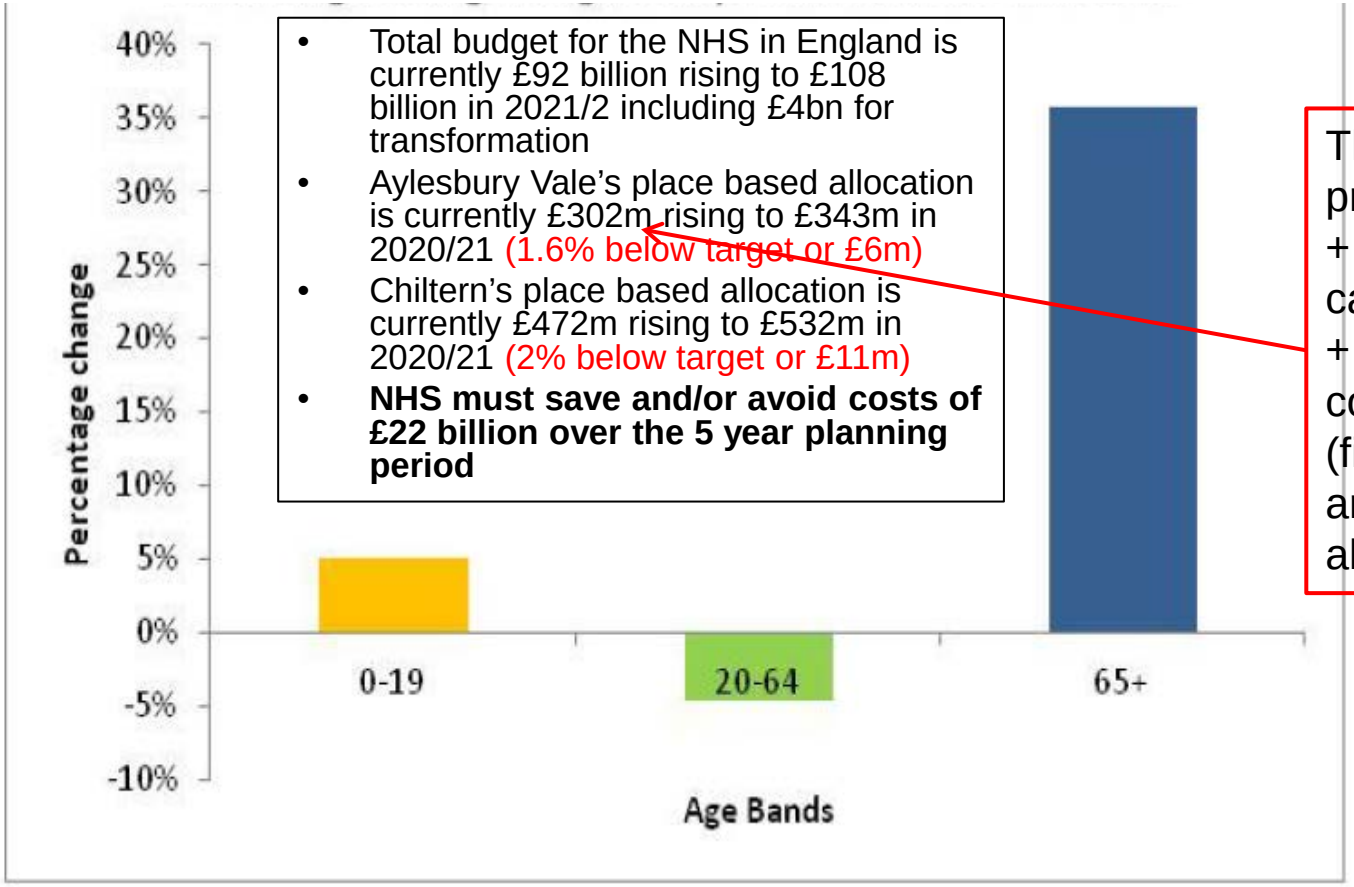
What Integration means for our Buckinghamshire Health & Social Care System

Louise Patten RGN DN BSc MBA
Chief Officer, NHS Aylesbury Vale CCG

What are our local Health Challenges?

NHS Allocations vs Projected Growth

Percentage change in Age Groups, 2011 - 2015



- Total budget for the NHS in England is currently £92 billion rising to £108 billion in 2021/2 including £4bn for transformation
- Aylesbury Vale's place based allocation is currently £302m rising to £343m in 2020/21 (1.6% below target or £6m)
- Chiltern's place based allocation is currently £472m rising to £532m in 2020/21 (2% below target or £11m)
- **NHS must save and/or avoid costs of £22 billion over the 5 year planning period**

This is £225m previous baseline + primary medical care allocation + specialist commissioning (first time these are seen in our allocation)

STP: Integrated Working is Essential

Sustainability & Transformation Plans (STPs) will be the single application & approval process for transformation funding for 2017/18 onwards

