Humber, Coast and Vale Health and Care Partnership Stakeholder Engagement Event

15th August 2019

Agenda

Welcome and setting the scene	Andrew Burnell	1:10 to 1:30
Update on York and Scarborough ‘Places’	Phil Mettam	1:40 to 2:10
Interactive workshops – session 1		2:15 to 2:45
Tea, coffee and networking		2:45 to 3:15
Interactive workshops – session 2		3:15 to 3:45
Interactive workshops – session 3		3:50 to 4:20
Close	Phil Mettam	4:20 to 4:30

Purpose of today's event

- Providing information about the Partnership and how it is developing;
- Sharing our vision and aims;
- Gathering your feedback and views on our Partnership Long-term Plan and what should be included.

Health and Care in Humber, Coast and Vale

3 acute hospital trusts (operating across 8 sites)

3 mental health trusts

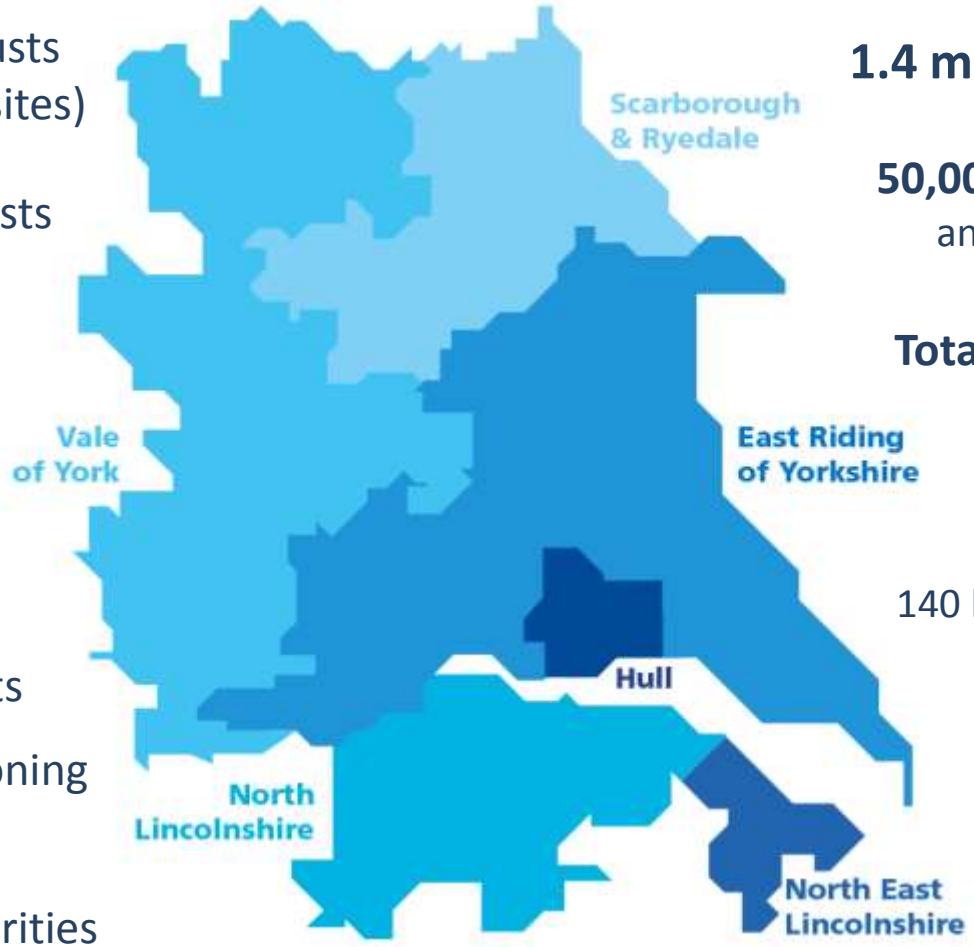
5 community services providers

29 Primary Care Networks (190 GP practices)

2 ambulance trusts

6 Clinical Commissioning Groups (CCGs)

6 Local Authorities



1.4 million people

50,000 staff across health and adult social care

Total budget of £3.0bn

450 care homes

140 home care companies

7 hospices

1000s of voluntary and community sector organisations

Partnership Vision

- We want everyone in our area to:

start well, live well and age well

- To achieve this we are working hard to create a health and system that supports everyone's health and wellbeing and that is there to help when people need it.

- We want to become a **health improving system** rather than an **ill-health treating system**.

