Item: 7.3

Report to:	NHS Hull Clinical Commissioning Group Board
Date of Meeting:	23 November 2018
Title of Report:	Jean Bishop Integrated Care Centre Interim Evaluation Update
Presented by:	Erica Daley, Director of Integrated Commissioning
Author:	Lesley Windass, Head of Transformation

STATUS OF THE REPORT:

To approve		To endorse	x
To ratify		To discuss	
To consider		For information	
To note	x		

PURPOSE OF REPORT:

This report will provide the board with an interim evaluation update following the opening of the Jean Bishop Integrated Care Centre in May 2018, share plans for phase 2 and outline risks and management approach to overcome issues of concern.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No [x] Yes [ ]

If yes, detail grounds for exemption

CCG STRATEGIC OBJECTIVE

- Clinically led development for improving the quality of life and value for money.
- Ensures active engagement and empowerment of patients, ensuring that quality is at the centre.
- Proactive approach.
- Joint initiative between the local authority and health.
- A pathway which integrates primary and secondary care.
- Optimises opportunities to redesign current services and builds on the transformation work already undertaken to redesign the community frailty pathway
- Tackling inequalities for residents of care homes.

IMPLICATIONS:	
Finance	Finance and activity implication addressed with the paper and subject to ongoing monitoring and evaluation
HR	Nothing to note , workforce covered in the paper
Quality	As above
Safety	Nothing to note outside of the paper

ENGAGEMENT: Programme structure ensures active engagement at operational and strategic level of all key stakeholders with an emphasis on patient outcomes and experience.

LEGAL ISSUES: Nothing to note

EQUALITY AND DIVERSITY ISSUES: (*summary of impact, if any, of CCG's duty to promote equality and diversity based on Equality Impact Analysis (EIA).* ***All*** *reports relating to new services, changes to existing services or CCG strategies / policies* ***must*** *have a valid EIA and will not be received by the Committee if this is not appended to the report*)

Done previously. Not Applicable for this report	***Tick relevant box***
	NA
	NA
	NA

THE NHS CONSTITUTION:

Patients are engaged and empowered, regardless of the home setting to work with the Multidisciplinary team, to take active steps to improve the quality of their lives

JEAN BISHOP INTEGRATED CARE CENTRE UPDATE

1. INTRODUCTION

This report will provide an update to the board on progress and ongoing evaluation in the first 6 months since the opening of the Jean Bishop Integrated Care Centre in May 2018.

The report will comprise of the following :

- An update on evaluation and methodology
- Interim reporting on Phase 1 of delivery
- Plans and objectives for Phase 2

2. BACKGROUND

The CCG identified that due to predicted demographics for the aging population, the system's over reliance on hospital care and ongoing workforce issues there was a necessity to embark on a fully integrated Community Frailty Transformation programme.

Following extensive consultation, the CCG Board approved a business case to build and deliver services from a purpose-built facility that would function as the "central clinical hub for frailty and integrated care". The hub would bring all strands of work together across a frailty pathway moving from an individual provider focus to a system-wide perspective.

The mobilisation of services for Phase 1 was written into the existing contract for the provision of community services with City Healthcare Partnership (CHCP). In addition to which the Aligned Incentive Contract (AIC) with Hull and East Yorkshire Hospitals NHS Trust (HEY), was agreed enabling the CCG to utilise an allocation increase to invest in out of hospital care.

A key objective was implementation of risk stratification using the Elderly Frailty Index tool (eFI) to identify patients in primary care and initiate proactive, rather than reactive care. Primary care transformation funding was utilised to facilitate this process alongside the redesign of pathways to deliver a modernised, integrated service model for frail patients with complex needs which would address the multifactorial requirements of those at risk.

In recognition of the complexity of the challenge there was agreement for a planned, phased approach to the programme, with active leadership from commissioners. An experienced strategic and operational leader was appointed to support the Clinical Lead and Community Geriatricians in negotiating with and inspiring teams across professional and organisational boundaries. As part of this process a Clinical Forum was established to ensure timely and effective clinical engagement, a clear evidence base and assurance that the quality governance elements of the programme were met.

2.1 KEY DELIVERABLES PHASE 1

A key objective for Phase 1 was the provision of anticipatory, integrated assessment and care planning for the 3100 patients identified on the Elderly Frailty Index tool (eFI) as being at risk of severe frailty. This would in turn equate to up to 21,0000 interventions with the interdisciplinary approach provided by key professional groups in the ICC including medical teams, nurses, pharmacists, occupational therapists, physiotherapists, social care, carers support and voluntary sector.

The key deliverables agreed are outlined below:

- Practices within the primary care setting were required to have a process for effective case finding (eFI/guidance/process)
- Patients would require information in advance and consent for sharing of their information
- A dedicated transport service would be provided for patients undergoing CGA
- Access to diagnostics (plain film x-rays/blood testing) with fast turnaround reporting
- The delivery of an Integrated Assessment Framework with timely information flow between provider organisations
- A core staffing and trained workforce would be required
- Plan for a sustainable Care Home support to be developed alongside a delivery plan
- Clinical Care Coordination to be in place for severely frail patients
- Robust methodology for impact analysis strategic and programme level

3. INTERIM PROGRESS AND EVALUATION UPDATE

3.1 EVALUATION METHODOLOGY

There has been a focus on evaluation since the introduction of the services. The evaluation process has been designed to provide evidence that the service is improving the quality of life for patients with severe frailty helping them to stay well and manage Long Term Conditions (LTCs) rather than reacting to ill health and crisis.

Baseline information has been collated to measure activity with the plan that as the service moves to full implementation there will be a return on investment through the reduction in some of the most costly, non-elective activity for the defined cohort of patients. The plan was designed to improve quality, improve hospital flow, manage predicted increase in demand and reduce costly GP call outs.

The CCG has commissioned the Deputy Director of Nursing at Midlands and Lancashire Commissioning Support Unit (MLCSU) to provide independent clinical support to analysis of the data. A comprehensive data dashboard to provide strategic, clinical and operational reports has been developed. The information collated will monitor progress over time, provide evidence of the impact of alternative community provision and assist financial modelling as the programme moves to full implementation.

The benefits realisation report and outcomes plan below will be reportable from July 2019 and anticipates:

- 10% reduction in Emergency department attends
- 10% reduction in Emergency admissions
- 10% reduction in occupied bed days
- An average saving of £72 per patient on drug costs (based on evaluation from care homes work in 2016)
- A reduction in GP ‘call-outs’

A contractual minimum dataset (MDS) was arranged and a data sharing agreement is in place between the two provider organisations which allows the exchange of patient level, (not patient identifiable) data for reporting purposes. This agreement is for the

provision of a years' worth of retrospective data and a year post Comprehensive Geriatric Assessment (CGA).

3.2 ACTIVITY

The Jean Bishop Integrated Care Centre (the ICC) became partially operational on 23rd May 2018 and fully operational from 2nd July 2018. The modelling for Phase 1 included the provision of eight integrated assessments and care plans for each of five GP groupings per week excluding care homes activity.

By 8th October 2018 645 patients had received fully integrated assessments with 6 being carried out in the patient's own homes for house bound patients requiring assessment.

