS

Aims

- Targeted care of "at risk" patients using risk stratification tool
- Enhanced involvement of existing primary care team members e.g. District Nurses
- Addition of novel members of primary care team e.g. dedicated Care Coordinator, Community Pharmacist working in GP, and a Social Worker
- Establish multi-morbidity clinics with time and resources to meet patients' needs

Method

- Two trial areas identified (New Earswick and Poppleton – 700 patients over 75)
- Use of risk of admission tool to identify those most at risk of admission to hospital
- Dedicated Care Coordinator – an experienced practice nurse with a special remit to facilitate regular multi-disciplinary and multi-morbidity clinics. Role stands apart from case managers as we know them as working on facilitating GP led care and are able to focus on all patients in need rather than having a closed case list
- Introduction of Community Pharmacist who attends the MDT and reviews patient's medication in detail and visits patients at home
- Social Worker attends MDT so that care package can be evaluated and priorities communicated to care agencies

Outcomes

- Pharmacist input
- 125 Patients discussed in MDT
- 75 had medication review by pharmacist
- 10 had pharmacist review at home checking medicines storage and ordering as well as dose simplification and recommending changes to medications
- Annual saving from pharmacist's intervention alone £3144 (10 patients)
- Multi-morbidity clinic
- Admission rates early signs of 51% reduction in admissions compared to last year.
- Social care involvement
- Nursing Homes workload

Recommendations for future work

- Develop the Community Pharmacist role further by creating capacity to review more patients
- Continue Multi-morbidity clinics expanding to entire practice "at risk of admission" population
- More detailed work with nursing homes and their residents

Working together to provide a caring, quality service

JORVIK GILLYGATE PRACTICE

£5/head funding 2014.15

ACTIONS	AIMS
1. We introduced daily Urgent Care Clinics at Woolpack House – manned by 3GPs Monday, 2 per day Tuesday to Friday	To provide opportunity for all patients to be seen within 24 hrs, reducing A & E attendance & unplanned hospital admissions
2. We redesigned our GP timetable to provide each GP defined time for daily prescription management and visits.	To increase capacity each day for more thorough review of medication lists and to avoid unnecessary polypharmacy and medicines waste
3. We undertook bi-monthly review of unplanned hospital admissions & monthly review of A & E attendance.	To consider ways of reducing A & E attendance and unplanned hospital admissions
4. We recruited and trained additional data support staff to provide capacity to implement a revised system for scanning and forwarding of documents to named GP or GP who admitted patient. We investigated employment of a Primary Care Pharmacist	To facilitate case management reviews. To ensure drug modifications or care plans initiated in hospital are translated into the primary care setting.
5. We provided in-house training to up-skill clinical staff in 'transitional care'	To reduce unplanned admissions and A & E attendances.
6. We ran Educational sessions to PHCT: leg ulcers; dementia; screening; chronic pain in the elderly; Parkinson's disease; Fall's prevention; Power of Attorney	To support patient care & reduce A & E attendance and unplanned hospital admissions
7. We considered ways of auditing patients with moderate to severe COPD and re-design of COPD template to include home supplies option	To optimise numbers who keep at-home supplies of steroids and antibiotics for use at an early stage of exacerbation
8. We surveyed Care homes home to establish extent of review on admission and annually : mobility; falls; continence; bowel habit; weight; diet; dental care; foot care; depression; cognitive function	To encourage Care homes to report initial review information and significant deteriorations to the named GP.
9. We updated our clinical software to EMISWeb We developed templates for personalised care to elderly patients	To better enable monitoring of medication usage and compliance, reducing wastage. To reduce unplanned hospital admissions & A & E attendances

The Kirkbymoorside Surgery Bid
Everyone Counts Planning 14/15
£5 per Head to Support the Accountable GP in Improving Quality of Care for Older People

1. **A description of the proposed scheme(s) explaining how they support the accountable GP in improving quality of care for older people**

   We wish to install a SurgeryPod in our waiting room to release time capacity within our GP and nursing and HCA workforce to be able to allocate longer appointment times to older patients with multiple morbidity- an attribute directly linked to the quality of care delivered and experienced.

   We wish to have patients do the measuring of health parameters in the waiting room before seeing the GP or practice nurse so the whole consultation can be focussed on what to do with the results- shared decision making- rather than the consultation time being taken up with measuring. Self-measurement enables self-management.

   The Surgery pod will allow new patient, contraception, asthma, hypertension and epilepsy reviews to be carried out safely and efficiently without the need for a face to face appointment with a health care professional.

