HFMA Webinars

ICS Stories: Integrated care in Humber, Coast and Vale ICS

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Chaired by Lisa Robertson, Policy and Research Manager, HFMA.

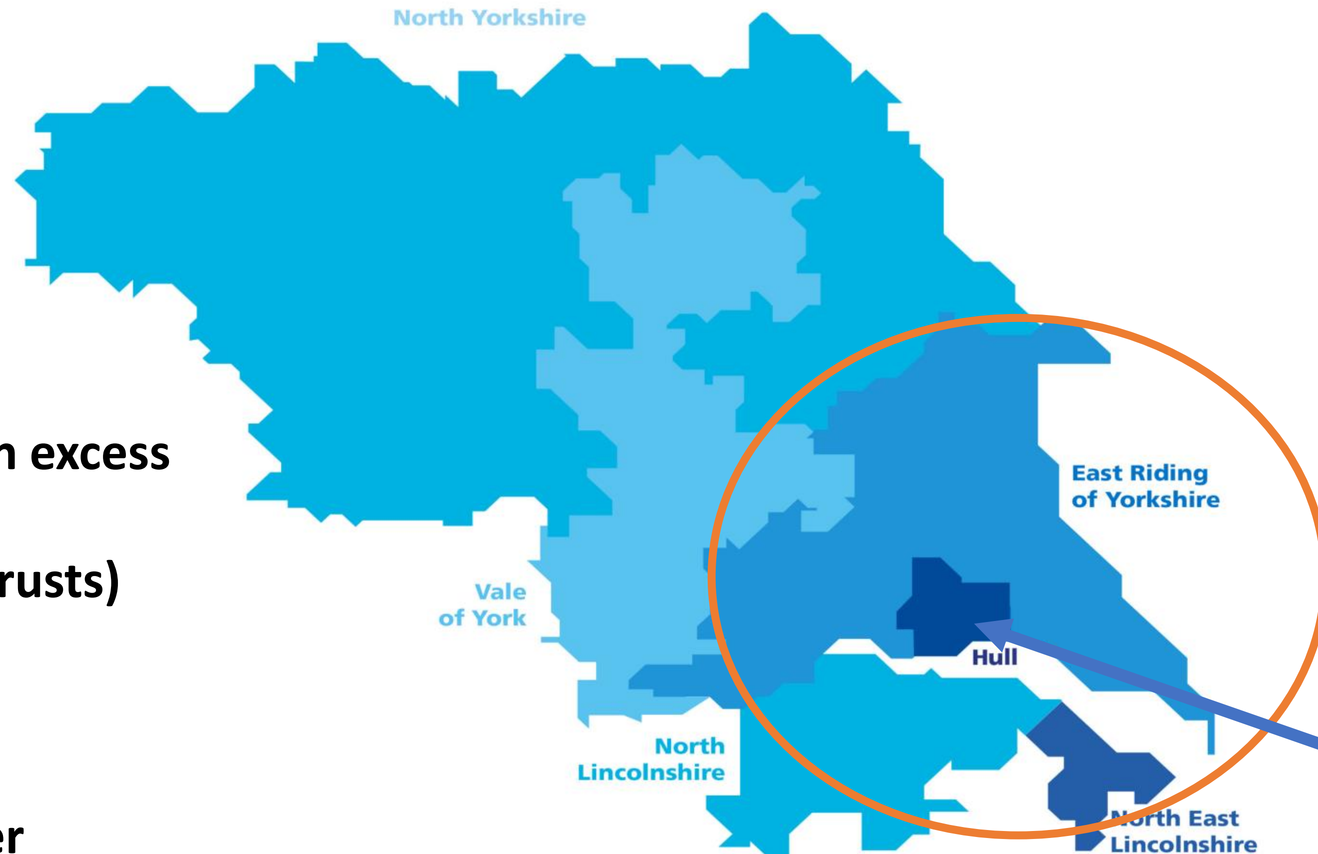
15 October 2021 - 13:30-14:30

Redesigned Community Frailty Model
The Jean Bishop Integrated Care Centre

Introduction

Hull CCG's strategy is to manage the challenges faced by the whole system for an ageing population in a manner that promotes independence, physical and mental well-being, prevents patient deterioration, supports carers, and safely delivers appropriate care in the community setting

Our System



- 1000 square miles
- Serves a population in excess of 700,000
- 5 Acute Hospitals (3 trusts)
- 12 PCNs
- 2 local authorities
- 2 CCGs
- 1 Community provider
- 1 Mental health provider
- 1 Ambulance trust

