

### 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



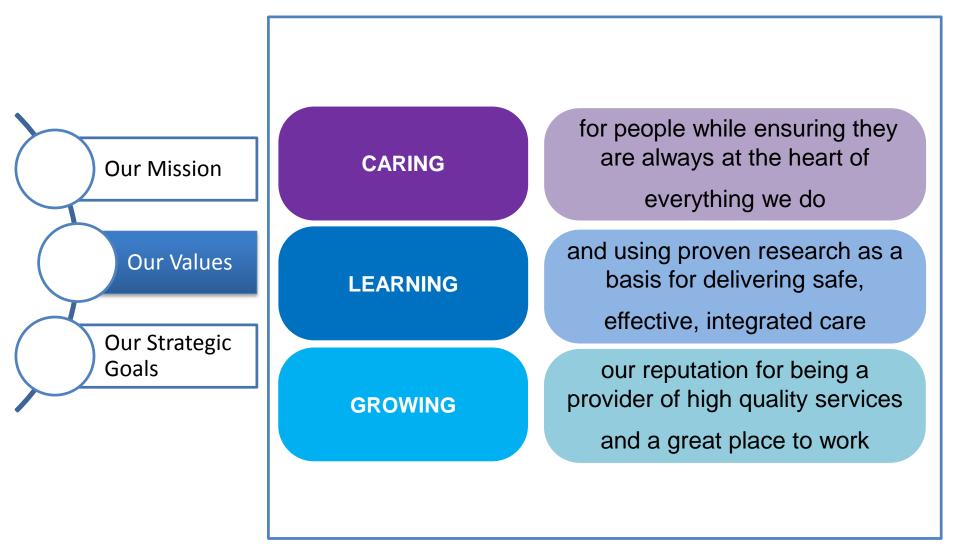
# **Our Mission**



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



## **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



## 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



## **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



## About Us Operational Care Groups

#### Mental Health

- Adult Mental Health
- Older People's
  Mental Health
- Mental Health
  Response Service &
  Crisis Pad
- Specialist Mental Health Teams e.g. Perinatal, Psychotherapy, Trauma, Veterans

Primary Care, Community, Children's and Learning Disability Services

- 7 GP Practices
- Whitby & Pocklington Community
  Services
- Child & Adolescent Mental Health
  Community Services
- Integrated Specialist Public Health Nursing & Immunisation Service
- Learning Disability Services
- Children's Therapies
- Health Trainers (Social Prescribing, Smoking Cessation, Health Checks & Weight Management)



Caring, Learning and Growing

#### Specialist Services

- Medium & Low Secure Inpatient Services
- Court Diversion & Liaison
- Substance Misuse
  Services

