**Buckinghamshire County Council**

# Select Committee

Health and Adult Social Care

**Date:** Tuesday 18 October 2016

**Time:** 10.00 am (there will be a pre-meeting for Members at 9.30am)

**Venue:** Mezzanine Room 2, County Hall, Aylesbury

## AGENDA

### 9.30 am Pre-meeting Discussion

This session is for members of the Committee only. It is to allow the members time to discuss lines of questioning, areas for discussion and what needs to be achieved during the meeting.

### 10.00 am Formal Meeting Begins

| | Agenda Item | Time | Page No |
|---|---|---|---|
| 1 | **APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP** | **10.00am** | |
| 2 | **DECLARATIONS OF INTEREST**<br>To disclose any Personal or Disclosable Pecuniary Interests | | |
| 3 | **MINUTES**<br>of the meeting held on Tuesday 6 September to be confirmed as a correct record. | | **7 - 12** |
| 4 | **PUBLIC QUESTIONS**<br>This is an opportunity for members of the public to put a question or raise an issue of concern, related to health. Where possible, the relevant organisation to which the question/issue is directed will be present to give a verbal response. Members of the public will be invited to speak for up to four minutes on their issue. A maximum of 30 minutes is set aside for the Public Questions slot in total (including responses and any Committee discussion). This may be extended with the Chairman's discretion. | | |

For full guidance on Public Questions, including how to register a request to speak during this slot, please follow this link:

http://www.buckscc.gov.uk/about-your-council/scrutiny/getting-involved/

**5 CHAIRMAN'S UPDATE** **10.10am**

For the Chairman to update Members on the recent Clinical Commissioning Group's AGM and Bucks Healthcare Trust's AGM.

**6 COMMITTEE UPDATE** **10.15am**

An opportunity to update the Committee on relevant information and report on any meetings of external organisations attended since the last meeting of the Committee. This is particularly pertinent to members who act in a liaison capacity with NHS Boards and for District Representatives.

**7 STRATEGIC SYSTEM PLANNING - UPDATE** **10.20am** **13 - 124**

The NHS Shared Planning Guidance asks every health and care system to co-create an ambitious local blueprint to accelerate implementation of the Five Year Forward View – Sustainability and Transformation Plan (STP). Buckinghamshire is part of a Buckinghamshire, Oxfordshire and Berkshire West footprint.

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services. In March 2015, the first group of 29 vanguard sites were chosen.

There were three vanguard types:

- Integrated primary and acute care systems;
- Enhanced health in care homes; and
- Multi-speciality community providers.

Members will receive a briefing on the progress on the STP to date as well as further information about the locality working model in Buckinghamshire – what it will look like and what new models are currently being developed. What can Buckinghamshire learn from the vanguard sites?

**Attendees:**

Lou Patten, Chief Operating Officer, Clinical Commissioning Groups
Robert Majilton, Deputy Chief Officer, Aylesbury Vale and Chiltern Clinical Commissioning Groups
Sophie Payne, Head of Customer Experience and Communications

**Papers and background documents:**

1. Update briefing – power point presentation
2. Update on locality working/new models of care
   a. New Care Models: Vanguards – developing a blueprint for the future of NHS and Care Services
   b. Primary Care Strategy
   c. Frail Older Person Strategy
   d. Primary Care Home model – see link below http://www.napc.co.uk/control/uploads/files/1457539294~PCH_Story_Feb2016.pdf
   e. NHS England guidance on Multi-speciality Community Providers – see link below https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf
3. Local planning for engagement – a brief summary of engagement intentions

| | | | |
|---|---|---|---|
| **8** | **COMMITTEE WORK PROGRAMME**<br>For Members to discuss and agree the work programme for future meetings. | **12.20pm** | **125 - 126** |
| **9** | **DATE AND TIME OF NEXT MEETING**<br>The next meeting will take place on Tuesday 24 January 2017 at 10am in Mezzanine Room 2, County Hall, Aylesbury. | **12.45pm** | |

**Purpose of the committee**

The role of the Health and Adult Social Care Select Committee is to hold decision-makers to account for improving outcomes and services for Buckinghamshire.

It shall have the power to scrutinise all issues in relation to Health and Adult Social Care. This will include, but not exclusively, responsibility for scrutinising issues in relation to:

- Public health and wellbeing
- NHS services

- Health and social care commissioning
- GPs and medical centres
- Dental Practices
- Health and social care performance
- Private health services
- Family wellbeing
- Adult social services
- Older people
- Adult safeguarding
- Physical and sensory services
- Learning disabilities
- Drugs and Alcohol Action Team (DAAT services)

* *In accordance with the BCC Constitution, this Committee shall act as the designated Committee responsible for the scrutiny of health matters holding external health partners to account.*

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*For further information please contact: Liz Wheaton on 01296 383856 , email: ewheaton@buckscc.gov.uk*

**Members**

Mr B Roberts (C)
Mr R Reed (VC)
Mr B Adams
Mr C Adams
Mrs M Aston
Mr N Brown
Mr C Etholen
Mrs W Mallen
Ms R Vigor-Hedderly
Julia Wassell
Vacancy

**Co-opted Members**

Ms T Jervis, Healthwatch Bucks
Mr A Green, Wycombe District Council
Ms S Jenkins, Aylesbury Vale District Council
Mr N Shepherd, Chiltern District Council
Dr W Matthews, South Bucks District Council

**Buckinghamshire County Council**
Select Committee
Health and Adult Social Care

# Minutes

*HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE*

Minutes from the meeting held on Tuesday 6 September 2016, in Mezzanine Room 2, County Hall, Aylesbury, commencing at 10.00 am and concluding at 1.00 pm.

This meeting was webcast. To review the detailed discussions that took place, please see the webcast which can be found at http://www.buckscc.public-i.tv/
The webcasts are retained on this website for 6 months. Recordings of any previous meetings beyond this can be requested (contact: democracy@buckscc.gov.uk)

**MEMBERS PRESENT**

**Buckinghamshire County Council**

Mr B Roberts (In the Chair)
Mr B Adams, Mr C Adams, Mr N Brown, Mrs W Mallen and Julia Wassell

**District Councils**

| | |
|---|---|
| Ms T Jervis | Healthwatch Bucks |
| Mr A Green | Wycombe District Council |
| Ms S Jenkins | Aylesbury Vale District Council |
| Mr N Shepherd | Chiltern District Council |
| Dr W Matthews | South Bucks District Council |

**Members in Attendance**

Mr M Appleyard, Deputy Leader and Cabinet Member for Health & Wellbeing

**Others in Attendance**

Mrs E Wheaton, Committee and Governance Adviser
Mr S GoldenSmith, Lead Commissioner: Later Life
Mr A Willison, Commissioning Manager: Later Life
Ms L Patten, Chief Officer, Chief Executive Clinical Commissioning Groups
Ms C Morrice, Chief Nurse and Director of Patient Care Standards, Buckinghamshire Healthcare NHS Trust
Ms A Anderson, Deputy Head of Midwifery, Wexham Park Hospital
Ms Audrey Warren, Head of Midwifery, Bucks Hospitals NHS Trust
Ms M Warren, Matron for Intrapartum Maternity Services
Dr D Sahota, GP Lead, Clinical Commissioning Group
Mr N Flint, Head of Commissioning for planned care and maternity, Clinical Commissioning Group
Ms L Duncan, Deputy Head of Maternity, Bucks Healthcare NHS Trust
Dr A Chapman, Associate Director, Strategic Clinical Network and Senate
Ms A Tysom, Senior Communications & Engagement Manager, NHS England South
Ms C Ni Ghuidhir, Thames Valley Vascular Network and Service Manager, Oxford University Hospitals NHS Foundation Trust

## 1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Mr R Reed, Mr C Etholen and Mrs M Aston.

## 2 DECLARATIONS OF INTEREST

Mr N Brown declared an interest in item 4 as a family member had recently joined the ITU department at Frimley Park Hospital.

## 3 MINUTES

The minutes of the meeting held on 26th July were confirmed as a correct record.

**Follow-up on actions**

- Lynton House – Ms Patten updated the Committee on this. A piece of engagement work across all the localities will commence over the coming weeks'.
- The Committee & Governance Adviser had met with the Council's media and communications to discuss ways of engaging further with members of the public.
- Dove Ward – awaiting dates from the CCGs for Member visits.

## 4 MATERNITY SERVICES

The Chairman welcomed the following people Mrs C Morrice, Chief Nurse (Bucks Healthcare Trust), Ms A Warren, Head of Midwifery (Bucks Healthcare Trust), Ms L Duncan, Deputy Head of Midwifery (Bucks Healthcare Trust), Dr D Sahota, GP (Clinical Commissioning Group), Mr N Flint, Head of Commissioning for Planned Care and Maternity (Clinical Commissioning Group), Ms M Warren, Matron for Intrapartum Maternity Services (Frimley Park Trust) and Ms L Patten, Chief Executive (Clinical Commissioning Groups).

The following main points were made during the presentation:

- Between April 2015 and March 2016, Buckinghamshire Healthcare Trust (BHT) provided labour care to women who delivered 5,541 babies.
- 30 complaints were received last year compared to a total of 13 this year. Lessons had been learnt and the aim was to reduce the number of complaints still further.
- Sharing information and ideas for improvement was an important consideration.
- A tool called "Birth rate plus" was used to establish the correct staffing levels.
- BHT had a slightly higher than national benchmark best practice rate for Caesarean

sections and was currently looking at ways to reduce the number.

- BHT had been accepted to participate in a pilot labour ward leadership programme which promoted team working.
- In partnership with Oxford Health NHS Foundation Trust, BHT had made perinatal mental health a priority and had employed a specialist mental health midwife.
- Wexham Park Hospital and Frimley Health merged in October 2014 and since then much work had been undertaken to bring the two units together.
- A total of 35 guidelines had been ratified and adopted across both sites and it would take approximately three years to complete all 92 guidelines.
- The CQC inspection in October 2015 rated the Women and Children Services as "Good". There had been a shift in leadership and culture of the organisation.
- There was a reported shortage of 10 midwifes within the unit. Consultant cover to the Labour Ward was now 132 hours per week.
- The current midwife to mother ratio funded at 1:30 with a 90/10 split between midwife and healthcare assistant.
- A Perinatal Mental Health specialist midwife, a Diabetic Midwife specialist and a Clinical Skills facilitator had recently been recruited.
- The biggest challenge for the Trust was around capacity of the ultrasound scanning. There was a national shortage of sonographers as well as a shortage of midwifes.
- Maternity Services had been given a focus within the Sustainability and Transformation Plans.
- An Open Day was being planned to find out the views of women.
- Ms Morrice confirmed that the transfer of care back to the Wycombe Maternity Unit was on track for 31 October with the Unit re-opening on 1 November.
- In response to a question around the challenge of an older workforce and recruiting new midwifes, the maternity team at BHT confirmed that they had two intakes each year – May and September and the challenge was to ensure they remain with BHT. BHT had over-recruited this year.
- A Member asked for the percentage of women in Bucks giving birth where English was not their first language. Nationally it was around 25% but in Bucks, the percentage was around 6-7%.
- A Member asked for more clarification on the data that was presented and Dr Sahota explained that there was a dashboard of data which contained around 32 parameters. There was a public facing page which provided headline figures for new mothers. It was agreed to share commissioner data with the Committee Members which could then be tri-angulated with providers. It was agreed that the traffic light system for reporting trends was very important.

**ACTION: Committee & Governance Adviser to discuss further with the Clinical Commissioning Group**

- In response to a query around why the figures provided by BHT in relation to vaginal birth rates and Caesarean section birth rates did not add up to 100%, Dr Sahota explained that the remaining % would be births requiring assisted deliveries, such as forceps.
- A Member asked for more information around a new mother's post-natal care and Ms Warren explained that the Community midwife would see the new mother on day 1, the new mother would receive a triage call on day 3, be invited to a drop-in session at day 5 and then be signed off at day 10 whereby the new mother would be handed over to a Health Visitor and their GP for ongoing care.

**SEE PAPERS AND WEBCAST FOR FULL CONTENT**

## 5 PUBLIC QUESTIONS

There were no public questions.

## 6 CHAIRMAN'S UPDATE

The Chairman updated the Committee on the following issues.

The Bedfordshire and Milton Keynes Healthcare Review

Milton Keynes had decided to work with Bedfordshire and Luton to produce its 5 year Sustainability and Transformation Plan (STP) and they had issued the following update:-

"Following detailed discussions with our STP partners and Regulators we have agreed that it would be confusing to have two parallel processes – ie. the Healthcare Review and the development of an STP both attempting to deliver similar things. We will, therefore, be consolidating the work of the Healthcare Review into a single STP process."

**ACTION: Committee and Governance Adviser to invite representatives to attend the October meeting to provide an update on the plans.**

Ridgeway Centre closure and transfer to Dove Ward

An email was received on Friday 2 September with the following update:

"The closure of the Ridgway Centre, which was due to be completed yesterday, has been delayed by a couple of weeks. This is because we need to ensure that remaining patients are being transferred or discharged in a safely manner and within a time scale that is their best interest. As soon as we have been able to ensure that all patients are safe, the centre will close. We anticipate this to be around the middle of September."

Pharmacy cuts

The Chairman reported that the Government's proposed cuts to the Pharmacy services had been withdrawn at a national level. An email had been sent to the Local Pharmacy Council for an update from a local perspective. And a response was awaited.

Forthcoming meetings

- Clinical Commissioning Group's AGM – Thursday 15 September at 6.30pm (Oculus, The Gatehouse)
- Buckinghamshire Healthcare Trust's AGM – Thursday 29 September at 6pm (Education Centre, Stoke Mandeville Hospital)
- Committee Member visit to Dove Ward – still to be arranged
- Care Home visits – Aylesbury Vale visits had already taken place, South of the County visits are due to take place on 13 September.

## 7 COMMITTEE UPDATE

District Councillor Sandra Jenkins updated Members on her recent care visits as part of the follow-up on the 15 minute care visit review.

## 8 VASCULAR SERVICES

The Chairman welcomed Dr A Chapman, Associate Director, Strategic Clinical Network and Senate, Ms A Tysom (in replace of Ms A Collins, Head of Communications and Engagement, NHS England South), Ms Cliodhna Ni Ghuidhir, Thames Valley Vascular Network and Service Manager, Oxford University Hospitals NHS Foundation Trust.

The following main points were made during the presentation:-

- Clinical Senate was made up of a group who can provide information and make recommendations on issues which had been referred to then by NHS England.
- Ms Tysom circulated copies of all the communications which were provided in the run-up to the 1 September when the Carotid Endarterectomy Surgery moved from Wycombe Hospital to the John Radcliffe Hospital. These materials had been shared with all the key stakeholders and those patients who would be affected by the change.
- Carotid Endarterectomy was described as a surgical procedure to unblock a carotid artery, which, if left untreated, could lead to a stroke.
- Patients requiring this specialist procedure would have access to a specialist vascular team 24 hours a day, 7 days a week.
- Day surgery, pre-operative care and follow-ups will continue to be offered locally to reduce the need to travel.
- The changes were based on national clinical guidance and best practice and ensure the safety of patients and ongoing provision of services.
- The Clinical Senate would be reviewing the service in 6 months' time.
- PROMS (Patient Reported Outcome Measures) update - A mixed-methods approach to investigating patient experiences in the network was chosen, entailing a questionnaire sent to all patients in the network and qualitative interviews with a specific patient cohort. This project sought to gain feedback from patients on their experiences of care across the network.
- The questionnaire was posted to each inpatient treated in the Thames Valley Vascular Network whose primary cause for admission was a vascular condition, starting with those discharged in May. The response rate of patients was approximately 34%.
- The network team decided to focus on patients treated for urgent conditions. The Network manager undertook to interview a minimum of three patients from each trust on different pathways in order to compare experiences across the network – eight interviews had taken place to date. It was agreed to report the results of both the qualitative interviews and questionnaires research to the Committee once a sufficient sample size for the questionnaire is reached.

**ACTION: NHS England to share this research with the HASC when it has been completed.**

- A Member commented that transport was a key issue for patients and family members but through Patient Transfer Services and Patient Community Transport, some patients were eligible for assistance with getting to and from their Hospital appointments. It was acknowledged that access to specialist services would involve an increase in travel times but every effort would be made for follow-up calls to be undertaken locally. A Member referred to the Better Healthcare in Bucks review which highlighted transport as a major issue at the time.

The Chairman concluded by highlighting the need for good communication and ensuring consistent messages are provided to the public.

**SEE PAPERS AND WEBCAST FOR FULL CONTENT**

**9 15 MIN CARE VISITS REVIEW - 12 MONTH RECOMMENDATION MONITORING**

The Chairman welcomed Mr M Appleyard, Deputy Leader and Cabinet Member for Health & Wellbeing, Mr S GoldenSmith, Lead Commissioner Later Life, Adults, Health & Communities and Mr A Willison, Commissioning Manager.

Five recommendations were made to Cabinet through the 15 minute Care Visit Inquiry and

this item looked at the progress made of each recommendation. The following main points were made by the Cabinet Member and Officers.

- All recommendations had been implemented.
- In terms of travel costs, carers receive an hourly rate which includes an element for travel. It was acknowledged that remuneration was a difficult issue as the providers are responsible for remunerating their staff.
- All carers were DBS checked.
- Regular meetings took place between the providers and the County Council. It was agreed that Committee Members would be invited to future meetings with Wendy Mallen and Brian Adams attending the next meeting.

**ACTION: Mr S GoldenSmith to send the Committee & Governance Adviser the details of the meetings.**

**The Committee AGREED to award a green RAG status to all the recommendations ("Recommendation implemented to the satisfaction of the Committee").**

*The completed recommendation monitoring report is attached.*

**SEE WEBSITE FOR FULL DETAILS**

## 10 COMMITTEE WORK PROGRAMME

Members noted the provisional items for the next meeting and discussed holding a workshop in November/December time to agree the items for the future meetings.

## 11 DATE AND TIME OF NEXT MEETING

The next meeting is due to take place on Tuesday 18th October at 10am in Mezzanine Room 2, County Hall, Aylesbury.