Background / Strategic Drivers

- Requirement to move from an individual provider focus to a system-wide perspective
- Quality issues for the frail elderly (‘System’ over-reliance on hospital care / complex pathways which were difficult to navigate, so patients default to hospital)
- Ageing population
- Workforce issues

To do nothing was not an option,

the system would neither cope operationally or financially

Enablers

- Business Case based on an Aligned Incentive Contract with the acute trust
- Assumption that there will be a return on investment

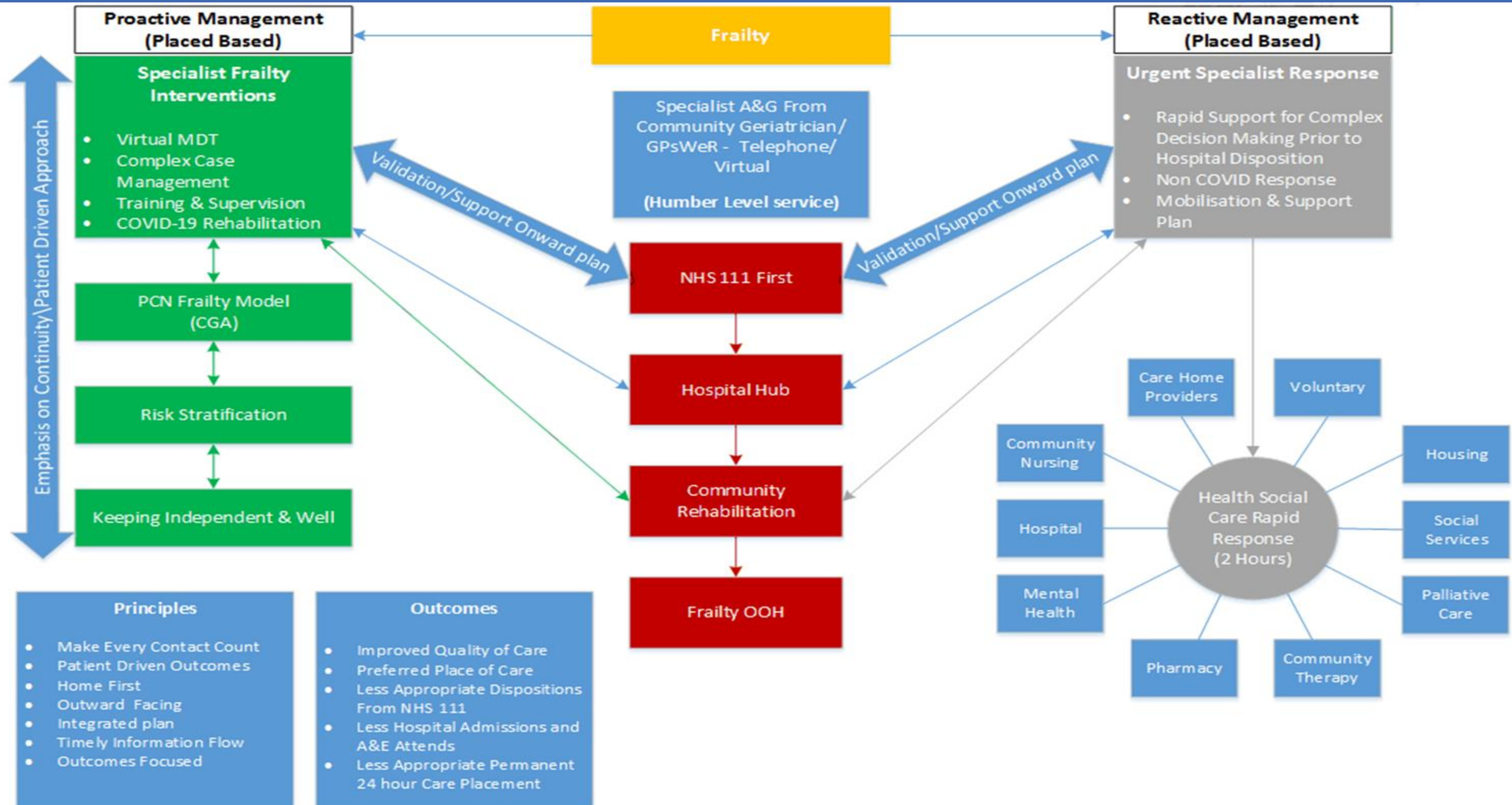
2018-20: The Jean Bishop Integrated Care Centre Ambition