After a slow start referrals are now being received and processed in a systematic way. The predictive modelling, which excludes bank holidays but includes combined care home activity (planned to increase from the beginning of November) highlights that at least 2500 additional patients will be assessed or reviewed during Phase 1 ensuring that the lead provider is on track to meet contractual activity requirements.

The DNA/Patients cancellation rate for pre-assessments (home visits) is low at 7.48% and the DNA/Patients cancellation rate for CGAs at the ICC is only 8.15%. It has been recognised that some patients are genuinely unwell on the day; the operational team make every effort to re-book a patient who has been unable to attend due to illness, as soon as is practically possible.

Following the opening of Phase I of the Jean Bishop Integrated Care Centre in June 2018, an engagement exercise has been undertaken with patients, carers and staff to support the evaluation of this phase of mobilisation.

3.3 PHASE 1 INITIAL BENEFITS AND ISSUES

The service went live with all key deliverables in place.

It is clear that full benefits will only be realised as the programme monitors impact and progress over time. There have been however, a number of immediately obvious benefits and issues that have been addressed which have helped the programme leads gain an understanding of potential sustainability and barriers to address going forward.

Frailty leads for the GP groupings have had the opportunity for regular and formal dialogue with the ICC Lead Clinician and have had influence over the prioritisation of the practices and ongoing modification and development of the Clinical Model. This has evolved and it is now considered appropriate where a GP, Long Term Conditions (LTC) Nurses, or the Frailty Intervention Team (FIT) at Hull & East Yorkshire Hospitals (HEYH) feel there is a patient who requires a rapid fast track assessment this can be organised in agreement with the patients GP. The practices involved have received follow up visits and every practice reports very positive feedback from their patients. As a result of practice feedback, the option to undertake prescription changes within the ICC is being explored and there has been expansion to the number of diagnostic investigations which can be ordered directly from the ICC.

Before going live a process for using the eFI to identify frail patients was in place giving practices the option to utilise intelligence to refer only appropriate patients. eFI data is being collated and will be analysed to understand the practical effectiveness of the risk stratification tool as an indicator of frailty also to understand the impact of the interventions for patients over the longer term.

A process is in place for visiting patients in their own homes pre-assessment, at this point they are provided with information about what to expect, capacity is assessed, permissions to involve carers in the care planning process is given, consent for record sharing is obtained and the patients have the opportunity to talk about what problems and issues they want to solve to improve their quality of life, then transport is booked when needed.

A fully integrated care plan has been developed within the SystmOne template. The flow of information is not an issue for primary care or community service teams for those using SystmOne however there is a lack of interoperability between EMIS and SystmOne meaning that it is difficult for the integrated care service to view the records of patients registered to GP practices using EMIS, and also for those practices to view the MDT Summary letter. Consequently the GP practices with EMIS systems will be scheduled to refer patients to the ICC at the end of Phase 1 whilst work continues to develop a solution locally. This is recognised as an issue nationally.

There is a process in place for information flow with social care.

There is some delay, for the acute hospital to have access to the plan should the patient be admitted. This is a risk to the sustainability of the plan and delivery of full benefits realisation and has been escalated at Director level.

The service has rapid access to fast turnaround for a range of routine blood tests and basic radiography as a result of feedback within primary care the ICC now have access to a wider range of diagnostics.

One of the key risks when the programme was initiated was staff recruitment and retention. Opportunities have been taken to develop new roles for GPs with extended roles (GPwERs), Advanced Nurse Practitioners and Generic Support Workers to optimise use of the skilled work force and free up the Geriatricians to provide dedicated sessions for the ICC.

In fact there have been no problems with recruitment and a core dedicated workforce has been established. This specialist team is now providing support and mentorship to other professional groups outside of the integrated care service.

Recruitment is therefore no longer predicted to be a risk as the service up-scales. There are a number a senior hospital registrars showing an active interest in the service and initial discussions have taken place with provider services to consider rotational roles to help with workforce issues within therapies and Urgent Care in particular. Consultant teams from chronic disease specialties including Chest, Renal, Diabetes, Endocrinology and Neurology are stepping forward to be actively involved as the service up scales.

Following the winter pilot there is a plan for care homes which has been supported and agreed by the CCG, for the sustained provision of a model in the care home setting.

The plan is to target most challenged homes, in order of priority (four at a time) facilitating CGA and care planning in the care home setting. The care homes team is aligned and rotates with the ICC team.

A major element of this work is to proactively build partnership working and relationships in recognition that active engagement of each home will be critical to sustainable success. It is also intended to improve the interface and support to care homes provided by the urgent care service especially in relation to advanced care planning.

3.4 MEDICATIONS MANAGEMENT

Medication management is an essential element of the service model. The British Geriatric Society has identified that up to 68% of care home residents have had no medication review and that between 5% and 17% of hospital admissions relate to medication issues.

There is a substantial opportunity to reduce pharmacy costs. Polypharmacy review of all patients assessed has led to an average saving of £114 per patient including those in both the ICC and care homes.

This excludes any potential savings associated with emergency transport to hospital, A&E attendance, admission costs or occupied bed days.

Typical side-effects of commonly prescribed medicines are that they can impact upon:

- Mobility, increasing the risk of falls and the potential to access other services including hospital
- Appetite, affecting nutrition
- Cause constipation which can also impact on appetite but at best can be uncomfortable

any or all of which can lead to patients seeking help from various parts of the health and social care system in an un-planned way.

The evidence to date suggests that it is possible to improve care quality and clinical outcomes whilst reducing cost.

Whilst data show clear evidence of cost efficiencies for the majority of patients seen to date and significant potential for future savings, other benefits, such as improved patient experience and quality of life should not be underestimated.

Pharmacy colleagues are continuing work which helps establish any association between changes to specific medications and potential hospital admission (the outcomes of this work will be included in future reports).

Detail is provided in **Appendix A**

3.5 PRIMARY CARE QUALITY PREMIUM - SCHEME 4

The CCG has commissioned the Primary Care Quality Premium Scheme 4, June 2018 to June 2019; a 'Primary Care Follow-up' post Jean Bishop Integrated Care Centre (ICC) Assessment

On 9th November 2018 an MDT was held to pilot the proposed operating model;

8 patients were identified for review as part of the MDT and outcomes found to be really positive in that since the CGA in June and July 2018 none of the patients reviewed had any unnecessary hospital admissions.

- Of the 8 patients reviewed there had been 4 hospital admissions
- All admissions were deemed appropriate by the GP and Consultant involved in the review
- Opportunities were identified to prevent some GP call outs and it is anticipated that improvements to the Clinical Care Coordination model will increase this potential even further

One example shows that, 1 patient had 1 A&E attend and 1 hospital admission due to an exacerbation of a respiratory condition. Whilst the admission was deemed appropriate in the circumstances that existed at that time it was potentially avoidable had a responsive COPD pathway been in place.

Since chronic respiratory conditions is a significant component of frailty this reinforces the need for inclusion of COPD in Phase 2; with adequate care co-ordinator sign-posting and increased inputs into planned (preventative) interventions where applicable.