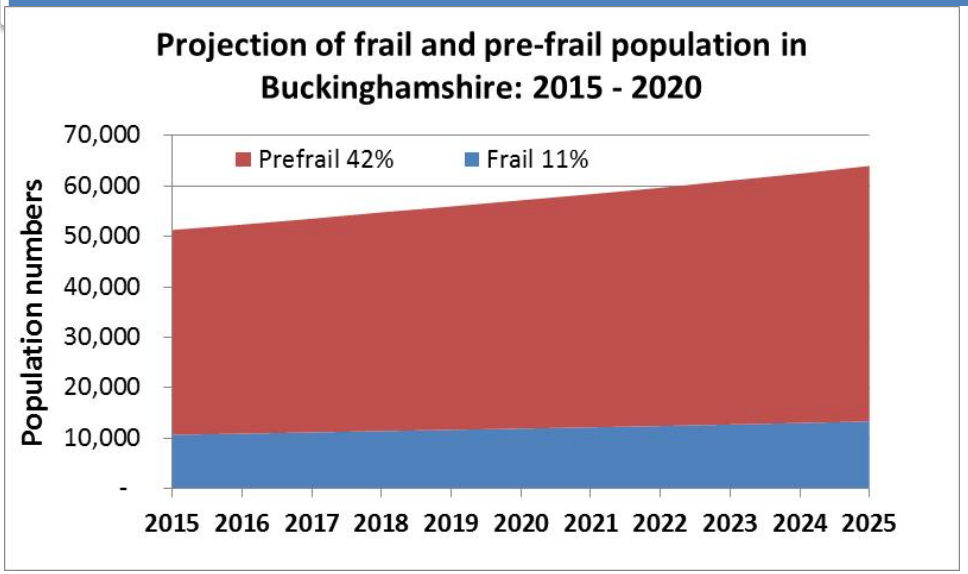
2016/17 resources largely already allocated to support organisations which are seriously financially challenged already

Buckinghamshire, Oxfordshire & Berkshire West 'footprint' budget is currently £2.5 billion rising to £3 billion in 2020/21 including £100m for transformation

Buckinghamshire's notional fair share of transformational £s is in the region of £30 million on a weighted capitation basis

Must be linked to delivering new models of care e.g. *Vanguard* models such as Multi Specialty Community Providers, Primary & Acute Care Systems

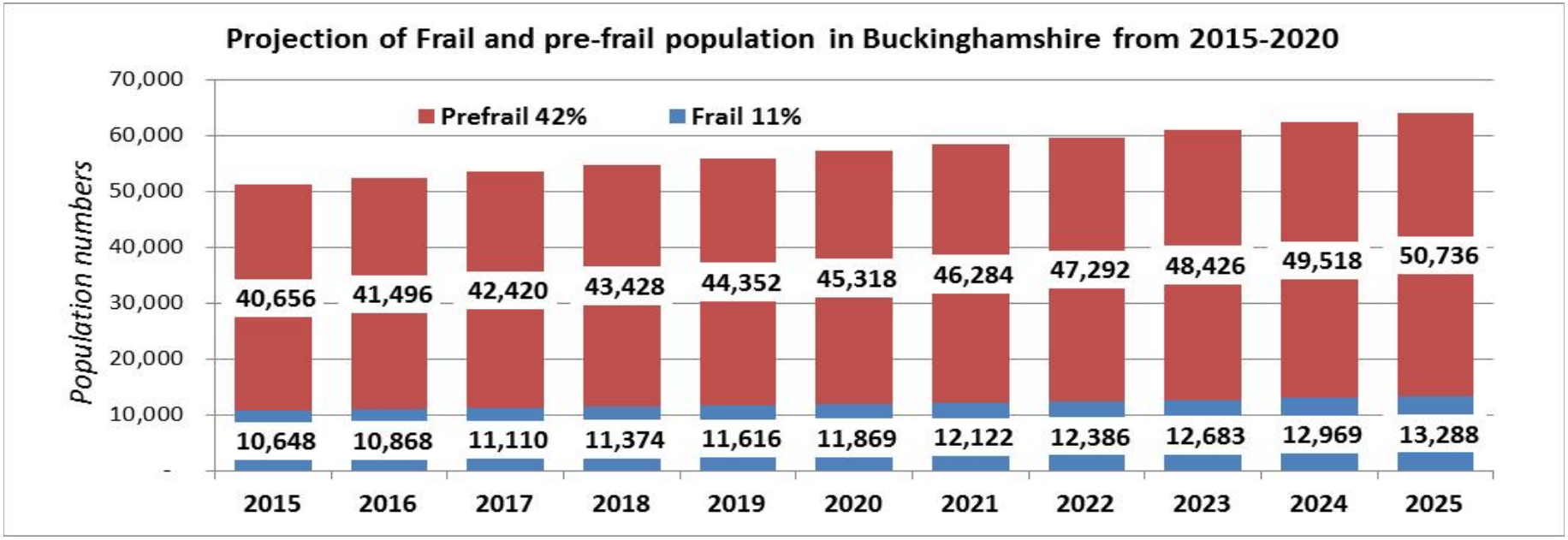
ESTIMATES OF FRAIL ELDERLY POPULATION - PROJECTIONS



1. **In 2015, around 10,700 Bucks residents are estimated to be frail elderly meaning those with more than one long term condition or those with a condition that needs assistance with activities of daily living (approximately 11% of the elderly population*)**

2. **By 2020, the estimated frail elderly population is expected to rise to 12,000 means a rise of 1300. Evidence shows that the frail elderly population is 3 times more likely to end up in a hospital compared to the non-frail older population aged 65 and over.**

