



**Humber Teaching**  
**NHS Foundation Trust**

**North Yorkshire County Council – Scrutiny of  
Health Committee**

**Lynn Parkinson, Interim Chief Operating  
Officer**

**Julia Harrison-Mizon, Care Group Director**

14 September 2018

**Caring, Learning and Growing**

# Our Mission



Our Mission

Our Values

Our Strategic  
Goals

***We are a multi-specialty  
health and social care  
teaching provider  
committed to 'Caring,  
Learning and Growing'***

# Our Values

Our Mission

Our Values

Our Strategic Goals

**CARING**

for people while ensuring they are always at the heart of everything we do

**LEARNING**

and using proven research as a basis for delivering safe, effective, integrated care

**GROWING**

our reputation for being a provider of high quality services and a great place to work

# Our Strategic Goals



Our Mission

Our Values

Our Strategic Goals

As part of our Trust Strategy (2017-2022) we have identified six strategic goals, key objectives and supporting measures to achieve our ambitions and deliver key improvements.

They are linked to government initiatives, regulatory findings and local health needs assessments based on discussions with Sustainability and Transformation Partnership (STP) representatives, patients, carers and families, staff, governors and partners.

# About Us

We are a provider organisation and our healthcare services are commissioned by:

- East Riding of Yorkshire CCG
- Hambleton, Richmondshire and Whitby CCG
- Hull CCG
- Scarborough & Ryedale CCG
- East Riding of Yorkshire Council
- Hull City Council
- North Yorkshire County Council
- NHS England - Specialist services and Primary Care Services

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# About Us

## How we do it

- We employ approximately 2,700 staff – operating across three care groups:
  - Mental Health
  - Specialist Services
  - Primary Care, Community, Children’s & Learning Disability Services
- We deliver our services from more than 70 sites across Hull, the East Riding and North Yorkshire
- Our annual budget in 2018/19 is £125.3m

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# About Us

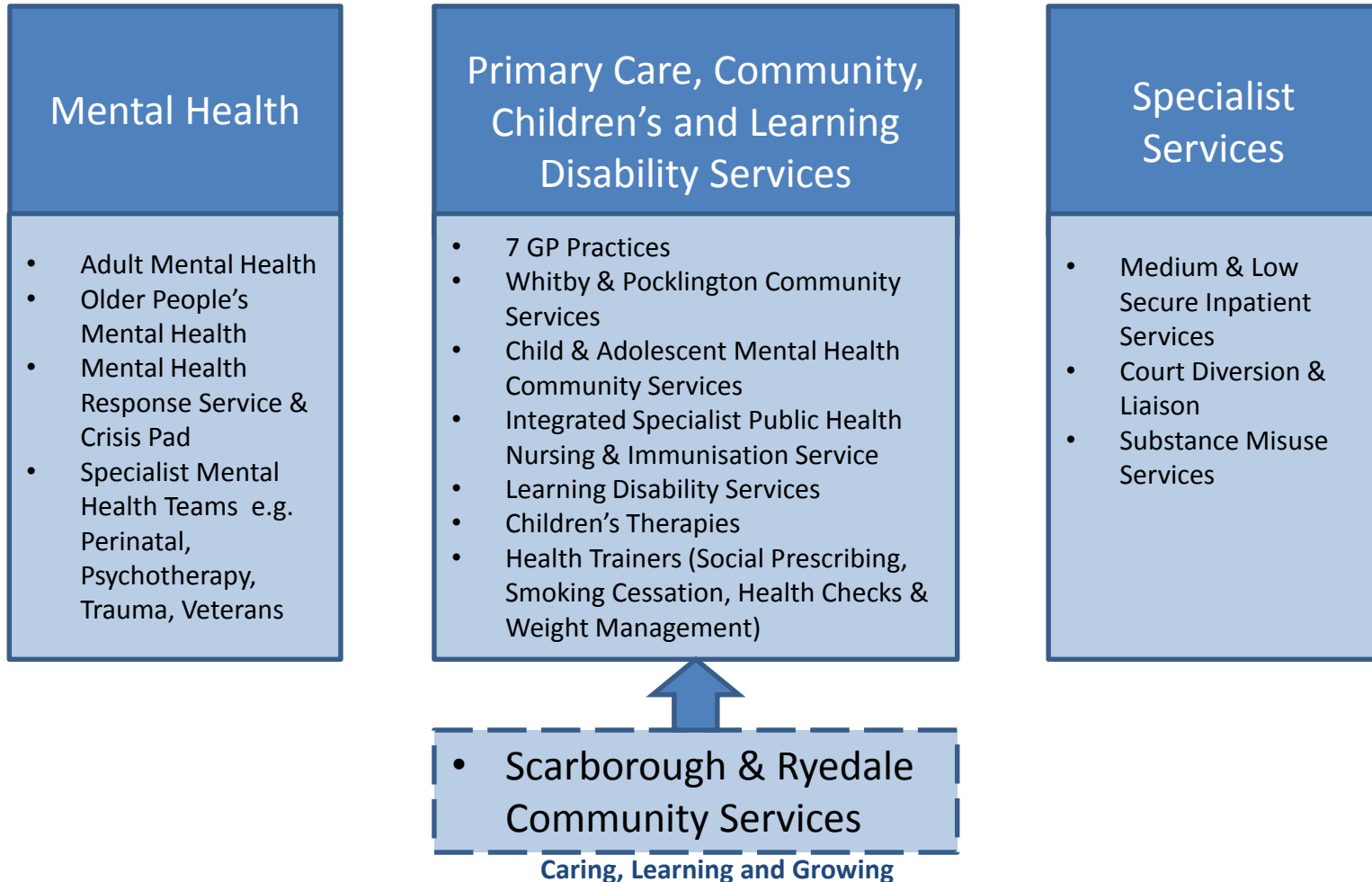
## Council of Governors

- Membership organisation – 16,000 members
- Members represented by our Council of Governors
  - 14 Public Governors (elected by the public)
  - 6 Nominated Governors
  - 5 Staff Governors