**CHAIRMAN**

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# Buckinghamshire health & care system plan & the Sustainability & Transformation Plan (STP) for the Buckinghamshire, Oxfordshire & Berkshire West footprint

## Update briefing

Health and Adult Social Care Select Committee
18th October 2016

Robert Majilton
Deputy Chief Officer, Aylesbury Vale & Chiltern CCGs

## Presentation content

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- Background
- STP footprint & approach
- Buckinghamshire's health & care system plan
- Programme management
- Next steps

## Sustainability and Transformation Plans (STPs)

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- 44 STP 'footprints' across England largely based on patient flows into tertiary (very specialised) acute hospitals
- STPs address strategic issues that span more than one local system e.g. Thames Valley Urgent & Emergency Care Network
- Buckinghamshire is part of a Buckinghamshire, Oxfordshire, Berkshire West 'footprint' 1.8m population, £2.5bn place based allocation, 7 Clinical Commissioning Groups, 16 Foundation Trust & NHS Trust providers, 14 Local authorities
- NHS Shared Planning Guidance 2016-17 asks every health & care system is to co-create an ambitious local blueprint to accelerate implementation of the *Five Year Forward View* – Sustainability and Transformation Plans (STPs) which are:
  - place-based and multi-year built around population needs
  - help ensure that the investment secured in the *Spending Review* does not (just) prop up individual organisations
  - drive a sustainable transformation in patient experience & health outcomes
  - build & strengthen local relationships with a shared understanding of challenges & scale of ambition
- The overall approach is based on developing STP plans in local systems where it makes sense with key partners e.g. for integrated health & care, and collaborating across the STP footprint as necessary on cross system issues e.g. for urgent & emergency acute care

## Buckinghamshire, Oxfordshire & Berkshire West 'footprint'

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## BOBW Sustainability & Transformation Plan (STP)

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- BOBW STP covers four key programmes and two enabling work streams where Buckinghamshire will work across the footprint to tackle issues that cannot be resolved by acting entirely locally which are:
  - Prevention of ill health 'at scale'
  - Urgent & emergency care e.g. accident and emergency treatment
  - Acute services particularly specialised services such as heart transplants
  - Mental health especially tertiary level and out of county care e.g. mental health high secure services
  - Workforce and the labour market
  - Digital interoperability and technology-enabled change
- STP is being developed 'bottom up' and represents a small proportion of the Bucks health & care system
- Main plan is being developed locally across the health & care system – the Bucks 'chapter'
- Bucks 'chapter' builds on 5 year system plan presented to H&WB in June 2014 and the primary care strategy presented to H&WB in March 2015 informed by:
  - patient experience feedback on services
  - previous engagement and consultation activities such as the Community Hubs engagement events in Bucks
  - urgent care survey results from across the patch
  - Joint Strategic Health Needs Assessment
  - Health & Wellbeing Strategy
  - input from the Thames Valley Clinical Senate & the Academic Health Science Network

## Buckinghamshire 'chapter'

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- Continuing to progress Buckinghamshire health and care system approach to developing plans under the leadership of *Healthy Bucks Leaders' Group*
- Identifying priorities where it makes sense to work at a greater population scale e.g. across Bucks, Oxfordshire and West Berkshire STP footprint or wider
- Considerable transformation of NHS services nationally and locally is required to meet the 3 gaps - health & wellbeing, quality and finance & efficiency - over the next five years
- Bucks Primary Care Strategy, published in 2015, describes how Bucks will build integrated care and community services, shifting from a bed base to more ambulatory and community model of care
- Next steps in the development of plans is to work together with local communities to understand their specific population challenges and to jointly describe how strategy will be translated into local health and care services across the Buckinghamshire's localities building on the recent community engagement around 'Community hubs' (led by Buckinghamshire Healthcare Trust)

## Buckinghamshire 'chapter'

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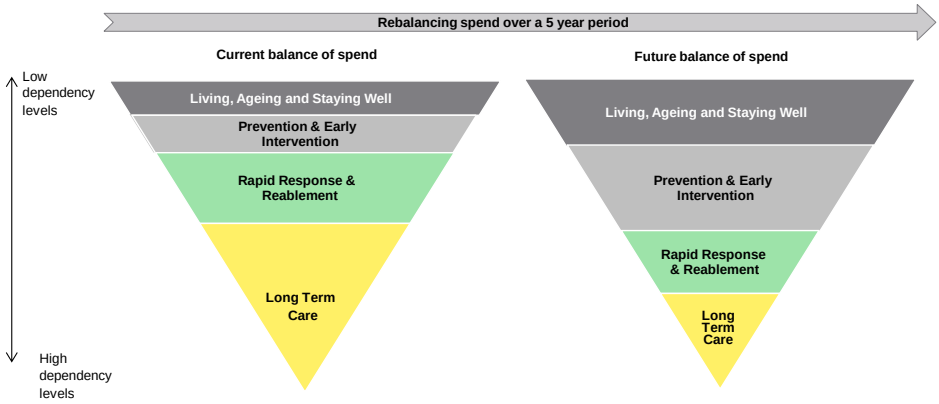
- 'Do nothing' risk £202m across the health & care system, low risk relative to elsewhere in the NHS
- Focus is to reduce spend on bed-based care into prevention & care at home
- To integrate health & care services, avoid unnecessary steps in pathways to reduce waste and duplication
- To deliver urgent and emergency care services in the right place at the right time
- To deploy technology to enable rapid access to advice, care and support




**BUCKINGHAMSHIRE HEALTH & CARE SYSTEM WORKING DRAFT PLAN ON A PAGE**

**Buckinghamshire has the advantage of the same geographical footprint for the delivery of health & care services. There is a long history of partnership working across public services particularly between the NHS and the County Council's Communities, Health & Adult Social Care and Children's Directorates to deliver health improvement and health & care services. The partners provide strong collaborative leadership to the Buckinghamshire health & care system, the *Healthy Bucks Leaders' Group*, underpinned by a programme governance structure to drive the change that is required to address the health & wellbeing, care and quality and finance & efficiency gaps.**

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| Context | Vision | Aim | Programme workstreams | | Strategic interventions & *FYFV* models | Enabling infrastructure |
|---|---|---|---|---|---|---|
| Overall good health status masks variation<br>Unhealthy lifestyles<br>Ageing population<br>Rising incidence of long term conditions<br>Generally system is seen as low risk & performing well<br>Financial challenge c.£200m over 5 years | Everyone working together so that the people of Buckinghamshire have happy and healthier lives | The aim of partners is to rebalance the health and social care spend in Buckinghamshire to increase support for Living, Ageing and Staying Well and Prevention and Early Intervention initiatives | Self care and prevention | A life-course approach to:<br>• Promoting healthy lifestyles<br>• Improving mental health and wellbeing<br>• Tackling inequalities<br>• Building community capacity & self help | • Implement the top 6 priorities in the refreshed Health & Wellbeing strategy | Estates – reducing capital asset footprint across Council & NHS through '*One Public Estate*' initiative, optimal use of all public service assets, refinancing PFI debt<br>IM&T digital interoperability – paperless by 2020, shared care records across all organisations<br>Workforce - reduce agency costs, renew skill mx & reduce corporate costs e.g. shared back office functions with Council & other partners |
| | | | Integrating the health & social care commissioning & delivery system | • Frail older people | • Design *multi specialty community provider teams* in community hubs accessed via a single point<br>• NHS & Council joint approach to residential care & continuing health care market<br>• Reduce acute hospital utilisation and investing in community & primary care<br>• Redesign community hospital care | |
| | | | | • Mental health & learning disability care | • Implement *Vanguard* 'prime contractor' model for tertiary services<br>• Commission services in a new way to improve outcomes & value for money | |
| | | | | • Children & families | • Improve access to care for tier 4 child & adolescent mental health services<br>• Improve the lives of children with special educational needs | |
| | | | Reforming urgent & emergency care | • Thames Valley integrated urgent care | • Implement new *Urgent & Emergency Care Network* model<br>• Improve transitional care for those medically fit for discharge<br>• Reduce length of stay and unnecessary use of beds within the acute sector | |
| | | | Planned & specialised care | • Tackling variation *Right Care*<br>• Maternity care strategy<br>• Cancer strategy<br>• Interventional radiology | • Improve performance to upper decile<br>• Plan & deliver extra capacity for increase in births<br>• Improve network pathways<br>• 24/7 day working plan | |
| | | | | • Primary care | • Implement the *GP Forward View* - strengthen & reform workforce, reduce & streamline workload, improve infrastructure, redesign & integrate care redesign | |

## Process for programme delivery

- ***Healthy Bucks Leaders' Group*** **continues to drive this work**
- **Agreed to create a Transformation Delivery Group to oversee delivery of Bucks-wide health & care system plan**
- **Aligns resources, reduces duplication and gives clear programme leadership and programme management**
- **Not delegated decision making – organisations remain accountable but supports getting plans developed to stage to be approved and then implemented**

## Next steps

- **End September 2016 - NHS planning guidance published**
- **21st October 2016 - STP submissions national deadline**
- **Mid November 2016 - Operational system & organisations' plans first cut**
- **End December 2016 - 2 year plans & contract negotiations concluded with provider sector**
- **Communications & engagement plan begins subject to NHS England approval**

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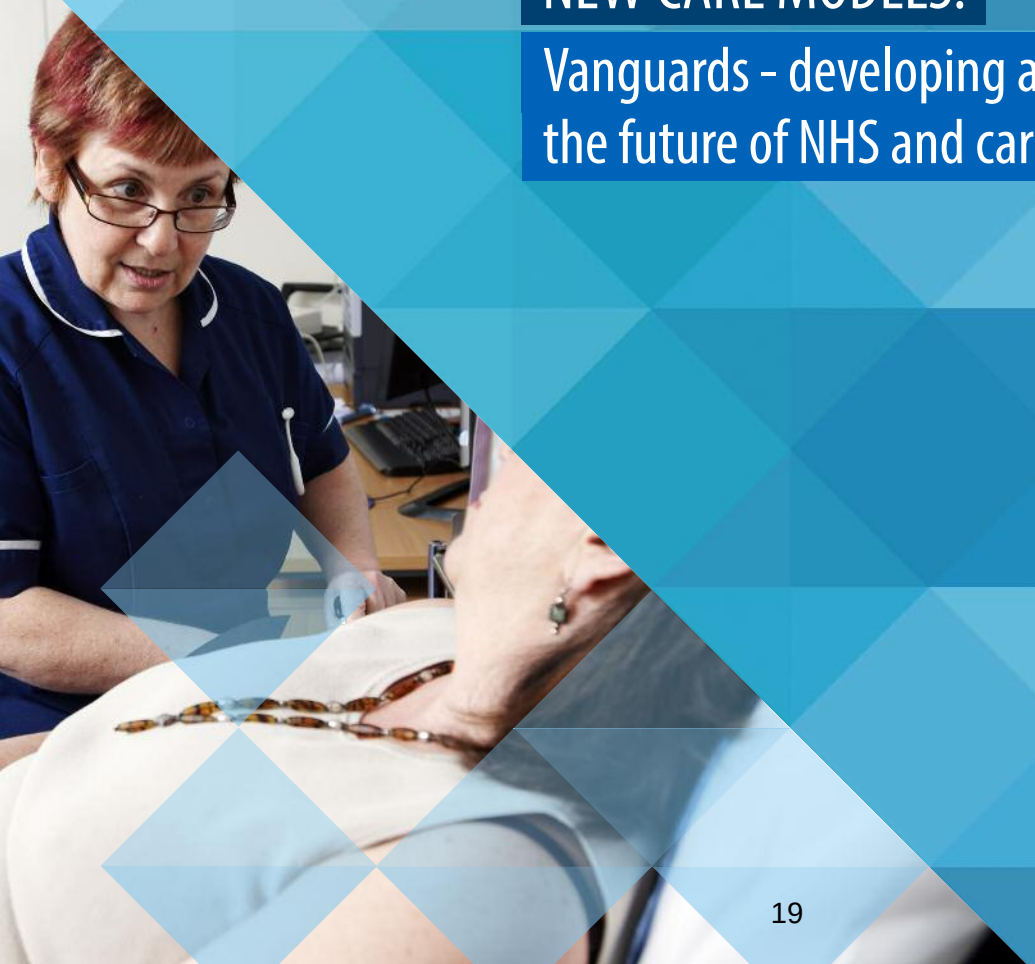
# NEW CARE MODELS:

## Vanguards - developing a blueprint for the future of NHS and care services



NOVEMBER 2015

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# WHAT IS THE NEW CARE MODELS PROGRAMME?

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the *NHS Five Year Forward View* and supporting improvement and integration of services.

In March, the first group of 29 vanguard sites were chosen. There were three vanguard types – integrated primary and acute care systems; enhanced health in care homes; and, multispecialty community providers.

Integrated primary and acute care systems will join up GP, hospital, community and mental health services, whilst multispecialty community providers will move specialist care out of hospitals into the community. Enhanced health in care homes will offer older people better, joined up health, care and rehabilitation services.

In late July, eight additional vanguards were announced. Urgent and emergency care vanguards will develop new approaches to improve the coordination of services and reduce pressure on A&E departments.

A further 13 vanguards were announced in September – known as acute care collaborations, they aim to link local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

All 50 vanguards were selected following a rigorous process, involving workshops and the engagement of key partners and patient representative groups.

Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

### What does it mean for patients?

The vanguards are improving the care received by millions people across England.

Through the new care models programme, complete redesign of whole health and care systems are being considered. This could mean fewer trips to hospitals with cancer and dementia specialists holding clinics in local surgeries, having one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

It will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, seven days a week.

### The partners

The new care model vanguards are a key element within the *Five Year Forward View* which is a partnership between NHS England, the Care Quality Commission, Health Education England, Monitor, the NHS Trust Development Authority, Public Health England and the National Institute for Health and Care Excellence.

### Supporting the vanguards

In July, the Forward View partners published an initial support package for the first 29 vanguards.

The support package was developed following extensive engagement with the vanguard leaders, including two-day visits to all 29 sites in April and May 2015 and follow-up discussions and seminars. It aims to enable them to make the changes they want to make effectively and at pace.

Building on the best practice already being displayed, the support package is designed to be led by vanguard leaders alongside national experts, and aims to help the vanguards be as successful as possible in making the changes they are planning.

It is also intended to maximise sharing of learning and practice across the vanguards and, importantly, with the wider NHS and care system – a key element of the vanguards' work.





The support package, which covers 2015/16, focuses on eight areas:

1. **Designing new care models** – working with the vanguards to develop their local model of care, maximising the greatest impact and value for patients;
2. **Evaluation and metrics** – supporting the vanguards to understand – on an ongoing basis – the impact their changes are having on patients, staff and the wider population;
3. **Integrated commissioning and provision** – assisting the vanguards to break down the barriers which prevent their local health system from developing integrated commissioning and provision;
4. **Empowering patients and communities** – working with the vanguards to enhance the way in which they work with patients, local people and communities to develop services;
5. **Harnessing technology** – supporting the vanguards to rethink how care is delivered, given the potential of digital technology to deliver care in radically different ways. It will also help organisations to more easily share patient information;
6. **Workforce redesign** – supporting the vanguards to develop a modern, flexible workforce which is organised around patients and their local populations;
7. **Local leadership and delivery** – working with the vanguards to develop leadership capability and learn from international experts, and;
8. **Communications and engagement** – supporting the vanguards to demonstrate best practice in the way they engage with staff, patients and local people.

A number of dedicated workstreams – which are being led by a vanguard leader and national subject matter expert – are working with the vanguards to refine what is being offered so that it is fully tailored to their needs.

In addition to the practical support outlined in the new document, vanguards also have access to a £200m transformation fund.

Support for more recently announced vanguards – acute care collaboration vanguards and urgent and emergency care vanguards – will be published shortly.

# New care models - vanguard sites

## Integrated primary and acute care systems - joining up GP, hospital, community and mental health services

1 Wirral Partners
2 Mid Nottinghamshire Better Together
3 South Somerset Symphony Programme
4 Northumberland Accountable Care Organisation
5 Salford Together
6 Better Care Together (Morecambe Bay Health
7 Community)
North East Hampshire and Farnham
8 Harrogate and Rural District Clinical Commissioning Group
9 My Life a Full Life (Isle of Wight)

## Multispecialty community providers - moving specialist care out of hospitals into the community

10 Calderdale Health and Social Care Economy
11 Erewash Multispecialty Community Provider
12 Fylde Coast Local Health Economy
13 Vitality (Birmingham and Sandwell)
14 West Wakefield Health and Wellbeing Ltd
15 Better Health and Care for Sunderland
16 Dudley Multispecialty Community Provider
17 Whitstable Medical Practice
18 Stockport Together
19 Tower Hamlets Integrated Provider Partnership
20 Better Local Care (Southern Hampshire)
21 West Cheshire Way
22 Lakeside Healthcare (Northamptonshire)
23 Principia Partners in Health (Southern Nottinghamshire)

## Enhanced health in care homes - offering older people better, joined up health, care and rehabilitation services

24 Connecting Care - Wakefield District
25 Gateshead Care Home Project
26 East and North Hertfordshire Clinical Commissioning Group
27 Nottingham City Clinical Commissioning Group
28 Sutton Homes of Care
29 Airedale & Partners

## Urgent and emergency care - new approaches to improve the coordination of services and reduce pressure on A&E departments

30 Greater Nottingham System Resilience Group
31 Cambridgeshire and Peterborough Clinical Commissioning Group
32 North East Urgent Care Network
33 Barking and Dagenham, Havering and Redbridge System Resilience Group
34 West Yorkshire Urgent Emergency Care Network
35 Leicester, Leicestershire & Rutland System Resilience Group
36 Solihull Together for Better Lives
37 South Devon and Torbay System Resilience Group

## Acute care collaborations - linking hospitals together to improve their clinical and financial viability

38 Salford and Wigan Foundation Chain
39 Northumbria Foundation Group
40 Royal Free London
41 Foundation Healthcare Group (Dartford and Gravesham)
42 Moorfields
43 National Orthopaedic Alliance
44 The Neuro Network (The Walton Centre, Liverpool)
45 MERIT (The Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)
46 Cheshire and Merseyside Women's and Children's Services
47 Accountable Clinical Network for Cancer (ACNC)
48 EMRAD - East Midlands Radiology Consortium
49 Developing One NHS in Dorset
50 Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)



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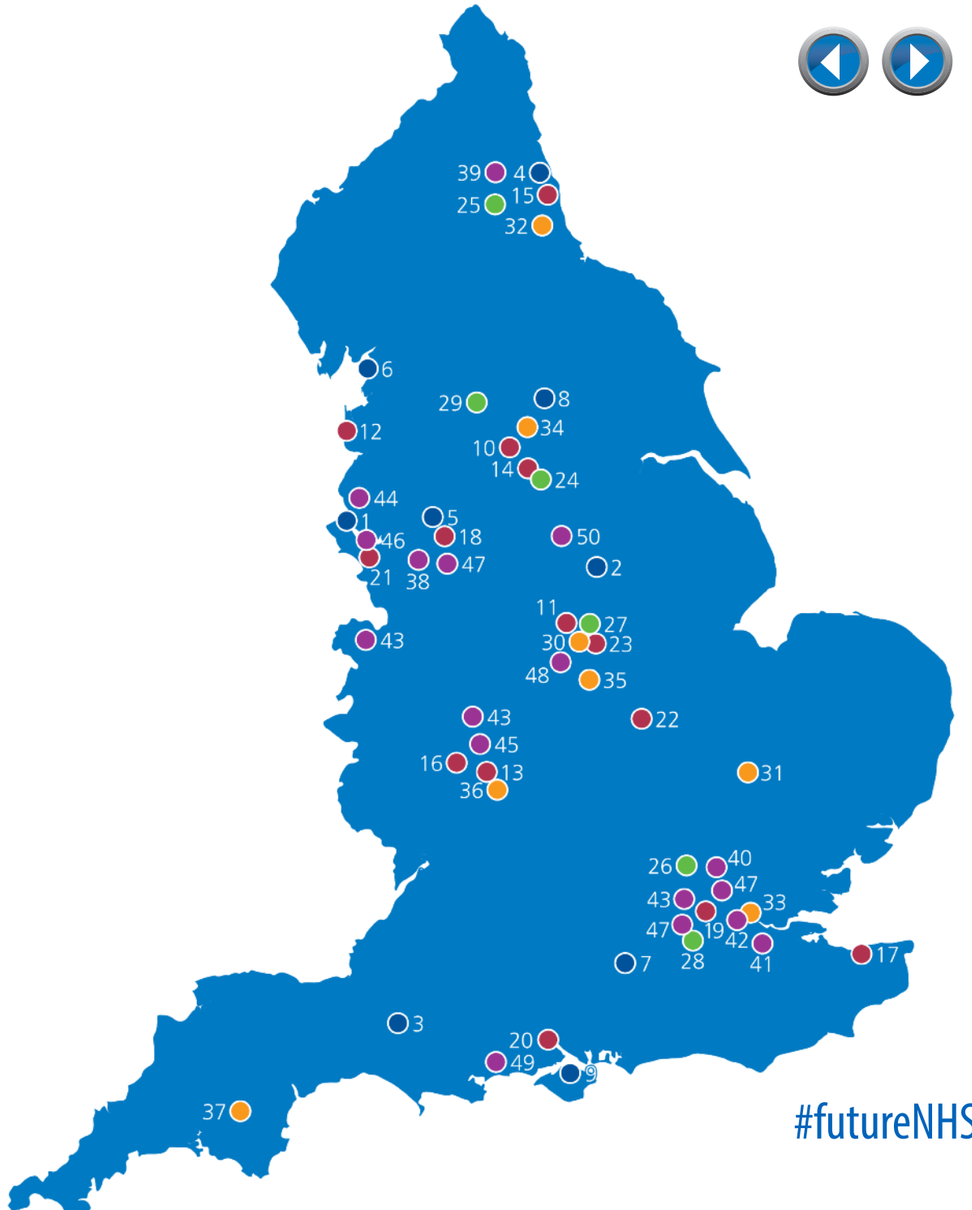


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# **The vanguards:** integrated primary and acute care systems





## 1. Wirral Partners

**PARTNERS**
Wirral University Teaching Hospital NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Trust, Wirral Clinical Commissioning Group, GPs on the Wirral, Wirral Metropolitan Borough Council, Cerner UK Ltd and Advocate Physician Partners (accountable care organisation) alongside local patient and community groups and Wirral Healthwatch.

The organisations jointly serve a population of more than 400,000.