Partnership Priorities

Helping people to stay well

Integrating and improving ‘out of hospital’ care

Creating the best hospital care

Improving services in priority areas including cancer and mental health

Deploying resources effectively – workforce, IT, buildings and equipment

Making the most of every penny to deliver good quality local services within the funding available

Partnership Operating Levels

Partnership Collaborative Programmes

Place and Sub-System Collaboration

- East Riding
- Hull
- North Lincs
- North East Lincs
- Scarborough
- York

At Scale Collaboration

Strategic Developments

1. Humber Acute Services Review
2. Scarborough Acute Services Review
3. Commissioning Review

System Resources

1. Workforce
2. Digital
3. Estates and Capital Investment
4. Finance
5. Population Health Management and Analytics
6. Quality Improvement

Clinical Priorities

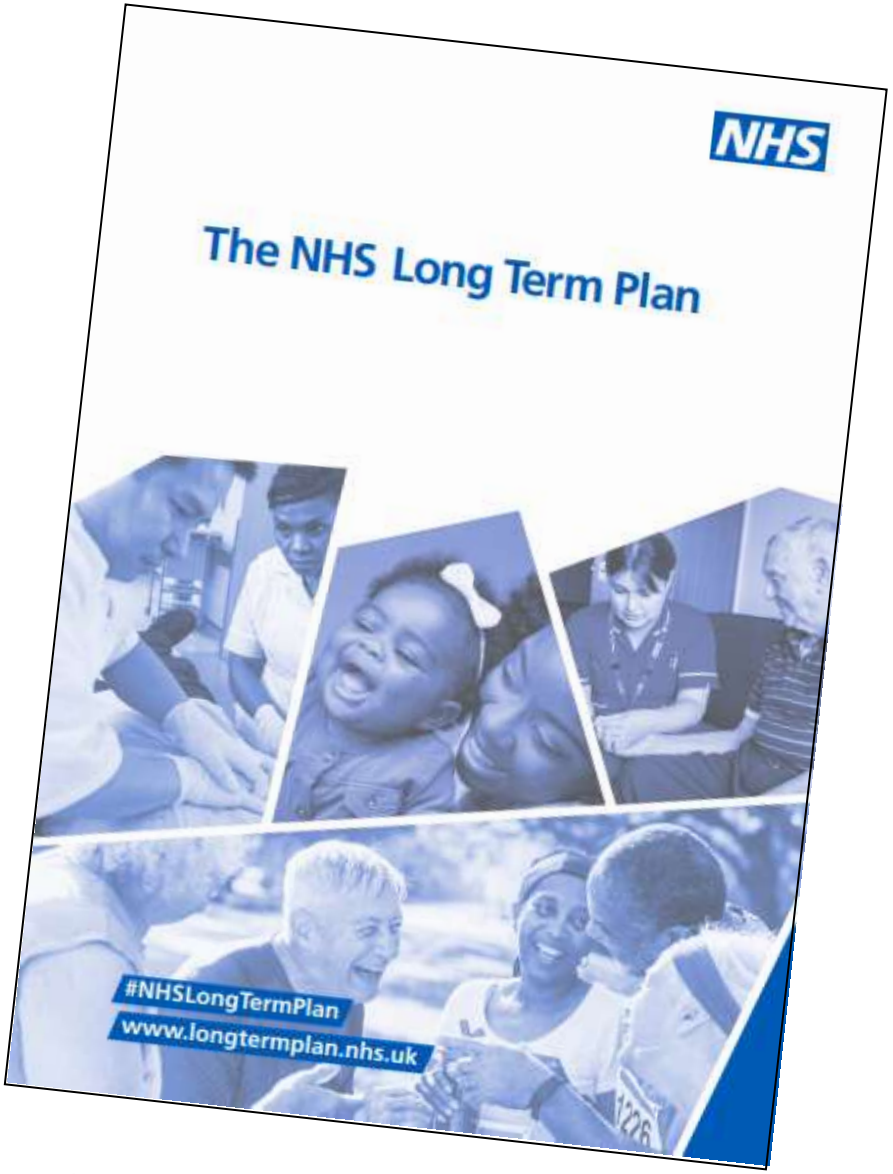
1. Cancer
2. Mental Health
3. Urgent and Emergency Care
4. Elective Care
5. Primary Care
6. Maternity
7. Diagnostics

Some of our successes so far…

- Wave 4 Capital bid - £88.6m secured for A&E improvements and diagnostic equipment
- Collaborative approach to planning and contracting has improved relationships in the Partnership
- Clinical programme achievements, e.g.
  - Over 1,100 Cancer Champions trained
  - Child and Adolescent Mental Health (CAMHS) new inpatient unit
  - Developed perinatal community specialist services
  - Significant reduction in 52 week waits
  - Launched National Diabetes Prevention Programme

Why are we here today?