   We would promote the use of the SurgeryPod to diagnose hypertension in those not wishing to have ambulatory BP or home BP recordings. We will use pod for patients to complete Friends and Family test.

   Our aspiration is that we use this facility to enable the greater use of PROMS (patient reported outcome measures) to facilitate patient centred care- shared decision making and better monitoring of care. For example the use of the EQ5D measure in long term conditions and the international prostate symptom score, Oxford hip and knee scores and the PHQ9. Patients would complete these before their consultation and use this information in assessing response to therapy trials and in making informed choices about future treatments.

2. **An indication of which outcomes will be improved and how these will be measured**

Condition	Practice numbers	20% using Pod year one	Appointment time released (mins)/year
Asthma	372	74	740
Hypertension	1074	214	2,214
Epilepsy	34	6	60
Contraception	324	64	640
New patient checks	360	360 (100%)	7,200
			10.824 mins = 180.4 hours
We will record which review were done at the Pod and which were done in a usual appointment for these populations		*We would anticipate the % use rising over time*	*Our Proactive care register is 119 patients. We would have an extra hour 50 mins of capacity for GP/nurse/HCA to give this group in contact time a year.*

Dr Tim Hughes 29/3/15

GP INNOVATION FUND

COMMUNITY BASED NURSE PRACTITIONER

Nursing home support

- Improve continuity of care
- Improve communication with nursing homes and agree procedures and pathways
- Educate staff within nursing homes
- Ultimate aim of reducing emergency admissions to hospital

Vulnerable patients in the community

- Identify and support vulnerable patients and co-ordinate their care to improve quality of life and reduce risk of emergency admission

WALK IN SERVICE

- Advance Nurse Practitioner working with GP support
- To see anyone who wishes to be seen that day no matter what their presenting problem
- The aim to increase routine GP appointment availability and to assess the impact on A&E attendance

YORK CARE HUB / TEST OF CHANGE

- Involvement in York Care Hub; Community Nurse Practitioner and GP
- To identify and support patients at risk of admission and promote early discharge of patients once they are admitted

EMIS PODS

- Automated blood pressure machine in each waiting room
- Links directly with the clinical system
- WIFI enabled
- Promote self management of conditions
- Free up HCA and Practice Nurse appointments and link in with annual reviews

PHASE 2 - PUBLIC WIFI

- To promote practice initiatives and provide education by linking from the landing page
- Aid self-management of conditions, promote appropriate use of medical services and ultimately reduce demand

MyHealthgroup.co.uk
01904 490 532

25,000 miles, 365 days, £25,000

CAPACITY

- CHALLENGE: Above CCG average A+E attendances- close A+E Proximity
- Three ANPs added to the clinical team
  - 23 additional clinical sessions a week
- Increased Urgent Care Access- 30% ^ in UC contacts in 14-15 cf 2013-14

A&E

	% Change Year on Year		
	Activity	**Cost**	**Unit Price**
Priory Med	-1.0%	0.4%	1.4%
Rest of VoY	3.0%	4.4%	1.4%

ENHANCED CARE PLANNING

- Nationally agreed searches identified our top 2% of patients at risk of emergency admissions: Diabetes single greatest LTC contributing to risk of UA.
- Increased clinical capacity enabled the development of an Outreach Programme for housebound/ Care home diabetics.
  - All patients on our high risk register with diabetes had a specialist Care plan from our diabetic specialist nurses (DSN).
  - Regular clinical outreach sessions dedicated to case management of Diabetes.

SELF-MANAGEMENT
'THE PATIENT LOUNGE CONCEPT'

- GOAL: to generate sustainable capacity by developing Education Programmes for low risk LTCs and Self- Management Resources.
- HOW: Focused project plan for Pre-Diabetes Introduction Group Session.
  - DSN- trained in Motivational Interviewing and group therapy.
  - All new pre-diabetics and annual reviews invited to our programme.
  - Given enhanced telephone contact with DSN.
  - Access to self-monitoring programme.
  - Innovative IT solutions

EB May 2015

Pocklington Surgery "£5 per head scheme"

Comprised 3 components

1) Exploring alternate ways of Demand Management "Doctor First"

The proposal was that by adopting Doctor First methodology we could improve access to the practice for patients by improved efficiency. The first stage was a 4 week data collection exercise.