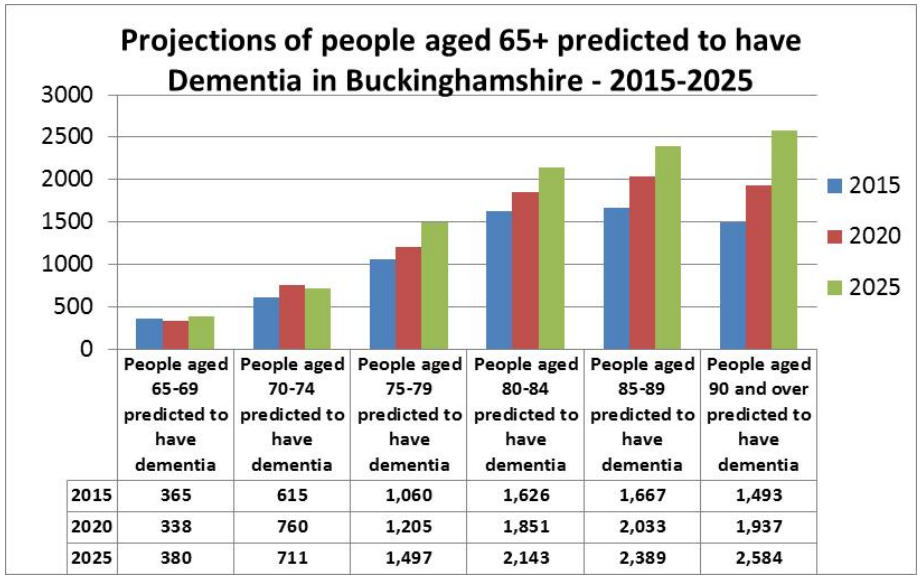
3. **Around 42% elderly population are considered as pre-frail which equates to around 45,000 people pre-frail in Bucks by 2020 compared to 40,000 in 2015**



*Reference: Collard et al (2012). Prevalence of frailty in community-dwelling older persons: A systematic review. J Am Geriatr Soc; 60: pp1487-92.

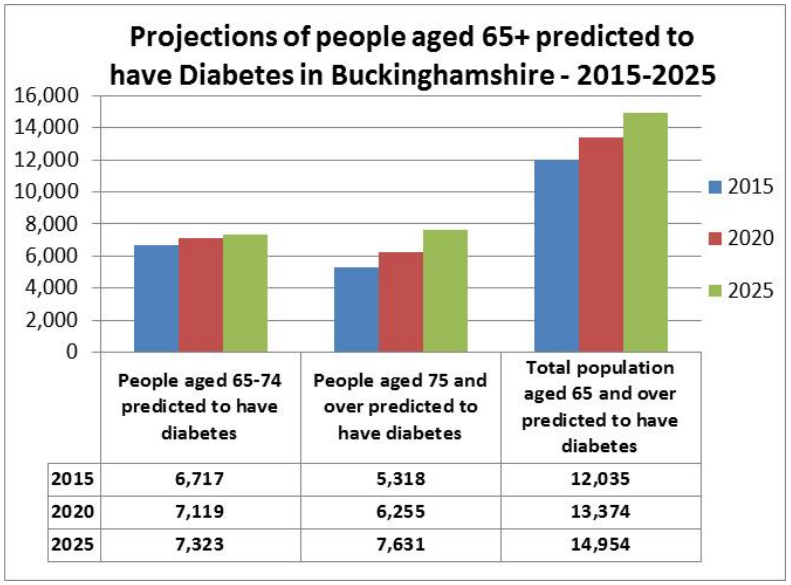
PROJECTIONS OF LONG TERM CONDITIONS

DEMENTIA



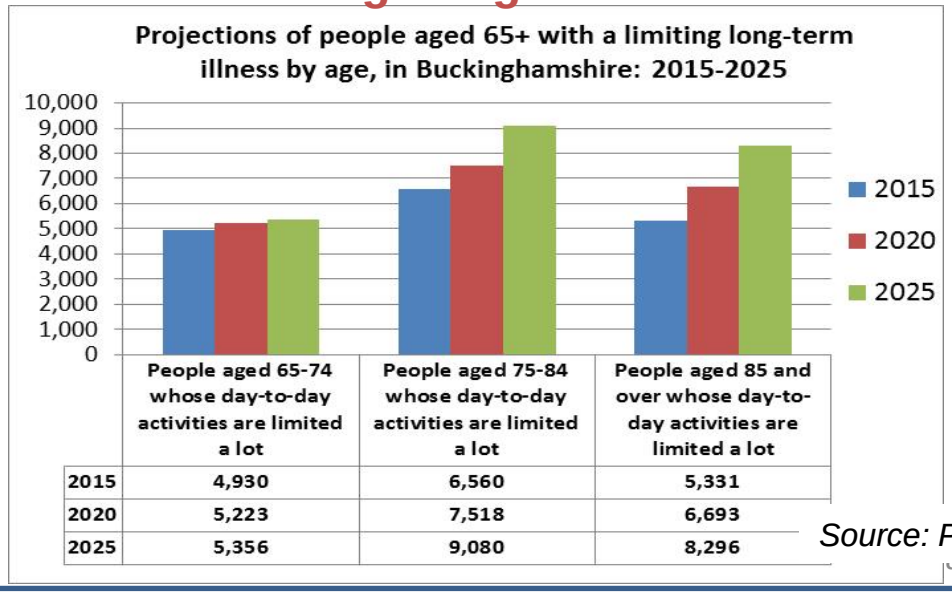
	People aged 65-69 predicted to have dementia	People aged 70-74 predicted to have dementia	People aged 75-79 predicted to have dementia	People aged 80-84 predicted to have dementia	People aged 85-89 predicted to have dementia	People aged 90 and over predicted to have dementia
2015	365	615	1,060	1,626	1,667	1,493
2020	338	760	1,205	1,851	2,033	1,937
2025	380	711	1,497	2,143	2,389	2,584

