West Yorkshire and Harrogate: Learning from the Vanguards

Rob Webster
CEO, SWYPFT NHS Foundation Trust
Lead CEO WY&H STP
# hello my name is.....
Sustainability, Transformation, Planning

Plus....

- 650 Care homes
- 319 Domiciliary care providers
- 10 hospices
- 8 large independent sector providers
- Thousands of Voluntary & Community Sector organisations

Serving a population of 2.6m

With a total allocation of £4.7bn across health by 20/21

Workforce of 113,000
Leadership Aim and Principles

**Our collective leadership aim is to achieve the best possible outcomes for the population through delivery of the Five Year Forward View**

We have **Guiding principles** that shape everything we do as we build trust and delivery

- We will be **ambitious** for the populations we serve and the staff we employ

- The WY&H STP belongs to **commissioners, providers, local government and NHS**

- We will **do the work once** – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.

- We will undertake **shared analysis** of problems and issues as the basis of taking action

- We will apply **subsidiarity** principles in all that we do – with work taking place at the appropriate level and as near to local as possible

**These are critical common points of agreement that bind us together**
NHS crisis deepens as bed blocking costs £6bn

Theresa May frustrated over GP opening hours amid pressure on hospitals

Pensioner 'angry' after GP shortage leads to 19-hour A&E ordeal

Theresa May has expressed frustration at the failure of more GP surgeries to offer extended opening hours amid intensifying pressure on NHS hospital services.
A vision for health and care in West Yorkshire and Harrogate ....

- Every place will be a **healthy place**, focusing on **prevention, early intervention and inequalities**
- We will work with local communities to build **community assets** and resilience for health
- People will be **supported to self-care**, with **peer support** and technology supporting people in their communities
- Care will be **person centred**, simpler and easier to navigate
- There will be **joined-up community services across mental & physical health and social care** including close working with voluntary and community sector
- Acute needs will be met through services that are “**safe sized**” with an acute centre in every major urban area, connected to a **smaller number of centres of excellence providing specialist care**
- In some areas local services will evolve into **accountable care systems** that collaborate to keep people well
- We will move to a **single commissioning arrangement** between CCGs and local authorities and have a stronger West Yorkshire and Harrogate commissioning function
- We will **share back office functions and estate** where possible, to drive efficiencies to enable investment in services
- West Yorkshire & Harrogate will be **great places to work**
- We will always **actively engage people** in planning, design and delivery of care
- West Yorkshire and Harrogate will be an international destination for **health innovation**
Impact........Health and Wellbeing

Improving people's health and wellbeing

- Reduce the number of smokers by **125,000** by 2021
- **226,000** people at risk of diabetes, we want to reduce this by a quarter by 2021
- Reduce number of people admitted to hospital due to alcohol by **500** a year
- Increase the one year survival rate of people with cancer to **75%** by 2021 with a potential to save **700** lives a year
- By **2021** we want to adopt a philosophy that all suicides are preventable, aiming to reduce the number of suicides by up to 75% as part of the **five year** forward view for mental health.
- Reduce the number of people experiencing a CVD incident by **10%** across the area by 2021. This would mean **600** people in Bradford alone.
Impact…….. Care and Quality

**Our targets for change**

<table>
<thead>
<tr>
<th>Our targets for change</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>95% of people attending A&amp;E will be seen in 4 hours, by 2017</strong></td>
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<tr>
<td><strong>92% of people will be seen by a specialist within 18 weeks and we will deliver these standards in physical and mental health services</strong></td>
<td></td>
</tr>
<tr>
<td>Supported self care for <strong>all people with a long term condition</strong>, with peer support and access to technology designed for your needs</td>
<td></td>
</tr>
<tr>
<td>A move to <strong>25%</strong> of the appropriate population accessing psychological therapies in their community and increasing the levels of recovery</td>
<td></td>
</tr>
<tr>
<td>Regardless of where you live, your experience of services will have improved by <strong>2021</strong></td>
<td></td>
</tr>
<tr>
<td>A new <strong>28 days</strong> standard to cancer diagnosis will be introduced</td>
<td></td>
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<tr>
<td>Reduce the number of people with mental health concerns going to A&amp;E by <strong>2021</strong> and bring their care closer to home</td>
<td></td>
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<tr>
<td>Increased focus on common thresholds for care and treatment to meet standards and <strong>reduce postcode variations</strong> in care.</td>
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</tbody>
</table>
Impact.......Finance and Efficiency