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# About Us

## Operational Care Groups





# Our Trust Board



## Humber Teaching NHS Foundation Trust



**Michele Moran**  
Chief  
Executive



**Sharon Mays**  
Chairman



**Lynn Parkinson**  
Chief Operating  
Officer



**Hilary Gledhill**  
Director of  
Nursing



**Dr John Byrne**  
Medical Director



**Mike Cooke**  
Non-Executive  
Director



**Mike Smith**  
Non-Executive  
Director



**Francis Patton**  
Non-Executive  
Director



**Peter Beckwith**  
Director of  
Finance



**Steve McGowan**  
Director of HR &  
Diversity



**Peter Baren**  
Non-Executive  
Director



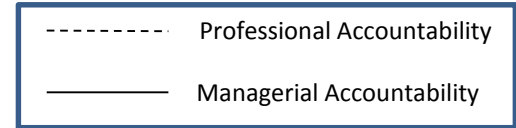
**Paula Bee**  
Non-Executive  
Director

**Caring, Learning and Growing**

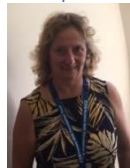
# Management Team for Scarborough & Ryedale



Lynn Parkinson  
Chief Operating Officer



Julia Harrison-Mizon  
Primary Care, Community, Learning Disabilities and  
Children's Services Care Group Director