DIABETES



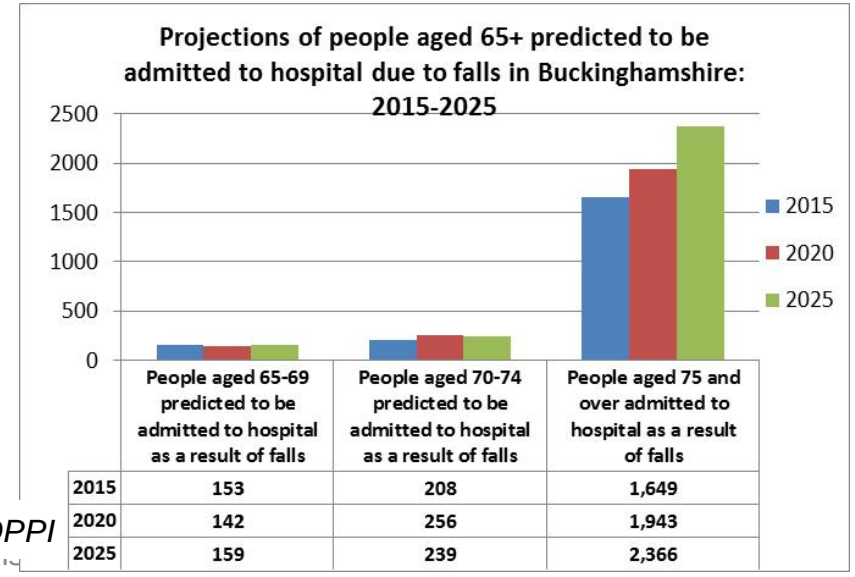
	People aged 65-74 predicted to have diabetes	People aged 75 and over predicted to have diabetes	Total population aged 65 and over predicted to have diabetes
2015	6,717	5,318	12,035
2020	7,119	6,255	13,374
2025	7,323	7,631	14,954

Limiting Long-term illness



	People aged 65-74 whose day-to-day activities are limited a lot	People aged 75-84 whose day-to-day activities are limited a lot	People aged 85 and over whose day-to-day activities are limited a lot
2015	4,930	6,560	5,331
2020	5,223	7,518	6,693
2025	5,356	9,080	8,296

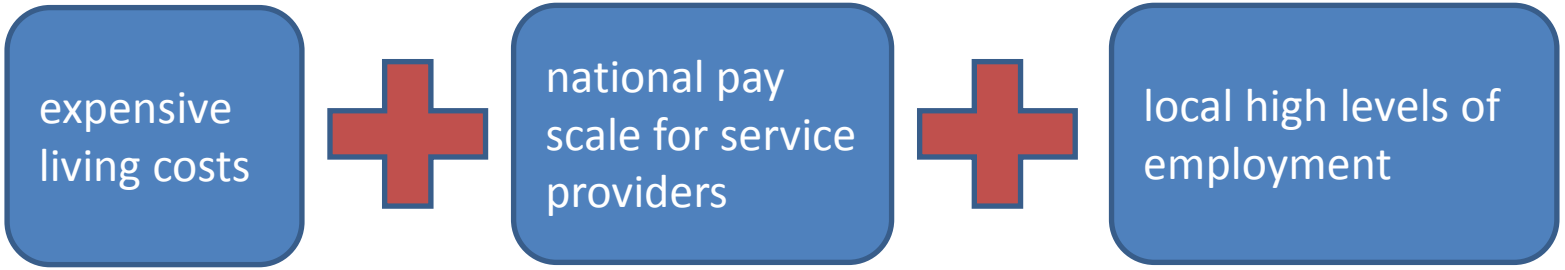
FALLS

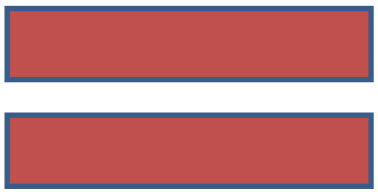


	People aged 65-69 predicted to be admitted to hospital as a result of falls	People aged 70-74 predicted to be admitted to hospital as a result of falls	People aged 75 and over admitted to hospital as a result of falls
2015	153	208	1,649
2020	142	256	1,943
2025	159	239	2,366