Delivering care more efficiently, £0.5billion
Providing the right care to everyone who use our services, £0.3billion
Programmes delivering savings across the area, £0.1billion
Securing our fair share of sustainability funding, £0.2billion
We are a guest in people’s lives
Six local area plans......
We identified the following priorities for working together at West Yorkshire & Harrogate level...

- Cancer services
- Urgent and emergency care
- Specialist services
- Stroke (hyper-acute and acute rehab)

- Standardisation of commissioning policies
- Acute collaboration
- Primary and community services

- Mental health
- Prevention at scale

- We work together because of the need for critical mass
- We work together to reduce variation and share best practice
- We work together to achieve greater benefits
Why do we have a primary and community services work stream?

“This is not the “out of hospital space” – it’s not defined by what it isn’t!

It’s about radical redesign and disruption

A move to personalised healthcare from mass production industrialised healthcare”
How do we chunk up the programme:

WAY OF WORKING
- Sharing good practice
- Constructive challenge
- Addressing systemic barriers

WORKSTREAM
- Primary care workforce
- Secondary care interface – care models and pathways
- Community services
- Social models and self care
What are we trying to achieve?

The providers of care

- Self Care
- Primary Care
- Secondary Care

- The acutely ill patient
- The developing person
- The deteriorating patient

Left Shift of Care Provision
1) Primary Care workforce – lead Andrew Sixsmith

Making Every Contact Count
Social Prescribing
Pharmacy First Contact
Asset Based Community Development
Care Navigation

Self Care

Primary Care

Expanded Workforce
Pharmacists
PAs
ANPs

Mental Health Workers

Complex patients
Health Coaching

Secondary Care

Specialists working in the community

Integrated Team Working

Pharmacist Medication reviews of complex patients

Knowledge
Skills
Attitudes
Primary Care workforce: over 1900 new workers in primary care space funded by GPFV money and new ways of working

<table>
<thead>
<tr>
<th>Year</th>
<th>GPs</th>
<th>Band 5-8</th>
<th>Band 2-4</th>
<th>Total</th>
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<tr>
<td>2016</td>
<td>1064</td>
<td>577</td>
<td>1395</td>
<td>3036</td>
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<tr>
<td>2021</td>
<td>1060</td>
<td>1377</td>
<td>2495</td>
<td>4931</td>
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</tbody>
</table>

Band 2-4 vs Band 5-8 workers comparison between 2016 and 2021.
It’s important we build on the local...

Which means the West Yorkshire team are going to look at patch wide data to create a model that can help the local implementation of admission avoidance schemes.

Which means a study of the long term initiatives which will genuinely enable the left shift.
3) & 4) Community, Social models and self care - leads Karen Barnet, Alyson McGregor and John Walsh

Benchmark community services, disseminate innovation and change in care delivery

Each of the six place plans has identified self-care as a priority, the focus of this work stream might be to:

- Develop an evidence base/business case of savings that could be delivered through widespread adoption of supported self-care approaches
- Build understanding of the approach being taken in each of the six places – consider scale of ambition/opportunities for levelling up
- Work with HEE to develop training packages for self-care
- Understand the impact of health coaching model – explore possibilities of procuring training at scale or co-ordinating
1. Use of lifestyle services at scale for primary prevention
2. Use of Community Pharmacy to be ‘first contact’ with minor medical illness
3. Use of **Social Prescribing** to de-medicalise presentations that are socially determined
4. Use of patient volunteers to peer support self care for patients with chronic disease
5. Use of care navigators to improve access to services
6. Use of media to communicate and educate and support the public
7. Use of digitally enabled platforms for access to information, people and services
In March 2018 we will have:

Made progress to determine how we approach delivering the left shift by:

Providing a robust evidence base: CCGs have access to high quality data in each of the sub work-streams:
- Primary Care Workforce
- Community Services benchmarking
- Care in the Community (admission avoidance)
- Social models, self-care and community development.