**AIM**
The vanguard aims to use a range of approaches to meet the different needs of specific sections of their local population.

**OUTLINE**
Wirral Partners health and wellbeing model is based on self-care and independence as a foundation to wellbeing. Work is underway to enable more timely access to services with a care-navigation approach which will guide people to the support they require to be healthier for longer.

There are plans for integration between traditional acute and primary care roles and the provision of more care in community settings.

Expected outcomes include a reduction in emergency admissions to hospital, fewer permanent admissions to residential or nursing care and a rebalancing of health inequalities such as life expectancy.

Another important element is the vanguard's plan to create health economy-wide patient records, giving real-time access to the best information to support care. This will also enable better care planning and the delivery of care pathways across organisational boundaries.

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# 2. Mid Nottinghamshire Better Together

**PARTNERS**
Central Nottinghamshire Clinical Services, Circle Health Limited, East Midlands Ambulance Service NHS Trust, Nottinghamshire County Council, Nottinghamshire Healthcare NHS Trust (including County Health Partnerships), Nottingham University Hospitals NHS Trust, Sherwood Forest Hospital NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust.

The partners together serve a population of around 310,000.

**AIM**
Better Together aims to ensure that everyone receives the best possible care with high quality, sustainable services. The vanguard is working towards care becoming much more integrated, with doctors, nurses and social care staff working together more closely to support the needs of patients, their families and carers.

**OUTLINE**
Better Together sets out a bold vision for the way health and care services will look over the next five years, based on population needs and public, stakeholder and staff feedback about current services.

It focuses on several important areas – urgent and proactive care (including care for people with long term conditions like diabetes or asthma, and frail older people) and early and planned care (such as surgery for hips and knees, or cataracts).

Feedback from local communities is central to planning and the Better Together team has completed a considerable amount of engagement with patients, the public and staff. They have used this feedback to shape the design of future care services and understand what health outcomes are important to the local population.

Follow us: @bettermidnotts







# 3. South Somerset Symphony Programme

**PARTNERS**
Yeovil Hospital, the Somerset GP Federation, Somerset Clinical Commissioning Group and Somerset County Council.

The population covered by the South Somerset Symphony Programme is 200,000.

**AIM**
This vanguard aims to develop an integrated care system in south Somerset which removes organisational boundaries and allows staff to work together to provide the population with swifter and easier access to services and support.

The integrated care organisation will be managed by a joint venture of health and social care professionals.

**OUTLINE**
The Symphony project will develop new care pathways which provide early intervention and proactive care, closer to where patients live. Patients – particularly those with complex conditions – will be supported to retain their independence, stay healthier for longer, and avoid unnecessary admissions to hospital.

GPs, hospital clinicians, therapists, social workers and patients will develop packages of care together which recognise the totality of an individual's care and lifestyle needs.

The Symphony project is also exploring new models of care which make routine clinical interventions – such as certain day surgery procedures – more accessible and efficient.

Follow us: @symphonyproj

# 4. Northumberland Accountable Care Organisation

**PARTNERS**
Northumbria Healthcare NHS Foundation Trust and NHS Northumberland Clinical Commissioning Group in North East England are the lead partners. Other partners include Northumberland County Council, local GPs, mental health services, the ambulance service, as well as local patients, Healthwatch and the Health and Wellbeing Board.

These NHS organisations jointly serve a population of more than 320,000 in Northumberland – one of the largest geographical and most rural areas of England.

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**AIM**
The collective ambition for the NHS in Northumberland is to create a single accountable care organisation (ACO) from 2017. The ACO will: focus on preventing ill health and empower people to live long and healthy lives at home; improve patient outcomes and experience; provide seamless coordination of care; and, maximise resources and reduce duplication.

What will this mean for patients?
- Better access to care seven days a week – both for serious emergencies and primary care.
- Better use of technology to empower people to take control of their own health and wellbeing, live independently and stay healthy.
- Care delivered by an aligned, integrated workforce, operating as one team, in one system with joined-up.
- One unified patient record, reducing the need for patients to repeat 'their story' to different health professionals and different parts of 'the system'.

**OUTLINE**
In June 2015, this vanguard completed its first phase of work by opening Northumbria Specialist Emergency Care Hospital to provide seven day specialist services in acute care for all serious emergencies. Urgent care is now available 24/7 for walk-in patients at general hospital sites.

The next phases of work involves creating central primary care 'hubs' across Northumberland with GPs working in networks to improve access to primary care services during working hours, in the evenings and at weekends to meet patient need.

Work will also take place to identify alternative, flexible, workforce solutions, to allow more care to be delivered by different types of health care professionals in people's homes and community settings with a strong focus on prevention.

Follow us: @NorthumbriaNHS
@NHSNLandCCG





# 5. Salford Together

**PARTNERS**
Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.

Salford has a population of 230,000.

**AIM**
Salford Together aims to integrate health and social care for older people in Salford, bringing the contributions of GPs, district nurses, social workers, mental health professionals, care homes, voluntary organisations and local hospitals into a more aligned system and provide older people with the support they need to manage their own care.

**OUTLINE**
This new care model has already been tested and refined in two areas which account for 40 per cent of older people in Salford. By the end of 2015, it is hoped the whole city will experience the benefits of this new, integrated way of working.

The vanguard is developing multidisciplinary groups of clinicians and other staff to provide targeted support to people who are most at risk. There is also a population focus on screening, prevention and signposting to community support.

This includes establishing a contact centre which acts as a central health and social care hub, supporting multidisciplinary groups. The centre will also help people to navigate services, access support and will coordinate the use of telecare. The vanguard also intends using local community support to help enable people to remain independent and develop greater confidence to manage their own care.

Follow us: @SalfordTogether

# 6. Better Care Together (Morecambe Bay Health Community)

**PARTNERS**
The Better Care Together vanguard is a partnership of 11 organisations based across Morecambe Bay and includes University Hospitals of Morecambe Bay NHS Foundation Trust, Cumbria Partnership NHS Foundation Trust, North West Ambulance Service, Blackpool Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust, Lancashire County Council, Cumbria County Council, Lancashire North Clinical Commissioning Group (CCG), Cumbria CCG, North Lancashire Medical Services and South Cumbria Primary Care Collaborative.

It serves a population of 365,000 people in an area that is geographically dispersed, financially challenged and has areas of deprivation and health inequality.

**AIM**
Better Care Together aims to improve the sustainability of services, enhance the quality, safety and experience for patients, and reduce the health system financial deficit. It aims to do this by working interdependently with a much more integrated out-of-hospital sector and moving to a smaller, more productive group of hospitals.

**OUTLINE**
Better Care Together will see the development of multidisciplinary core teams based within communities across Morecambe Bay. There will be increased general practice capacity and capability, with an expansion of community based specialist services.

Increasingly, hospital clinicians will work within the community based teams fostering a shared approach to staff development and improving pathways of care.

The vanguard is focusing on ensuring that people who use local services experience care and support that works the way it should and that they are supported to take control of their health and wellbeing. Most of their care and support will be provided within their local community, based around their GP practice, with access to safe and high quality specialist care as and when it is needed.

This vanguard programme was developed by over 200 healthcare professionals together with input from a wide range of local patients, community groups and third sector colleagues.

Follow us: @BCTMorecambeBay





# 7. North East Hampshire and Farnham

**PARTNERS**
NHS North East Hampshire and Farnham Clinical Commissioning Group, Frimley Health NHS Foundation Trust, Southern Health NHS Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust, Virgin Care, South East Coast Ambulance NHS Foundation Trust, North Hampshire Urgent Care, and Hampshire and Surrey county councils.

This vanguard serves a population of more than 220,000.

**AIM**
The vanguard aims to keep people happy, healthy and at home by motivating and supporting local people to improve their own health and ensuring a seamless service when they are ill or need support.

**OUTLINE**
The focus of the vanguard is on the way services are commissioned and the way organisations are set up. These will be reshaped to best support the new model of care.

The programme will focus on preventing ill health and maximising self-care, helping people to manage their own health conditions, empowering them to make choices about their care and ensuring the right services are available to all.

It will also develop integrated teams of specialist health and social care professionals. These teams will comprise community nurses, occupational therapists, physiotherapists, social workers, a psychiatric nurse, a lead psychiatrist, a pharmacist, a geriatrician, GPs, the voluntary sector, and specialists in palliative care and domiciliary care. They will ensure joined up care for patients, especially those who are vulnerable or have complex needs.

There will also be enhanced community services for people in their own homes, in GP surgeries and local community hospitals. There will also be access into and out of specialist inpatient care – in community hospitals (such as in Farnham and Fleet) as well as Frimley Park Hospital.

The vanguard's work will enable health and social care professionals to speed up plans to develop new ways of providing and paying for support and services for local people. It will also provide better value for money, helping to close the gap between the available resources and the costs of providing services to meet need.

# 8. Harrogate and Rural District Clinical Commissioning Group

**PARTNERS**
Harrogate District NHS Foundation Trust, Harrogate and Rural District Clinical Commissioning Group, North Yorkshire County Council, Tees Esk and Wear Valley Foundation Trust, Harrogate Borough Council and Yorkshire Health Network.

The vanguard covers a population of approximately 160,000.

**AIM**
This vanguard aims to transform the way care is provided locally with GPs, community services, hospitals, mental health and social care staff working together to support people to remain independent, safe and well at home. The vanguard wants to see care provided by a team that a person knows and feels they can trust. This will be set out in a care plan.

**OUTLINE**
The vanguard focuses on prevention. Targeted services will be increased including their Stronger Communities Programme (focused on building communities and self-care), prevention officers (working with people who may need care in the future) and falls, bereavement and mental health preventative support services.

This work is built on what local people told the vanguard partners is important to them. Services will be provided by an integrated care team including GPs, community nurses, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector.

Boundaries between primary, community, acute, mental health and social care will be removed and hospital beds will be used only when they are truly needed.





# 9. My Life a Full Life (Isle of Wight)

**PARTNERS**
Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust (a unique provider of ambulance, community, hospital, learning disability and mental health services), Isle of Wight Council, One Wight Health (a GP collaborative) and the voluntary and independent sectors.

Jointly the partners serve a population of 140,000.

**AIM**
The vanguard's new care model is aimed at improving health and wellbeing. It also works to enhance care and improve quality outcomes, delivering more care in people's own homes and in the community, and making health and wellbeing more financially sustainable. Care on the island has historically been reliant on statutory services and is no longer financially sustainable. Vanguard support is helping accelerate the move to the new care model.

**OUTLINE**
The integrated 'My Life a Full Life' model is prevention-based, promotes health and wellbeing and is built on experience-based co-design. It is also founded on the principles of self-care and empowered communities.

At the centre of our model is the person, whose care across the community and system is coordinated and supported by care navigators. This single point of contact will triage, reduce perceived system complexity, increase awareness of services, and maximise efficiency.

Another key element of the model is integrated locality teams which deliver person-centred care and support in the community, with GP clinical leadership and multi-specialist teams.

Follow us: @MyLifeAFullLife

# **The vanguards:** multispecialty community providers

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## 10. Calderdale Health and Social Care Economy

**PARTNERS**
Calderdale Pennine GP Alliance, Calderdale and Huddersfield Foundation Trust, Calderdale Clinical Commissioning Group , Calderdale Metropolitan Borough Council, South West Yorkshire Partnership Foundation Trust, Locala Community Partnerships and Voluntary Action Calderdale.

This vanguard will service a patient population of around 100,000.

**AIM**
This vanguard will build on ongoing work to integrate health and social care – the 'care closer to home' programme – enabling the team to deliver benefit at a greater pace and scale. It aims to offer a measurable shift in the balance of service delivery from avoidable unplanned admissions to hospital, to planned, integrated care, delivered in primary care and community settings.

**OUTLINE**
Calderdale has a shared commitment towards a common goal – a sustainable people-centred, future proof system for delivering health and social care locally.

One of the challenges that the vanguard faces is its valley geography, which has an impact on access and flow. The team is already trialling pilot schemes to provide truly integrated services closer to where people live.

The focus of the programme is on three patient cohorts – people with long-term conditions, people at risk through frailty, and children with complex health and care needs.

The vanguard will pilot innovative schemes to help these groups, firstly in the more remote west side, the 'upper valley,' but quickly roll-out learning across Calderdale.

The team has also already installed telecare technology in care homes and is confident about the positive effect that it is having upon the experience of care for residents, reducing their dependency upon hospital care. Patients with chronic obstructive pulmonary disease (COPD) now have access to telehealth.

Progress is also being made on a 'staying well' programme for older people, helping to tackle social isolation and loneliness.

At the other end of the age spectrum, a child health pilot has been launched in north east Halifax, bringing together the local hospital trust, GPs and children's community nurses to run paediatric clinics at a children's centre in the community.

# 11. Erewash Multispecialty Community Provider

**PARTNERS**
Derbyshire Community Health Services NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Erewash GP Provider Company, Derbyshire Health United and NHS Erewash Clinical Commissioning Group.

This vanguard covers a population of 97,000 people.

**AIM**
This vanguard aims to bring together major community and mental health services alongside GPs to develop a prevention and support team. The team is made up of health and care staff, including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support.

**OUTLINE**
The vanguard focusses on the delivery of services to people with long-term conditions including diabetes, chronic vascular disease and chronic lung conditions.

There are also plans to extend GP access and improve records so that the treatment plans of the most vulnerable people are available for all community and primary care staff. This will reduce duplication and assist in times of need for out of hours or emergency treatment.

Health professionals will talk frail and vulnerable people through their concerns and support them to remain in their homes. Healthcare 'hubs' will bring medical, nursing and mental health professionals together to share information and knowledge about patients with long-term conditions and acute medical needs so they get the best care possible to stay well for longer.

The vanguard will also further develop telehealth technology to help people with long-term conditions to manage their health better – particularly for those with cardiovascular disease, respiratory diseases and diabetes.

Follow us: @DCHStrust
@NHS_Erewash_CCG @derbyshcft







# 12. Fylde Coast Local Health Economy

**PARTNERS**
NHS Blackpool Clinical Commissioning Group, NHS Fylde and Wyre Clinical Commissioning Group, Blackpool Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust, Lancashire County Council and Blackpool Council.

NHS Blackpool and NHS Fylde and Wyre Clinical Commissioning Groups have a joint registered population of 320,000 people living across a mix of coastal town and rural villages.

**AIM**
The vision for the Fylde Coast is to 'wrap' healthcare around the patient, delivering more support in the heart of the community and less in hospital.

**OUTLINE**
This vanguard is already delivering new extensive care services where clinical and non-clinical staff work together, providing proactive care for elderly and frail patients with long-term conditions. This dramatically reduces the need for unplanned hospital visits. Two extensive care services went live in June 2015 and another five will become operational during the next 18 months.

Complementing extensive care, plans for enhanced primary care will enable even more support to be delivered closer to patients' homes. Integrating community services will see GPs working in neighbourhoods alongside community care and social workers. Supported by shared electronic care records and a single point of contact for all out-of-hospital services this will ensure seamless care for all.

Follow us: @blackpoolccg
@fyldeandwyreccg @BlackpoolHosp
@Bpoolcouncil @lancashirecc
@lancashirecare

# 13. Vitality (Birmingham and Sandwell)

**PARTNERS**
Birmingham Children's Hospital, Birmingham City Council, Birmingham Community Health Care Trust, Birmingham and Solihull Mental Health Trust, Sandwell and West Birmingham Hospital Trust, Sandwell and Birmingham Clinical Commissioning Group, and Vitality Partnership (15 GP practices).

The vanguard covers 200,000 patients within Birmingham and Sandwell.

**AIM**
This vanguard aims for a future where patients will tell their story once. It wants care to be better joined up and for patients to be at the very heart of care planning and health management.

**OUTLINE**
By working together and centralising some processes for streamlined, efficient and effective care, health and social care staff will release more time for patients. A new clinical model has already released capacity with positive feedback from patients and clinicians.

The vanguard will also be looking at improvements in technology to help make it easier for people to access healthcare. In the new model of care, all health and care organisations will encourage patients to take responsibility for their health – making sure they get checks, attend appointments and live a healthy lifestyle.

The model will be delivered by the full range of health and care partners who are committed to the long-term vision of transformation for healthcare through the 'Right Care Right Here Partnership'. This includes the build of a new hospital (Midland Met) by 2018, moving more services into local settings and a drive for improving people's health by focusing on prevention, access and choice.





# 14. West Wakefield Health & Wellbeing Ltd

**PARTNERS**
West Wakefield Health & Wellbeing Ltd is a federated network of GP practices in west Yorkshire. Other partners include: NHS Wakefield Clinical Commissioning Group, Wakefield Council, Wakefield District Housing, South West Yorkshire Partnership NHS Foundation Trust, Healthwatch Wakefield, Mid Yorkshire Hospitals NHS Foundation Trust, NOVA (voluntary community sector representative body), Yorkshire Ambulance Service and Local Care Direct.

It is currently responsible for around 65,000 patients. Under vanguard there are plans to merge with two other GP practice networks in the area, which will see the number rise to 152,000.

**AIM**
As a multispecialty community provider, West Wakefield Health & Wellbeing Ltd will be working to provide a larger, more diverse primary care team locally. There are currently 73 care navigators working in practices. The majority of these care navigators are administrative staff who generally have first contact with patients, trained to direct them to the most appropriate care.

**OUTLINE**
A key element of this vanguard's programme is improved physical access to care. It is working to improve its care navigation system, directing patients to the help they need faster. The extended operating hours service has been running since October 2014, and the plans to work with two other GP networks under vanguard will expand both the number of clinicians and patients. Meanwhile the HealthPod, West Wakefield's mobile clinic, is improving engagement with 'hard to reach' groups such as members of the gypsy/traveller community.

The vanguard is also creating more ways for patients to digitally access healthcare. This includes an online directory of local services, which pulls information from a variety of sources online including social media and a library of helpful health apps on its website. The vanguard is also engaging primary school pupils in health using a competition to design health apps. An app is now being built based on the idea of last year's winning team.

Self-service kiosks in practices will help patients to access these and other helpful resources, pointing to appropriate care before a patient enters a clinic room. The vanguard is also looking at the potential for use of email/instant messaging and video consultations.

Follow us: @westwakefield

# 15. Better Health and Care for Sunderland

**PARTNERS**
This vanguard is led by NHS Sunderland Clinical Commissioning Group (CCG) and Sunderland City Council, in collaboration with local providers including Sunderland Care and Support Service, South Tyneside NHS Foundation Trust (providing community services in Sunderland), Sunderland City Hospitals NHS Foundation Trust. It also includes the city's two GP Federations (Sunderland GP Alliance and Washington Community Healthcare), Sunderland Carers Centre, Sunderland Age UK, and Northumberland and Tyne and Wear NHS Foundation Trust.

This vanguard covers a population of 284,000 people.

**AIM**
The vanguard has an ambitious vision to transform care out of hospital through increased integration of community services to provide person-centred coordinated care.

**OUTLINE**
The vanguard is working to provide an enhanced citywide recovery at home service to offer rapid response at home or in community beds to prevent emergency admissions to hospital and support patients after they are discharged from hospital.

Another key area is integration of community nursing, social workers, GPs and voluntary staff in five locality teams, wrapped around GP practices providing planned and proactive care.

The integrated locality teams will ensure care is better coordinated, planned and more proactive, particularly for patients most at risk of avoidable emergency admissions. Based in one location in each locality but working closely with clusters of practices, the teams will be supported by the recovery at home service.

GP practices will be supported to work more collaboratively through the two federations, with the aim of providing enhanced care to patients with long-term conditions.

Follow us: @BhforSunderland





# 16. Dudley Multispecialty Community Provider

**PARTNERS**
NHS Dudley Clinical Commissioning Group, Dudley Metropolitan Borough Council, Dudley Group NHS Foundation Trust, Black Country Partnership Foundation Trust, local GPs, Dudley and Walsall NHS Partnership Trust and Dudley Council for Voluntary Service.

Dudley has a population of around 318,000 people.

**AIM**
This vanguard aims to integrate services in order to wrap health and social care around patients – putting them at the centre of their care and in control.

**OUTLINE**
The vision is for teams to work together, and with patients, their families and carers to ensure they have the help and support to live life as independently as possible.

GPs are at the centre of the model as they have the responsibility for the patients that choose to register with them. The vanguard seeks to empower local communities to take control and responsibility for their health and happiness, and use their skills and expertise to build community connections and cohesion.