- Address health and social care **inequalities**
- Deliver **out of hospital** care
- Strengthen collaborative **partnerships**
- **Share** skilled multi-disciplinary workforce
- Empower individuals and **communities** to promote and support improving ageing well
- Shifting the focus of delivery to **early help** and prevention
- Integrated care that is **responsive** to support older people with urgent care needs or in crisis to stay at home
- Enhanced health in **care homes**
- Improve wellbeing and focus on **person centred care**
- **Prevent or reduce** demand for acute and social care services
- **Sustainable** health and social care provision in the city
- **Continuously evaluate** and refine the model

Where did we start

- Governance infrastructure
- Experienced managerial leadership
- Clinical Leadership (given the head space)
- CCG new financial models
- Willingness to take a risk
- Phased approach

Shared Vision



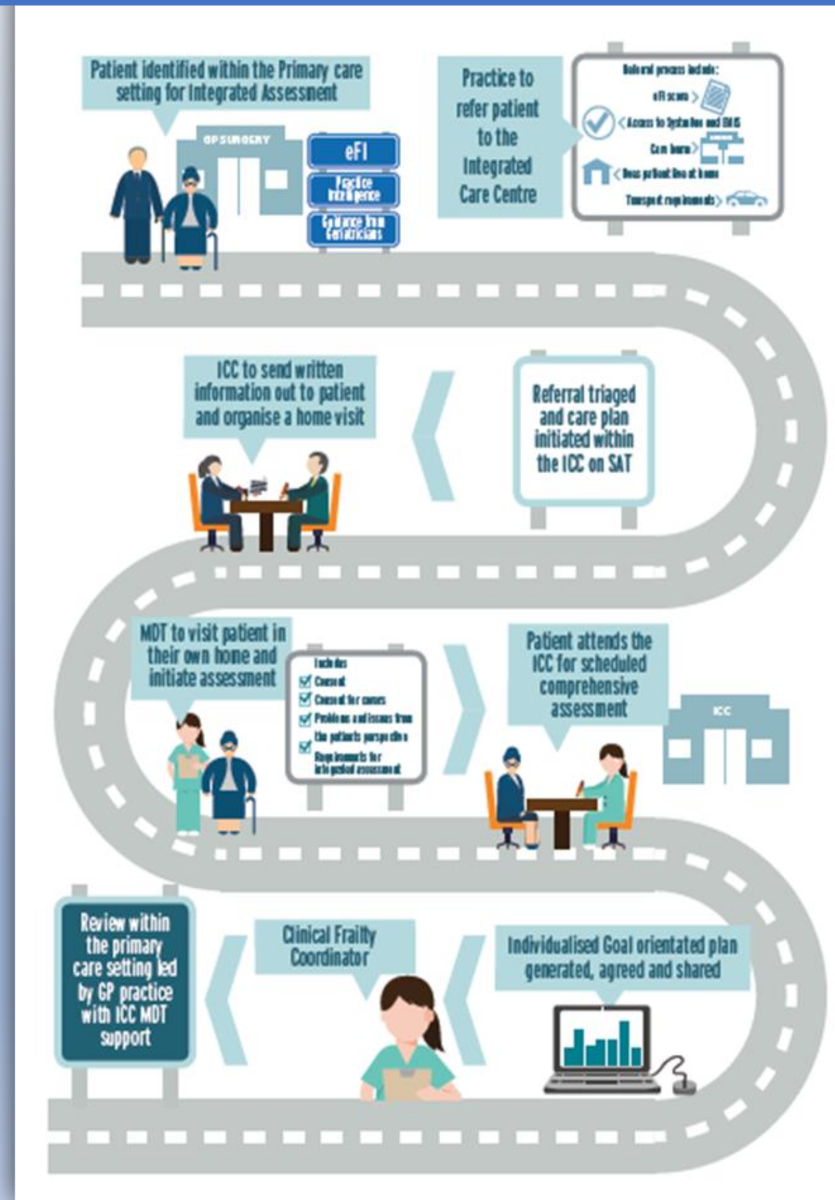
Phased Approach

- 2018-20: The Jean Bishop Integrated Care Centre
  Our Approach to Anticipatory Integrated Care
- 2020-21: Responsive pathway
- 2021-Beyond: Future care model and digital opportunities

Who is involved in our Integrated care centre?