3.6 UPSTREAM PATHWAYS

As a consequence of the MDT assessments and preliminary patient tracking it is apparent that a number of upstream inputs, i.e. inputs recommended by the ICC MDT for example, falls assessment, audiology referral, review medication, could potentially have wait times that are not commensurate with preventing attendance at hospital or other access to unplanned care.

As an illustration, a wait for an audiology appointment, whilst still an issue for a patient, may not cause an individual to access unplanned care in the same way that a delay to be assessed by a therapist at home might, where risk of falls is an issue.

Upstream response has potential to impact on the success and sustainability of the model following Comprehensive Geriatric Assessment (CGA), and is therefore a key driver for change in the way interventions are scheduled and how the ICC integrates with other planned services, e.g.:

- The responsiveness of Community Rehabilitation services following assessment and the requirement for pathway redesign and alignment
- The alignment and responsiveness of urgent care services to utilise the care plan to support rapid assessment if a patient deteriorates to inform decision making
- The engagement with the Clinical Care Coordination model to retain oversight, be a direct point of contact and manage any escalation

- The requirement for structured follow-up model within primary care supported by an MDT coordinator

With this in mind the CCG has worked alongside Clinical Teams and Operational General Managers (CHCP Transformational Board) and used the contract variation process with the lead provider to agree a prioritised plan for Phase 2 and review key priorities for 18/19.

The demand for services within community teams is being monitored and measured to understand the impact on individual services and changes in the profile of demand as we move from a reactive to a proactive service model. This will capture the impact on services within the community setting and also help inform commissioning and skill mix requirements as the service up scales.

Detail of the agreement of priorities with CHCP as lead provider is in **Appendix C**

4. PATIENT FEEDBACK AND STORIES

Following the opening of Phase I of the Jean Bishop Integrated Care Centre in June 2018, an engagement exercise has been undertaken with patients, carers and staff to support the evaluation of this phase of mobilisation.

The CCG communications team supported the production of questionnaires and patients were selected opportunistically when they attended the ICC.

The goals of the engagement exercise are:

- To gauge professional experience and views of the centre, both working with and for the service.
- To use the experience and views of patients and carers accessing the centre, to identify the valued aspects of service and areas for improvement.

Methodology

Three paper questionnaires were developed, one for each of the following stakeholders; patients, carers and the staff working at the centre. All the questionnaires were completed by people as they visited the centre.

The questionnaires were informed by the formal consultation that took place 26 January – 19 April 2015; and supplementary semi-structured interviews with people who were likely to benefit from the Integrated Care Centre, undertaken at the beginning of 2018.

Engagement Reach

- 50 people took part in the engagement exercise;
- 27 patients, 8 carers and 15 members of staff
- There are 5 written case studies and one video case study
- These case studies give a vivid insight into the impact that the Jean Bishop Integrated Care Centre (JBICC) is having on the lives of frail people of Hull

4.1 SURVEY RESULTS – Jean Bishop Integrated Care Centre Phase I Engagement Findings Summary

Patient Survey Results Summary

Apart from highlighting that signage could be improved, in as much as some patients had difficulty locating the ICC, the results of the survey have been extremely positive.
In terms of getting to the ICC whilst the majority of people who have attended the ICC to date travelled to the centre by car, of those who used the travel provided by the service, a third would not have attended had transport not been provided.

The benefits of attending the ICC can extend beyond the formal MDT assessment. The ICC team is aware that a number of patients and carers have taken advantage of the opportunity to return to use the café as a place to meet and socialise. One or two bereaved families have reported this as having been invaluable.

Detail provided in **Appendix B**

Patient Stories – Case studies

In summary, patients and carer's feedback via the surveys and informally, highlights the importance to them of care quality as they have remarked on a range of issues relating to their experience and quality of life, and the value of the service to them.

They have related to feeling better following a change in medication, or because they have been able to mobilise more safely, or even to be able to get out and about. Patients and some staff have expressed relief at having improved understanding of their condition or that of their relative and the prognosis; what to expect and how that can be managed.

A number of patients have given permission to share their experience, and these have been collated. The information has been anonymised and a sample of these will be available to the Board.

Below is also a web link to Ray's story. Ray was one of the first patients to attend the ICC.

https://www.youtube.com/watch?v=GKxG213opfo&feature=youtu.be

4.2 FAMILY AND FRIENDS SURVEY RESULTS SUMMARY

The carer's experience was shown to be very similar to those highlighted by the patient surveys.

All the carer's taking part in the survey felt they were able to talk to the healthcare professionals about any worries or fears they may have, and that they had enough time with the healthcare professional.

Examples of their comments include

- 'Well executed all round'
- 'Detailed assessment that was ALL in one location'
- 'Staff are very efficient, welcoming, reassuring and knowledgeable'
- 'Brilliant concept; only hope that this is rolled out nationally!'
- 'Improvements that are needed; road signage/directions from all main routes.

- ‘Name badges of staff to be visible to all patients. Clear indication of uniforms, colours and position’

5. INTERFACE WITH HUMBERSIDE FIRE AND RESCUE SERVICE (HF&R)

For Phase 1 it was agreed that Humberside Fire and Rescue service would initially relocate staff normally based at East Hull Fire Station to the ICC site.
It was anticipated that co-location would improve understanding of cross-cutting issues and opportunities between services such as falls prevention, home safe and well assessments and potential follow-up visits.

Initial dialogue between the ICC team and HF&R has highlighted potential for further collaboration, for example, carrying out checks for patients who have home oxygen to ensure they are safe.

6. NATIONAL INTEREST

The Integrated Care Centre has generated a great deal of national interest since it opened and the team has received a number of high-profile visitors see **Appendix D**

In particular the national NHSE medical director and the national director for older people and integrated person-centred care have expressed a desire to maintain an on-going dialogue so as to remain in touch and up to date with developments and progress. The ICC team have also briefed the NHSE team working on the 10year plan on the Hull model for frailty.

Specific enquiries and areas of interest relate to:

a) How we have utilised the eFI in operational delivery, in particular:
   - our work to assess the validity of the tool
   - impact on eFI scores for patients and
   - how patients move between levels of frailty

b) How we have translated the vision into an operational delivery plan.

c) Training and education, what is required to support effective, sustainable inputs by appropriately skilled workforce

d) Learning and Evaluation of the programme, e.g:
   - What key measures monitor the impact of the ICC; have deliverables been met?
   - What do data highlight are the next steps, e.g. how the data might inform future workforce planning.

7. PLANS AND OBJECTIVES PHASE 2

Plans are now in place to build on the initial success of the frailty programme.

The Phase 2 proposals have been refreshed and expanded accordingly to reflect wider organisational and system requirements and priorities. This work has been completed with the active involvement of the Clinical Forum and has been supported by the Programme Delivery Board as being consistent with the CCG’s strategic aims for improvement.

