social care institute for excellence

in collaboration with Integration and Better Care Fund

Better Care Fund resources

York Integrated Care Team

Scheme

Who?

Vale of York clinical commissioning group (CCG)

York City

What

A multidisciplinary team made up of:

- nurses (including mental health and learning disability nurses), GPs, occupational therapists, urgent care practitioners, care workers, care coordinators, administrators
- the person's family and friends
- secondary care and social care colleagues
- the ambulance service
- third-sector colleagues
- everyone!

Why?

The scheme was set up to:

- reduce avoidable hospital admissions
- expedite safe discharge from hospital
- enable patients to remain independent longer
- deliver person-centred care
- deliver support In the 'right place at the right time'.

When?

- May 2014 – trial with 55,000 patients
- January 2015 – following the success of the trial, the scheme was expanded to cover four York-based practices totalling a population of 130,000 patients
- September 2015 – start of rapid expansion to cover all City of York practices (207,000 patients).

How?

The team supports 11 GP practices and works across three integrated workstreams:

- avoiding admissions team
- complex care – care homes
- community carers service.

The focus is on the person.

- There is one telephone contact point for all health and social care services and fast response times to calls.
- The person only has to tell their story once.
- A named nurse acts as facilitator within the local system.

The integrated approach enables:

- access to multiple clinical and social care systems: SystemOne, EMIS and Core Patient Database, Mosaic
- streamlined support to care homes from primary care making best use of time and resources, freeing up capacity for more complex case management and support
- connecting with communities and making third-sector referrals
- sharing knowledge and mentoring students
- upskilling care home staff
- reviewing admissions and discharges for all patients on the register at a daily multidisciplinary team meeting
- Pre-emptive multidisciplinary teams: all discharged patients on the register are contacted within 72 working hours.

Challenges

- Engagement with other services – people were sceptical about the integrated care team remit.
- Recruitment – it was hard to find enough people with the appropriate skills when the team was first set up.
- Data-sharing – improvements have been made in data-sharing but social care teams still cannot access clinical data.
- Workspace – finding adequate space to grow the team was difficult.

Impact

- Positive patient feedback – all respondents (43) to a patient feedback survey said that they were very happy with the York Integrated Care Team service.
- Positive staff feedback.
- Improved integration and referrals to third sector.
- Improved integration with secondary care services and social services through multidisciplinary team working.
- Slight increase in hospital discharges facilitated through 'One Team' pathway.
- Reduced numbers of excess bed days (XS bed days).
- Initially reduced number non-elective admissions (due to coding changes of ambulatory care conditions, there has been a significant increase in zero length of stay admissions, affecting the overall total).
- Reduced lengths of stay over four days (LOS>4 days).

Case study

Mrs P, a patient on the case management register, was feeling unwell and causing her daughter concern. The daughter called the single contact number and a coordinator passed the case on to a nurse.

The nurse visited Mrs P at home to assess her condition and diagnosed a urinary tract infection (UTI). The nurse then contacted a GP for a prescription of antibiotics. This integrated approach meant that Mrs P's daughter was able to pick up the antibiotics locally within three hours of first making contact.

View all practice examples link 1

link 1 | https://www.scie.org.uk/integrated-care/better-care/practice-examples