Source: POPPI

Unique Workforce Challenges…





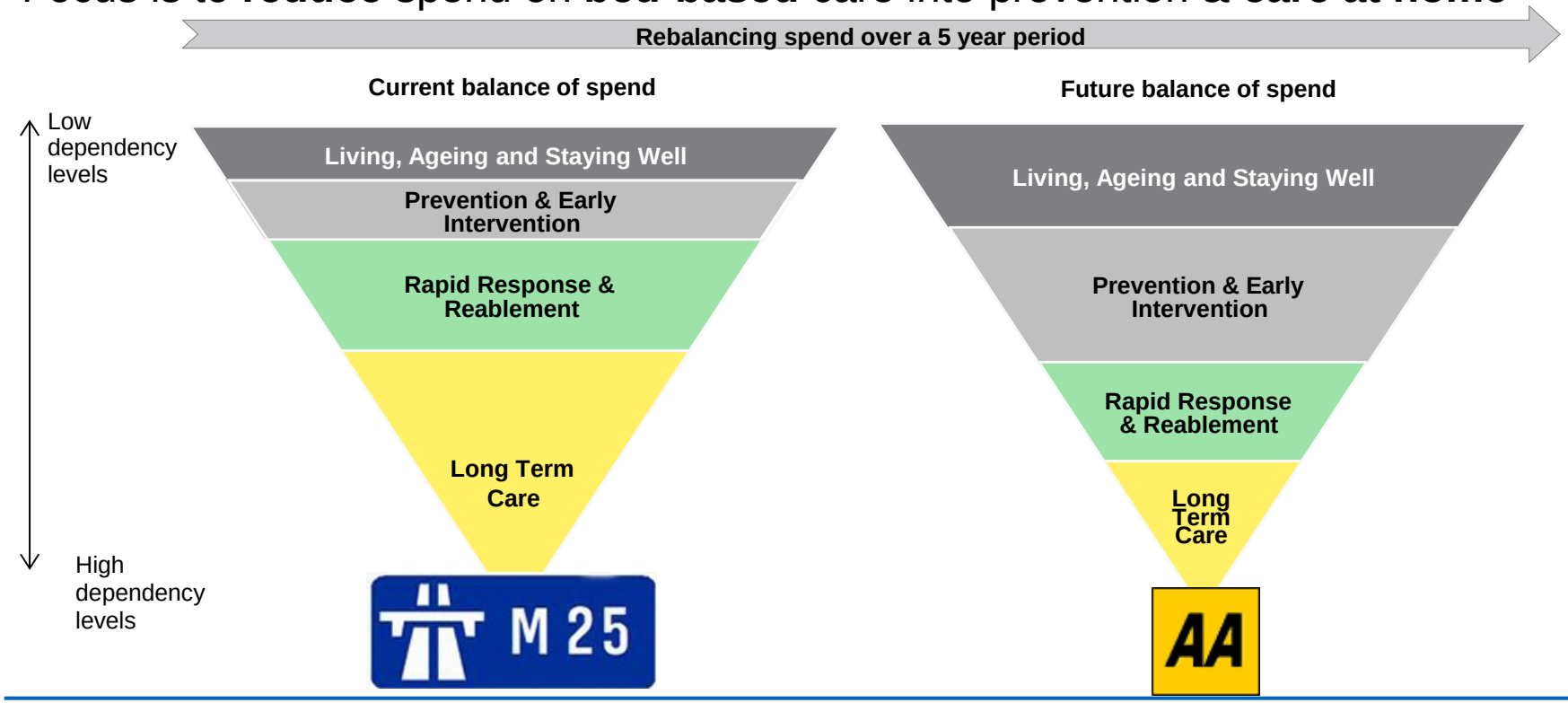
Low numbers of available health and social care professionals

Buckinghamshire's 'share' of financial challenge

Buckinghamshire must save and/or avoid costs of £205 million over the 5 year planning period across the health & care system

Low risk relative to elsewhere in the NHS in England

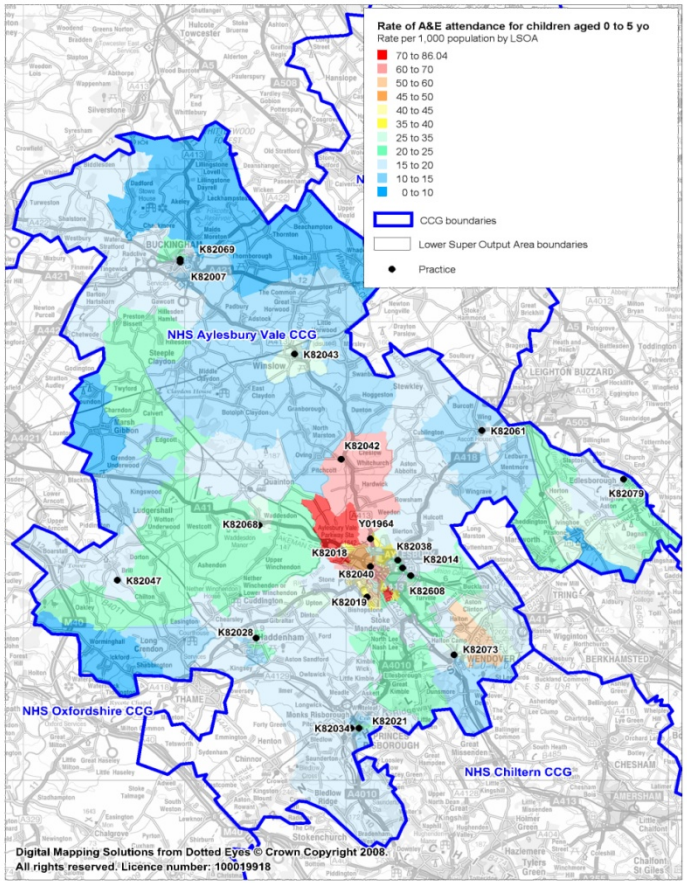
Focus is to **reduce** spend on **bed-based** care into prevention & **care at home**