- NHS Long Term Plan
- All local Partnerships to produce their own system plans
- Our plan will be built around our existing collaborative programmes and work at place



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Shaping future care, together

The NHS Long Term Plan set out how we will invest the funding commitment from government

- Do things **differently, through a new service model**
- Take more action on **prevention** and **health inequalities**
- Improve **care quality and outcomes** for major conditions
- Ensure that **NHS staff** get the backing that they need
- Make better use of **data** and **digital technology**
- Ensure we get the most out of **taxpayers' investment** in the NHS

Population health priorities 2019-20

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- Cardiovascular disease
- Cancer
- Mental health and depression
- Obesity
- Alcohol related attendances

Locally focused priorities

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North	South	Central (York)
▪ Clinical pharmacist investment ▪ Care coordinator to support cancer and frailty agenda and MDT ▪ Explore shared records and single point of data entry ▪ Shared learning ▪ Dementia ▪ Frailty and Anticipatory care planning – including care home work programme ▪ Cancer ▪ Long term conditions ▪ Reducing inequalities ▪ Children's services work stream	▪ Social prescribing link worker and clinical pharmacists ▪ Advanced nurse practitioner to focus on care homes ▪ Shared learning ▪ Dementia ▪ Frailty and Anticipatory care planning – including care home work programme ▪ Long term conditions ▪ Reducing inequalities	▪ Social prescribing ▪ Clinical pharmacists ▪ Practice resilience primary care model ▪ Broadly similar clinical priorities as North and South locality

Guiding principles

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Right person - Right care - Right time - Right first time	**Patients**
Identification, Communication, Shared responsibility, Learning	**Clinicians and professionals**
Six principles of achieving integrated care ▪ Collaborative leadership ▪ Subsidiarity ▪ Building on what already works locally ▪ A person-centred approach ▪ A preventative, assets-based, population health approach ▪ Achieving best value	**System**

Anticipatory Care

- Programmes that prevent or postpone illness and promote health
- Self-management
- Triage and referral to right provider
- Right medical care
- Comprehensive chronic disease management

Making it work

Engaging, up-skilling and supporting patients to address their diseases and optimise care in order to reduce exacerbations that lead to unplanned hospitalisation

SHIFT

- focus of care
- ways of working
- location of care
- impact
- evidence that it works

- improved patient outcomes
- clinical productivity
- better management of hospital admissions

Making the change happen

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A different workforce	**Creating authority at a local level**
Advanced care planning	**Sharing / managing the risk**
Influencing communities	**Making time for conversations**
IT connectivity	**Bed capacity (in and out of hospital)**
Multidisciplinary Teams	

Making decisions based on evidence

Evidence of reduction in activity and whole-system costs		
Most positive evidence	Emerging evidence	Mixed evidence
▪ Improved GP access to specialist expertise ▪ Paramedic triage in community ▪ Condition-specific rehab ▪ Additional clinical support in care homes ▪ Remote monitoring of some LTCs ▪ Support for self-care	▪ GP continuity of care ▪ Extensivist model of care for high risk patients ▪ Social prescribing ▪ Senior assessment in A&E ▪ Rapid access clinics for urgent specialist assessment	▪ Peer review and audit of GP referrals ▪ Shared decision making to support treatment choices ▪ Shared care models for chronic disease management ▪ Direct access to diagnostics for GPs ▪ Intermediate care: rapid response services ▪ Intermediate care: bed based services ▪ Hospital at Home ▪ Case management and care coordination ▪ Virtual ward

Shaping future care together

Long Term Plan investment priorities

Doing things differently through a new service model	Take more action on prevention and health inequalities	Improve care quality and outcomes for major conditions
Ensure that NHS staff get the backing that they need	Make better use of data and digital technology	Ensure we get the most out of taxpayers' investment in NHS