Trish Bailey  
Clinical Care  
Director



Jon Duckles  
Head of Primary  
Care



Dr Nick Cross  
Associate  
Medical  
Director & GP



Nia Abbott  
Assistant Director  
Children's  
Services



Helen Cammish  
Assistant Director  
Community Services



Maggie Bean  
Primary Care  
Matron



Carol Wilson  
Community Services  
Matron

Community  
Services  
Matron  
*In recruitment*



Sarah Locker  
Hub Manager  
Scarborough North

Hub Team



Sarah King  
Hub Manager  
Ryedale

Hub Team

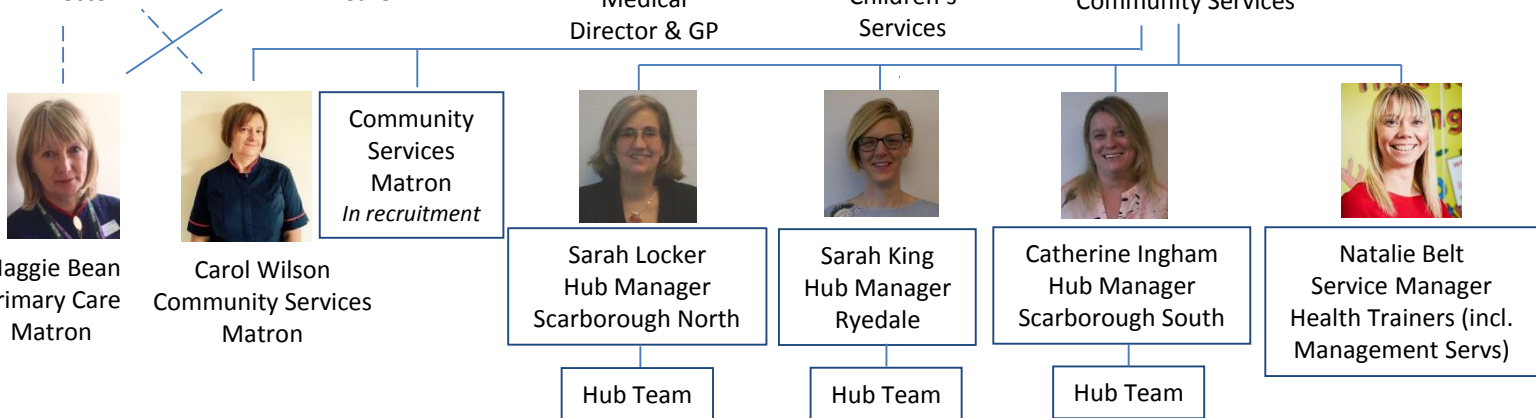


Catherine Ingham  
Hub Manager  
Scarborough South

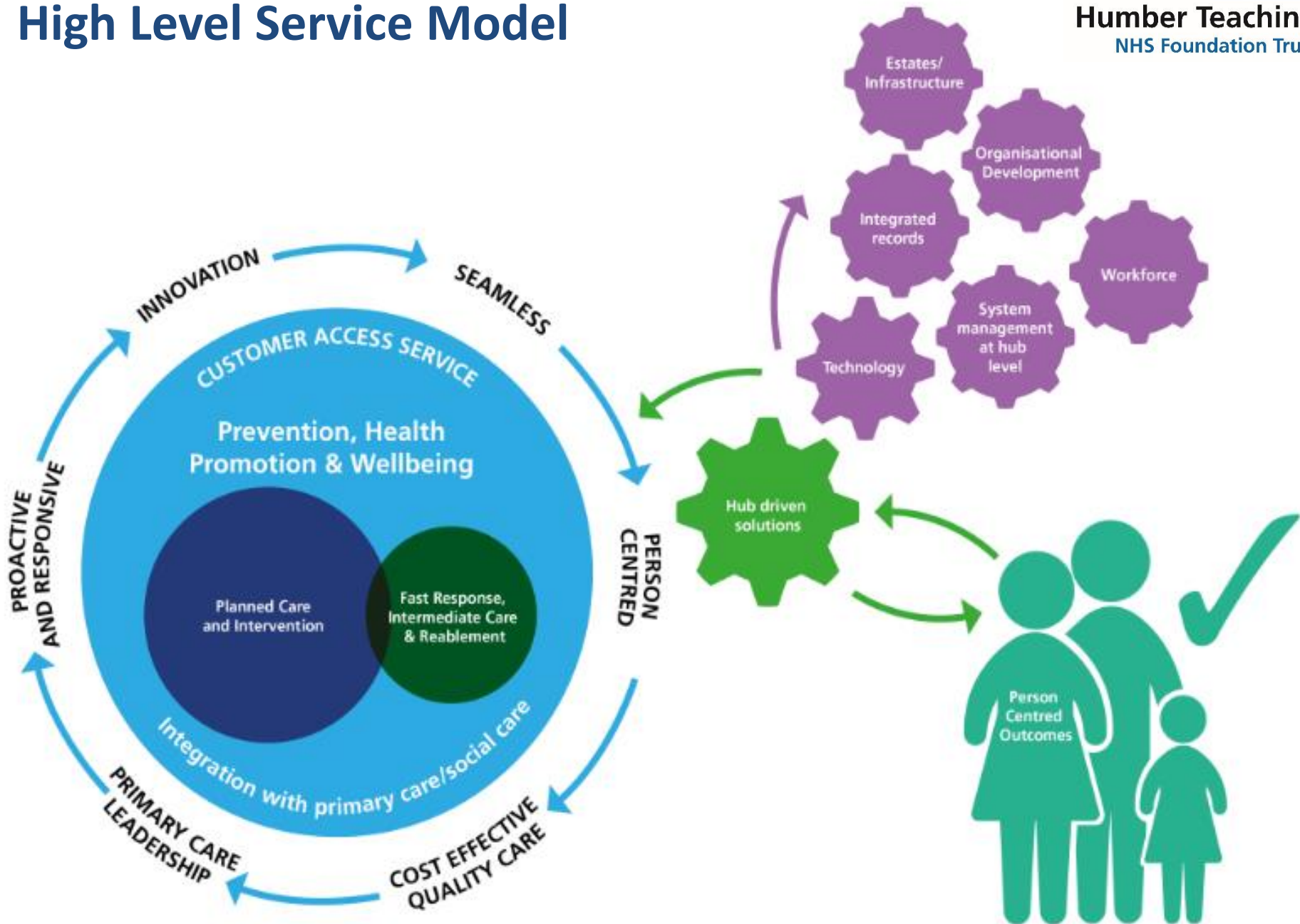
Hub Team



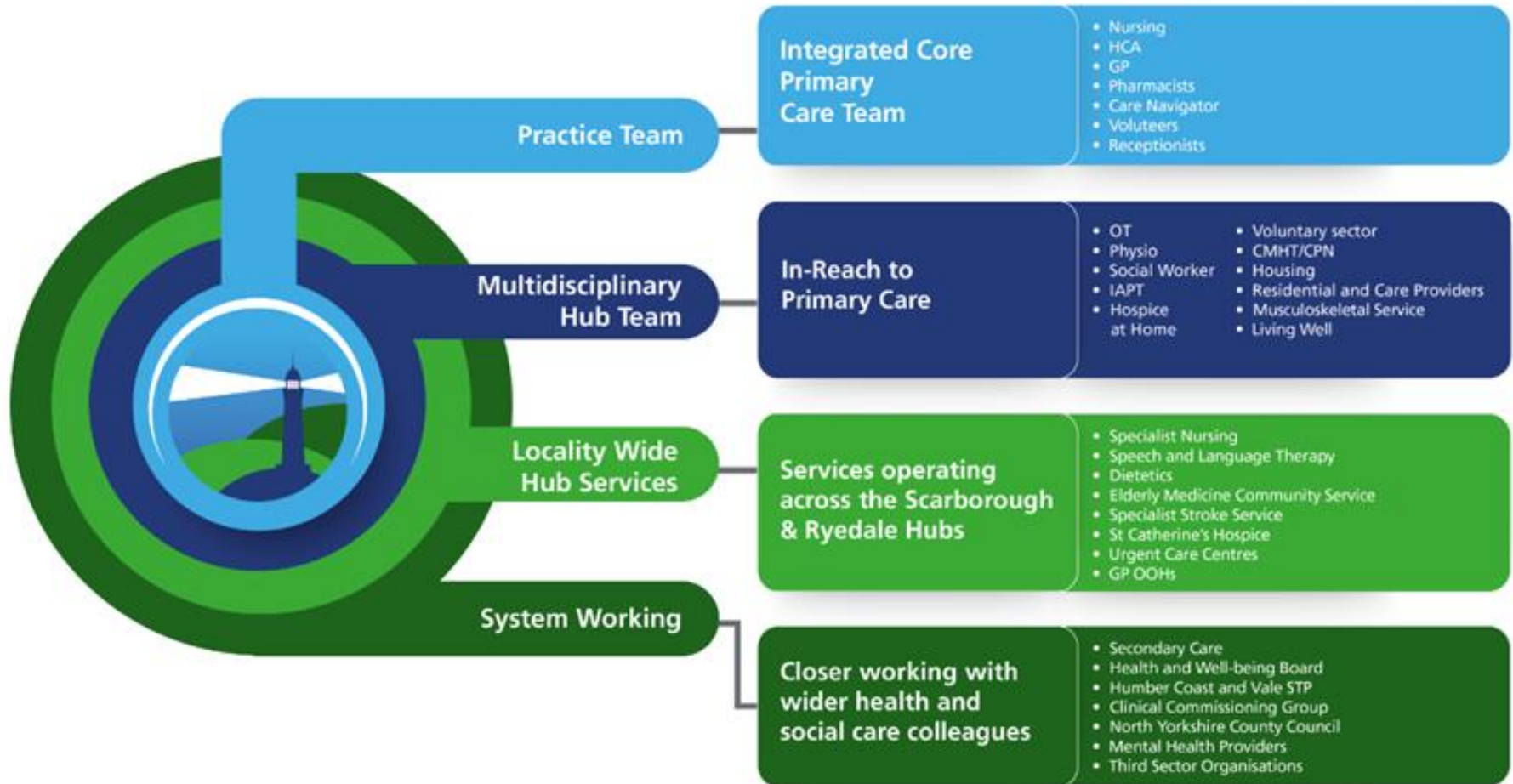
Natalie Belt  
Service Manager  
Health Trainers (incl.  
Management Servs)