### **Our Trust Board**

## **NHS** NHS Foundation Trust



Chief Executive





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



Peter Baren Non-Executive Director



Paula Bee Non-Executive Director

#### Management Team for Scarborough & Ryedale





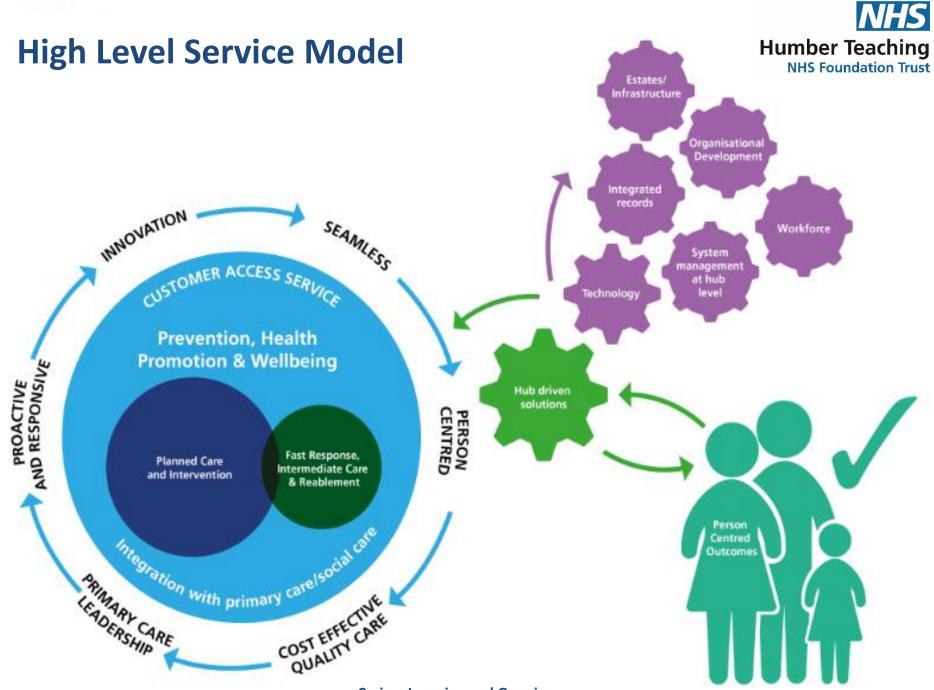
Lynn Parkinson Chief Operating Officer



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

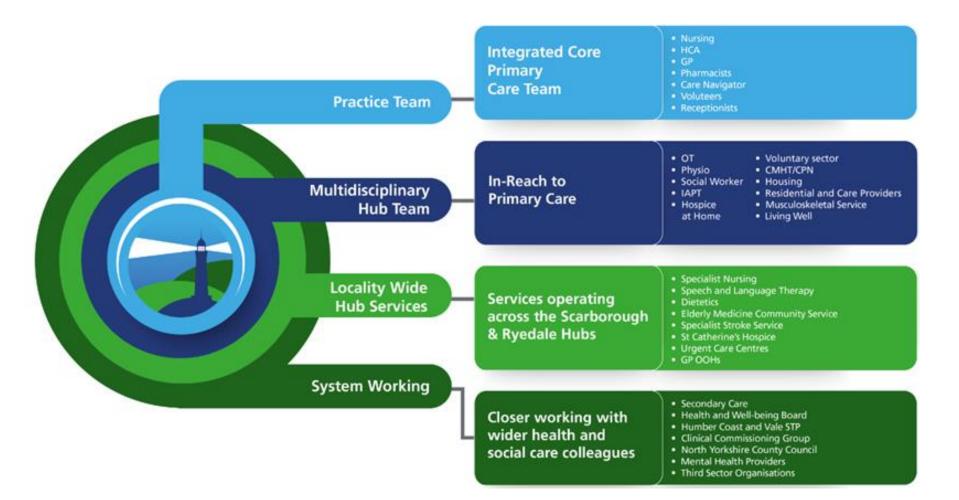
 Professional Accountability
 Managerial Accountability





### **Operating Model**







## **Customer Access Service**



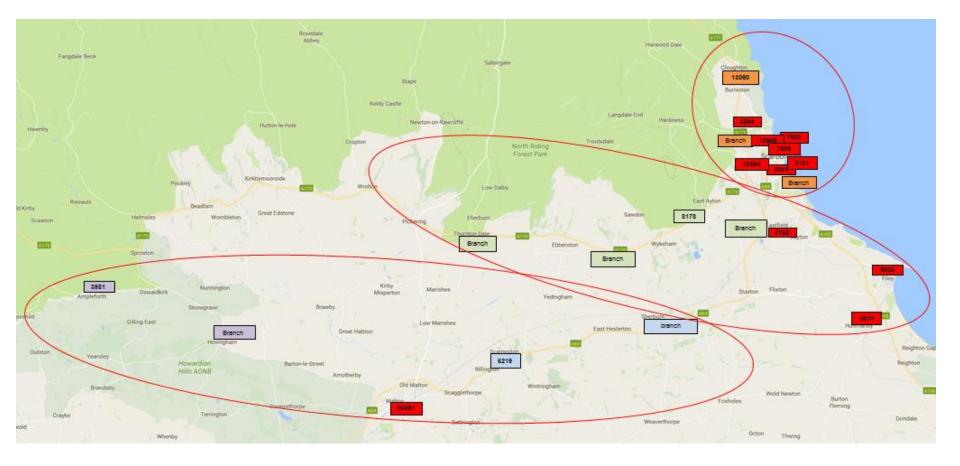


### **Scarborough and Ryedale Integrated Hub Structure**





### **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

#### <u>Weeks 1 - 4</u>

- 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 t 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**