For Programme Structure Phase 2 see **Appendix E**

Opportunities have been identified to:

- Increase the provision of 'care closer to home'
- Integrate frailty services with Chronic disease specialties to reduce duplication, fragmentation and waste
- Develop evidenced based, fully integrated pathways through specialist Clinical Leadership
- Maximise opportunities to reduce hospital based outpatient activity
- Maximise opportunities for Clinical strategy to evolve alongside estates strategy
- Share the learning as Integrated Care Partnerships develop
- Continue to monitor progress over time and provide independent evidence of the impact of alternative community provision
- Undertake financial modelling as the programme moves to full implementation

7.1 KEY DELIVERABLES PHASE 2

The key deliverables in the refreshed transformation programme are summarised below and will be overseen by the Programme Delivery Board (PDB). The PDB will maintain management attention on the execution of transformation plans; receive assurance that each work stream has clear measurable goals and milestones to keep the programme on track.

COPD PLAN

- Relocate and integrate Pulmonary Rehabilitation with ICC
- Relocate MDT Clinics for COPD patients and align with frailty services
- Develop a clinical model for better integrated community COPD services

Approximately one third of patients on the QOF register for COPD (2017/2018) are at risk of severe or moderate frailty

- Patients on QOF Register: 6563
- COPD register and eFI Severe: 711
- COPD register and eFI Moderate: 1694

Based on information from 28 practices (11 practices out of 39 not yet returned).

CARE HOMES PLAN

- Deliver a pathway which integrates primary and secondary care.
- Deliver a standardised CGA and sustainability model for anticipatory care planning (Top 10 care homes Oct. 2018 -Feb. 2019).
- Have oversight of the pilot and evaluation led by Quality Governance for Intermediate Assessment Beds and Continuing Health Care Assessment.
- Bring together all strands of care home support.

DEMENTIA PLAN

- Identify the likely demand for specialist Psychological assessment for the defined cohort of patients.
- Establish a robust baseline and evaluation methodology.

- Redesign the Older People's Mental Health pathway to ensure responsiveness and contingency for patients with a plan.
- Explore options to provide educational support and training to staff within the frailty team.

PARKINSONS PLAN

- Avoid and reduce unnecessary hospital admissions
- Risk Stratify those patients with Parkinson's disease
- Develop a pathway that ensures appropriate anticipatory MDT approach dependent on level of risk

PALLIATIVE CARE PLAN

- Establish a clinical care pathway that ensures patients with severe frailty understand and can access specialist palliative care pathways when appropriate
- To ensure alignment of the frailty and palliative care pathways
- To improve knowledge and access where appropriate for frail patients to access services offered by the Hospice
- Ensure that access process is clear and formalised

EVALUATION OF PHASE 1

- Evaluate the impact of Phase 1 as planned, monitoring progress over time and adapting the model with a clearer understanding of the barriers to sustainability
- Ensure insights from data analysis to enable fact-based understanding for future decision making; understand shift opportunities and any investment requirements for up-scaling

8. RECCOMENDATIONS TO THE BOARD

In summary, having been operational for only 6 months the interim assessment of the ICC service demonstrates some clear benefits realisation in respect of patient, carer and staff experience, cost reductions relating to pharmacy costs and improved care quality.

The board are asked to note completion of Phase 1 and endorse progressing plans for Phase 2, the Board is asked to recognise the scale of the task in evolving the frailty programme so that it remains fit for purpose and achieves its key deliverables whilst acting as the catalyst for system change and integration.

The Board is asked to acknowledge and endorse the continued structured, incremental implementation of the service, so that adequate time is given to embed and build upon the good practice that is clearly evident.

APPENDICES
Appendix A

Medicines Management - Summary of Cost Savings
CHCP Data source: CHCP Community Frailty Pathway Meds Management Reports for Q1 and Q2

The table below summarises the results from all clinical medication reviews undertaken. The data is shown separately for the ICC and then combined for the ICC and care home reviews.

Within the community frailty pathway, the medicines management element involves:
Clinical medication review as part of a holistic assessment of a patient within the Integrated Care Centre (ICC) and within the Care Home MDTs
Review of medicines management processes within care homes with the aim of reducing medicines waste.

	ICC		Care Homes		ICC and Care Homes	
	Q1	Q2	Q1	Q2	Q1	Q2
Number of patients receiving a clinical medication review	71	270	139	105	210	375
Number of recommendations made	279	1071	472	281	751	1352
Number of recommendations agreed	275	1053	430	268	705	1321
Changes to medication	154	574	288	151	442	725
Medication started	43	265	46	28	89	293
Medication stopped	164	547	-75	177	89	724
Number of medications before review		2759	0	701		3460
Number of medication upon completion of review	65	2443	-65	568		3011
Change/clarification of dose of medication	65	123	49	39	114	162
Cost savings due to medication stopped	£12,801	£15,555	£23,214	£9,738	£36,015	£25,293
Average cost saving per patient	£180.30	£57.61	-£8.80	£92.74	£171.50	£67.45
Potential cost savings from waste audits		-	3566	£1,736	£3,566	£1,736
Total cost savings	**£12,801**	**£15,555**	**£26,780**	**£11,474**	**£39,581**	**£27,029**

Appendix B - Jean Bishop Integrated Care Centre Phase I Engagement Findings Summary – Survey results

This includes;
Patient Survey Results
Family and Friends Survey Results
Staff Survey Results

Jean Bishop Integrated Care Centre
Phase I Engagement Findings Summary

Introduction
Following the opening of Phase I of the Jean Bishop Integrated Care Centre in June 2018, an engagement exercise has been undertaken with patients, carers and staff to support the evaluation of this phase of mobilisation.

Goals
The goals of this engagement exercise are:

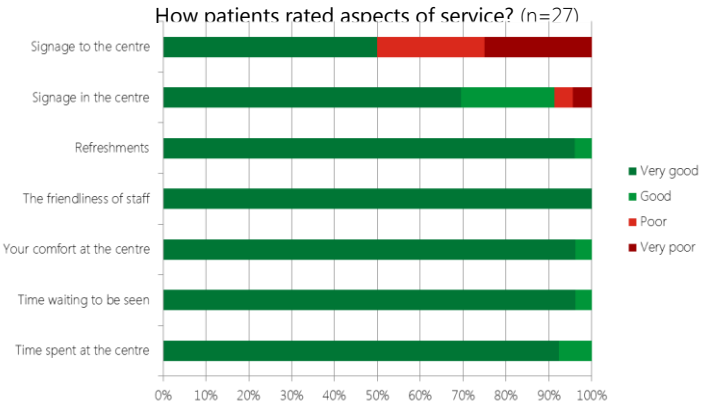
- To gauge professional experience and views of the centre, both working with and for the service.
- To use the experience and views of patients and carers accessing the centre, to identify the valued aspects of service and areas for improvement.

Methodology
Three paper questionnaires were developed, one for each of the following stakeholders; patients, carers and the staff working at the centre. All the questionnaires were completed by people as they visited the centre. The questionnaires were informed by the formal consultation that took place 26 January – 19 April 2015; and supplementary semi structured interviews with people who were likely to benefit from the Integrated Care Centre, undertaken at the beginning of 2018.

Engagement Reach
50 people have taken part in this engagement exercise; 27 patients, 8 carers and 15 members of staff completed their respective questionnaires. 3 written case studies have been developed, and one video case study is available to watch here, these case studies give a vivid insight into the impact that the Jean Bishop Integrated Care Centre (JBICC) is having on the lives of frail people of Hull.