# High Level Service Model

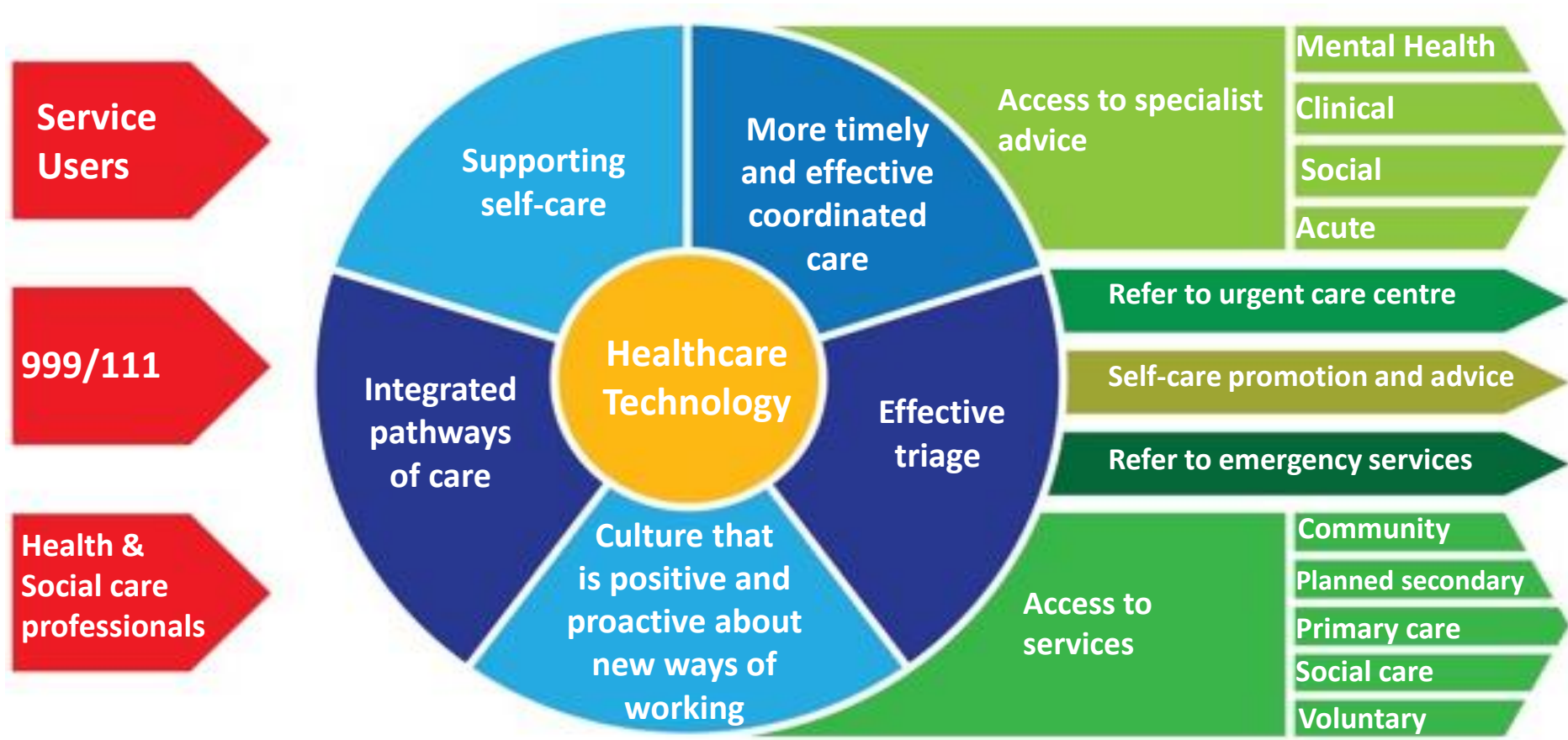


# Operating Model

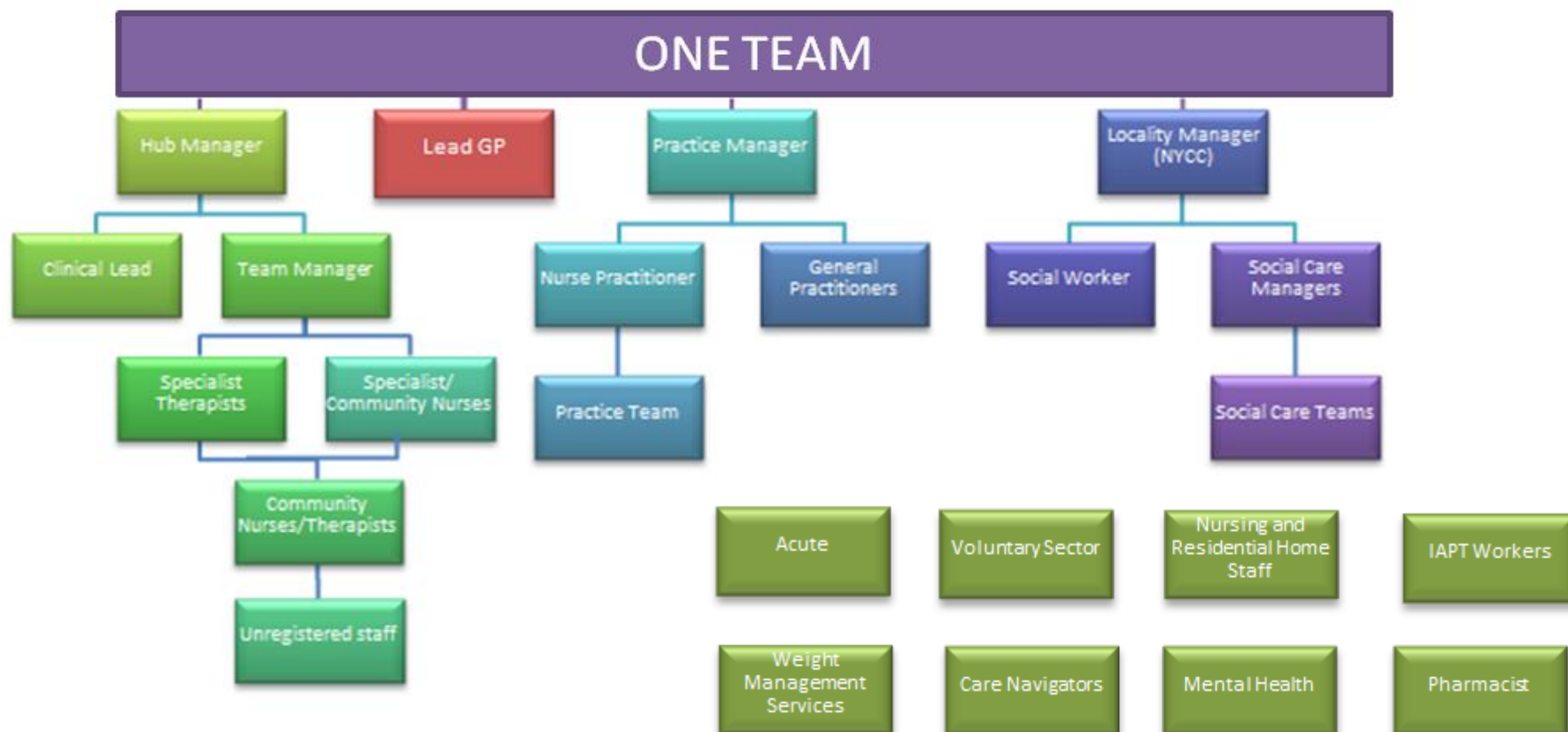




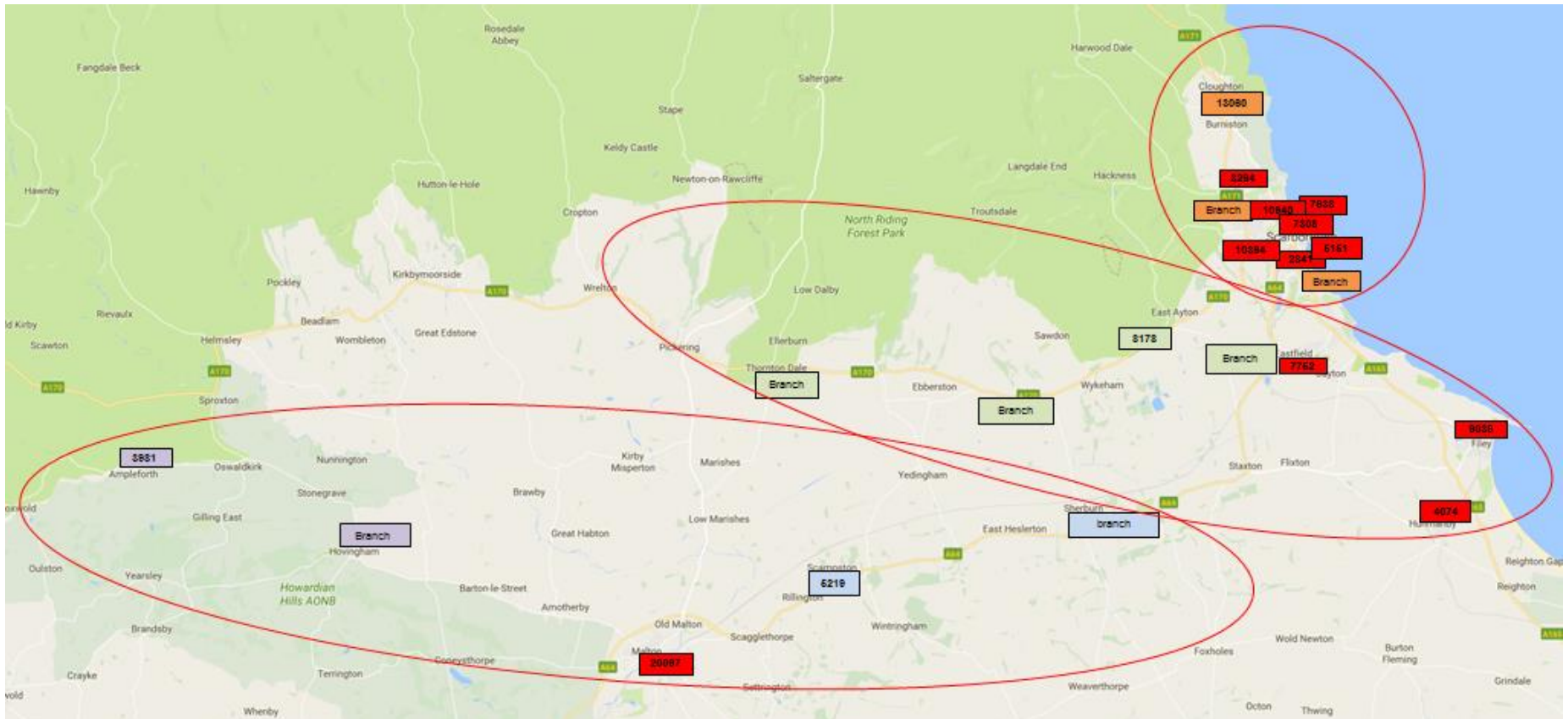
# Customer Access Service



# Scarborough and Ryedale Integrated Hub Structure



# Hub Structure



# Metrics

- Over 200 staff transferred under TUPE
- 5,500 referrals & 4,140 unique patients migrated to the S&R Community Services clinical system

## Weeks 1 - 4

- 3,140 phone calls to the Customer Access Service (CAS) – 194 (6.2%) missed or not picked up by first operator
- Approx. 1,800 new referrals received via the CAS
- Increase to 5,700 unique patients registered
- Of which, 5,165 have an open referral
- 1,850 patients received 9,150 face to face contacts

## Months 1 – 4 (May to August 2018)

- 12,034 phone calls to the Customer Access Service (CAS) – 780 (6.48%) missed or not picked up by the first operator
- 6,315 new referrals received via the CAS
- Increase to 7,319 unique patients registered
- Of which, 7,174 have an open referral – continue to be receiving input
- 10,119 patients received 37,719 face to face contacts