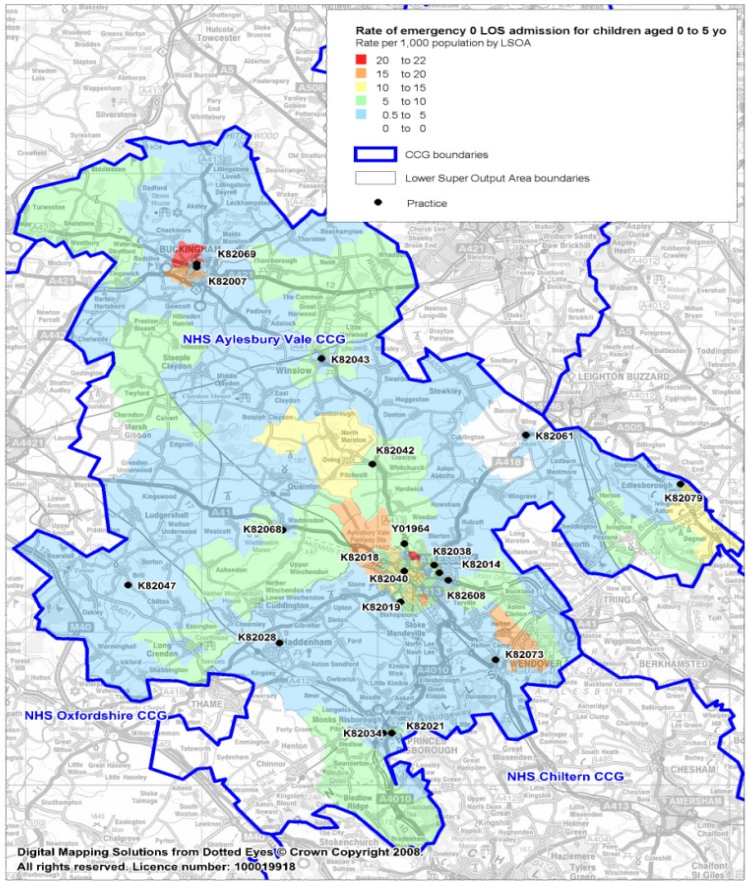
How can the Integration Agenda help us to achieve System Sustainability?

1. Know Our Population:

Rate of A&E attendance for patients aged 0 to 5 years old in NHS Aylesbury Vale CCG by LSOA (Feb 2012 - Jan 2013)



Rate of emergency zero length of stay admission for patients aged 0 to 5 years old in NHS Aylesbury Vale CCG by LSOA (Feb 2012- Jan 2013)