Results

Chart 1



Patients

The feedback relating to all aspects of the JBICC from patients has been extremely positive, chart 1 shows how patients have rated aspects of service; time spent at the centre, time waiting to be seen, comfort at the centre, the friendliness of staff and the refreshments all received a rating of good or very good, with the majority rating them as very good. The only areas receiving a negative rating related to signage, both to centre and in the centre. Although 90% of respondents felt that signage in the centre was good or very good, 50% rated the signage to the centre as poor or very poor.

Contact with the clincial team

The majority of patients felt supported by the healthcare professionals they had contact with at the centre (chart 2), 23 out of 26 felt able to discuss any worries or fears that they had (chart 3), the majority of patients felt that the healthcare professtionals had enough information about their medical history, 3 people felt they did not. Only one patient stated that they thought it would be useful to have other professionals involved in their assessment, but did not state who; all the other respondents didn't feel that any other professionals were needed. All respondents felt they had enough time to discuss thier health or medical problems with the healthcare professional. All patients taking part in the questionnaire felt that they had enough privacy when discussing their care with the professionals, and when being examined.

Chart 2

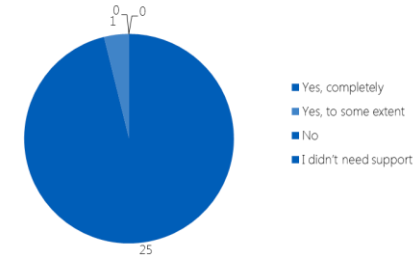


Chart 3

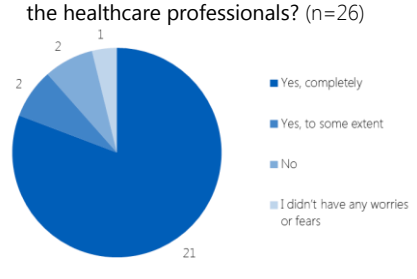
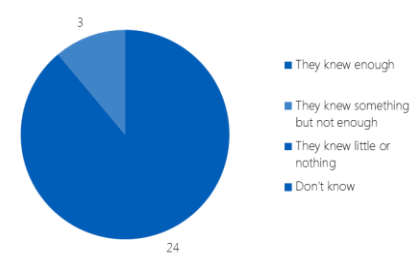


Chart 4



Informed and involved

The majority of respondents felt they had been told everything that would happen during their appoinment at the JBICC, 4 patients stated that they were not told (Chart 5). The majority of patients were asked what was important to them when managing their conditions, only one person felt this hadn't happened and would have liked it to (chart 6). Everyone taking part in the patient survey felt that they were involved in the planning of their care when at the JBICC (chart 7). Two third of respondents were told who to contact if they were worried about their condition, a third reported that this did not happen.

Chart 5

Before your appointment today, were you told what would happen during your appointment? (n=27)

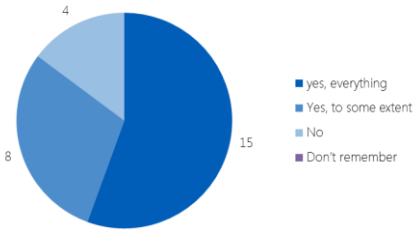


Chart 6

Did the healthcare professionals ask you what was important to you in managing your conditions, and the effect it may have on your day to day life? (n=26)

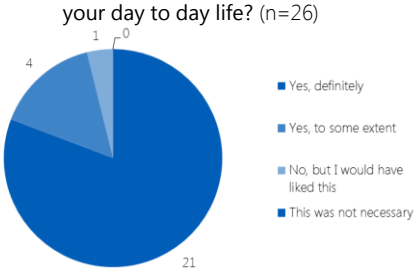


Chart 7

Do you feel you have been involved the planning of your care at the integrated care centre? (n=25)

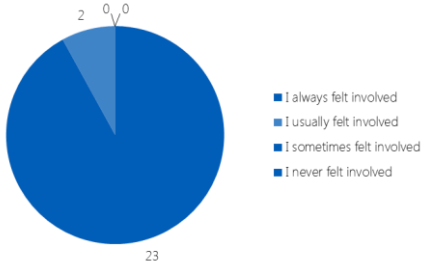


Chart 8

Before your appointment today, were you told what would happen during your appointment? (n=27)

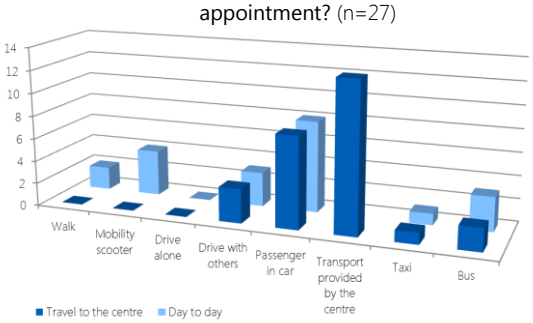
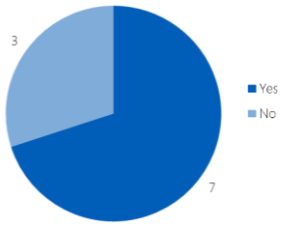


Chart 9

Would you have attended if transport had not been provided? (n=10)



Travel to the centre

Chart 8 shows that the majority of people travel to the centre by car, they way people travel to the JBICC roughly mirrors people's day to day travel preferences. Chart 9 shows that of those who used the travel provided by the service, a third would not have attended if the transport was not provided.

Diagram 1

Word cloud summarising patient comments about the integrated care centre

Reasons why people would not attend if transport had not been provided:

- Would have had to rely on someone else to get me there, can't afford taxis.
- I don't know how I don't think I could have come have no one to bring me.
- Have family to bring me but not if they couldn't
- Wouldn't be able to get there especially if weather is bad.
- I don't know I don't think I could have come have no one bring me
- Have family to bring me but not if they couldn't
- Unable to get there on own due to poor mobility

The overall experinece of patients is very positive, this was reflected in the freetext comments, and is illustarted in the word cloud (diagram 1)

Carers

The feedback from carers relating to all aspects of the JBICC is as positive as the feedback from patients. chart 10 shows how carers have rated aspects of service; time spent at the centre, time waiting to be seen, comfort at the centre, the friendliness of staff and the refreshments all received a rating of good or very good, with the majority rating them as very good. The only area receiving a negative rating related to signage to the centre 70% rated the signage to the centre as poor or very poor.