- Senior Responsible Officer
- Consultant Community Geriatricians
- Social Workers
- Specialist GPwER
- Medicines Management team
- Occupational Therapists
- Advanced Nurse Practitioners
- Physiotherapists
- Voluntary organisations
- Carers Support Service
- Care Home providers
- Mental Health Practitioners
- Fire and Rescue Falls team
- Community Support Workers

Pathway for Access to the Integrated Care Centre (phase 1)



March 2020 - Phase 2: Planned next steps

- Year 2 of CGA at ICC: eFI Moderately frail
- Managing Demand
- Rapid access slots – Hospital and community
- Care Homes
- Ongoing specialist MDTs
- Dementia/Older People's Mental health Hub

- 223 care homes
  - **6500 residents** (vast majority frail regardless of age)
- Using Electronic Frailty Index (eFI)
  - >24,000 residents moderately / severely frail
- Limited advance care planning to date

2020-21:Rapid service redesign during COVID

- **Hull and East Riding (previously just Hull)**
- **Anticipatory care**
  - Ceased in wave 1
  - On-site social care staff redeployed to support acute discharge model
- **Reactive care**
  - Frailty Support Team (ICC-FST)
  - 3 work-streams
    - Specialist Frailty Advice and Guidance Line
    - Care Homes Outbreak support
    - Community Beds Response
- **Operational 7 days/week**

How we Responded

- **Guidance**
- **Operational Model**
- **Technological Solutions**
- **Dashboard**
- **Evaluation**

Proactive and Reactive - What have we achieved?

- Reduced duplication
- **Integrated** care records
- Adopted **Home First** principles - moved specialist provision **closer to home**
- Reduced emergency **attends and admissions**
- **Increased** utilisation of step up community bed capacity
- Created new pathway for **paramedic support** at the scene
- **Reduced costs** of medication
- Shared learning and **understanding** of different roles and responsibilities
- Created a **can do** culture
- Feeling of belonging – **a shared identity** / hub of excellence / pride
- **Co location** has nurtured the ICC vision and kept it person centred
- **Supported** carers

Hull's frail residents have improved outcomes
Demand for Health Care is being managed

LTC + CFS 6-7	ED attends	ED admissions	Length of Stay
COPD	-16%	-19%	-45%
Dementia	-15%	-28%	-49%
Palliative Care	-29%	-22%	-51%
Diabetes	-36%	-30%	-47%