Describing a Primary and Community Care Road Map: setting out the actions the STP and CCGs will need to take to drive the agenda on key areas of the “Next Steps on the FYFV” document e.g. extended access, expanded multidisciplinary care (primary care home), delayed discharges and front door A&E streaming.

Agreeing STP and place based care in the community implementation plans: to support implementation of care in the community models e.g. Super practices and community services collaboration to meet urgent and non urgent demand.

Engaging local communities: working actively with our communities to ensure an active role on the individual’s health, care and support.
Objectives for April 18 onwards

We think there are two key objectives:

1. **Implementation** of STP and place based plans to support delivery of care in the community models which will meet health and social care demand

2. **Development** of social models which engage communities in their care and support, building on best practice from across the public sector.
We are committed to establishing a **new relationship with our communities** built around good work on the co-production of services and care.

Our proposals to support people to self-care, prevent ill-health, implement the GP 5YFV and join up community services require a new relationship that sees **people as assets** not issues.

They are fundamentally linked to **building resilience through community assets, local populations and the large numbers of thriving voluntary and community sector organisations** across West Yorkshire and Harrogate.
West Yorkshire and Harrogate Vanguards

Seven of the 50 Vanguards nationally are within the West Yorkshire and Harrogate footprint:

**Integrated Primary and Acute Care Systems**
- Harrogate and Rural District Clinical Commissioning Group

**Multispeciality community providers**
- Calderdale Health and Social Care Economy
- West Wakefield Health and Wellbeing Ltd

**Enhanced Care in Care Homes**
- Connecting Care – Wakefield District
- Airedale & Partners

**Urgent and Emergency Care**
- West Yorkshire Urgent Emergency Care Network

**Acute Care Collaboration**
- Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)
Progressing our model of integrated care across the Wakefield District
Wakefield Vision

GP Federations, MYT, SWYPFT, WMDC, WDH, YAS (111,999), LCD, Spectrum, Fire & Rescue, Carers Wakefield, Age UK, Other VCS

PMO & Governance
OD & Leadership
Business intelligence

Information Hub and Response Centre

Fusion Cell

Admissions avoidance
Early Supported Discharge

Improved Access

Extended Primary Care Access inc modes of access
Community Anchors & Micro Commissioning
Pharmacist in General practice
Physiotherapy First
Care Navigation & Social prescribing inc Digital Self care Citizen-held record

Primary Care Health Champions
HealthPod/Pop up Primary Care
Disruptive prevention / Schools app challenge

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Pharmacy in General Practice

“I’m pleased to announce the feedback from GPs and prescription clerks is excellent. We all feel that our workload has reduced and we feel we are providing an effective, safe service to our patients.”

Dr Abdul-Wahed Mustafa, a GP from Trinity Medical Centre in Wakefield

April - December 2016
50,742 contacts with patients
94,101 interventions
Estimated 6250 GP Hours Released
4816 Face to Face medication reviews
2291 polypharmacy medication reviews with an estimated ROI of £343,650
1339 Minor Illness consultations done
Only 1% of cases referred onto the GP
“Physiotherapy is ‘absolutely vital’ as part of ‘first contact care’

- Dr James Kingsland, president of the National Association of Primary Care.