The model already includes voluntary sector link workers as part of the teams which are contributing to building relationships and networks and reducing social isolation. There are also plans for a single GP record operating across the whole system and to develop new technologies to improve access, continuity and coordination of care.

The vanguard aims to streamline and simplify patient pathways, removing complexity and bureaucracy from the system and looking holistically at the whole person and not just their illness or issue.

# 17. Whitstable Medical Practice

**PARTNERS**
GP practices across Whitstable, Canterbury and Faversham, NHS Canterbury and Coastal Clinical Commissioning Group, Kent County Council, Pilgrims Hospices, local NHS trusts, mental health services, public health and voluntary and community services.

The organisations jointly serve a population of approximately 170,000 people.

**AIM**
The new model of care being developed by Whitstable, Northgate and Saddleton Road Medical Practices is a multispecialty community provider. This is expanding to include an additional 13 practices across the Canterbury and Coastal area.

This new model will ensure health and social care is integrated and based around local needs and patients can receive more of their treatment in their local communities, rather than having to travel to hospital.

**OUTLINE**
This vanguard is focussed on developing a seven day a week expanded primary care team approach. This will reduce hospital admissions and length of stay through expansion of community health and social care teams.

We want to create a more cost and clinically effective service by treating patients closer to home using specialist GPs, allied health professionals and community based consultants. There will also be a greater use of information technology, using telecare and telemedicine to enable people to maintain their independence through self-care and self-management, and a shared single electronic patient record.

Three health and social care hubs will also be created and will include community hospital beds, nursing home beds and extra care facilities.

Additionally, focusing on prevention will ensure that the whole health and social care system is working seamlessly to support people to stay well and supports them where necessary.

Patients are involved in helping to decide which services the vanguard should include through groups known as community networks.





# 18. Stockport Together

**PARTNERS**
Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust and Stockport Metropolitan Borough Council along with Stockport's GP federation, frontline staff, the public and third party voluntary organisations.

Stockport Together will be serving a GP registered population of more than 305,000.

**AIM**
Stockport Together aims to develop a single strategic plan to improve health and social care services across the borough. It wants to fundamentally reform the way health and social care is delivered in Stockport to ensure the best possible outcomes for local people. This is against a backdrop of growing demand and restricted funding

**OUTLINE**
The model in Stockport is a GP-led neighbourhood-based out-of-hospital service, which includes community health services, mental health, social care and the third sector.

Initially, the vanguard will be commissioned to deliver care to the over 65 population of Stockport on a weighted capitation basis. The model covers a range of measures including screening for early detection of diseases and supporting people to manage their own care where appropriate through education.

Where people have complex conditions crisis response will be put in place through an anticipatory plan to help support them in the management of exacerbations themselves and reduce the stress that this can cause.

A facility will also be developed to allow GPs to call consultants directly for advice initially across up to eight specialties using a cascade system. The vanguard will also utilise the skills of social care and third sector partners to build community capacity in each neighbourhood.

Follow us: @Stockport2gther

# 19. Tower Hamlets Integrated Provider Partnership

**PARTNERS**
Tower Hamlets GP Care Group Community Interest Company, Barts Health NHS Trust, East London NHS Foundation Trust and London Borough of Tower Hamlets.

The vanguard serves around 280,000 people.

**AIM**
This vanguard aims to establish a new model of community care which will enable social care, primary, community and acute health services to truly coordinate their services around the patient.

**OUTLINE**
The vanguard is working to ensure that more patients have their care coordinated around their needs and are not left to navigate themselves through numerous different services. It will also help more vulnerable patients receive care in their own homes, limiting time spent in hospital away from their family and friends.

A key part of the vanguard is a greater focus on a positive patient experience. Patients can expect improved experience of care across all health and social care services in the local community.

Follow us: @THIPPVanguard







# 20. Better Local Care (Southern Hampshire)

**PARTNERS**
Better Local Care is a growing partnership of around 30 GP practices, Southern Health NHS Foundation Trust and local commissioners based in Hampshire.

The teams currently support around 220,000 people with more teams following in the coming months.

**AIM**
This vanguard aims to provide better access, experience and outcomes for patients closer to their homes. This means fewer people will need to go to hospital, and more will be supported to take control over their own health and wellbeing.

**OUTLINE**
Better Local Care is joining services up to form one extended team of health, social care, third sector and GP colleagues who support the same local population. This will improve access to the right professional at the right time, including specialists – with fewer unnecessary appointments in between.

By working in this way, health and care professionals will have more time to support people who are most at risk of worsening health and wellbeing.

This vanguard understands that people who use services are experts too. A big part of Better Local Care is finding new ways to collaborate with users and carers so new care models really work for them and their families.

Follow us: @betterlocalcare

# 21. West Cheshire Way

**PARTNERS**
Primary Care Cheshire (GP Federation involving all 36 GP practices based in west Cheshire) and the local community services provider supported by West Cheshire Clinical Commissioning Group, Cheshire and Wirral NHS Partnership Foundation Trust, the Countess of Chester NHS Foundation Trust, Cheshire West and Chester Local Authority and partners from the third sector. Local patient voluntary and community groups are involved too, including Healthwatch Cheshire West.

These organisations serve a population of around 250,000.

**AIM**
With an emphasis on transforming care from cradle to grave, West Cheshire Way focusses on starting well, living well and ageing well as the drivers for change.

**OUTLINE**
A key theme running throughout the West Cheshire Way vanguard is that the individual and their family and carers will be given the tools and confidence to manage their condition for themselves, so far as is possible. This will involve clinicians and local people working together to build an understanding of what self-care means and to co-design it together. Where self-care is not the solution, West Cheshire Way is committed to involving local patients, families and carers in co-designing care models that meet their needs.

Babies, children and young people will look to their local GP and cluster team as their gateway to coordinated support. Adults will be helped to make healthier choices via innovative self-care programmes, and people with long-term conditions will be identified and supported to minimise the impact on their daily lives.

Vulnerable older people will be cared for by GPs and integrated community teams who will proactively identify and target those most at risk, develop shared care plans with a single care coordinator and ensure care is provided by specialist, multidisciplinary teams.

Follow us: @WestCheshireCCG





# 22. Lakeside Healthcare (Northamptonshire)

**PARTNERS**
Kettering General Hospital, University Hospital Leicester, Northampton County Council, Corby Borough Council, Celesio, Lloyds Pharmacy, Leonard Cheshire Homes and Olympus Social Care Services.

Lakeside Healthcare is the largest single GP 'super-practice' partnership in the NHS with a patient list of over 60,000. It is headquartered in Corby, Northamptonshire with several branch surgeries in nearby towns.

Through Lakeside Healthcare this vanguard looks after over 100,000 patients.

**AIM**
By April 2016, Lakeside Healthcare aims to be one of the first accountable care organisations in the NHS.

**OUTLINE**
The model is to further develop their home and community based service that puts the patient at the very centre of everything they do.

The vanguard will offer patients four new models of care which complement each other: Lakeside Extensivist Services; Lakeside Enhanced Primary Care; Lakeside Ambulatory Surgery Centres; and, CorbyCare Urgent Care Model.

Lakeside Extensivist Services is a holistic care system which will provide coordinated, comprehensive care to the most needy and frail patients. It aims to ensure patients receive highly personal care with better access and are engaged in the management of their conditions.

Lakeside Enhanced Primary Care is team-based care that provides comprehensive and convenient medical care to a specific patient segment. This will also allow patients to receive whole-person focussed care delivered by their current GP.

Lakeside Ambulatory Surgery Centres are outpatient centres delivering high efficiency care in a convenient setting with improved patient scheduling which supports increased patient choice.

CorbyCare Urgent Care operates either as a standalone service or on a hospital site and has satellite primary-pharmacy spokes.

# 23. Principia Partners in Health (Southern Nottinghamshire)

**PARTNERS**

12 GP practices in Rushcliffe are coming together as a 'partnership of partners' to form the cornerstone of a new multispecialty community provider organisation. It will combine with general practice, GP out-of-hours services, community and local mental health services, social care, third sector, hospital and ambulance trusts.

This vanguard will serve a population of 126,000.

**AIM**

Serving Rushcliffe's whole population, the vanguard aims to accept contractual responsibility for the quality and costs of healthcare within a single capitated budget. The vanguard will be defined by integrated working and a culture of mutual accountability for patient experience and outcomes.

**OUTLINE**

A new model of integrated care will focus on promoting health and wellbeing through prevention and providing care at the right time in the right place. This will enable people to live independently at home for as long as possible and avoid unnecessary hospital admissions by moving traditional hospital-based services into community settings, such as specialist long-term conditions management, nursing, diagnostics and some consultant-led care.

This vanguard will see the local health and social care system working as one to focus on proactive healthcare, with commitment and pride in bringing benefits to patients and the professionals who serve them. The result will be a significant culture change, with the health and social care workforce coming together to agree ambitions that are patient-centred and empower people to personalise the care they receive, replacing the one-size-fits-all model currently delivered by individual organisations.



**NEW CARE MODELS:** Vanguards – developing a blueprint for the future of NHS and care services



## **The vanguards:** enhanced health in care homes

#futureNHS

# 24. Connecting Care - Wakefield District

**PARTNERS**
NHS Wakefield Clinical Commissioning Group, Wakefield Council, seven GP networks and the Provider Alliance which includes Nova-Wakefield, Age UK, Wakefield District Housing, South West Yorkshire Partnerships NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust and Yorkshire Ambulance Service.

Wakefield district has a population of around 361,000.

**AIM**
This vanguard focuses on the wider determinant of wellbeing – 'somewhere to live, someone to love, something to do'.

**OUTLINE**
The vanguard is working to ensure people in care homes are offered proactive, holistic assessment and care planning. Care needs will be reviewed on admission to a care setting, at scheduled intervals (according to need) and after an unplanned episode e.g. an urgent GP call out.

There will be a joined up support package for people in independent living schemes, i.e. sheltered housing, to keep them socially connected within the scheme and in the wider community.

Evidence from existing pilots indicates this will reduce fragmentation in care and give equal access to high quality health care whether in a care home or their own home. It will also help keep residents and their families in control of their care and reduce accidents and health deterioration, resulting in urgent GP calls and hospital attendance or admission.

This will also reduce the number of people choosing to go from independent living into care settings to escape loneliness and enable couples to be supported to stay together in independent living schemes.

The vanguard is also working to ensure every resident has an end of life plan – allowing people to die in their place of choice.







# 25. Gateshead Care Home Project

**PARTNERS**
NHS Newcastle Gateshead Clinical Commissioning Group and Gateshead Council.

Gateshead has a population of around 206,000.

**AIM**
This vanguard is a pioneering project to improve the health of care home residents in Gateshead.

**OUTLINE**
Gateshead Care Home Project sees individual GP practices each allocated to a specific care home, making it possible to offer greater continuity of care and more effective prevention of illness through regular home visits.

There will also be changes to the way services are commissioned and contracts managed with a wide range of providers for this group of patients. It will bring together a network of organisations working together for a more coherent health and social care offer to patients.

The vanguard is also reviewing the care pathway and a new model for contracts and payments as well as the development of co-commissioning for all community bed and home based care. Co-commissioning is the clinical commissioning group and Gateshead Council working together to bring a simplified and joint approach to enhanced healthcare, making it easier for patients and professionals to navigate, with the potential to take out some transactional costs.

Personalised care delivery and multidisciplinary working has already brought a 14% reduction in avoidable hospital admissions, together with an improvement in the quality of care delivered.

Follow us: @NHSngccg @GMBCouncil

# 26. East and North Hertfordshire Clinical Commissioning Group

**PARTNERS**
East and North Hertfordshire Clinical Commissioning Group, Hertfordshire County Council and the Care Home Providers Association.

East and North Hertfordshire Clinical Commissioning Group covers a population of 580,000.

**AIM**
This vanguard aims to facilitate all parts of the health and social care system to work together to do more to look after vulnerable patients in care homes and prevent them having to make unnecessary trips to hospital.

**OUTLINE**
Patients living in care homes are often some of the area's most vulnerable patients. Most have more than one long term medical condition, such as diabetes, breathing problems or heart disease and often need to take several medications. These patients can also become very unwell very quickly and can sometimes need to be rushed to hospital because their condition has deteriorated.

This vanguard will focus on improving services for these patients in a number of ways.

It will enhance the skills of care home staff through a package of education and training, so that patients with complex care needs can be looked after with confidence. It will also create teams of GPs, district and practice nurses, mental health nurses, older people's specialists and pharmacists, who will work closely with care home staff to support residents.

The vanguard aims to bring together 'rapid response' teams of community nurses, matrons, therapists and home-carers who can get to care homes within 60 minutes, as an alternative to sending elderly patients to A&E, when that is in their best interests.

There will also be an investment in technology to give all GPs access to comprehensive information about each care home resident when they visit them.







# 27. Nottingham City Clinical Commissioning Group

**PARTNERS**
Nottingham City Clinical Commissioning Group in partnership with the Care Home Steering Group which includes Nottingham CityCare Partnership, Nottingham University Hospitals, Nottinghamshire Healthcare Trust, Age UK Nottingham and Nottinghamshire, Care Home Managers Forum, Nottingham City Council and Nottingham University.

The organisations jointly serve a population of more than 314,000 people.

**AIM**
Nottingham City's vision is for care home residents to be healthier, have a better quality of life and to be treated with dignity and respect. This vanguard will focus on the capabilities of those living in care home settings rather than their dependencies with the aim that all residents, and their families, are able to enjoy a positive experience of care.

**OUTLINE**
Care home residents, commissioners and providers are committed to working together to transform the model of support provided to care homes by developing a value-based approach. To support the transformation of services, providers will be given greater freedom to innovate in the way they deliver health and care services whilst being held to account for the outcomes and costs of care.

The vanguard wants to remove organisational barriers, implement new technology and ensure that care home staff have support from specialist health services to identify, understand, manage and respond to the everyday impact of providing essential care. Residents will receive coordinated care from GPs and specialist health professionals in partnership with social care and their care home staff. These partnerships are essential and will be built on reliable communication and trust between teams and individuals through a shared ambition to transform services for care home residents and their families.

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# 28. Sutton Homes of Care

**PARTNERS**
NHS Sutton Clinical Commissioning Group, the London Borough of Sutton, Epsom and St Helier Hospitals NHS Trust, St Raphael's Hospice, Sutton and Merton Community Services (the community division of The Royal Marsden), Age UK Sutton, South West London and St George's Mental Health Trust, The Alzheimer's Society, London Ambulance Service and Sutton Centre for the Voluntary Sector.

Sutton Clinical Commissioning Group serves a population of over 190,000.



**AIM**
The aim of this vanguard is to work together with local care home providers and communities to provide high quality care that enhances the health and wellbeing of care home residents, as well as proving to be financially beneficial to the tax payer.

**OUTLINE**
The vanguard has introduced a number of interventions including the development of a community team to help prevent unnecessary admissions to hospital and the establishment of end of life care nursing teams. They have also set up a joint intelligence group and established forums for care home managers and senior nursing staff to share best practice, education and training.

These interventions have already demonstrated not only an increase in the quality of care provided to residents, but have also shown a reduction in pressures on the health system.

Whilst much has already been achieved, the vanguard believes that further work could bring even greater benefits not only the population of Sutton, but also care home residents nationally through replication of successful strategies.

Follow us: @SuttonHoC





# 29. Airedale & Partners

**PARTNERS**
Airedale & Partners vanguard is a partnership of over 15 organisations in Yorkshire and Lancashire and includes three hospitals, GPs, three councils, community healthcare, IT partners and a range of independent care home providers.

The organisations jointly serve a population of more than 750,000 people.

**AIM**
The vanguard is being led by doctors, nurses, and other health and social care professionals, and its main aim is to improve the quality of life and end of life care of thousands of nursing and care home residents.

**OUTLINE**
This vanguard is using technology to improve care locally. Improvements include supporting residents who are sick by providing a secure video link to senior nurses so they can remain in the care home, where safe to do so.

This means patients have, at the touch of a button, 24/7 access to local care and support.

This helps residents remain active and independent, and reduces hospital admissions and A&E and GP visits, including people with breathing problems, heart conditions and dementia.

The vanguard also aims to help residents improve their health and wellbeing, including older, vulnerable people who are most at risk of getting sick. Using remote technology, such as telemedicine, doctors and nurses can monitor people on screen to stop them from becoming ill or provide care earlier.

Technology partners are also helping to support a shared patient record, including real time information, which is safer, quicker and avoids duplication.

Follow us: @AiredaleNHSFT

# **The vanguards:** urgent and emergency care





## 30. Greater Nottingham System Resilience Group

**PARTNERS**
Nottingham University Hospitals NHS Trust, The South Nottingham and Erewash clinical commissioning groups, Nottingham City and County Councils, East Midlands Ambulance Service, Nottingham CityCare Partnerships, County Health Partnership, Nottinghamshire Healthcare NHS Foundation Trust, Derbyshire Health United Ltd (111 provider), Nottingham Emergency Medical Services (GP out of hours), Healthwatch Nottingham and Healthwatch Nottinghamshire.

This vanguard has a population of 685,000.

**AIM**
The partners which form this vanguard are supporting ambitious improvements to urgent and emergency care services across South Nottinghamshire.

**OUTLINE**
They are looking at what more they can do, using innovative workforce solutions, to ensure that people receive care in a timely way and closer to home - in many cases avoiding the need for assessment or admission to hospital.

In particular they will focus on enhancing mental health services in the community to ensure that patients get the care they need, in the right setting and in a timely manner. This will include rolling out and extending the National Mental Health 111 pilot to provide faster and better care when it is needed.

The vanguard will also be working to improve access to primary care clinicians at the 'front door' of the emergency department as well as clinical assessments and treatment to allow patients to be assessed and then followed up closer to home. The team is also enabling more direct clinician to clinician conversations so that a greater number of patients are directed to the right service, first time, every time.

The system will involve patients, carers and wider partners to lead the way in developing more timely and safe emergency care.

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# 31. Cambridgeshire and Peterborough Clinical Commissioning Group

**PARTNERS**
Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has three System Resilience Groups (SRG) and is part of the East of England Urgent and Emergency Care Network.

This vanguard covers a population of 950,000.

**AIM**
The clinical commissioning group's vision is to create an overarching super system resilience group with strong clinical leaders, as part of the existing network.

As an urgent and emergency care vanguard the CCG will accelerate improvements and develop a best practice model for urgent care services. In particular it aims to address variations in access to services and health inequalities in the region.

**OUTLINE**
This vanguard's new super SRG will focus on providing highly responsive urgent care services outside of hospital and promoting self-care and management. It will work to help people with urgent care needs get the right advice first time, and to access the right service seven days a week.

In order to meet these needs the vanguard's plans include developing the right workforce  including GP Fellows; Advanced Nurse Practitioner and advanced AHP roles; developed community pharmacist roles; physician's assistants, and staff equipped to meet mental and physical health needs.

There will also be a reassessment of service standards based on outcomes and a redefinition of payment methods to incentivise system redesign.

Follow us: @fitforfuturenhs







# 32. North East Urgent Care Network

**PARTNERS**
Academic Health Science Network, Clinical Health Information Network, Health Education North East, Nine Strategic Resilience Groups and associated members, North East Ambulance Service NHS Foundation Trust, North East Local Authorities, North of England Commissioning Support, Regional Out of Hours Providers, Royal College of Psychiatry, Voluntary Organisations' Network North East.

This Network covers areas around Northumberland, Tees, Esk and Wear Valley, Newcastle, Northumbria, Gateshead, Tyneside, Sunderland, County Durham, Darlington and Hartlepool – a region with a population of 2.71 million.

**AIM**
The North East Urgent Care Network– which consists of all the key physical, mental health and care stakeholders and providers – already has a strong history of working collaboratively to deliver successful innovative projects. These support the recommendations made in the Urgent and Emergency Care Review as well as, importantly, improving patient outcomes and experience, benefiting the whole of the North East region.

**OUTLINE**
This programme will enable the Network to transform the regional urgent and emergency care system and its services to further improve consistency and clinical standards, reduce fragmentation and deliver high quality and responsive health and social care to patients.

It will also enable them to move at pace in terms of creating and implementing one urgent and emergency care model as well as giving strategic oversight to urgent and emergency care services across the region. This will provide consistent and seamless care, wherever patients present, whatever the day or hour with no difference in their clinical outcomes.