>10% reduction in GP appointments

>10% reduction in ED attendance and emergency admissions

>50% reduction in ED attends and admissions for Frequent flyers

Average saving on drug costs: £100/patient/yr

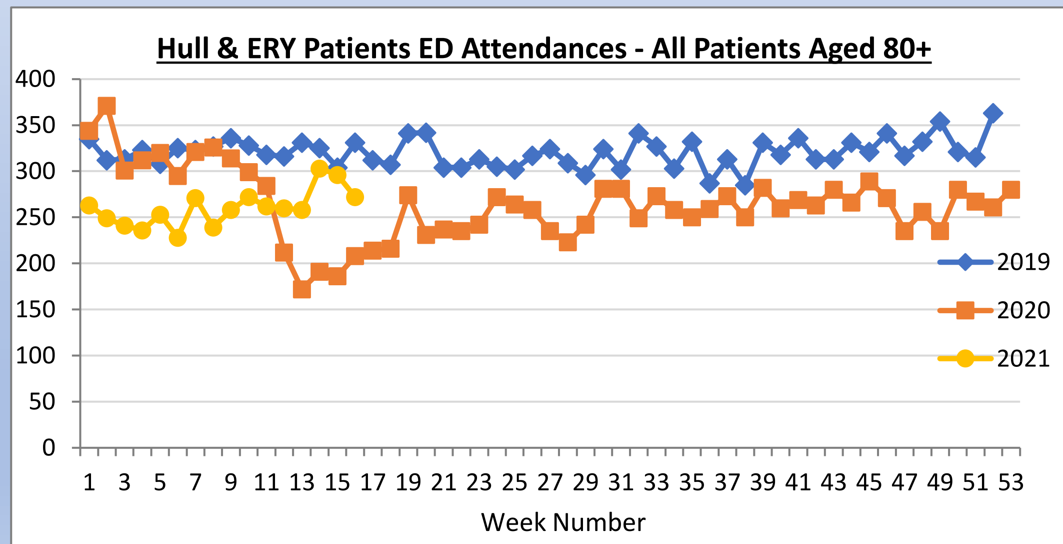
Data is driving the change process

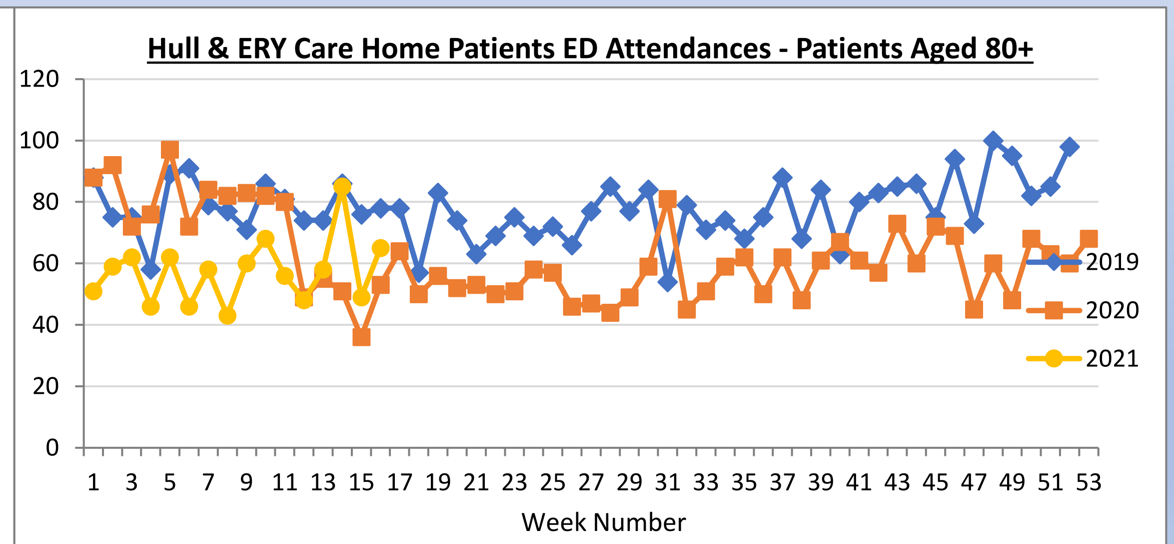
Patients, their families and carers, say the care they've received has changed their lives

Outcomes

- > 6700 calls to the Specialist frailty advice and guidance line
- Sustained reduction in unnecessary ED attends and hospital admissions
- Increased utilisation of "step-up" admission to community rehabilitation beds
- Low conveyance rates for paramedics using the advice and guidance line
- Preferred place of death achieved for 94% of patients who sadly died of COVID-19
  - National average: 47.8% (ONS,2020)

- **YAS Deputy Chief Executive:** "Our rate of conveying patients to hospital after being attended by a paramedic is currently at its lowest ever point and it looks like this service is likely to be playing a positive part in enabling that in the area"





Next Steps

- Hub and Spoke model (Humber)
  - Place based teams operating to same principles and outcomes
  - Clinical Support across ICS
- TBYW expansion
- 2hr community crisis response & SDEC
- D2A – virtual wards
- Ageing well and frailty education and training hub
  - ICS
  - Care homes (ReSTORE 2 mini)
  - PCN frailty teams

Critical Success Factors

- **Leadership** – dedicated to the delivery of the shared vision, resilient and with credibility
- **Relationships** – mutual respect for different professions / codes of practice / legislation / roles and responsibility
- **Trust** – systems, processes, sharing information, each other
- Involve and **include everyone** – many professions, several organisations, **1 team**
- Stop thinking organisations and **think people**
- Create a **shared purpose** and goals that meets principles of health and social care
- **Be brave**, be involved, be confident
- Honest, transparent communication at all levels, Make sure **everyone is heard**
- Start with **small steps** build on success before expanding
- Embrace **Digital solutions**

Lessons Learned

- It’s not easy
- No good if a quick fix is required
- You need your best people in service transformation
- Its really not all about money
- Clinical Engagement and buy in critical to success be clear at the outset about what you are trying to do
- Importance of analytical support for data to drive service changes

Thanks for listening

Further information:

- The Concept: The Jean Bishop Integrated Care Centre - YouTube
- Patient Experience: The Jean Bishop Integrated Care Centre, Hull - Ray's story – YouTube
- Ambulance service: Frailty Response Line, Hull & East Riding - aace.org.uk
- Yorkshire & Humber AHSN: Understanding-our-response-to-COVID-19-report-singles.pdf (humbercoastandvale.org.uk)