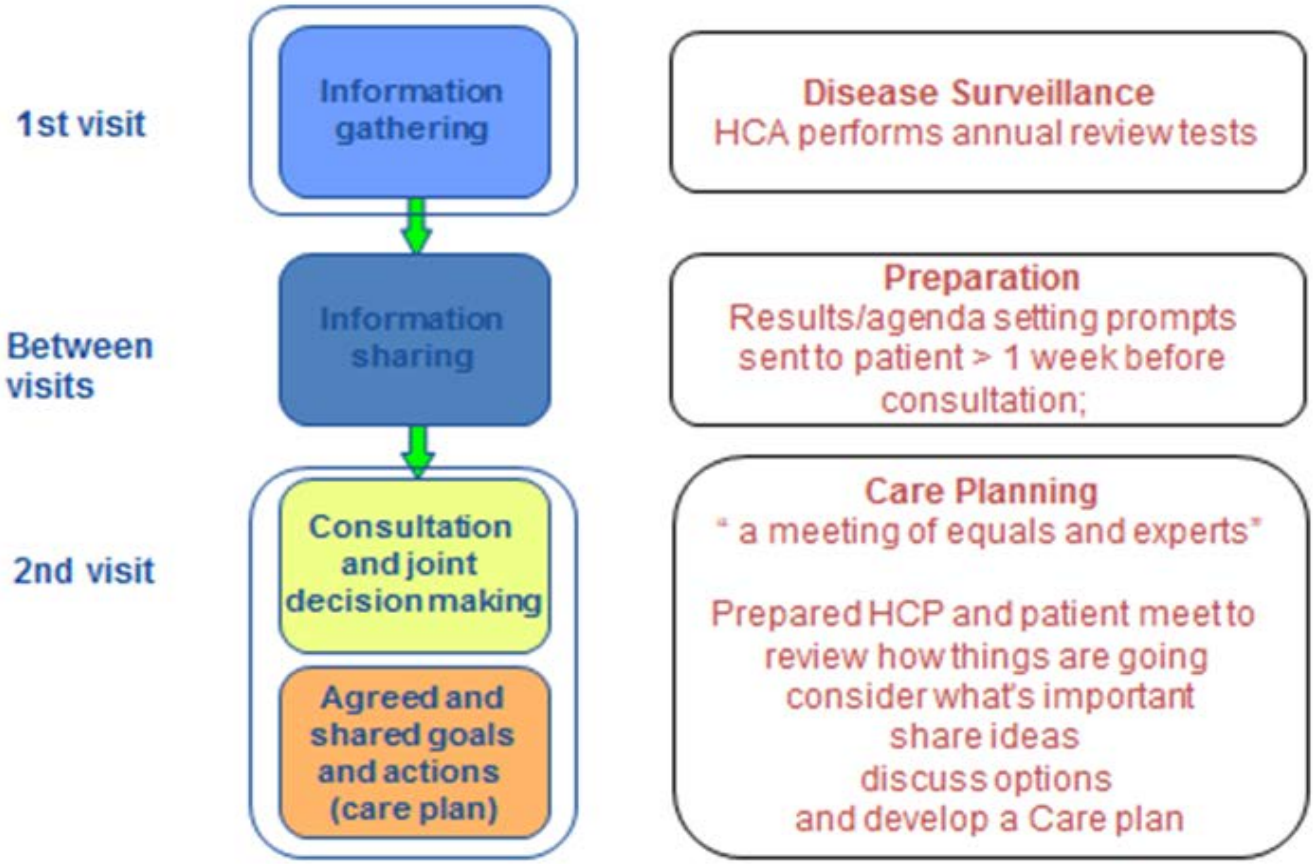


2. Encouraging Self Management

House of Care model

The House of Care emphasises that effective care and support planning (CSP) consultations rely on four elements working together in the local healthcare system

Changing GP Consultations



3. Changing Commissioning Mindset: current

Mr Smith has COPD and a painful hip that limits his mobility

He is referred to the orthopaedic consultant and a hip replacement is undertaken

After rehabilitation he is home but it will be 3 months before he gets back to previous levels of activity

Current commissioning:

- Commissioners plan for specific activity levels (emergency admissions, hip replacements)
- Quality markers based on mortality rates, infection control, patient satisfaction with hospital experience

Outcomes based commissioning: future

After discussion with his nurse and GP, he decides he wants to keep his bridge club visits twice a week and to be as pain free as possible for maximum mobility

His treatment was physio and OT for safe movement around the house, together with a robust pain control plan

Commissioning outcomes:

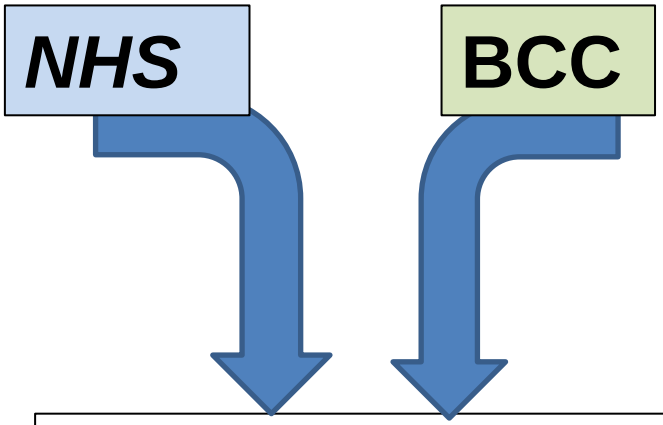
Paying for health & care services based on rewarding the outcomes that are important to the service user

…a value based approach

4. Developing our Integration Agenda:

Success….

- Child & Adolescent Mental Health Services (CAMHS)
- Better Care Fund
- Trusted Assessments in Aylesbury



Next Steps….
Pooled Budgets and shared risk
Driving quality **UP**
And cost **DOWN**

Integrated Commissioning for Quality

Understanding the patient's quality of life before admission, **setting targets**

Maximising independence throughout hospital stay

Increased independence
Reduced social care requirements
Reduced need for care home admission

Integrated Commissioning – Emergency Services

Ambulance service struggles at times to reach targets – little time to stop and look for alternative care solution

Hospitals have poor control over their 'supply' of patients from GPs and Ambulance calls

May have to admit because no transport home or it's late at night

What would a local emergency service look like?

COMMUNITY FIRST RESPONDERS

5. Encouraging Self Help: attitudes are changing…

- Facebook/Twitter to comment real time on health & social provision
- Personalised Risk Profile
- On line Health Trainer & FitBit
- Baby Buddy App
- Text Appointment request for GP

"Future health services will not revolve around consultants in hospitals. Instead, they will facilitate the active involvement of users themselves in providing their own care…" *Lord AraDazi*