Chart 10

How carers rated aspects of service? (n=8)

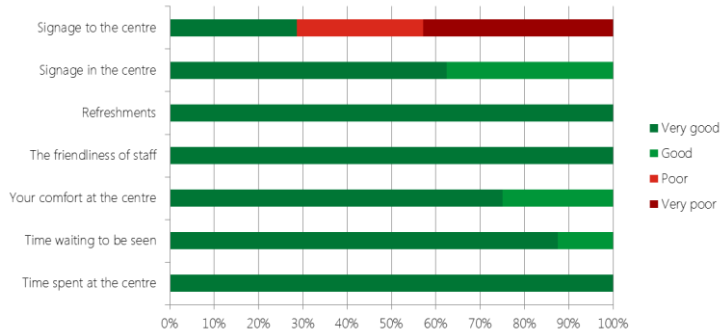
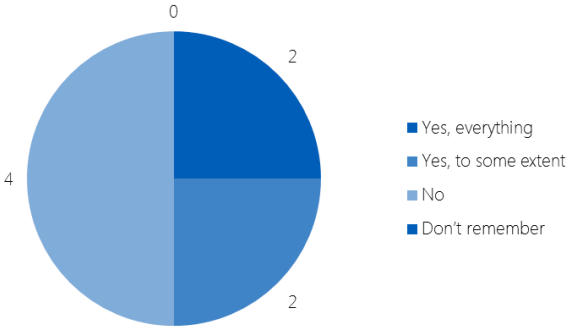


Chart 11

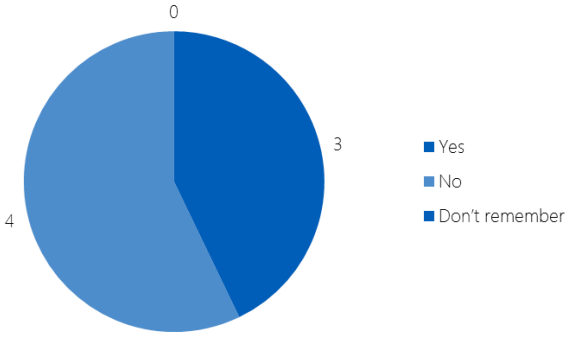
Before your appointment today, were you told what would happen during your appointment? (n=8)



The carer's experience is very similar to the patients; all the carer's taking part felt they were able to talk to the healthcare professionals about any worries or fears they may have, and had enough time with the healthcare professional. All but one respondent felt that they had been involved in the care planning at the centre. None of the carer respondents felt that there needed to be any other professionals involved in the assessment.

Chart 12

Did the staff tell you who to contact if you were worried about the person you care for after you left the service? (n=7)



The main area of difference between the patients and the carers related to the amount of information they felt they have received; charts 11 and 12 show that fewer carers reported receiving information than patients.

Staff

A range of staff took part in this engagement exercise:

- Carers Information and Support Service
- Doctor
- MDT Co-Ordinator
- Physiotherapist
- Clinical Support worker
- Reception/Admin
- Pharmacy Technician
- Locum Occupational Therapist

Although patients and carers do not feel that any other professionals are needed to be involved in the assessment at the centre, staff have suggested some other professionals that it may be beneficial to engage with:

- Mental Health Services
- Dietetics
- Podiatry
- Orthotics
- Diabetic service
- Nutrition
- Age UK
- Benefits advice
- Audiology
- Optician

Although the majority of staff feel that they are able to access all the required information they have highlighted some issues relating to numerous patient computer systems not being able to interact with each other, the other area of mixed view is the amount of time with the patient, with a preference for more time. These issues are illustrated in charts 13 and 14.

Chart 13

Are you able to access all the information you require about the patients you see? (n=12)

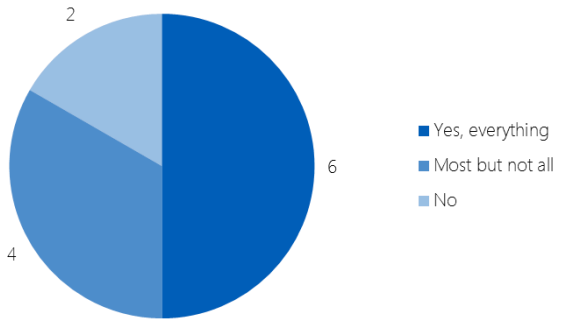
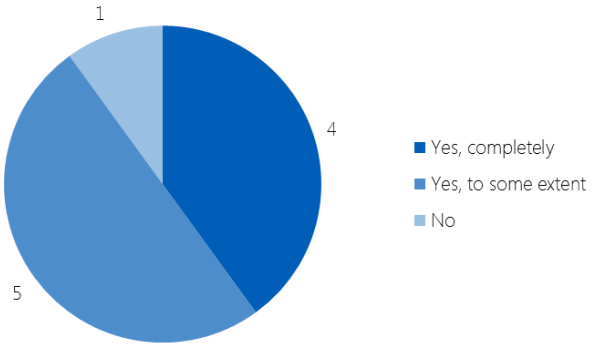


Chart 14

Do you have enough time with patients to carry out your comprehensive assessment? (n=10)



Conclusions

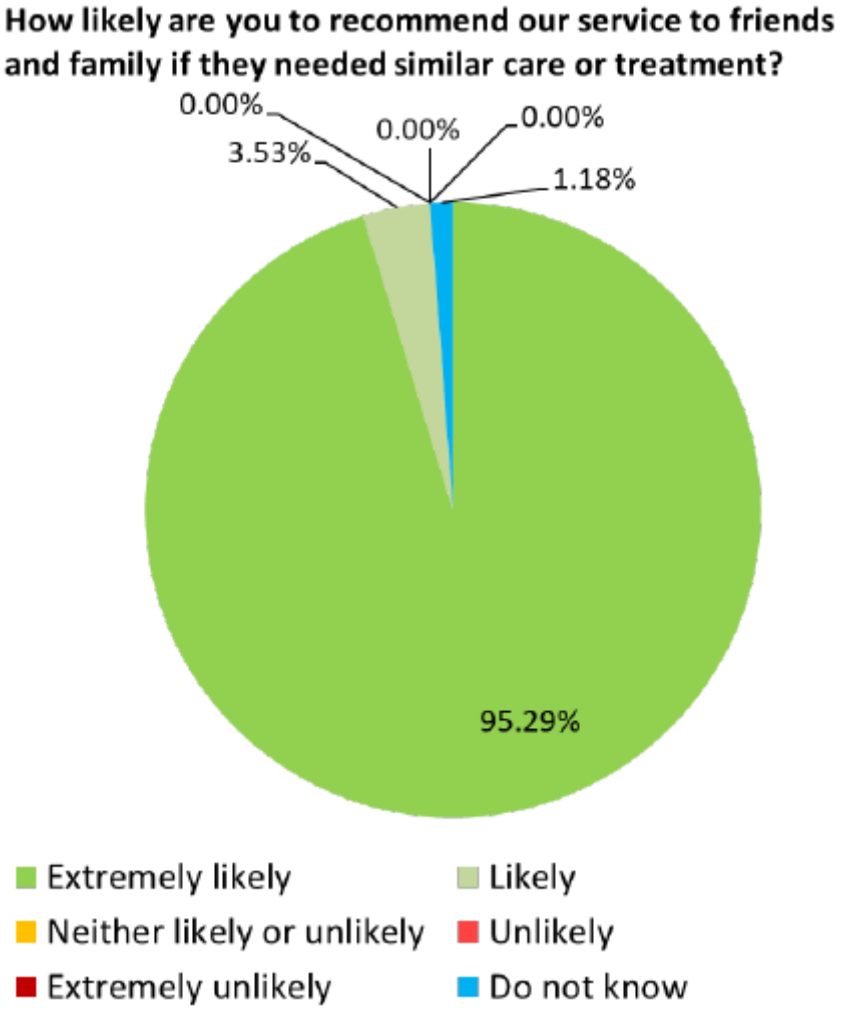
- Patients and carers report a positive experience when attending the Jean Bishop Integrated Care Centre across all aspects of service.
- Although not all patients required the transport provided by the service, it is clear that there is a cohort of patients who are reliant on transport to the centre. The commitment made during the formal consultation should be maintained and some level of transport be offered as part of the service mix of the centre.
- The information for patients and carers received positive comments, however there is some variation in the information the patients and carers report to have received, a review of how the information is delivered might be required to determine if this is an issue relating to the format of the information or simply omission.
- Staff have highlighted some areas that could be improved, the issues raised could all be attributed to teething problems experienced by all new services and ways of working, continuing the engagement with staff as new phases of the service become live is recommended.