- 2419 Appointments Used
- 403 GP Hours released
- Top 4 presentations have been back, knee, shoulder, neck pain accounting for 70% of contacts
- 29% of patients are sent for Community-Physio
- 8% of patients are asked to make a GP appointment
- 100% of practice managers agreed or strongly agreed that it had helped their practice become more effective in supporting patients

- 15 minute appointments
- Assessment and advice & signposting
- Must be a new MSK problem or an acute exacerbation of a pre-existing problem
- Experienced Physios with SystmOne smartcard read/write access
- Recommendations can be tasked on SystmOne to GPs or admin team
## Social Prescribing

### Health & Wellbeing Workers
- Social prescribing scheme
- All ages from 18+
- Mild cognitive impairment
- Mild anxiety/depression
- Case finding
- Wellbeing assessment Pre and post intervention
- 64% Improvement
- Identify gaps in provision

### Community Anchors
- Engagement with anchors
- Visits and Talks
- Support projects
- Specific initiatives e.g. Sloppy Slippers and Healthy Ageing
- Now self-sustaining

### Micro-commissioning
- Micro-commissioning budget (from vanguard)
- Allocated to Nova Wakefield
- Small grants scheme
- Need to identify gaps better

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**Note:**
- Community Anchors include Health & Wellbeing Workers, and Micro-commissioning budget is from vanguard.
Social Prescribing

‘I’ve had 3 serious bouts of depression, singing is a really a good way of letting go of stress in our lives’, ‘People have been saying the singing group has been their lifeline’

Social prescribing patient

Social Prescribing Interventions

April – December 2016
- 401 Interventions
- 64% Improvement in Wellbeing Scores
- SystmOne social prescribing templates improved
- Social prescribing tool undergoing NICE endorsement
- 1st round of Micro-commissioning £36k distributed to 16 grass-roots groups, with 615 beneficiaries, £59 Per head
HealthPod

Pop-up Primary care

- Citizen’s Advice
- Housing Association
- Carers Wakefield
- Age UK
- Youth groups
- Mental health worker
- Sexual health outreach
- Council
- Health Trainers
- Health and wellbeing
- Social prescribing
- and more…
‘I came in last week, you said my blood pressure was high and there was a big difference between my left and right arm. I went to the doctors and he gave me some tablets and today my blood pressure is normal, it's fantastic’

Healthpod Visitor

April – December 2016
• 3341 interventions with citizens
• 459 found to be high risk and sent for GP advice
• Atrial Fibrillation detected in 26 citizens with an ROI of £23,823.60
• Diabetes detected in 28 Citizens
• 98% of citizens Extremely Likely or Likely to recommend Healthpod to Friends or Family
• 7% of Citizens would have presented at their practice if they hadn’t of visited the Healthpod
• Over 60 locations have been used
Care Navigation
Making every contact count. Developing staff and signposting patients to appropriate services.

Not clinical, non-binary

Low-cost, high-impact

• Upskilling of existing personnel
• Over 120 care navigators trained and counting
• Supported by primary care health champions
• Using Service Directory and other on-line tools
• New front door experience: ‘Apple Store’
• Kiosks in Reception
• Accredited Training Provider
• On-line Course developed – Available January
• Approved for GP Forward View 10 High Impact Actions
Care Navigation

‘It frees up the GP to see someone more needy, you are able to see the best person to help you. Makes the system more efficient’
‘Yes. Saves GP time. Target the problem.’

Local patient feedback

April – December 2016
- 2097 GP hours released
- 19707 Signpost away from GP appointments
- 92% accepted signposts
- 100% of patients surveyed were happy to see the health care professional they were signposted to
- 277 Trained Care Navigators
- New improved SystmOne template & signpost criteria
- 81.5% of patients feel it is appropriate for Receptionists to Care Navigate
Schools App Challenge

Context
• Attack war on ill health and improve outcomes for children
• 1 in 10 increases to 1 in 5 obesity
• 1 in 10 child visits to A & E for dental extractions (90% preventable)
• Intersection of health & digital (STEM) skills

End of Project Stats & Highlights
• 77% reporting behaviour change (e.g. not rinsing after brushing)
• 83% reporting positive experience
• 1440 children directly involved in Schools App Challenge
• 1946 App Downloads, 5000+ HTML plays, 200+ app designs
• Over 50% of app entry teams are all girls

Industry / Patient Perspective
“ I hope we can change children’s attitudes to health in the future – our app looks incredible.”
“The fantastic method of delivery of SAC makes the topics of digital skills and health relevant, engaging and most of all, fun.”