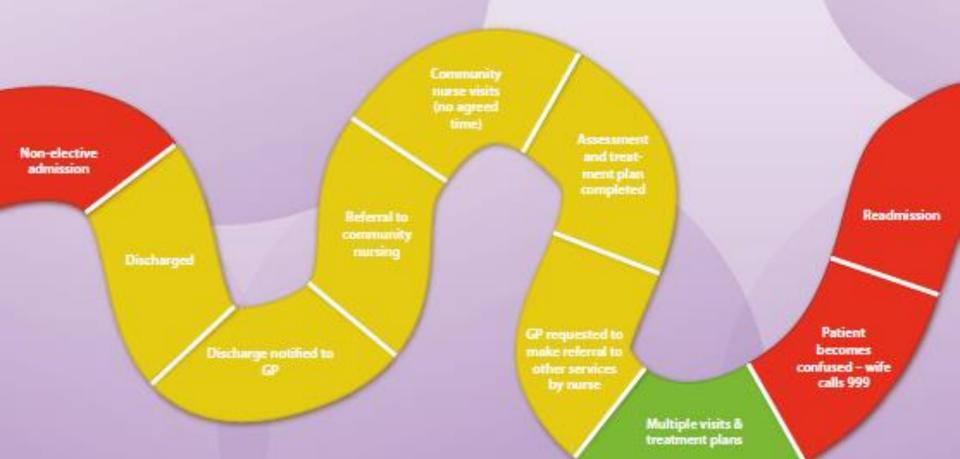


Mr lives in central Grey Scarborough. He is a 67 year old married gentleman, with diabetes and heart failure. He is due to be discharged from his third unplanned admission to secondary care in three months following an episode of unstable diabetes. Mr Grey has increasing breathlessness, poor and deteriorating 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**

Non-elective admission

> Hospital notifies CAS of admission and EDD

> > Discussed at Salety Huddle

Care co-ordinator visits to assess & develop care plan within 24 hours

Assign a care coordinator

CAS notify Hub Discharged Referred to Specialist diabetes nurse Referral to Diabetic Footcare service

Review at weekly MDT

> Patient becomes confused - wife checks & calls Fast Response

Nurse continues to be care coordinator

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Stabilise & review issues/ care plan

Fast response visits within 1 hour

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#### **OneTeam Pathway** Social - housing, relationship, issues Refer to IAPT for anxiety Poor diet & lack of awareness for him & wife Psychological - isolated, low mood, financial management Amputation Physical - ulcers, breathless, poorly control, diabetes, HF, mobility, no flu vaccination, stroke Goal - stay at home and avoid Record assessment/interven ferral to diabetic foot tion/actions/risk and relaces another admission care service plan in S1 - record shared Stop smoking CONSULT More control over his health Goal - stay at home and avoid another admission IDT recorded in 51.51 Co-produced patient Carers Strain Index referral to Podiatry Hospital notifies experience questionnaire P admission to CAS CAS notifies GP Assessment sent to CAS with EDD CAS refer to customer resource centre for **Specialist diabetes** Goal - more control over Provided with smoking cessation - smoke free life health and improved eHEALTH Hub to ŵ mobility nitor and track info. Ð Referral to Diabetic S1 Trusted assessor template. Patient consent to **Recorded** in S1 share with Hub team Footcare service Care co-ordinator Non-elective Ward ® visits to review admission **Telehealth for HF** staff/hospital assessment & diabetes, weight Podiatrist social worker care plan within becomes Care Allocate to Hub 24 hours Skype or F2F MDT caseload. Visit Coordinator and trusted assessor time/date scheduled S1 updated reviews care plan holistic assess via 51. Friends and family test Send text reminder S1 Care plan updated at follow up visits Assign a care Discharge date confirmed Band 6 nurse S1 mobile utilised newed by Hub team Hub triage **Review at weekly** Hub MDT ŵ EAS review S1 and eHEALTH Hub data. and safety Stabilise & review huddle issues/care plan KEY Patient becomes Risks confused - wife mmunication/ visits within 1 checks & calls CAS to access Fast Outcomes/ Response Goals Improved Patient Experience Patient Experience Partners **Caring, Learning and Growing**

Barry

### 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

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

GP request Fast Track 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

Decision to change care provider and increase care provision time

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

#### 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

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

OT completes referral

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

Original Fast Track paperwork amended









### 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

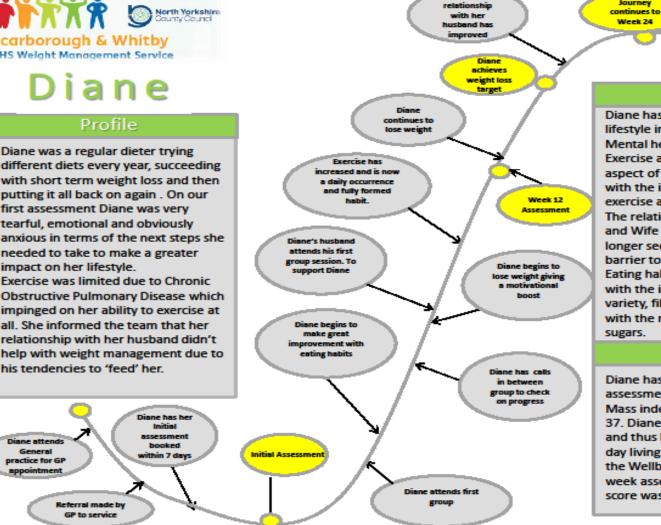
New tasks undertaken by different team members

### NHS **Humber Teaching**

**NHS Foundation Trust** 

### Scarborough & Whitby NHS Weight Management Service

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.



Diane's

#### Support continues post 6 months

#### Impact

Journey

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.

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