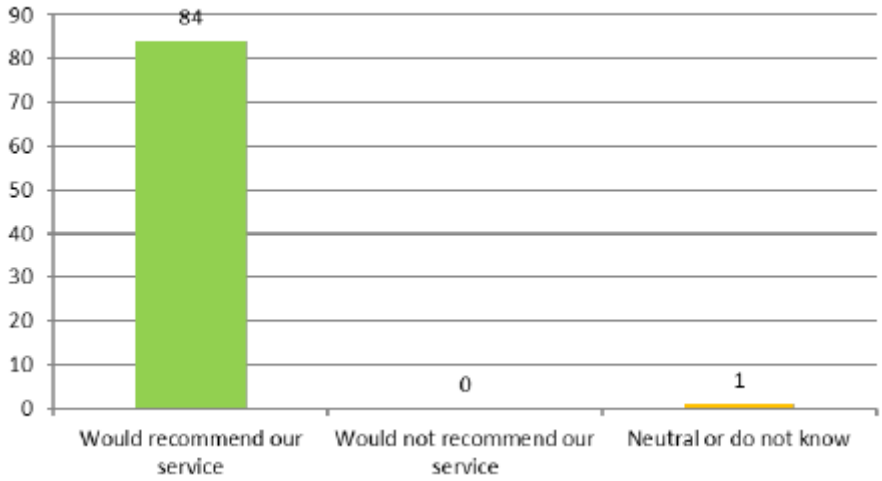
Friends and Family Test

Jean Bishop ICC **Total: 85**

Recommendation	Amount	%age
Extremely likely	81	95.29%
Likely	3	3.53%
Neither likely or unlikely	0	0.00%
Unlikely	0	0.00%
Extremely unlikely	0	0.00%
Do not know	1	1.18%

Recommendation	Amount	%age
Would recommend our service	84	98.82%
Would not recommend our service	0	0.00%
Neutral or do not know	1	1.18%


How likely are you to recommend our service to friends and family if they needed similar care or treatment?
0.00%
0.00%
0.00%
3.53%
1.18%
95.29%
Extremely likely
Likely
Neither likely or unlikely
Unlikely
Extremely unlikely
Do not know


90
80
70
60
50
40
30
20
10
0
84
0
1
Would recommend our service
Would not recommend our service
Neutral or do not know

June

• Can't be improved at all. Staff are all lovely.
• Nothing could be improved. Everybody been so kind.
• Everything perfect, people are so kind & helpful including doctors, nurses and other staff, been a pleasure spending the morning at ICC.
• Very informative, staff very helpful, great treatment.
• Nothing could be improved. The friendliness, kindness and caring made it a very good day.
• Everyone was friendly, staff brilliant, everybody has been top class.
• Everything was alright. Everyone pleasant & explained the process.
• Kindness & consideration shown by all members of staff. Enjoyable experience.

July

• Made to feel welcome from going in to coming out. Everyone treated us with care, kindness and respect. People had the time to listen and show interest. We enjoyed our lunch. All together a very good experience and all the staff were good.
• Most pleasant time spent with lovely staff. Great food lovely surroundings. I may book a holiday here!!
• Well executed all round. Detailed assessment that was ALL in one location. Staff are very efficient, welcoming, reassuring and knowledgeable. brilliant concept only hope that this is rolled out nationally! Improvements that is needed Road signage/directions from all main routes. Name badges of staff to be visible to all patients. Clear indication of uniforms, colours and position.
• Everything was extremely professional. All staff were pleasant, caring, helpful and very kind too me and I have been in private hospitals and this place is better!!
• Brilliant supportive friendly staff (mum wants to come back) Couldn't fault anything. Had a full MOT on mum which was superb and we had a lovely dinner. Staff couldn't have been more caring - Brilliant place.
• Everything is under one roof. All staff were very nice and caring. Nothing was too much trouble.
• Everything I have experienced today was good. I don't think anything could be improved.
• Everyone helpful and friendly nothing to improve excellent.
• Really lovely friendly staff and very helpful.
• Everything was excellent
• All of it was good!!
• Everyone was very friendly. Breakfast was very nice. Physio lady was very nice. No prejudice.
• Everybody is nice and friendly and things well explained.
• I don't feel anything could be improved. Everyone is so kind and lovely. Everyone is helpful.
• Very friendly staff with positive suggestions. Explanations given at every step very easy to understand.
• There is nothing that can be improved. Fantastic staff, nurses and Doctor made us so welcome. Mum's assessment was extremely professional. Parking facilities excellent 10/10.
• Lovely building - from walking in staff were very friendly and kind. Everyone had done an excellent job sorting tablets out and for us to understand what is going on. Very useful that lots of things have been sorted i.e. bloods, tablets, physio, social care etc. Staff were very caring towards my mum. Thank you so much it has been great including lunch.
• I don't think it could be improved. Everything was nice, everyone couldn't do enough for you.
• Everything!! People were lovely, had a lovely day. Nothing to improve on.
• Nobody could fault it. Thoroughly enjoyed it. Came with anxieties leaving totally relaxed.

• Everything was extremely professional. All staff were pleasant, helpful and very kind to my mother.