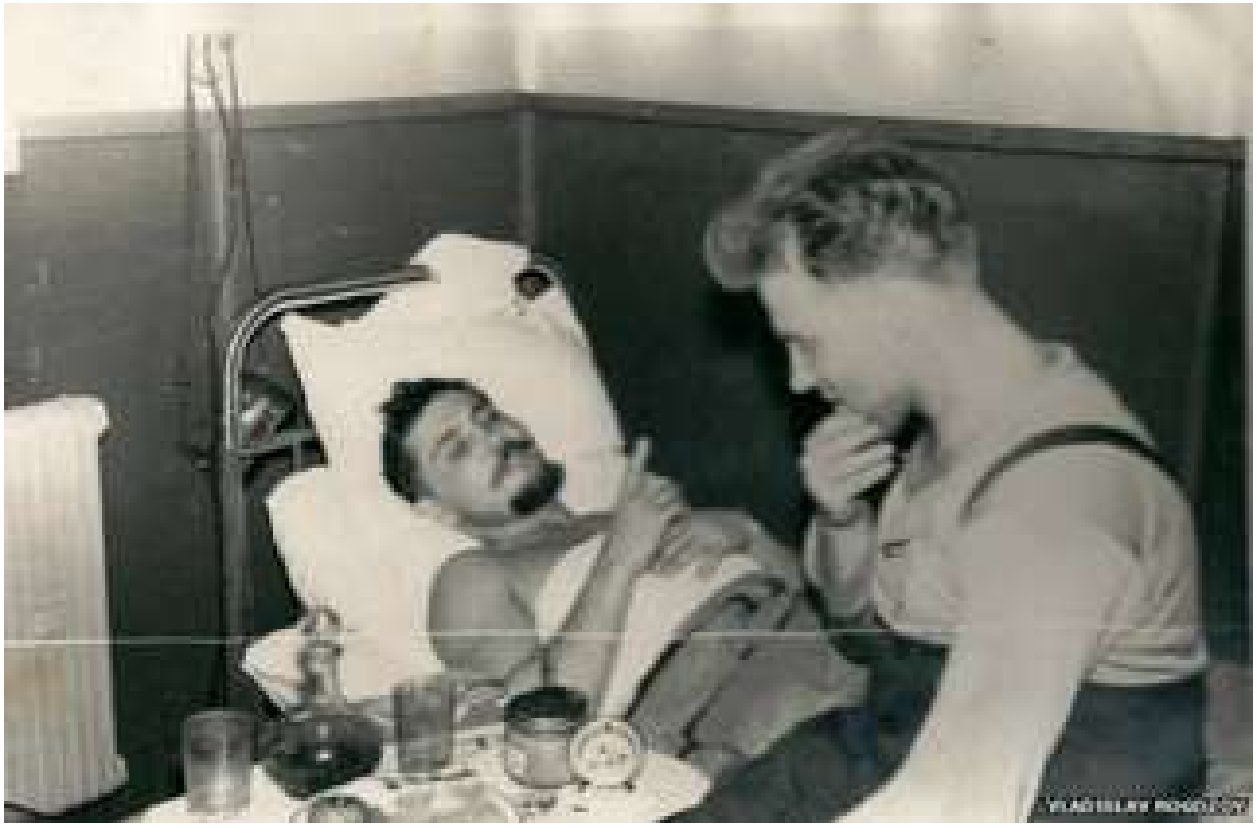
6. Assistive Technology

- Patients store own data on their cloud;
- Shared patient notes – consent obtained at time of consultation
- **Facetime, video** consultations
- **Fit bits** and linkage to health support

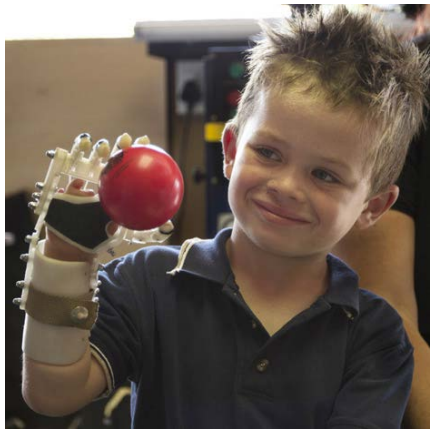
<u>Independent living technology:</u>

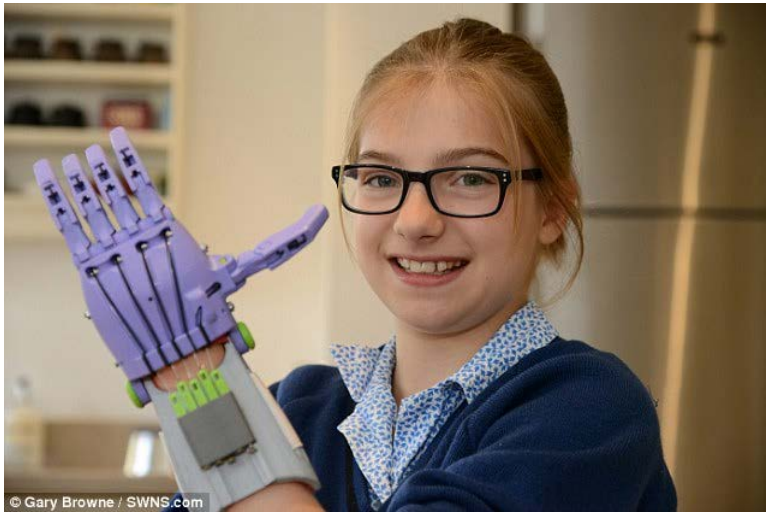
- **Automatic lights -** prevent trips and falls
- **Automated shut-off devices** for gas, water
- **Special plugs for depth, temperature**
- **Fall sensors** that can register if a person has fallen.
- **Tracking devices – absence from a chair, leaving the house**

What degree of self care management?



And finally- the future?





Self care – but not as we know it!

Thank You!