Locally focused priorities for 2019-20

	North	South	Central
Vale of York population health priorities	**CVD, cancer, depression, obesity, alcohol related attendances**		
	▪ Clinical Pharmacist investment ▪ Care co-ordinator to support cancer and frailty agenda and MDT ▪ Explore shared records and single point of data entry ▪ Shared learning ▪ Dementia ▪ Frailty and Anticipatory care planning – including care home work programme ▪ Cancer ▪ Long term conditions ▪ Reducing inequalities ▪ Children's services work stream	▪ Social prescribing link worker and Clinical pharmacists ▪ Advanced nurse practitioner to focus on care homes ▪ Shared learning ▪ Dementia ▪ Frailty and Anticipatory care planning – including care home work programme ▪ Long term conditions ▪ Reducing inequalities	▪ Social prescribing ▪ Clinical pharmacists ▪ Practice resilience primary care model ▪ Broadly similar clinical priorities as North and South locality

Vale of York priorities for 2020-21

Investment and impact fund - support for:

- Reducing A&E attendances
- Reducing emergency admissions
- Improving hospital discharge
- Reducing outpatient appointments
- Improving prescribing

Guiding principles

Right person - Right care - Right time - Right first time	**Patients**
Identification – Communication - Shared responsibility - Learning	**Clinicians and professionals**
Six principles of achieving integrated care Collaborative leadership Subsidiarity Building on what already works locally A person-centred approach A preventative, assets-based population health approach Achieving best value	**System**

Anticipatory Care

- Programmes that prevent or postpone illness and promote health
- Self-management
- Triage and referral to right provider
- Right medical care
- Comprehensive chronic disease management

Making it work

Engaging, up-skilling and supporting patients to address their diseases and optimise care in order to reduce exacerbations that lead to unplanned hospitalisation

SHIFT

- focus of care
- ways of working
- location of care
- impact
- evidence that it works

- improved patient outcomes
- clinical productivity
- better management of hospital admissions

Making the change happen

- A different workforce
- Advanced care planning
- Influencing communities
- IT connectivity
- MDT
- Proactively supporting subsidiarity (creating authority at a local level)
- Sharing / managing the risk
- Time for conversations
- Bed capacity (in and out of hospital)

Evidence of reduction in activity and whole-system costs

Most positive evidence	Emerging evidence	Mixed evidence
▪ Improved GP access to specialist expertise ▪ Paramedic triage in community ▪ Condition-specific rehab ▪ Additional clinical support in care homes ▪ Remote monitoring of some LTCs ▪ Support for self-care	▪ GP continuity of care ▪ Extensivist model of care for high risk patients ▪ Social prescribing ▪ Senior assessment in A&E ▪ Rapid access clinics for urgent specialist assessment	▪ Peer review and audit of GP referrals ▪ Shared decision making to support treatment choices ▪ Shared care models for chronic disease management ▪ Direct access to diagnostics for GPs ▪ Intermediate care: rapid response services ▪ Intermediate care: bed based services ▪ Hospital at Home ▪ Case management and care coordination ▪ Virtual ward