August

• The visit was for my mum, who could not get over how helpful everybody was. Also that all the food and drinks were free. Although she would have been quite happy to pay for them. Mum was very happy with her review and change of medication and is hoping to start feeling better in the following weeks to come.
• Lovely catering staff, Dave Carla and the team. Excellent food and service a credit to them all.
• No improvement needed Brill! Keep up the good work - Polite staff in all departments well done and the lovely meal (FREE!)
• I was a little hesitant about attending the centre for assessment of how the different services could help me. However, I was worrying for nothing. The whole team that I saw were fantastic. Each one had the same focus on how they could help me. I didn't feel rushed and they allowed me to take my time. :)
• Everything lovely, doctors, nurses and all staff, everybody. Wish my husband had this years ago.
• From the start to the finish of our visit to Jean Bishop Centre. We received from all the staff doctors and the Receptionist a perfect service and help.
• Everybody so kind and friendly which immediately puts you at your ease. A very positive day spent in lovely surroundings.
• Everybody was lovely and very helpful. My mum was treated like a princess. Thanks to everybody.
• Excellent in every way! Lovely girls especially Ann-Marie and Deborah. Beautiful décor, so unexpected to see such an excellent place.
• From start to finish has been a very positive experience, all staff were wonderful!!
• It was a 4 hour visit. The staff were just excellent could not have been better. They were helpful, considerate and so pleasant. I felt much better after my visit.
• Excellent care and attention, can't think of anything to improve on. Staff nice, café very nice.
• Excellent facility. Staff very professional and friendly would highly recommend the service.
• Very impressed with the facilities and all the medical staff we met.
• Nothing to be improved. Extremely good really enjoyed it.
• Made to feel welcome from going in to coming out. Everyone treated us with care, kindness and respect. People had the time to listen and show interest. We enjoyed our lunch all together a very good experience and all the staff were good.
• Having time to talk about worries lots of smiles all round everyone listens
• Visit was great lots of help. Plenty of kindness and care, food was very nice. Thanks to all who took the time to listen to me
• Everyone nice and friendly very Informative felt well cared for and looked after.
• All of the visit and the professionals were great. A marvellous experience and service given to my mother and myself as a carer. Well done everyone
• Very good got a lot off my chest.
• Nothing to improve on. Everyone is so helpful and considerate. I felt able to ask questions at ease, very comfortable, nice, lovely atmosphere.

September

• No improvement needed, staff made us feel relaxed and very welcome. Information given about help and support that is available was very helpful. Think this is an excellent centre. Very thorough in all they did. Café was lovely 10/10.
• Everything was good, everything excellent. Could not get better treatment from all staff, was reluctant to come but so glad I did. Will be coming to coffee mornings.
• An exceptional service with professional and considerate staff
• Relaxing, Professional and Friendly
• The staff were superb and pleasant.
• Excellent service from beginning to end.
• Everyone was very helpful and east to talk to very nice lunch and free flowing drinks.
• Staff very pleasant I was told everything and my problems were discussed in detail.
• It is the first time I have been at the centre and found that both the doctors and nurses were very good. They couldn't do enough for me and I got the results I wanted to know. I wouldn't hesitate to come again. I cannot stress how nice and friendly everyone was.
• Good service
• Everybody was so friendly and lovely the only thing that could be improved is if I could come once a week.
• Couldn't improve anything, Staff all very nice and helpful wouldn't mind working here myself.
• Very reassuring, concise understood what was said. The only improvement would be much shorter waiting times for transport
• 99.9% nobody is perfect!
• A very positive morning spoilt by having to wait an hour for transport with the wrong transport turning up and having to wait another half an hour.
• A lot of medical issued and was given advice. The experience was marvellous
• All of the services were really good nothing could be improved.
• Friendly atmosphere. Everyone was very nice and nothing was too much trouble for anyone. Nothing to be improved on.
• Everyone so good and kind
• Nothing to be improved. Examinations and staff fantastic. Great to know I am fit and healthy gave me peace of mind, Café was lovely everyone was very nice.
• Nothing to be improved on. I was frightened about coming but really enjoyed it everyone was so nice and helpful
• Nothing could be improved I think the premises and the attention you receive is excellent. I will definitely recommend it to friends in need.
• Wonderful premises and staff. No improvements required.
• Everybody was very helpful. Good suggestions from the professionals for improvement
• Excellent service.
• Everyone was very helpful and pleasant
• Beautiful centre well planned but could do with more sign posts to say where it is.
• Staff very helpful friendly and informative. Re-assessment by the Doctor on the medication was good. Café food very nice.
• Everything was good about the visit. You're made to feel like everyone cares and made to feel at ease and really welcome. Everything was explained fully and was absolutely brilliant. Nothing was rushed and everyone had plenty of time for you. We would go back anytime if needed!!
• Lovely staff, consultants, pharmacist, physio, nurses and social services all very kind. There was no rushing and I was encouraged to talk without any clock watching. All in all a morning very well spent. A lovely lunch as well.

• Lovely staff - consultant, pharmacist, physio and nurses, s.services. All very kind. No rushing. Encouraged to talk with no clock watching. All in all a morning very well spent. Lovely lunch by the way.
• Excellent. No improvements necessary. Caring, friendly, efficient staff. Lovely lunch 10 out of 10!!

Appendix C - CHCP Priorities

This includes the following:

1	Assurance that every severely frail patient is provided with a named clinical person who will retain oversight of the patient. *This named individual will work to an agreed plan and have a clearly defined role and responsibilities.*
2	Assurance that essential performance reports are made available as per the cyclical agreement or as required to: - support and inform ICC and care home operational teams to manage their services - monitor agreed KPIs - model future activity (see no.3) These reports will identify progress made to achieve the benefits identified 12 months post-operational launch, however data is being collated for an interim update.
3	Modelling of the projected activity and impact. For example, this will inform the demand on upstream services and feed into the pathway redesign and integration of existing services referred to above.
4	The planning and coordination of MDTs, which involve the clinical and non-clinical care coordinator in conjunction with the GP practice.
5	Direct access to urgent care for patients with an integrated care plan, with associated operational process and monitoring of demand to understand the impact.
6	Alignment of the rapid response team to optimise the benefits of the care planning process.
7	Alignment of the palliative care pathway for frailty in the context of the ICC care planning process.
8	Deliver the standardised and sustainable model for care homes proposed by the transformation programme.
9	Work with the transformation lead to support the alignment of the care homes work to bring together a clear vision and strategic planning process.

Appendix D

Table 1 - ICC Visitor list (as at October 2018)

Name	Job Title
Professor Steven Powis	National Medical Director, NHS England
Dr David Black	NHS England Medical Director - Yorkshire & Humber / Deputy Medical Director - Specialised Commissioning
Dr Dawn Moody	Associate National Clinical Director for Older People and Integrated Person-Centred Care, Clinical Policy Unit, NHS England
Moira Dumma	Director of Commissioning Operations, Yorkshire and the Humber, NHS England
Dr Jane Fitch	Strategic Estates Planning Team, NHS I
Chris Shaw	Architect, Chair of Architects for Health
Diana Johnson	Labour Member of Parliament for Hull North. Member of Health Select Committee
Katie Walkin	Programme Support Manager, Clinical Policy Unit, NHSE

Table 2 – ICC Visitor list including Better Care Support Team Representatives

Name	Job Title
Mags Walsh	Regional Relationship Manager – North, Better Care Support team
Ben Tunstall	Communications and Engagement Manager- Better Care Support team
Susan Hart	Integration Lead, Care and Reform, MHCLG
Nicole Valenzuela-Sotomayor	Better Care Manager, London
Jenny Sleight	Better Care Manger, Humber and Yorkshire
Patrick Allen	Adviser, Care and Health Improvement Programme, LGA
Jayne Robson	Better Care Manager, Cumbria and the North East
Roy McNally	Regional Development Manager, Foundations
Sue Ward	Assurance Manager, NHSE
Emma Hidayat	Care Sector Lead, Yorkshire & Humber
Shaun Jones	Interim Director of Delivery (Y&H), NHSE

Appendix E - Programme Structure - Phase 2