Experiential recap (video)
Wakefield Model

The model is aligned to National Care Homes Framework:

- **Enhanced Primary Care Support**
  - Access to consistent, named GP and wider primary care service
  - Medicine reviews
  - Hydration and nutrition support
  - Access to out of hours / urgent care when needed

- **Multi-disciplinary (MDT) support including coordinated health and social care**
  - Expert advice and care for those with the most complex needs
  - Helping professionals, carers and individuals with needs navigate the health and care system

- **Reablement and rehabilitation**
  - Rehabilitation/reablement services
  - Developing community assets to support resilience and independence

- **High quality end-of-life care and dementia care**
  - End-of-life care
  - Dementia Care

- **Joined-up commissioning and collaboration between health and social care**
  - Co-production with providers and networked care homes
  - Shared contractual mechanisms to promote integration (including Continuing Healthcare)
  - Access to appropriate housing options

- **Workforce development**
  - Training and development for social care provider staff
  - Joint workforce planning across all sectors

- **Data, IT and technology**
  - Linked health and social care data sets
  - Access to the care record and secure email
  - Better use of technology in care homes
Engaging with people in care and assisted living
LEAF -7

A person centred approach to valuing people by understanding Quality of Life
Dementia Care Mapping

• Observational Tool developed by Bradford University
• Five mapping exercises completed
• Outcomes
  • Highly productive staff feedback sessions in 4 care homes resulting in
    • Constructive discussion around key issues and individuals
    • Review of individual care plans to address observed behaviours
    • Changed working practices
      • Focus on activity and resource around key periods of the day
      • Commitments to build observation into working day for staff
  • Does not work in Assisted Living – has to be in a group situation over prolonged period
Portrait of a Life
Wakefield District Housing
Tilly & Archie
Intergenerational Activities
### Outcomes - Care Homes Data

<table>
<thead>
<tr>
<th>Activity</th>
<th>Reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Admissions</td>
<td>19% reduction</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>12% reduction</td>
</tr>
<tr>
<td>Ambulance call outs</td>
<td>9% reductions</td>
</tr>
</tbody>
</table>

- This data compares our 15 care homes within the vanguard against the other 73 homes in Wakefield.
- This data includes December 2016 figures (YTD).
“The big community secret is that self care already exists.... our role in organisations is to see it, value it and to connect and support it”
Professor Don Berwick after visiting Wakefield 18 January 2017 commented:

“The passion that these people feel for that mission is truly extraordinary and they are getting results. Today we have seen some results in reduction of A&E use, reduction of hospital bed day use. They prove that compassionate, team-based, patient centred care in the care home setting can enrich lives and preserve health.”
Airedale Vanguard
Service, Benefits, Learning and Opportunities Jan 2017

With thanks to Martin Ford
Vanguard Programme Manager
Digital Health

- Telecare
- Telecoaching
- Telemonitoring

✅ Teleconsultation
right care today

Teleconsultation
- Prison health care
- Care at home
- Nursing & residential care
- Supporting end of life patients
- 24/7 clinical hub
- improving patient experience
- changing patient flow
- reducing costs

Electronic shared record
- connecting primary & secondary care now
- connecting whole health & social care economy tomorrow
Telemedicine Service

- Teleconsultation by secure video link between nursing and residential homes and the Airedale Digital Hub
- Hub based at Airedale Hospital staffed by team of senior clinicians 24/7
- Triage and assessment of all requests for GP visits in hours (GP Triage)
- Fully managed technical service utilising bespoke lap tops with HD cameras and with 4G SIM or Broadband
Service Benefits

- Enables residents to remain in their care home
- Supports safe, effective high standards of care
- Supports care/nursing staff and residents in the planning and delivery of care
- Reduces inappropriate demand on GPs, Ambulance and Non elective care
- Effective, informed and trusted onward referral
- Full electronic recording and messaging
- Clear governance and accountability
Impact ...