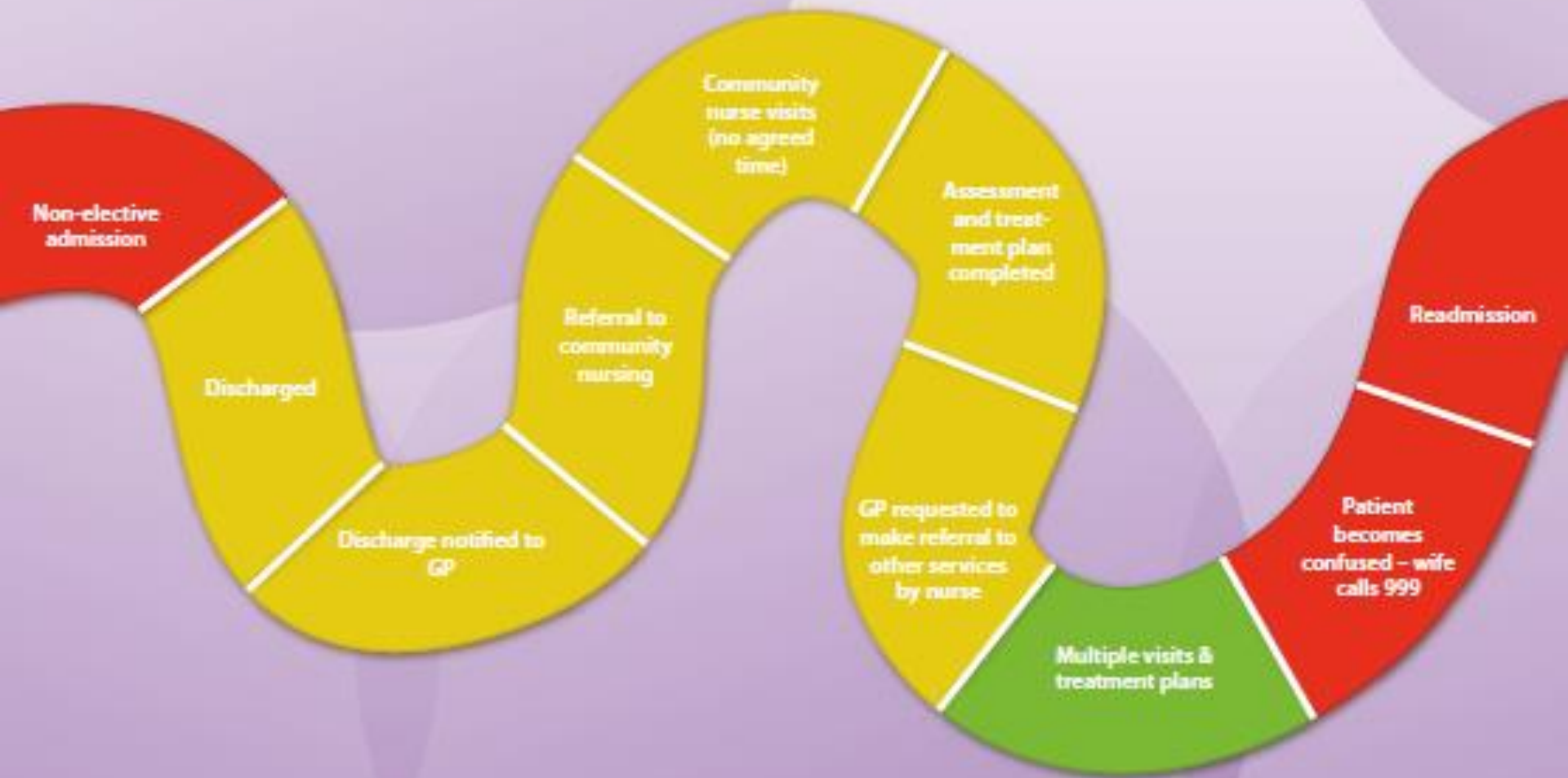
# Pathway Examples & Case Studies

# Barry Grey

Mr Grey lives in central Scarborough. He is a 67 year old married gentleman, with diabetes and heart failure. He is due to be discharged from his third unplanned admission to secondary care in three months following an episode of unstable diabetes. Mr Grey has increasing breathlessness, poor and deteriorating mobility, smokes and has failed to have a flu vaccine due to difficulty getting to the surgery. He requires dressings to leg ulcers.



# Current Pathway



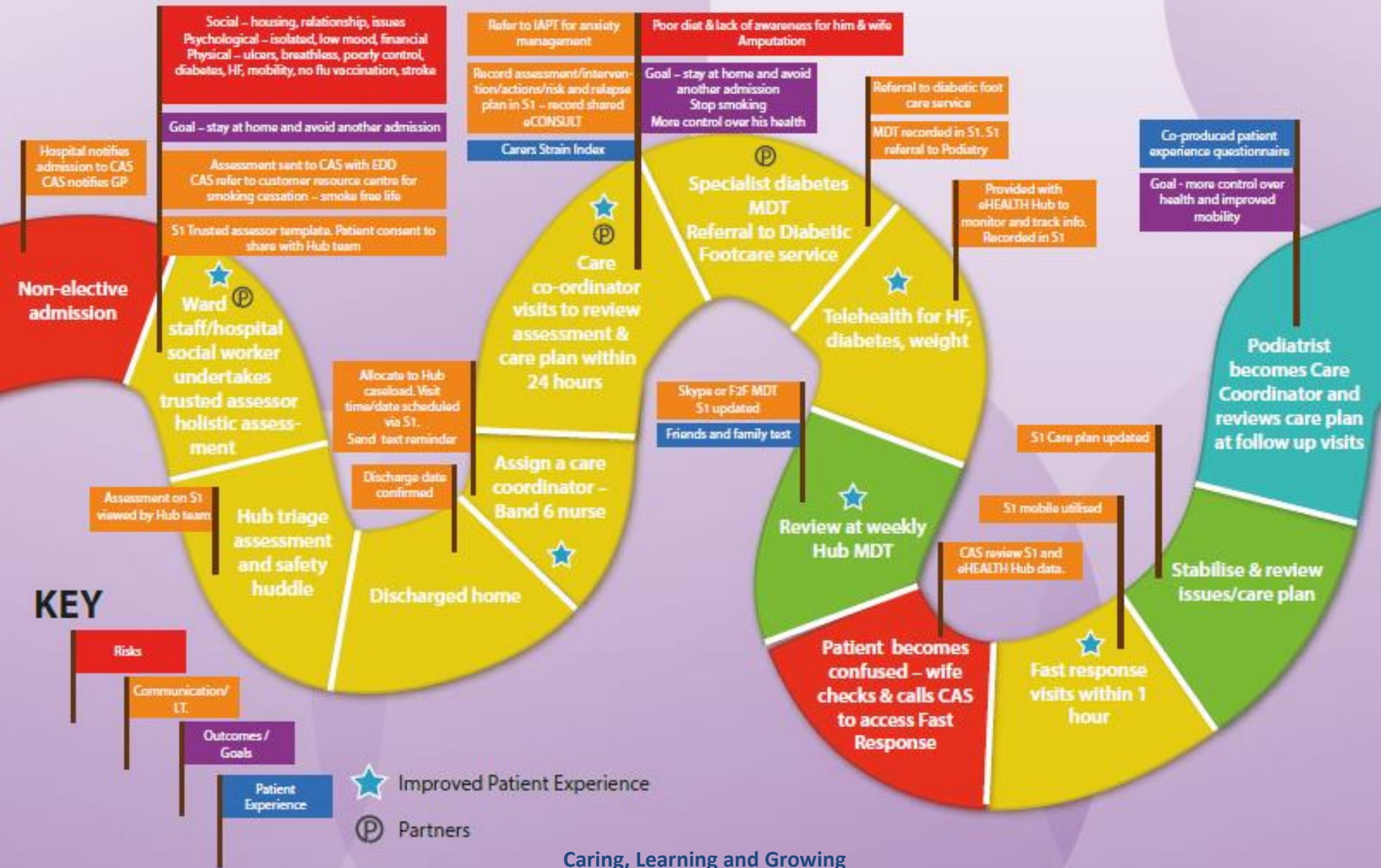
# Day One Pathway





Barry

# OneTeam Pathway



# Case Study – Gentleman, EOL who's wish was to be cared for at home

## Our pathway

CAS receive referrals and deploy urgent response from the community team (CRT) & routine District Nurse (DN) visit



## What was different

Single point of contact for all staff/services  
DN able to view CRT SystmOne (S1) clinical visit record

CRT staff deploy profiling bed/mattress

Joint DN/CRT visit re: anticipatory drugs, bloods, skin integrity assessment



OT identified as care co-ordinator  
Generic Support Worker undertakes dressings and supported to do continence assessment

GP request Fast Track referral



OT completes referral

Care transferred to Fast Track care provider

Family contact CAS – difficulty passing urine/upset at speed of progression of diagnosis & concerns regarding care provider