£ - Returning the system to balance

Indicators	PCH1	PCH2	PCH3	PCH4	PCH5	PCH6	England
Income deprivation - English Indices of Deprivation 2015 (%)	6.5	9.8	5.5	9.8	6.8	12.3	14.6
Low Birth Weight of term babies (%)	2.1	2.6	1.6	2.4	2.3	2.2	2.8
Child Poverty - English Indices of Deprivation 2015 (%)	6.8	15	5.2	20.9	8.9	17.2	19.9
Child Development at age 5 (%)	66.4	61	69.2	56.7	67.4	65.7	60.4
GCSE Achievement (5A*-C inc. Eng & Maths) (%)	68.6	51.3	75	58.8	64.4	52.5	56.6
General Health - bad or very bad (%)	4.3	4.2	4.2	3.6	3.9	4.5	5.5
General Health - very bad (%)	0.9	1	1	0.8	0.8	1	1.2
Limiting long term illness or disability (%)	17.9	14.1	15.7	12.8	16	15.2	17.6
Overcrowding (%)	2.5	11.9	6.6	11.5	2.3	8.6	8.7
Provision of 1 hour or more unpaid care per week (%)	10.9	7.8	9.9	7.5	11.1	8.1	10.2
Provision of 50 hours or more unpaid care per week (%)	2	1.5	1.8	1.6	2.3	1.6	2.4
Pensioners living alone (%)	30.3	37.2	28.9	37.6	26.8	39.3	31.5
Older People in Deprivation - English Indices of Deprivation 2015 (%)	8.5	14.7	8.8	14.1	8.3	16	16.2
Deliveries to teenage mothers (%)	0	1.6	0.8	1.9	1.7	1.6	1.1
Emergency admissions in under 5s (Crude rate per 1000)	196.3	176.3	160.4	193.4	165.7	183.2	149.2
A&E attendances in under 5s (Crude rate per 1000)	400.6	491.4	362	481.1	347.8	404.6	551.6
Admissions for injuries in under 5s (Crude rate per 10,000)	129.3	151.9	100.6	147.1	122.6	148.1	138.8
Admissions for injuries in under 15s (Crude rate per 10,000)	105.5	111.3	74.6	111.5	97.9	108	108.3
Admissions for injuries in 15 - 24 year olds (Crude rate per 10,000)	156.8	115.6	104.1	80.5	117.9	164	133.1
Obese adults (%)	25.5	22.3	20.2	21.2	24.3	23.8	24.1
Binge drinking adults (%)	23.7	33.9	29	33.5	26.6	32.1	20
Healthy eating adults (%)	28.8	27.1	31.3	27.5	29.3	26.3	28.7
Obese Children (Reception Year) (%)	5.8	7.9	7.7	9.1	7.9	8.8	9.3
Children with excess weight (Reception Year) (%)	17.8	23.1	19.6	22.9	21.2	22.9	22.2
Obese Children (Year 6) (%)	13.9	18	12.9	18.8	12.3	17.5	19.3
Children with excess weight (Year 6) (%)	26.8	31.6	28	32.1	25	30.6	33.6
Emergency hospital admissions for all causes (SAR)	100.6	104.1	86.5	91.4	90.3	105.8	100
Emergency hospital admissions for CHD (SAR)	102.1	101.7	100.8	107.4	81.4	104.2	100
Emergency hospital admissions for stroke (SAR)	93.2	90.4	93.5	88.6	91.9	103.5	100
Emergency hospital admissions for MI (heart attack) (SAR)	105.7	116.9	111	129.9	95.7	118	100
Emergency hospital admissions for (COPD) (SAR)	69.2	116.9	65.5	96.6	67.2	128.9	100
Incidence of all cancer (SIR)	94.7	98.9	98.4	99.2	100.8	99.3	100
Incidence of breast cancer (SIR)	94.4	94.3	97	99.9	100	93	100
Incidence of colorectal cancer (SIR)	109.8	99.2	113.2	115.5	107.9	102.9	100
Incidence of lung cancer (SIR)	88.1	110.8	90.6	87.2	73.9	106.5	100
Incidence of prostate cancer (SIR)	96.4	85.6	98.1	92.2	112.9	92.9	100
Hospital stays for self harm (SAR)	109.3	128.7	98.4	103.2	88.7	134.7	100
Hospital stays for alcohol related harm (SAR)	89	107.4	82.6	86.9	84.8	108.6	100
Emergency hospital admissions for hip fracture in 65+ (SAR)	102.6	106.5	91.9	107.1	87.6	99.4	100
Elective hospital admissions for hip replacement (SAR)	138.5	114.7	141.1	111.9	131.9	116	100
Elective hospital admissions for knee replacement (SAR)	107.2	101.8	94.9	114.7	100.3	105	100
Deaths from all causes, all ages (SMR)	90.5	108.8	104.3	97.7	85.7	105.1	100
Deaths from all causes, under 65 years (SMR)	75.7	113.9	79.1	118.3	81.6	107.3	100
Deaths from all causes, under 75 years (SMR)	79.5	115.9	81.2	113.1	80	110.8	100
Deaths from all cancer, all ages (SMR)	87.5	108	97.7	106.5	96.8	105.7	100
Deaths from all cancer, under 75 years (SMR)	84.2	118.8	84.1	123.7	97.4	102.8	100
Deaths from circulatory disease, all ages (SMR)	96.4	108.9	121.4	104.9	90.8	104.9	100
Deaths from circulatory disease, under 75 years (SMR)	80.2	113.6	84.3	115.6	72.9	98	100
Deaths from coronary heart disease, all ages (SMR)	94.5	95.2	128.7	120.7	88	111.2	100
Deaths from coronary heart disease, under 75 years (SMR)	72.3	113.6	87.1	119	74.5	97.3	100
Deaths from stroke, all ages (SMR)	109.4	125.3	138.3	86	91.9	99.9	100
Deaths from respiratory diseases, all ages (SMR)	87.4	113	95.6	90.8	82.9	121.8	100

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Developing our Partnership Long-term Plan

- 6 hubs
- 30 minutes per hub
- Number on your name badge tells you which workshops to go to when
- Comfort break at 2.45pm – opportunity to visit other hubs

Close