# 33. Barking and Dagenham, Havering and Redbridge System Resilience Group

**PARTNERS**
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups, Barking, Havering and Redbridge University Hospitals NHS Trust, North East London NHS Foundation Trust, London Borough of Barking and Dagenham, London Borough of Havering, London Borough of Redbridge, Together First (Barking and Dagenham GP Federation), Havering Health (Havering GP Federation), Healthbridge Direct (Redbridge GP Federation), Partnership of East London Cooperatives, London Ambulance Service, NHS England Area Team, Healthwatch, Local Pharmaceutical Committee.

This vanguard has a population of 750,000.

**AIM**
Barking and Dagenham, Havering and Redbridge System Resilience Group (SRG) aims to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for its residents which live in one of the most challenged health economies in the country.

**OUTLINE**
The SRG believes there is a need to do things differently and that patients are confused by the various urgent and emergency care services available to them – A&E, walk-in centre, urgent care centre, GPs, pharmacists, out of hours services.

Becoming an urgent and emergency care vanguard supports the SRG in its ambition to streamline these points of access to just three – supported by a smart digital platform that will recognise patients and personalise the help they get as soon as they get in contact. This involves:

1. 'Click' – online support and information – will help people to self-care and book urgent appointments when needed.
2. 'Call' – telephone for those who need more advice, reassurance or to book-in.
3. 'Come in' – where patients really need emergency care – the front door of the hospital will become new ambulatory care centres.

This ambitious plan is being developed with patients and staff, and will be implemented by building on existing successful partnership working between NHS and social care organisations locally.

Follow us: @BHRpartnership





# 34. West Yorkshire Urgent Emergency Care Network

**PARTNERS**
10 West Yorkshire Clinical Commissioning Groups; Harrogate and Rural Districts CCG; Five West Yorkshire plus Harrogate system resilience groups including primary care and local authority partners; Seven NHS acute and community providers; Three NHS mental health service providers; Three providers of district-wide services; Yorkshire and Humber Academic Health Science Network; West Yorkshire HealthWatch organisations; NHS England Yorkshire and Humber; Yorkshire Ambulance Service.

This vanguard reaches a population of 3 million people.

**AIM**
This vanguard's collective local vision is that all children, young people and adults with urgent and emergency needs in West Yorkshire will get the right care in the right place, first time, every time.

**OUTLINE**
To achieve this the vanguard will transform services provided by local community and primary care and provide urgent acute and mental health services out-of-hospital where appropriate. There will also be a focus on self-care with individuals and communities provided with the support they need to self-care.

The vanguard will also work to ensure that emergency medical centres have the facilities and expertise needed to provide the highest levels of care and there will be improved integration of information and services to streamline the system.

This vanguard is building on the firm foundation of existing network activity, shared learning and system-wide leadership to deliver the five principles set out in the national Keogh Urgent Care Review.

# 35. Leicester, Leicestershire & Rutland System Resilience Group

**PARTNERS**
Leicester City, East Leicestershire and Rutland and West Leicestershire Clinical Commissioning Groups; the three upper tier local authorities (Leicester City, Leicestershire County, and Rutland County); Arriva (patient transport service); University Hospitals of Leicester NHS Trust; East Midlands Ambulance Service; Leicestershire Partnership NHS Trust; George Elliott (Leicester Royal Infirmary Urgent Care Centre); CNCS (GP out of hours /Loughborough Urgent Care Centre); Derbyshire Health United (NHS 111); Soldiers, Sailors Airmen and Families Association (acute visiting services).

This vanguard has a population of 1.1 million.

**AIM**
This vanguard's vision is for a new urgent and emergency care model that blurs organisational boundaries, and clearly defined outcomes enabling it to be responsive to the needs of its diverse city/county population. It also aims to develop a model which will be replicable nationally.

This vision forms part of a five-year whole-system reconfiguration plan signed up to by all local commissioners and providers.

**OUTLINE**
The vanguard will create a new alliance-based urgent and emergency care system where all providers work as one network. This will bring together ambulance, NHS 111, out-of-hours and single point of access services to ensure that patients get the right care, first time.
The network will include a same-day response team with GPs, acute home-visiting and crisis response services, community nursing, older peoples' assessment unit and urgent care centres.

University of Leicester Hospitals NHS Trust runs the largest single site A&E department outside of London. In 2016, the hospital's urgent and emergency care front door will be re-launched to include an assessment team with the ability to refer patients to ambulatory clinics, assessment beds, on-the-spot urgent care centres or primary or community care.

The vanguard also has plans to work with the national team, IBM and Loughborough University to develop a demand and activity model, using realtime data to inform providers' and patients' choices.

Follow us: @UrgentCareLLR





# 36. Solihull Together for Better Lives

**PARTNERS**
Heart of England NHS Foundation Trust (includes acute and community services); Birmingham and Solihull Mental Health NHS Foundation Trust; Solihull Metropolitan Borough Council; NHS Solihull Clinical Commissioning Group; Voluntary and Community Sector providers; Primary Care (including confederation of GP practices in Solihull); West Midlands Ambulance Service; West Midlands Police; West Midlands Academic Health Sciences Network; Lay members representative of service users, carers and the wider Solihull community.

The population in this area is 210,000.

**AIM**
The local Solihull vision is to create an integrated health and care system that optimises wellbeing through preventative and out-of-hospital care, with rapid access to specialist services. The vanguard has the ambition to extend healthy active life and independence with equal focus on physical and mental health. This will be achieved by encouraging healthy lifestyle choices, care co-ordination and empowerment to self-manage long-term conditions which will reduce pressure on secondary care services and alter the balance of care provided in hospital and the community.

**OUTLINE**
This vanguard's programme is delivering an integrated approach to urgent and emergency care, which incorporates a number of elements.

Patients and carers will be supported in their homes and at the 'Health and Wellbeing Campus' (on the hospital site) through open and accessible information and services using various portals, building on the local authority 'Solihull Connect' service.

There will also be integrated community teams which include improved access to diagnostics and secondary care specialists supported by innovative information technologies.

Mental health services will be enhanced - building on rapid assessment interface and discharge, street triage, dementia and delirium team and outreach.

Finally the vanguard plans to build an urgent care centre that includes GP out-of-hours, walk-in and minor injuries services within the hospital site as part of the 'Health and Wellbeing Campus'.

Follow us: @SolihullCouncil @SolihullCCG @heartofengland @bsmhft

# 37. South Devon and Torbay System Resilience Group

**PARTNERS**

South Devon and Torbay Clinical Commissioning Group; South Devon Healthcare Foundation Trust; Torbay and Southern Devon Health and Care Trust; Torbay Council; South Western Ambulance Services Foundation Trust; Devon Doctors Ltd; Community pharmacy (via Local Pharmaceutical Committee).

This vanguard has a population of 287, 594.

**AIM**

As a vanguard this System Resilience Group will be able to move quickly on the implementation of its urgent care strategy, transforming the local urgent care system, for a sustainable future. This strategy aims to make the best use of the resources spent locally on urgent and emergency care - deriving greater quality and value for money by avoiding duplication of effort, first time.

**OUTLINE**

The model enables the vanguard to implement two sets of priorities, for 2016 and 2017.

For next year, the priorities will include the rapid development of urgent care centre (UCC) facilities in at least two centres, prioritising areas of higher deprivation to reduce inequalities. The vanguard will also share primary care records with the out-of- hours provider, and co-locate primary care facilities with A&E/UCC facilities in at least two locations.

The following year's priorities will include making a full complement of urgent care centres available. There will also be the co-location of primary care in all A&E/UCC facilities, as well as the decrease in 999 conveyance to A&E of at least 5%.







# **The vanguards:** acute care collaborations

# 38. Salford and Wigan Foundation Chain

**PARTNERS**
Salford Royal NHS Foundation Trust and Wrightington, Wigan & Leigh NHS Foundation Trust.

This vanguard serves around 2 million patients.

**AIM**
The aim of the two organisations is to create a healthcare group that will deliver faster improvements in patient outcomes and greater productivity.

**OUTLINE**
Salford Royal NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust are working together with Devo Manc partners to create a new healthcare group. This will help them to increase the pace at which they are able to make improvements which will result in better outcomes for their patients and increases in productivity.

They are working in partnership with commissioners and provider organisations across the region to create an Integrated or Accountable Care type organisation and a single service model for elective and specialist services.

Follow us: @SalfordRoyalNHS @WWLNHS





# 39. Northumbria Foundation Group

**PARTNERS**
Northumbria Healthcare NHS Foundation Trust supports a number of organisations in the North East and across England.

The population served by the Foundation Group will depend on which partners are identified.

**AIM**
The Trust aims to create a Foundation Group that drives efficiency and clinical effectiveness within the NHS and delivers high quality patient care for the long term.

**OUTLINE**
Northumbria Healthcare NHS Foundation Trust's plans to create a Foundation Group will widen the support and services it can provide to other organisations.

The Trust is already supporting a number of organisations within the North East and across England (including North Cumbria University Hospitals NHS Trust for which it is the appointed acquisition partner and buddy), and will use the development of the Foundation Group as a vehicle to better coordinate and further develop this support.

Through the Foundation Group, the Trust and its partners could support others more effectively in a range of ways, these include: acquiring and/or merging other hospital trusts; providing corporate services to other NHS organisations; and creating a standard operating model built on providing excellent clinical outcomes.

This will benefit patients by helping partner organisations to be more efficient and to make sure that patients are receiving the best possible care and that high quality services are more sustainable for the future.

Follow us: @northumbrianhs

# 40. Royal Free London

**PARTNERS**
Potential partners will be identified as the proposal is developed but the trust plans to work with Salford Royal NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust to develop proposals on a group model.

The population served by this vanguard is dependent on which partners are identified.

**AIM**
The trust is interested in exploring horizontal growth to find ways to improve the quality of patient care while also reducing the cost to the healthcare economy as a whole.

**OUTLINE**
The Royal Free London NHS Foundation Trust plans to become the heart of a group that other organisations will want to collaborate with.

The trust is considering options including buddying, merging specific office functions and other innovative models such as joint clinical and corporate ventures.

The key benefits of this approach are that it would reduce the variation patients can experience in care, increase efficiency and identify ways that high quality services can be delivered at reduced cost.







# 41. Foundation Healthcare Group (Dartford and Gravesham)

**PARTNERS**
Dartford and Gravesham NHS Trust (DGT); Guy's and St Thomas' NHS Foundation Trust (GSTT).

**AIM**
Dartford and Gravesham NHS Trust is exploring and moving into one of the first Foundation Group models with Guy's and St Thomas' NHS Foundation Trust on a management contract basis.

**OUTLINE**
The Trusts are working together to assess the benefits for patients and staff of becoming one of the first Foundation Groups. These groups will involve different hospitals working closer together, offering clinical services into another site, and sharing corporate services via a management contract.

At present DGT is unsustainable in its current form. The partnership's vision is to create a sustainable care system for Dartford and Gravesham, with DGT patients benefiting from greater integration locally with primary, community, and mental health partners; secondary care partners and a more seamless transition to specialist and tertiary care at GSTT when required. The proposal will also respond to expected population growth in the area (at Ebbsfleet).

Follow us: @darentvalleyhsp

# 42. Moorfields

**PARTNERS**
Moorfields Eye Hospital NHS Foundation Trust.

The potential patient population of this vanguard depends on which partners are identified..

**AIM**
The Trust aims to learn from its experience of existing satellite models to develop future networks and share good practice across the wider NHS.

**OUTLINE**
Moorfields Eye Hospital NHS Foundation Trust already runs services in 22 locations in and around London in a variety of healthcare settings, but recognises that this model has grown in response to ad hoc requests. Therefore it aims to identify the best approach to establishing and sustaining a chain of services and to produce a toolkit which can be used to roll out service level chains regardless of the specialty to benefit patients in other parts of the NHS.

In addition to analysing the best approach for a successful chain of services, the Trust will also explore the opportunities and risks associated with running an extended network of eye services, based on increasing the number of Moorfields satellite sites and widening the Trust's geographic reach.







# 43. National Orthopaedic Alliance

**PARTNERS**
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in Oswestry; Royal National Orthopaedic Hospital NHS Trust in Stanmore and Royal Orthopaedic Hospital NHS Foundation Trust in Birmingham.

This vanguard has national reach.

**AIM**
The National Orthopaedic Alliance vanguard aims to create a UK-wide franchise or chain of orthopaedic providers to deliver outstanding and consistent care in more areas.

**OUTLINE**
The vanguard partners will explore formal ways of collaborating more closely to explore how they could extend their model more widely across the country. This work builds on their already established base of collaboration and will formalise the way organisations work together on a clinical basis as well as through back office functions.

The vanguard will also explore the possibility of enabling exemplar orthopaedic services to be offered on a franchise model across England. Their work will include developing a single common model for NHS franchising that can be picked up by any speciality; to implement best practice; to identify ways of expanding across a wider geography; and to ensure that scale brings with it stronger local patient and community involvement.

For patients this could help deliver higher quality care more consistently across the country and also provide a new model for smaller hospitals and specialist providers.

Follow us: @rjah_NHS @ROHNHSFT @RNOHnhs

# 44. The Neuro Network (The Walton Centre, Liverpool)

**PARTNERS**
The Walton Centre NHS Foundation Trust; Warrington and Halton Hospitals NHS Foundation Trust; Liverpool Clinical Commissioning Group; Warrington Clinical Commissioning Group; NHS England Specialised Services Commissioning Team (North).

This vanguard reaches 3 million patients.

**AIM**
The Neuro Network aims to work with its partners to develop a high quality and cost effective neuroscience service chain.

**OUTLINE**
The programme will build on partners' extensive experience in developing the network models for neurology and spinal services in Cheshire and Merseyside. It will also strengthen the neurological support provided by the Walton Centre to local hospitals, GPs and patients, and look to extend the spinal model in partnership with The Royal Liverpool & Broadgreen University Hospitals and Aintree University Hospital. This approach enables patients to have rapid access, locally, to high quality care from a regional specialist centre.

Follow us: @waltoncentre





# 45. MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)

**PARTNERS**
Birmingham and Solihull Mental Health NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Coventry and Warwickshire Partnership NHS Trust.

This vanguard has a patient population of 3.4 million.

**AIM**
This vanguard aims to share best practice and create replicable models for long-term clinically and financially sustainable specialist mental health services. They will work together to solve efficiency, workforce, equality and policy implementation challenges.

**OUTLINE**
MERIT will focus on three priority areas where the greatest challenges for urban mental health services exist. These are seven day working in acute services; crisis care and reduction of risk; and recovery and rehabilitation. In these areas better integration across organisations will aim to improve quality and increase efficiency rapidly while reducing variations and spreading best practice.

Service users will benefit from faster decision making, such as discharges seven days a week and a co-ordinated emergency response. They will also have a shared care plan, meaning just one assessment and only having to tell their story once.

The vanguards will also be providing more support for recovery in the community to reduce the chance of a relapse or return to secondary care services; and less unnecessary time spent in A&E or police cells.

Follow us: @MERITvanguardwm

# 46. Cheshire and Merseyside Women and Children's Services

**PARTNERS**
Alder Hey Children's NHS Foundation Trust; Countess of Chester Hospital NHS Foundation Trust; Liverpool Women's NHS Foundation Trust; Mid Cheshire Hospitals NHS Foundation Trust; Southport and Ormskirk Hospital NHS Trust; St Helens and Knowsley Teaching Hospitals NHS Trust; Warrington and Halton Hospitals NHS Foundation Trust; Wirral University Teaching Hospital NHS Foundation Trust; NHS Halton Clinical Commissioning Group (CCG), NHS Knowsley CCG, NHS Liverpool CCG, NHS St Helens CCG, NHS South Sefton CCG, NHS Southport and Formby CCG, NHS Warrington CCG, NHS West Lancashire CCG, NHS Wirral CCG, NHS West Cheshire CCG; Cheshire and Merseyside Maternity, Children and Young Strategic Clinical Network; North West Neonatal Operational Delivery Network; Adult Critical Care Operational Delivery Network.

2.4 million people could benefit from the work of this vanguard.

**AIM**
This vanguard aims to develop a clinically managed network for women's and children's services (including maternity, gynaecology, neonatal and paediatric services) across Cheshire and Merseyside in order to further improve quality and ensure services are clinically and financially sustainable.

It has the backing of all provider trusts, clinical commissioning groups and networks across Cheshire and Merseyside.

**OUTLINE**
The vanguard will address the challenges facing services for women and children locally by creating a new approach between commissioners, clinicians and providers that goes beyond organisational boundaries.

These challenges include a greater demand for services and an increase in patients with more complex needs as well a variation in quality of services. No single organisation, commissioner or provider can alone resolve these issues and this vanguard will also allow organisations to work together to tackle challenges around workforce like recruitment, retention, retirement and skills mix, as well as overall financial sustainability.

Working more closely together will also allow the vanguard to better engage with the people who use their services and create a more personalised offer for them.

Follow us: @LiverpoolWomens





# 47. Accountable Clinical Network for Cancer (ACNC)

**PARTNERS**
The Royal Marsden NHS Foundation Trust, The Christie NHS Foundation Trust and UCLH (University College London Hospitals NHS Foundation Trust).

The partners in this vanguard jointly support a population of 10.7 million

**AIM**
Individual networks led by The Royal Marsden NHS Foundation Trust, The Christie NHS Foundation Trust and UCLH (University College London Hospitals NHS Foundation Trust) will work together to develop plans for implementing Accountable Clinical Networks for Cancer, capable of being reproduced nationally.

**OUTLINE**
Working with a range of partners, including Devo Manc partners in Manchester, this vanguard will support integration across the entire cancer patient pathway (including public health, primary care and diagnostics), in order to secure improvements in delivering patient centred, quality and more financially sustainable cancer care.

Working together the networks will focus on a number of areas. These include improving early diagnosis and detection of cancer by taking advantage of the scale and pace working together will allow. The aim of this will be on driving improvements in clinical outcomes, particularly around patient survival rates through an alignment of objectives and focussed leadership across cancer services at a local level and less variation in access and outcomes.

Patients should also see an improvement in their experience across the whole pathway from diagnosis to living with and beyond cancer.

Follow us: @royalmarsden @uclh @TheChristieNHS

# 48. EMRAD - East Midlands Radiology Consortium

**PARTNERS**
Chesterfield Royal Hospitals NHS Foundation Trust, Kettering General Hospital NHS Foundation Trust, Northampton General Hospital NHS Trust, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, University Hospitals of Leicester NHS Trust.

The population covered by this vanguard is approximately 6 million patients in the East Midlands.

**AIM**
EMRAD - East Midlands Radiology Consortium is a consortium of seven NHS trusts within the East Midlands working together, hosted by Nottingham University Hospitals NHS Trust. Together they aim to create a clinical network, providing timely and expert radiology care for patients across the East Midlands regardless of their location. Once developed, this Network will be seen as a national benchmark for new models of clinical collaboration within NHS radiology services.

**OUTLINE**
In order to achieve this vision they will deliver a number of improvements. They have already started work on purchasing a shared, technical system to allow access to patient radiology images at the point of clinical need. In order to maximise the benefits of this technical investment they will develop and implement new regional systems of governance, patient consent, commissioner support and education.

The vanguard also has plans to develop a collaborative network of services, aided by the shared technical systems, which support network-wide clinical care for patients. They hope to develop a mechanism for working regionally, bringing work back into the NHS which is currently being delivered in other sectors, providing expert trusted opinions within the NHS, and supporting both large and small trusts by creating cross-trust expert radiology networks.

Follow us: @emradNHS







# 49. Developing One NHS in Dorset

**PARTNERS**
Dorset County Hospital NHS Foundation Trust; Poole Hospital NHS Foundation Trust; The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Patient population: 850,000.

**AIM**
The recent Dorset Clinical Services Review, had a vision of sustainable models of care for in- and out-of-hospital care, to meet the needs of local people 24 hours a day, seven days a week. The three district hospital providers in Dorset aim to use a multi-service joint venture to deliver this vision and ensure the future sustainability of health services in Dorset.

**OUTLINE**
Patients will benefit from a reduction in avoidable variations in care, the implementation of standardised best practice and the spread of service innovation. There will be a more equitable delivery of services to patients across the whole of Dorset, with the clinical network(s) organised to ensure that all patients have faster access to a consistent, high standard of care irrespective of where they live.