"THE GOOD NEWS IS, PROFITS ARE UP 74%, THE BAD NEWS IS, WE DON'T KNOW WHY."
## Airedale Telemedicine Studies & Reports
(Report used in impact forecast highlighted)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Date</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthwatch</td>
<td>2016</td>
<td>Telemedicine in Care Homes: A Qualitative Evaluation</td>
</tr>
<tr>
<td>NHS England</td>
<td>2016</td>
<td>Top 100 Care Homes Ambulance Conveyance</td>
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<tr>
<td>SS CCG</td>
<td>2016</td>
<td>Care Home Innovation Programme (CHIP)</td>
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<tr>
<td>Lancashire County Council</td>
<td>2016</td>
<td>Analysis of NWAS call outs to care homes – older people service user category</td>
</tr>
<tr>
<td>East Lancashire District North West Ambulance Service</td>
<td>2015</td>
<td>NWAS Cost savings per care home data</td>
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<tr>
<td>Airedale Digital Hub</td>
<td>2016</td>
<td>Audit of 30 GP referrals for Pendle Care Homes</td>
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<td>Bain &amp; Co</td>
<td>2016</td>
<td>Detail to support development of Vanguard Hypothesis Generation</td>
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<td>Airedale Vanguard</td>
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<td>Value Proposition</td>
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<td>AWC CCG/ANHSFT</td>
<td>2015</td>
<td>AWC Review of case notes to assess effectiveness of TM</td>
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<td>Airedale Digital Hub</td>
<td>2016</td>
<td>Telehealth Jan 2016 current awareness</td>
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<td>YHEC</td>
<td>2015</td>
<td>Telemedicine Service Evaluation and Economic Modelling</td>
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<td></td>
<td>2016</td>
<td>Telemedicine in care homes in AWC. Clinical Governance</td>
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<tr>
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<td>2016</td>
<td>Evaluation of a Pilot project for the implementation of TM in CH in Bradford</td>
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</table>
Care Homes in Bradford and Airedale circa 130 homes Impact Warning data not yet validated

A wide range of home installation dates are all aligned as month 0

Number of A&E attendances before and after telemedicine

Demonstrates circa 33% reduction in A&E attendances 12 months after installation
Care Homes in Bradford and Airedale circa 130 homes Impact Warning data not yet validated

A wide range of home installation dates are all aligned as month 0

Demonstrates circa 25% reduction in admissions via A&E 12 months after installation
"Of all the changes in the 15 years I have been working this is the greatest change which has reduced workload I can remember. I don't mind the extra "late" duty doc visit as this is more than made up in the drop in other visits. A big thank you to all involved."
Innovation potential

“The innovation that telemedicine promises is not just doing the same thing remotely that used to be done face to face, but awakening us to the many things that we thought required face to face contact, but actually do not.”

David D Asch MD, MBA, Perelman School of Medicine, University of Pennsylvania
Delivery into patient’s own home – Potential Opportunity for significant impact across West Yorkshire

- Identification of patients at high risk of hospital admission or readmission
- Proactive Digital Hub care management via care plans
- Linked to Community Nursing and GP care
- Move equipment between high risk patients at 6 week intervals to improve cost effectiveness
- Potential for tele monitoring engagement
- Potential for prescribing enhancement
- Reduce unnecessary 999 and 111 demand, reduce inappropriate GP call outs, reduce inappropriate admission rates
- Improve Patient care