Improved communication of full team inc. Macmillan Nurse, St Catherine's consultant, GP practice safety huddle, S1 tasks & electronic record

Decision to change care provider and increase care provision time



Original Fast Track paperwork amended

Gentleman deteriorated rapidly and was able to die at home as per his wishes

# **Case Study – Gentleman, EOL who's wish was to be cared for at home**

## **Case Study - Summary**

Improved communication

Improved response to patient and family

Increased skill/competency of generic support workers

Care co-ordination

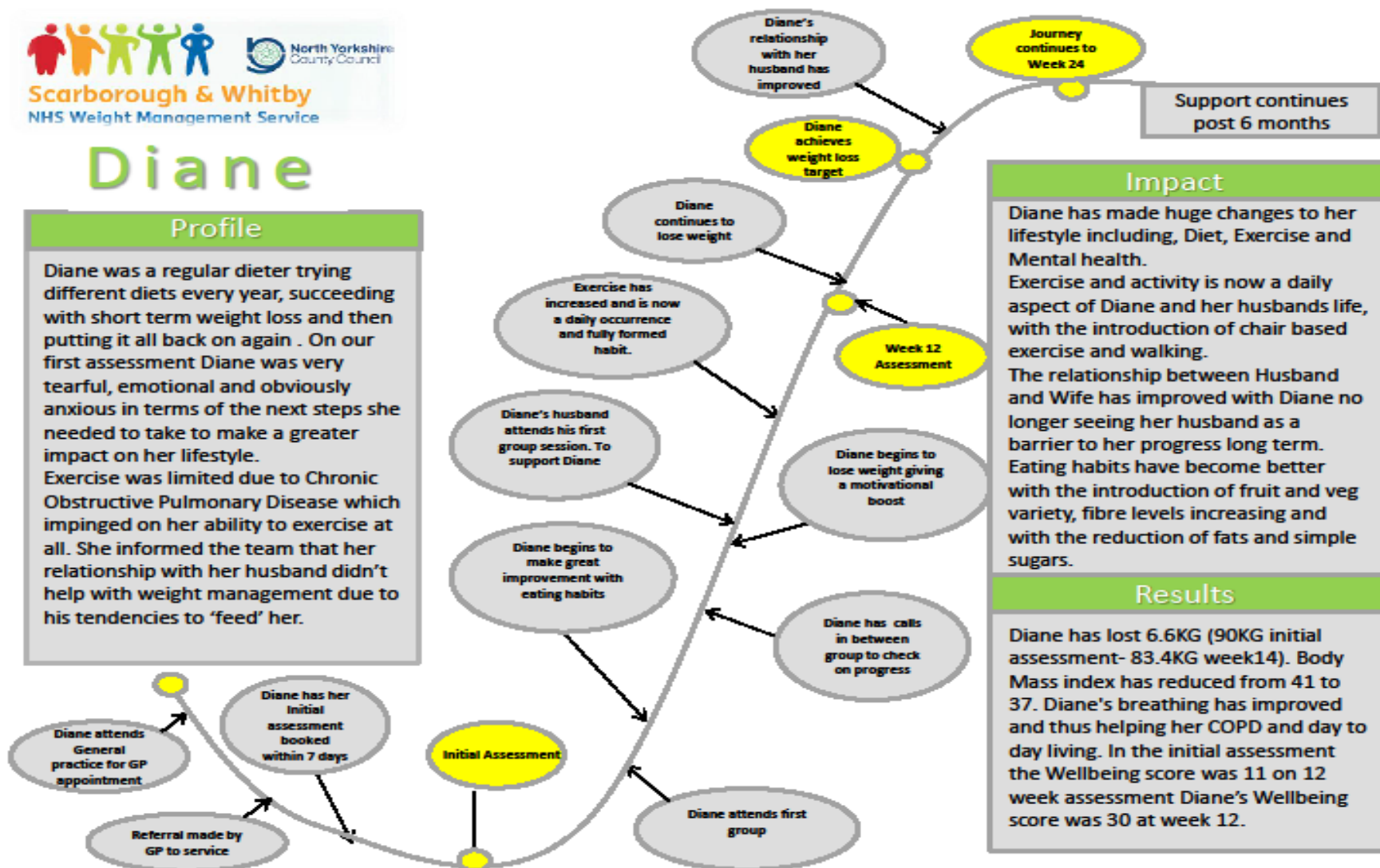
New tasks undertaken by different team members



# Diane

### Profile

Diane was a regular dieter trying different diets every year, succeeding with short term weight loss and then putting it all back on again. On our first assessment Diane was very tearful, emotional and obviously anxious in terms of the next steps she needed to take to make a greater impact on her lifestyle. Exercise was limited due to Chronic Obstructive Pulmonary Disease which impinged on her ability to exercise at all. She informed the team that her relationship with her husband didn't help with weight management due to his tendencies to 'feed' her.



### Impact

Diane has made huge changes to her lifestyle including, Diet, Exercise and Mental health. Exercise and activity is now a daily aspect of Diane and her husbands life, with the introduction of chair based exercise and walking. The relationship between Husband and Wife has improved with Diane no longer seeing her husband as a barrier to her progress long term. Eating habits have become better with the introduction of fruit and veg variety, fibre levels increasing and with the reduction of fats and simple sugars.

### Results

Diane has lost 6.6KG (90KG initial assessment- 83.4KG week14). Body Mass index has reduced from 41 to 37. Diane's breathing has improved and thus helping her COPD and day to day living. In the initial assessment the Wellbeing score was 11 on 12 week assessment Diane's Wellbeing score was 30 at week 12.



# Questions

Thank you