It is envisaged that there will be movement to a single shared rota for some agreed clinical services across Dorset which will ensure the best use of senior clinicians. The creation of job plans that allow for the recruitment and retention of high calibre clinicians will facilitate the development of sustainable clinical models.

Follow us: @poole_hospital @DCHFT @RBCH_NHS

# 50. Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)

**PARTNERS**
Sheffield Teaching NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw NHS Foundation Trust, Rotherham NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust, Chesterfield Royal NHS Foundation Trust.

The population covered by this vanguard is 2.3 million.

**AIM**
The programme aims to develop a clinical strategy involving different models highlighted in the Dalton Review.

**OUTLINE**
The Provider Working Together Partnership is an existing partnership established in March 2013 between seven acute trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. The partners are focussing on key areas like delivering a seven day service and improving patient care. The partners also plan to develop solutions and models for joint ventures on shared services and to work across organisational boundaries.

Models will include greater use of networking, sharing of clinicians across sites and delivery of specialist and diagnostic services across a number of different providers. The focus will be on making sure that local services are both clinically and financially viable in the future.

Follow us: @MidYorkshireNHS @DBH_NHSFT @SheffChildrens @royalhospital @RotherhamNHS_FT @SheffieldHosp @barnshospital @MidYorkshireNHS





***"The new care model vanguards are about delivering real change for patients and staff. Working with clinicians and the people who use their services, they are developing a blueprint for the future of NHS and care services across England. They're being led locally, but with national support to help them move forward at pace and to unlock barriers that get in their way."***

**Samantha Jones**
Director - New Care Models Programme
@SamanthaJNHS

**NHS England Publication Gateway Reference: 04386**

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www.england.nhs.uk/futureNHS

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# Primary Care in Buckinghamshire

## Our strategy for proactive, co-ordinated, out-of-hospital care.

NHS Aylesbury Vale Clinical Commissioning Group and NHS Chiltern Clinical Commissioning Group

# Contents



> In short, there has never been a more exciting time to create a vision for a transformed primary care.

# Foreword

## NHS Aylesbury Vale Clinical Commissioning Group

**We are proud to introduce our Primary Care Strategy for Aylesbury Vale and Chiltern CCGs, for the period 2015 – 2020.**

Shaped by the public, our member practices and other stakeholder contributions, we hope that by reading about our plans for transformation of primary care services, you will share our excitement for the real opportunities this provides us to deliver a better service for our patients and service users.

The construction of this Primary Care Strategy began in summer 2014; AVCCG hosted a half day event for practices, with the LMC, Local Authority and Bucks Healthcare Trust in attendance. We specifically started with 'a blank sheet' to encourage participants to freely think about future options of service delivery.

In the autumn a Clinical Executive Board member visited each of our member practices to discuss ideas with GPs, nurses and other team members. Public engagement events were held in all 3 of our localities to gain views and opinion from potential users of future health services and we linked all relevant public comments from our previous consultations such as the out-of-hours services work.

Primary care in England faces unprecedented challenges. Challenges so great, that failure to meet them head on is not an option. Putting it simply, people are living longer and many more people are living with complex, long-term medical conditions, like diabetes, heart disease and dementia.

It is not unreasonable to say the future success of our National Health Service, as a whole, depends upon getting primary care right. Although the challenges are daunting, we believe there is now a unique opportunity for transformational change. The recently published NHS Five Year Forward View, which places primary care at the heart of the NHS, illuminates the possibilities ahead of us.

Technology will facilitate the empowerment of patients. The recent advent of co-commissioning will, for the first time ever, mean that clinicians are playing a part in the design and commissioning of all parts of the wider healthcare system.

This strategy reflects the collective view of both CCGs across Buckinghamshire, Chiltern CCG having engaged with partners in the south of the county.

In short, there has never been a more exciting time to create a vision for a transformed primary care.

**Dr Graham Jackson**
Clinical Chair AVCCG

**Dr Malcolm Jones**
Primary Care Lead AVCCG

> "The Bucks Primary Care Strategy - a model for proactive, co-ordinated, out of hospital care."

# Foreword

## NHS Chiltern Clinical Commissioning Group

As local GPs in Buckinghamshire for many years we have seen that the needs of our local population have changed. Thanks to the success of the NHS and better living standards, people are living longer. With longevity, however, comes differing needs - long term illnesses, often several of them together. Dealing with these conditions requires a different type of general practice to that which developed when the NHS was new, when communities were close knit, infections were the main illnesses, life expectancy was shorter and hospital based care was needed for many treatments.

For 21st century primary care to flourish and respond to current demands a new model of working is needed. For people living with more complex illnesses and frailty a much more integrated, joined up approach between health and social care professionals in Buckinghamshire is needed. This can offer better outcomes, enable co-ordinated high quality care to be delivered in the community avoiding hospital admissions or visits where these are not necessary and a more comprehensive patient experience. This is the vision for this Primary Care Strategy.

In order to develop this strategy for new potential integrated models Chiltern CCG has worked extensively with health and social care professionals across Buckinghamshire, bringing them together in a programme of large scale change workshops under the facilitation of NHS Improving Quality (NHSIQ). GP members of both Buckinghamshire CCGs have been integrally involved and given valuable contributions throughout the development of this strategy.

We have engaged members online and at learning events, locality meetings and practice visits. We have consulted the public and patients in local meetings, via our new consultation portal www.letstalkhealthbucks.nhs.uk and our Engagement Steering Group.

We are pleased to present the culmination of this work "The Bucks Primary Care Strategy - a model for proactive, co-ordinated, out of hospital care". This has been produced in collaboration with Aylesbury Vale CCG.

We hope that you will share this vision for an integrated future. This is just the start. We will continue to work with patients, GPs and other health, social care and voluntary sector providers on a locality basis through the next steps for development of community based services.

**Dr Annet Gamell**
Chief Clinical Officer
Chiltern CCG

**Dr Chris North**
Primary Care Lead
Chiltern CCG

**Mrs Nicola Lester**
Development Director
Chiltern CCG



# Introduction

**This is the Primary Care Strategy that underpins our vision across Buckinghamshire for proactive, co-ordinated, out-of-hospital care.**

In order to ensure our proposed primary care strategy is fit for purpose, a group of some thirty individuals from across local commissioner and provider organisations was created and worked under the guidance of NHS Improving Quality on a large-scale transformational change programme from June to September 2014. The outputs of this change programme have significantly contributed to this work.

Although it is strongly focused on the role of general practice in primary care, the implementation of the strategy will require the support of independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care.

Together, NHS Aylesbury Vale and NHS Chiltern Clinical Commissioning Groups (CCGs) aim to ensure that primary and community care is offered as part of a whole system network to provide person-centred care as accessible and close to home as possible.

## What is primary care?

Broadly speaking, primary care could include any part of the healthcare system that has first contact with a patient embarking on an episode of care. Traditionally, primary care services have been thought of as general practice, community pharmacy, dental services and optometry. The scope of primary care however is much wider and could also include appropriate self-care interventions, mental health support, community healthcare teams that incorporate nursing and other multidisciplinary care. Given that general practice has been such a large element of what has traditionally been viewed as primary care, it will be a core component of this document.

This strategy will also consider the role of other providers and professionals like community pharmacy in delivering a more personalised and proactive model of care that builds our out-of-hospital services. We aim to keep people healthy and independent, ensuring those who require treatment or care are treated in the most appropriate place by the right person.

The two Buckinghamshire CCGs consider this strategy to be a transformational journey for building patient centred, out-of-hospital care which will be realised over a number of years. A key area of focus will be on improving outcomes for patients and thinking beyond traditional boundaries as system leaders.



# One System, 7 Localities, 53 Practices

Buckinghamshire has 53 GP practices forming two member organisations, Aylesbury Vale and Chiltern CCGs. Within the CCGs, clusters of GP practices have formed into seven geographical locality groups.

At locality level, there is a greater understanding of the current health needs of the population, the views of the community on healthcare and the assets available to them in that community. As such, the locality clinical leads can act as the driving force behind localisation and implementation of services appropriate to their population needs – making this model a very effective way to deliver change.

At CCG level, the wider population current and future health needs are taken into account, including monitoring hospital activity and trends of healthcare challenges. Commissioning is at greater scale at this level and enables greater value for money.

Across Buckinghamshire, the two CCGs actively work together, addressing the countywide health needs and sharing commissioning responsibilities on behalf of their populations to maximise efficiencies. The two CCGs share the same community, main acute, mental health and social care providers and act as a single unit of planning.

At this level, the county wide system of health and social care works closely together, formally linked thorough the Health and Wellbeing Board, where our overarching strategy for Health and Wellbeing is developed.

River barge – Aylesbury



## Further reading

Edwards, Smith and Rosen's work (2014) on primary care offers a framework for developing primary care services and plans that has influenced our strategy.

## Design Principles

Aylesbury Vale and Chiltern CCGs aim to commission out-of-hospital care services that have the eight characteristics described below. These principles will be widely adopted and systematically applied in any future commissioned service.

In Buckinghamshire we are committed to a primary care which will be:

**Safe and high quality** - care will be evidence-based whenever possible and clinical decisions will be informed by peer support and review.

**Comprehensive** - with access to a wide range of professionals in order to meet the majority of the patient's physical and mental healthcare needs; to include wellbeing and prevention, acute and chronic care (e.g. multi-specialty community providers).

**Person-centred and holistic** - recognising the impact of broader life influences such as housing, education and family circumstances on a patient's health and care. Patients and their carers will be at the centre of decision making about their care and treatment and will be offered continuity of care.

**Population orientated** - focused on the needs of those resident in a specific geographical location, and/or individuals in certain population groups such as those with specific long term conditions, the frail elderly or the homeless.

**Maximising care in the community setting** - acknowledging patients and clinicians agree that more care could move further away from traditional hospital based care into community settings.

**Co-ordinated across a whole system** - accountable for transitions between providers; building and sustaining open, clear coordination and communication between the patient and their care teams.

**Accessible** - responsive to the patient's needs with appropriate waiting times for initial consultation and advice, diagnosis and care.

**Sustainable** - viable for the future in terms of finance and workforce. Maintain public trust and fit with the wider health system.

# The case for change

## Our local population and health inequalities

As our population ages and more people are living longer with disease and multiple illnesses, the demand for healthcare services in every sector of health and social care is increasing. These factors, and the enabling features of new medicines and technology, change the focus of healthcare requirements and mean that current models of care delivery need review. This is very much the case in primary care where around 90 per cent of patient interaction with the NHS occurs.

## What is "Primary Care"?

When a patient has their first encounter with healthcare, it is usually in what is known as Primary Care.

Over the years, primary care services have been thought of as general practice (doctors' surgeries), community pharmacies, dental services and optometry. However, the real picture of primary care is much wider and can also include a patient's self-care, mental health support and community healthcare teams made up of nursing and other care specialists.

## Modern healthcare – a need for integration

More people are living longer with disease and multiple illnesses meaning the demand is increasing for healthcare services in every sector of health and social care.

Primary care, where around 90 per cent of patient interaction with the NHS occurs, will need to operate at greater scale and in greater collaboration with other providers and professionals so that we can transform patient experience.

# Modern healthcare

A need for **integration** of health and social care if the NHS is to remain viable for those that need it, we need to provide **solutions** and **support** for those whose attendances could be avoided.

**64%** are overweight or obese. Almost a quarter of people are inactive.

If we carry on like this, by **2023** there will be:

**54%** **increase in diabetes**

**28%** **increase in high blood pressure**

**18%** **increase in heart attack**

**5%** **increase in stroke**

Numbers in training to become GPs has dropped, and almost **20%** of GPs in Bucks are over **55**

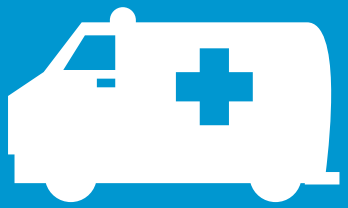
The number of older people with care needs will **increase by** in the next **twenty years.** **60%**

# What patients want

A **co-ordinated approach** across all providers, increased **access to GP services**, greater **use of technical solutions** and **help to self-care.**

In 2013-14 there were attendances at **A&E** **108,604**

This is expected to rise by **10%** in 2015-16

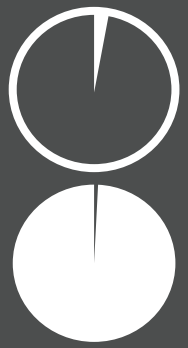


the typical cost of attending **A&E** is **£100**

## General practice

**8.39%** is the amount general practice has of the NHS budget

**95%** is the amount of urgent care needs handled in general practice.



The average emergency admission charge is around **£2,200**

**90%** of **patient interaction** with the NHS occurs in **primary care**

There are **536,442** **people registered with a GP**

Aylesbury CCG received **£965** **per person**

Chiltern CCG received **£856** **per person**

...the England average is **£1,115**

Aylesbury Vale General practices are allocated around **£113** **per patient** per annum

Chiltern General practices are allocated around **£110** **per patient** per annum

more than **16%** of **residents are aged over 65** and this will rise to more than **20%** by **2025**

# Further reading

The Joint Strategic Needs Assessment and the CCGs' Locality Profiles.

In order to respond to these growing health challenges, general practice will need to operate at greater scale and in greater collaboration with other providers and professionals as we all move towards a whole system transformation.

This will not necessarily require changes in organisation form and mergers, it will be achieved through practices working in partnership and networking.

More evidence on the case for this change and the benefits of networks/federations is outlined in the Kings Fund and Nuffield Trust Report on Securing the Future of General Practice (2013).





# Primary Care – Voice of the People

Both CCGs have undertaken stakeholder engagement, the outputs of which have been used to inform this strategy. During October and November 2014 engagement with the public, patients, primary care clinicians and secondary care was undertaken with a series of meetings and online surveys.

From August to November 2014, Buckinghamshire County Council's Health and Social Care Select Committee undertook a robust and comprehensive inquiry into access to GP services and have shared with us their final report.

In early autumn, Healthwatch consulted the public on urgent care services and the headline findings relevant to this strategy have been taken into account.

### Public and patient involvement in developing this strategy identified four common themes:

- more support for people to manage their own care
- greater use of technical solutions including shared health records
- increased access to GP services
- a co-ordinated approach across all providers

### Our stakeholder feedback included:

The Bucks Health and Social Care Select Committee (HASC) GP Inquiry Report. This covers the area of access to general practice in some detail. The key findings in respect of access were:

- Demand for urgent appointments is being met
- A lack of capacity for non-urgent appointments has led to variation in waiting times
- There is a need to reduce avoidable appointments with GPs
- There is a need to promote and support more people to self-care

### Our work with NHS Improving Quality and other stakeholder feedback included:

- There are opportunities in working differently and in closer collaboration
- Improving communication between providers using information technology
- Reducing duplication by improving care co-ordination and system integration
- Patients would prefer care in the community
- Acknowledgement of a greater role for community pharmacy

### Our member practices told us:

There were a number of common themes which emerged across localities, with GPs acknowledging challenges, but also welcoming the opportunity to establish the "direction of travel" within a Primary Care Strategy:

- Patient's needs are becoming more complex, requiring more time and resource
- Need to improve information sharing between providers
- Joined up care from community nurses and social services needs to significantly improve
- The increase in workload means less time to think innovatively or to manage the changes required
- The reducing GP workforce needs to be addressed.



> Everyone working together to provide high quality, personalised care to help keep Buckinghamshire people happy and healthy, optimising value from our collective efforts

# Our vision

Our collective Buckinghamshire vision, developed with all our local stakeholders and agreed across the system's health and social care providers and commissioners is:

*Everyone working together to provide high quality, personalised care to help keep Buckinghamshire people happy and healthy, optimising value from our collective efforts.*

In order to achieve this, we must develop a much more integrated approach to our delivery of commissioned services. Such a seamless way of working requires a new model of delivery across the whole health and social care system, including primary care.

Our population's health needs can be broadly categorised into four tiers of care (see diagram on page 13). These tiers of care are recognised by the Health and Wellbeing Board and enable us to develop a framework for all our health, social and voluntary services, which clarifies for patients exactly what levels of support will be delivered at each level of service.

## Tier Three – Transforming Primary Care

Our Primary Care Strategy focuses mainly on Tier Three, when patients need support from a primary care clinician or professional.

With more people managing their own health (in tier two), at times they will require input from GPs or other primary care clinicians. This might be because they require some additional support in managing their long term condition(s) or to check an unexpected health concern. This tier of care, mainly planned appointments with some urgent interventions from time to time, forms the core elements of care provided by all GP practices.

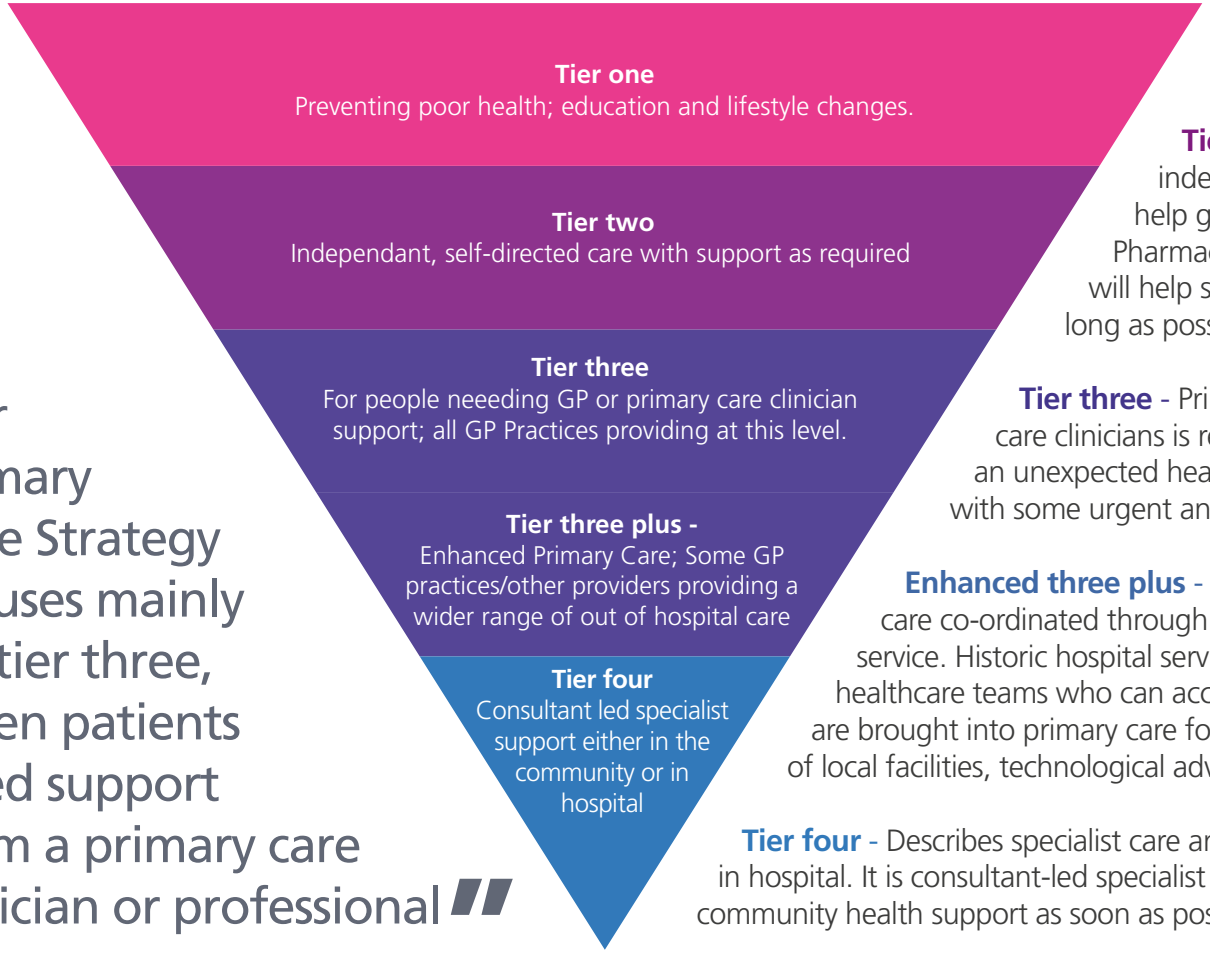
In moving care out-of-hospital and closer to home, an additional "Tier Three Plus" is created, with services that were historically provided in hospital now being available in the community, led by local healthcare teams with access to specialist advice as required.