Summary of results

- Planned capacity 907 appointments/week.
- Average patients helped per week 1067 appointments/week.
- Estimated demand per week based on list size 1584.
- 80% of those who called would have preferred on the day appointment 20% requesting book ahead slot.
- Current system provides 20% on the days and 80% book ahead.
- PPC (provider of Doctor First) concluded from this that we do not have the capacity in our system to successfully run their full system and suggested a compromise solution.
- Practice conclusion not to spend further £5 per head money on adopting compromise but will look at alternative ways of matching capacity and demand more effectively.

2) Proactive Case Management

Comprising the bulk of the funding for the scheme and the bedrock of Pocklington Group Practice's contribution to our local hub pilot. Funding for 4 key roles. Care co-ordinator (Nurse Practitioner skilled in Chronic Disease Management supported by a Health Care Assistant and dedicated administration support. In addition, one session per week of GP support.

Working together with our community provider and Local Authority – 3 hub beds in local care home to keep people out of hospital or facilitate early release. Linda, our Care Coordinator, has identified 'at risk patients' and then worked with them to address the risks where possible, in line with the DES specification.

Figures taken from clinical system show that since starting the project (July 2014), Linda has provided 479 home visits, 1796 consultations in the surgery, 703 telephone contacts and 160 third party consultations. Her supporting HCA (later into post) provided 961 consultations at the surgery.

The administration support role has been vital in freeing up the clinical staff from the administrative tasks involved in this project, allowing more direct patient contact. We are in the process of working with the CCG to provide outcome data for our main hub project which started in December 2014.

3) Provision of mobile technology

The Doctor First data collection exercise highlighted our practice's relatively high visit rate. We also have an expanding newly built nursing home and the new Care Coordinator role and Community Matron visiting our complex patients in their own home. It has been essential to improve access to records on visits compared to the brief paper summary that we have had to rely on.

The final component was to use funding for EMIS mobile licence and equip clinicians with tablet computers to access the record and record data, greatly enhancing the quality of information available on home visits and therefore improving patient care.

SHIELD

£5 per head

SOCIAL PRESCRIBING

Principle
Use of voluntary sector to provide help to patients following referral from GP. Connects patients to sources of support in their community

Objectives
Reduce pressure on NHS & social care
Improve outcomes for patients with long term conditions
Increase options for primary care & patients
Increase independence & resilience of patients
Do things differently – 'more of the same' is not an option

Eligible Patients
Over 65's or
Patients suffering from dementia or
Patients with a recent unplanned hospital admission

Referral Pathways
Exercise/healthy lifestyles
Self-management
Social & Leisure
Arts & Crafts
Befriending/mentoring
Confidence building
Learning/Training
Money – benefits, debt, fuel
Housing/adaptions
Carers support
Dementia support
Transport/mobility
Advocacy

SLA
Single point of contact (Selby AVS)
Telephone contact with patient within 1 working day of referral
Home visit within 7 working days from referral
500 patients per annum
Baseline wellbeing assessment carried out at first visit
Final wellbeing assessment to be carried out at 3 months or end of intervention
Database of 250+ different services/activities

EVIDENCE
Based on independent evaluation of Rotherham model by Sheffield Hallam University

1. **Hospital Episodes – 12m cohort**

Inpatient admissions - 21% reduction

A&E attendances - 20% reduction

Outpatients - 21% reduction

2. **Wellbeing Improvements**
Based on 8 outcomes

83% of patients made progress in at least one outcome area

60% made progress in looking after themselves

57% made progress in managing symptoms

61% felt more positive

3. **Cost/Benefits**
For an annual investment of £500,000

£415,000 cost savings in first year post referral

£870,000 to £1.9M potential full cost savings (dependent on length of intervention/drop off rate)

4. **Broad Outcomes**
Improved wellbeing – in particular mental wellbeing, anxiety & depression, personal confidence & self-efficacy (an individual's belief that he or she will be able to accomplish a specific task)

Reduced social isolation & loneliness – linking people with limited mobility & social contact with the wider community

Increased independence – linked to improvements in physical health

£5 per Head

This project will transform the way patients access their Unity Health surgery and redesign service delivery.

We will implement a technology based, innovative, enhanced access model for patients to consult with their named GP, Practice Nurse and care coordinator using proven virtual technologies.

Unity Health Vision:
To develop and maintain a good quality healthcare experience for all our patients

Project aims;

- Increase capacity
- Provide more choice for patients
- Allow patient controlled access
- Permit patients to proactively contribute to their healthcare
- Give patients direct access to their named GP and care team
- Enhance access outside of core hours
- Enhance access to health care for hard to reach groups
- Increase patient engagement

www.unityhealth.info

Unity Health