**Development of this tier is the real transformation of primary care, with proactive patient-centred care being co-ordinated through GPs at the heart of a seamless integrated health service.**

This transformation will develop across Buckinghamshire, significantly changing the way we work as a health and social care system. Transformation will also take place at CCG locality level, as different communities have different health needs and different local facilities available.

Exactly which services are moved out of hospital and into primary care for local delivery is subject to a number of other factors.

# Tiers of care




**Tier one** - Education and self support to maintain a healthy lifestyle.

**Tier two** - People manage most health needs independently with support such as websites, self help groups and other community professionals (e.g. Pharmacists). Planned GP appointments (see tier three) will help support people to remain independent for as long as possible.

**Tier three** - Primary Care support, where input from GPs or Primary care clinicians is required either to support long term condition(s) or an unexpected health concern. This is mostly planned appointments with some urgent and unexpected interventions from time to time.

**Enhanced three plus** - This is the real transformation, with patient centred care co-ordinated through GPs at the heart of a seamless integrated health service. Historic hospital services will be provided in local communities led by local healthcare teams who can access specialist advice as required. Exactly what services are brought into primary care for local delivery is subject to factors such as availability of local facilities, technological advances and value for money.

**Tier four** - Describes specialist care and advice, either in community-based setting or in hospital. It is consultant-led specialist care that aims to return the patient back to their community health support as soon as possible.

"Our Primary Care Strategy focuses mainly on tier three, when patients need support from a primary care clinician or professional"

# Our goals:
## achieving the transformation

### We have identified six goals which we believe will achieve our vision.

Defining these goals and identifying what we mean is only the beginning. They are a starting point to help us work with you over the next five years to develop and implement innovative solutions which meet our shared vision and aspirations.

So we can stimulate ideas about the way we deliver these goals, we have given examples describing how our goals could be delivered. We hope this encourages everyone to think about the best way of getting the outcomes we need.





# **Our Goal:** Enable people to take personal responsibility for their own health and wellbeing, and for those that they care for, with access to validated, localised and readily available educational resources.

**What this means: People will be encouraged to manage their own mental and physical health and wellbeing (and those they care for) so they stay healthy, make informed choices about care and treatment to manage their conditions, and avoid complications.**

This could include group-based educational and self-management courses, as well as encouraging "expert by experience" peer support.

**How it could happen – the patient's perspective:**
Jo Smith is boasting about the new man in her life – her husband of 20 years. Pete has been transformed by a health coach.

He was overweight, drank too much, smoked, and never exercised. Only in his 40s, he had developed heart disease and diabetes. When he lost his job he sank into depression and took little interest in anything other than the telly.

Jo went online to get support and found out about steps Pete could take to help himself, but he wasn't interested. Then a community forum member told Jo about health coaches, who help individuals find the best solutions for their health and wellbeing challenges.

The best part about it was that Jo could ask the health coach to come and see Pete, it didn't rely on him making the first move.

It took a few weeks for Pete to accept that he needed to change, but once he did he hasn't looked back and working with a group of other people with similar problems has meant they are all helping each other, as well as themselves.

**How it could happen – the clinician's perspective:**
Fiona, a GP in her mid-40s had become increasingly frustrated in recent years.

She felt under severe pressure from a huge growth in demand for her practice's services. She felt particularly frustrated that many patients were coming to see her for self-limiting minor illnesses while many of her complex patients with serious long term conditions grumbled that they could never get to see her.

She was sceptical when her practice manager bought a web-based self-help programme for patients to access through the practice website. However, over the course of a couple of years, she noted a definite drop in the number of people consulting for minor illnesses. On the other hand, through her training in "year of care" care planning, she felt more enabled to assist her more complex patients to better manage their health and wellbeing.

She was able to engage Pete in the care planning process. Pete for the first time was taking his heart disease and diabetes seriously and Fiona felt optimistic about his future care.

# **Our Goal:** Health, social care and voluntary sector providers working together to offer community based, person-centred, co-ordinated care which proactively manages long term conditions, older people and end of life care out of the hospital setting.

### What this means: Combining resources and expertise so that people receive joined-up care.

Moving away from the traditional barriers between different care-giving and wellbeing organisations, so people's needs are understood and shared between the different organisations with which they come into contact.

People understand their needs are being met through proactive teamwork and they do not have to distinguish between different caregivers.

### How it could happen – the patient's perspective:

Ethel Walker has always been house-proud. When her husband Albert died she thought it would mean giving up and moving into a home.

What was worrying her particularly was giving up Albert's beloved dog Jack. Ethel suffers from arthritis and breathing difficulties, so Albert had done most of the housework, walked Jack and had made sure Ethel took her pills and ate well.

Grieving over Albert and worrying about the future were taking their toll on Ethel. But then Emma came into her life. Emma, a nurse, was part of an integrated locality team and called in a few days after Albert died. She explained she was Ethel's first point of contact for any problems she had. Emma made sure Ethel's care needs were assessed, got her some benefits advice and ensured she got proper home help.

Emma worked with the locality team to assess Ethel's medical treatment and made sure they understood what Ethel wanted out of life and how they could all work together to make it happen. She even took the trouble to find a local charity which offered volunteer dog walking services, so every day Ethel has a visitor who takes Jack and Ethel out for a walk, a trip to the shops or just for a cup of tea and a chat.

### How it could happen – the clinician's perspective:

Fiona had been Ethel and Albert's GP for many years. Ethel had lots of health issues but with her husband's support, had generally only come to the surgery when required.

When Albert died, Fiona was worried that Ethel would rapidly deteriorate both mentally and physically and become housebound. Fiona was worried how she, as Ethel's GP might best meet her changing needs. Her experience in similar situations in years gone by suggested there would be inexorable decline towards a health or social crisis point, which would result in hospitalisation and placement in a care home.

However, Fiona referred Ethel to the integrated locality team – comprising district nurses, social workers, physiotherapists, occupational therapists, with input from all the local general practices and the community gerontology and older people's mental health services.

The locality team had a more proactive and holistic approach to assessing and managing a patient's risk of decline and Fiona felt the team was providing a level of service to Ethel that could never have been emulated by Fiona's efforts alone.

Clock Tower – Aylesbury

# **Our goal:** Improved and appropriate access for all to high quality, responsive primary care that makes out-of-hospital care the default.

**What this means: Making sure people can access good quality advice and care in the most suitable and convenient way possible, as early as possible to prevent problems becoming more serious.**

Understanding that not everyone needs to "see someone" and that care can be provided by phone, email or online and, when needed, face-to-face anytime, day or night.

**How it could happen – the patient's perspective:**
Paul Jones doesn't even know what his GP looks like. A fit and busy 54-year-old, he can't remember the last time he had to go to the doctor.

But just lately he's seen all the adverts about bowel cancer on his commute into London and he's worried because there is some blood in his poo.

He goes online while he's travelling to work and the advice tells him to go and see the doctor if the symptoms persist for more than three days. Days later he can still see blood in his poo so he phones his GP surgery on the way home from work. They aren't open late that evening, but make an appointment for him the same evening at another surgery in the locality.

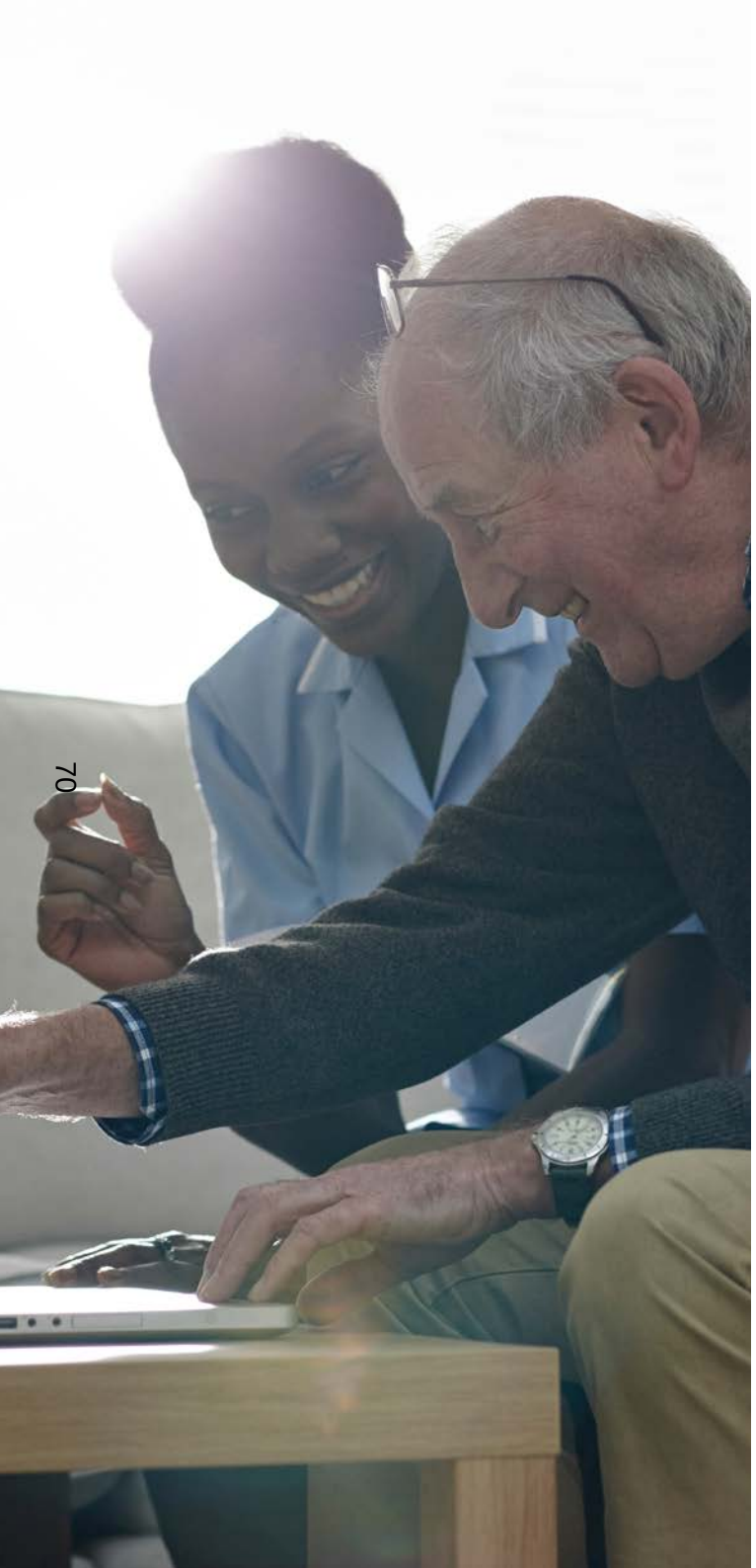
He actually has haemorrhoids and is given advice and access to online resources about how to manage his condition. They also book him in for an NHS health check with the practice nurse at his usual surgery.

**How it could happen – the clinician's perspective:**
Fiona, Paul's GP, perpetually felt it was a struggle to keep her work-life balance right – especially given the ever changing needs of her young family.

When discussions were mooted about her practice extending its hours, she felt both anxious and angry – how could she possibly make this work? However, by pooling the resources of the other locality practices, it became clear that commitment to working some extended hours was nowhere near as onerous as she feared.

In fact, working one late evening a fortnight quite suited her as it meant she had a later morning start at the practice once a fortnight – which made for a much less stressful school run and gave her valuable daytime hours to get other household jobs done.

She enjoyed her late evening clinics – they tended to have a different "feel" to them than her daytime surgeries and the patients often expressed great satisfaction with the service.



# Our goal: Develop clearly understood care pathways that offer consistent and co-ordinated care, using bed-based services only when necessary.

**What this means: Giving people access to specialist support in their community, working with a named responsible clinician.**

Working together, patients and their care co-ordinator would identify a clear plan about the type and level of care the patient needs. This would be provided by a team of clinicians, who may be from different providers, but they all have access to a shared care record which will also be available to the patient.

Care would be regularly reviewed so potential issues are identified and dealt with early and locally.

**How it could happen – the patient's perspective:**
When Harry Evans' dad got diabetes in the 1980s he was in and out of hospital all the time, went blind and had to have a leg amputated. So when Harry developed diabetes himself he expected the worst.

But he worked with a diabetes nurse, Jenny, who talked him through what was going to happen and how he would be working with a team of people to help him manage his condition.

She arranged for him to meet a nutritionist and they sorted out his diet and he had regular meetings with Jenny on Skype, so he didn't even have to leave work to have a check-up.

Jenny also arranged for an ophthalmologist to assess his eyesight so they could understand how his vision might be affected by the diabetes.

**How it could happen – the clinician's perspective:**
Fiona found the "year of care" approach to care planning had led to a transformation within her practice.

All the clinicians in her practice had been trained in this approach and most of the care planning was done by the practice nurses.

As a consequence the practice was achieving better glucose and blood pressure control with its diabetic population

Fiona was only directly involved in the care planning of the more complex patients. It was of great benefit to her to be able to share electronically her patients' care plans with the local community diabetes consultants. This enabled Fiona to get the best advice for her complex patients more conveniently, and expediently.


Penn Pond - Chiltern

# Our goal: Improve health outcomes for our whole population through adopting best practice, stimulating innovation and aspiring to improve.

**What this means: Working together on prevention, not just as professionals but with communities and individuals.**

Reducing variation and inequalities in health outcomes by increasing health screening and early interventions, in particular targeting groups of people whose health outcomes are not as good as they should be.

**How it could happen – the patient's perspective:**
Becky now has the courage to be the mum she always wanted to be and give her son, Sam, the best possible start in life.

When Sam was born Becky was on her own and she didn't think she had what it took to be a good mum.

But her health visitor set her up with a mentor, Heather, who helped Becky discover for herself what she needed to do for the best and introduced her to other mothers nearby.

Becky is even looking after herself better now, using online resources, knowing how important it is to stay healthy so she can care for Sam and set him a good example.

**How it could happen – the clinician's perspective:**
Jean was Becky's community midwife. She had seen many young, socially disadvantaged single mums over the years and often worried how they would fare during those early years of parenthood.

However, the local health visiting team, in conjunction with the family nurse partnership, had become more aware of those at risk during the early years and were employing a much more proactive strategy for engaging with their clients.



# Our goal: A commitment to invest in and support our primary care providers in helping build our out-of-hospital services.

**What this means: Making sure people being cared for at home, or in their care home, is the default and that services are focused on this.**

Co-commissioning with NHS England will enable us to shift investment to primary and community care. Using this investment we aim to improve infrastructure, provide more comprehensive services which support GPs to enable more care in the community, to enhance training for community nurses and other primary care staff including extended use of community pharmacists.

**How it could happen – the patient's perspective:**
Keeping Sally at home isn't easy for her daughter, but the team supporting her makes it as smooth as possible.

As Sally has dementia it is always difficult if she has to go into hospital, but just lately she has been able to stay at home, even when she got a chest infection, because the team monitors Sally and has a plan to manage any risks to her health.

Using a pre-agreed care plan, Sally's daughter called the integrated locality team as soon as her mum appeared to be unusually breathless. A qualified healthcare professional came out to assess her.

They decided with the right medication, regular checks by the care co-ordinator and a package of support from the locality team, there was no need to send her to hospital.

**How it could happen – the clinician's perspective:**
Fiona was half way through a busy morning surgery when a message from the locality integrated team appeared on her screen.

The message was to let Fiona know that they had received a call from Sally's daughter at 8am, saying that Sally was very breathless. Fiona had been Sally's GP for more than 10 years, over which time the combination of dementia and COPD was proving a real challenge; Sally had been hospitalised on a number of occasions.

Fiona was relieved to have the assistance of the integrated locality team – under other circumstances, she would not have been able to visit Sally until mid-afternoon, by which time she might have become more unwell.

The locality team was treating Sally at home with intravenous antibiotics and oral steroids and were going to continue to manage this acute episode until Sally was fit for discharge back to GP care.

Fiona was able to keep abreast of events, as the locality team were able to access Sally's medical record from the same IT platform that Fiona used in her practice.



# Supporting the change: enablers and critical success factors

In order to achieve the vision and goals set out in the strategy a number of key enablers and critical success factors will be vital.

## The Better Care Fund

The Better Care Fund (BCF) is a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the CCGs and the local authority.

This creates an opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care.

However, the funding is not new or additional money; part of it comes from CCG allocations, in addition to NHS money already transferred to social care. This means that the integration of services needs to happen swiftly, in order to achieve value for money and shift activity and resource from hospitals to the community.

## Information Management and Technology (IM&T)

In order to deliver our strategy we need to exploit the opportunities offered by the information revolution and we should significantly enhance our use of information and technology.

Buckinghamshire's comprehensive IM&T strategy is designed to deliver this, setting out clear goals to leverage maximum benefits from existing systems and deploying new systems to fill identified gaps.

Those goals can be summarised into four key themes:

- commissioner enablement
- shared records interoperability
- use of patient centred technology (including Telehealth)
- developing an enabling infrastructure across our whole system and beyond.



## Practice premises and community assets

In order to achieve the ambition of care delivered in alternative settings with a shift into the community, it will be necessary to understand the premises assets and challenges across the whole health and social care system.

Joint working across all local commissioners and providers will be required to do this. This includes NHS England which has committed to supporting the preliminary stages of this work with an audit of estate encompassing fitness for purpose and usage. This will enable the CCGs to understand what the opportunities and challenges are across the system so that informed decisions can be made on the best use of existing resources and the investments required.

Working with partners across the system will also enable the CCGs to not only be aware of planned housing growth and the associated increase in demand for healthcare services, but also to work with the local authorities as part of the planning decision making process. NHS England offers a national commitment to support and invest in the development of primary care infrastructure and both CCGs are keen to maximise this opportunity.

## New contracts and incentives

The methods by which we commission services will be influential in shaping how providers can respond effectively. There are a number of different approaches being piloted nationally and the CCGs will want to test some of these. New models of commissioning and new payment arrangements such as lead / prime provider and joint ventures which encourage organisations to work collaboratively to improve patient outcomes could be of great benefit.

The CCGs will work with providers to develop contractual mechanisms, approaches to measurement and rules of behaviour that facilitate the development of new models of care while managing any associated risks.

These new models of care could include multispecialty community providers, primary and acute care systems, or enhanced health in care homes as described in the Five Year Forward View or the development of other innovative and transformational models

Co-commissioning will be a significant opportunity for CCGs to increase their involvement in the commissioning of primary care. It is expected to be a key enabler in developing seamless, integrated out-of-hospital services as CCGs will be able to commission care across the whole patient pathway through different sectors including primary care. This is an opportunity that the CCGs will take up with their members support

## Workforce

The current primary care workforce will be very challenged to deliver this transformation of service delivery. In line with the national picture, Buckinghamshire has an increase in the proportion of part-time workers and declining numbers of GPs and practice nurses which creates pressure in the system.

This transformation of service delivery into out-of-hospital services creates significant workforce requirements that are a challenge to the whole health and social care system.

Additional capacity is unlikely to be met by investing in additional people alone - simply providing more of the same is not the answer for the future. Providers will look to create new roles with different skills that adapt to the patient's changing health needs in order to improve productivity and create a seamless care service for our patients.

As new models of care develop and existing roles change, there will be a need to understand the changing educational needs of our workforce and how we meet these future requirements.

The CCGs will continue to work with partners including Health Education Thames Valley (HETV), Oxford Academic Health Sciences Network (AHSN), and The Institute of Integrated Care at Bucks New University (IIC) to undertake local workforce mapping, describe potential new roles and identify subsequent educational and recruitment needs.

In the meantime, the CCGs will actively work with partners to review recruitment and retention locally and consider initiatives such as making posts more attractive and encouraging people back to work after maternity leave, career breaks and retirement.

This could be supported in part by offering education to healthcare professionals that ensures they are competent not only to deliver the essential requirements of primary care (ongoing education and "back to work" courses), but also courses offering a higher degree of competence for the new enhanced levels of out-of-hospital care where some specialist skills and knowledge will be required.

## Programme management

In order to do this effectively, a programme management structure will be put in place designed to ensure that the most appropriate people are working together, that changes made continue to be relevant, that responsibilities for delivery are clear and that risk is managed.

## Engagement - patient and community empowerment

A key element to success will be the ongoing and meaningful engagement of patients, carers, communities and stakeholders.

The CCGs recognise the need to work differently with our communities to maximise their input into designing services and decision making. For each individual project area the most appropriate way to engage with the target population will be considered.

The aim will be to involve the relevant community in the most effective way, thereby attempting to engage with those that have historically been described as "hard to reach".

The outcome of this will be to empower patients to have a say in the services that affect them and their community. This will be supported by a multichannel communication plan which will define a number of communication methods available including group sessions, expert patients and web based discussion forums.

## Engagement - integrated and partnership working

Achieving transformation of out-of-hospital care will require effective partnership working to:

- understand local nuances and variation in service delivery, healthcare roles, patient needs, behaviours and cultures
- align expectations
- ensure clarity and continuity of message
- ensure effective delivery.

Where necessary this will be through informal relationships and networks, also more structured approaches as required.

## Dynamic and responsive localities

The importance of locality working in achieving our ambition has been highlighted earlier in this document.

Our vision for increased out-of-hospital care is clear. It is strongly believed that different localities may wish to adopt different approaches to delivering our overarching Primary Care Strategy to their particular population and the diversity of innovation required would be supported.

View from Great Missenden Church - Chiltern

# Next steps

The next step on our journey for primary care and increased out-of-hospital provision is to get the strategy out to our stakeholders so that they know and understand the positive intention for primary care. This will take a concerted communications effort and some of this work has started as a work stream under the diabetes redesign. This requires responsive and capable providers so work will be ongoing to assist providers to respond effectively to this strategy.

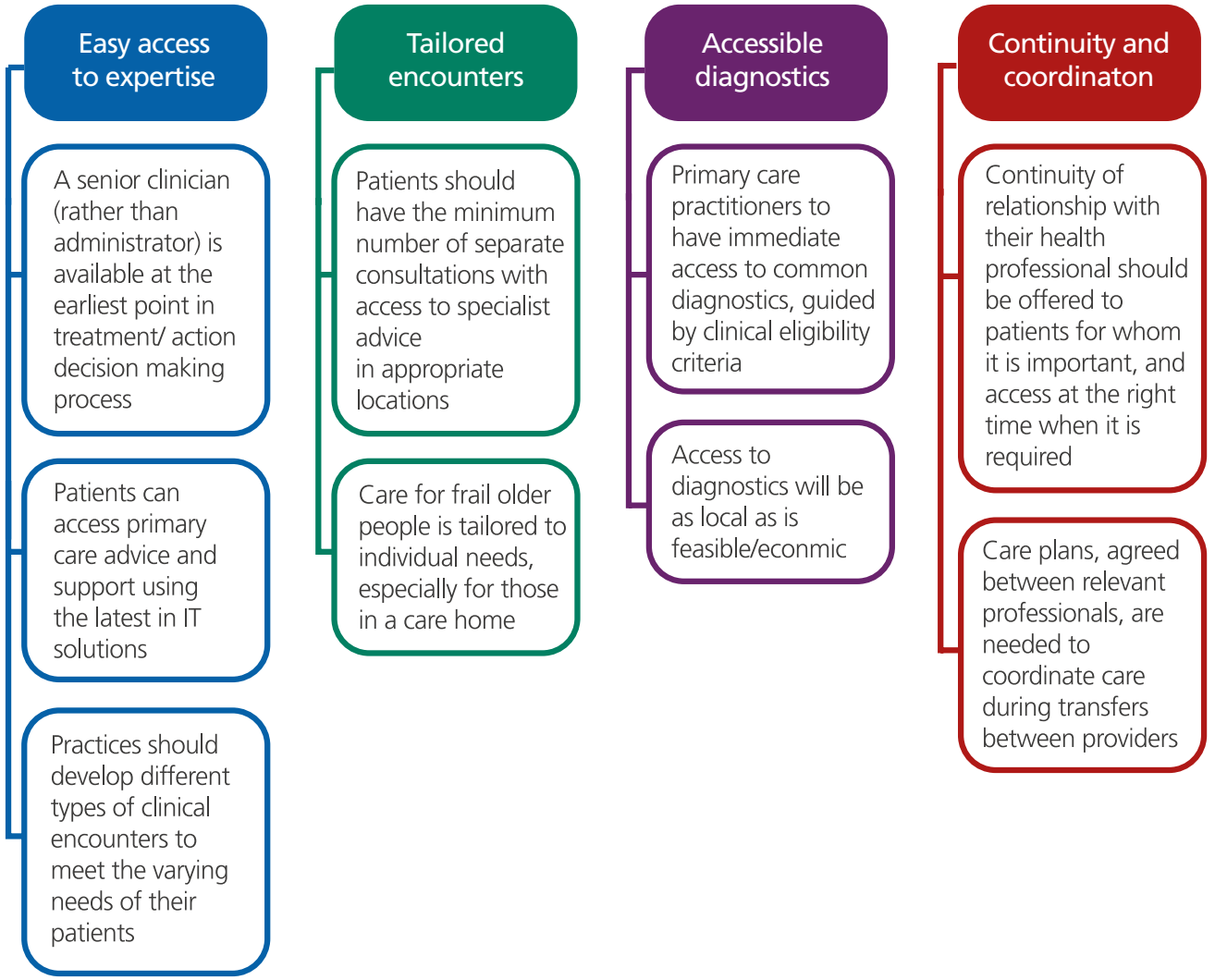
This is a five year strategy which will be delivered through a number of operational plans owned by the relevant CCG locality and project teams. These plans will be more focused with clear deliverables expected over a one to two year period depending on the scope and complexity of work. The plans will be reviewed each year to ensure alignment with the strategy, local ambition and subject to agreed programme management structures.

During year one it is our ambition to deliver the following:

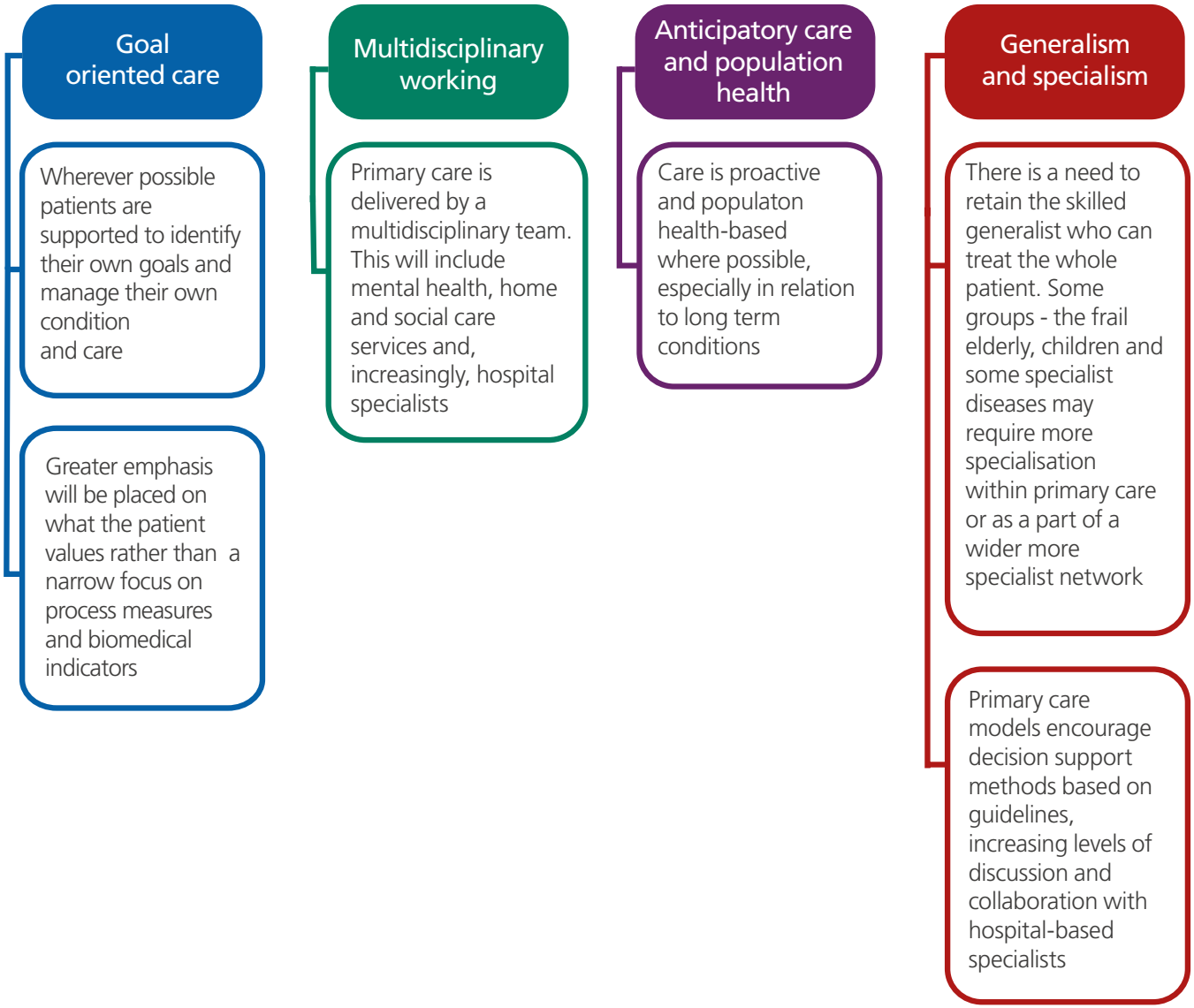
- Primary care workforce audit and plan in collaboration with partners including NHS England, HETV, Oxford AHSN, and The IIC.
- A whole system programme to increase self-management building on the Stay Well-Live Well model (see appendix 2). This model brings Public Health programmes and Psychological Wellbeing services together for the first time in primary care to support patients and primary care practitioners. It will proactively encourage patients to understand the impact of lifestyle choices on both their mental and physical health - to either reduce the risk of developing long term health conditions (i.e. to 'Stay Well') and/or to limit the impact of an existing long term health condition/s (i.e. to 'Live Well' with the condition). This work will contribute to the general practice demand management action plan as recommended from the HASC inquiry and linked to NHS England under co-commissioning.
- An integrated 24/7 patient record building on the work started with the Bucks Co-ordinated Care Record and implementation of the Medical Interoperability Gateway (MIG).
- Implementation of system-wide care planning approach to care supported by the House of Care Model developed by the Year of Care Partnership. Our aspiration is to embed a new system of working to deliver a care planning "Quality Standard" across services using diabetes as the preliminary focus and then systematically rolling it out.

# Appendix 1 - Design Principles

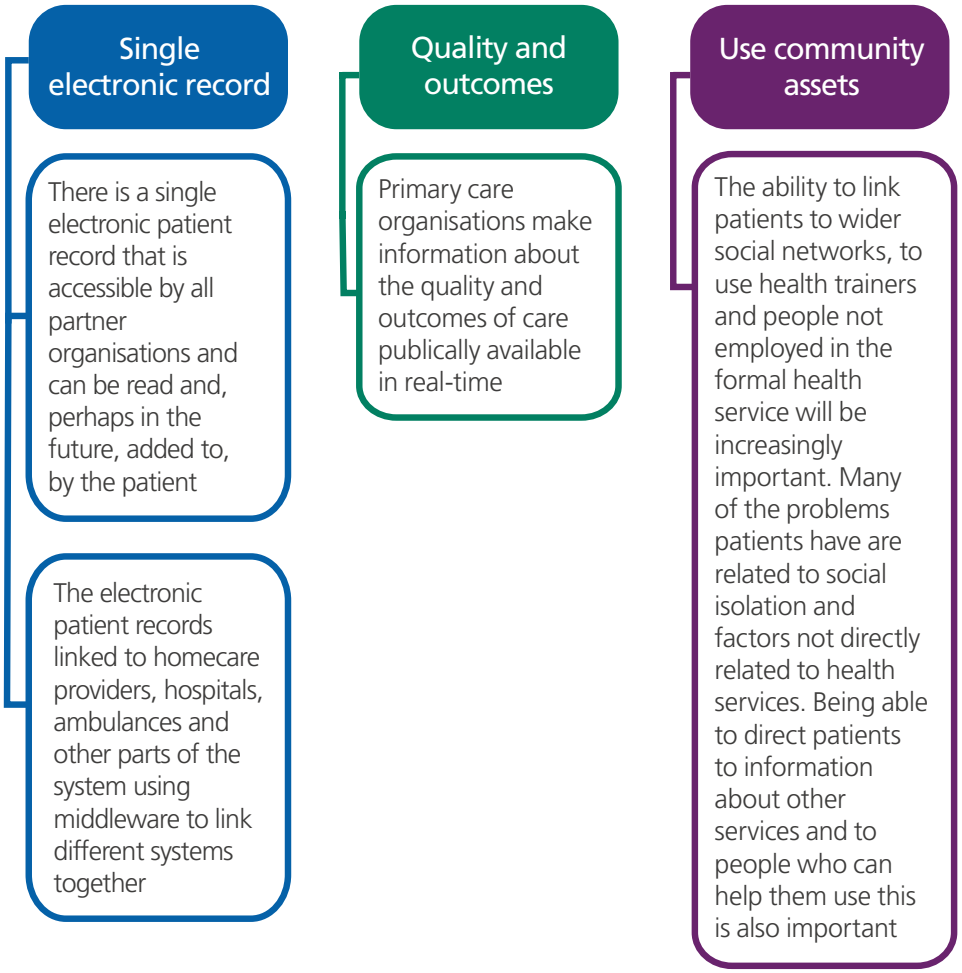
## Access and Continuity



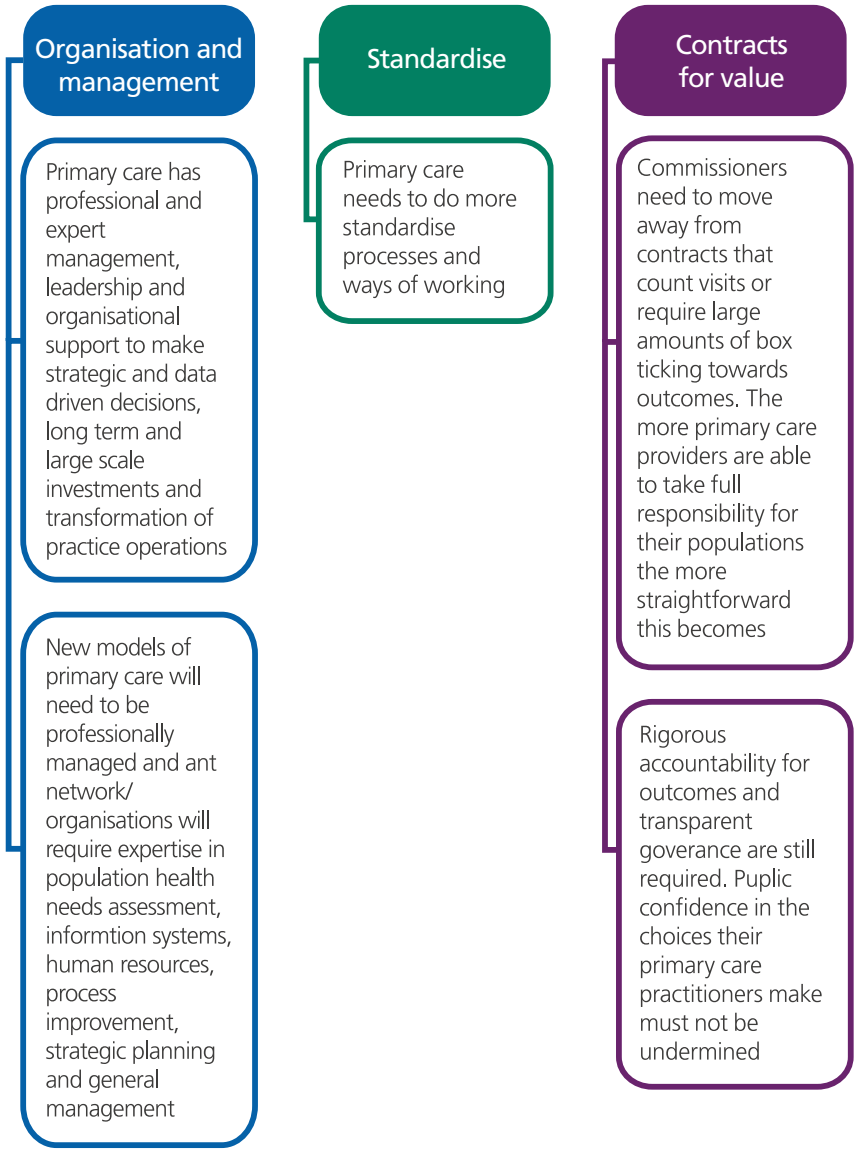
# Patients and populations



# Information, outcomes and engagement



# Management and accountability



# Appendix 2

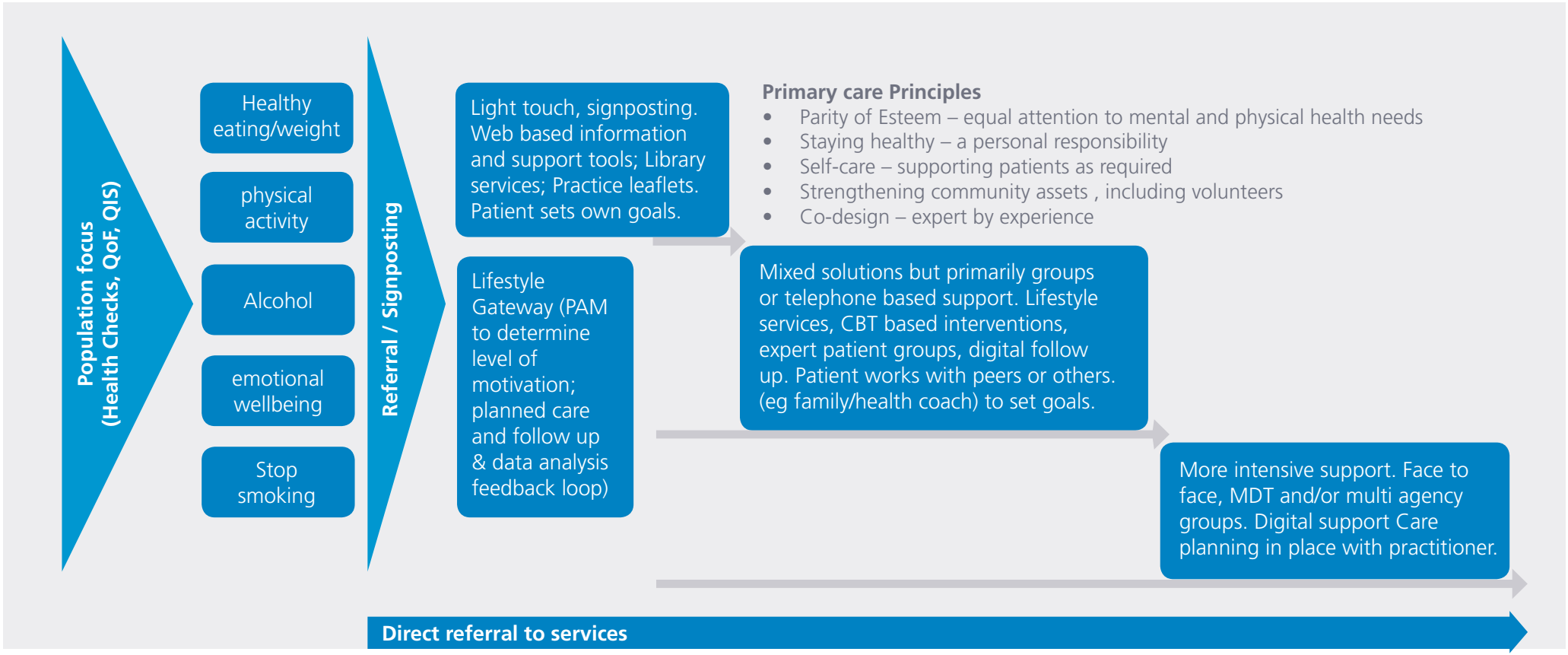
# Stay well - live well

**Identification and Brief Interventions (MECC principles)**

**Step one**
Patient: Low-risk factors, motivated, access to and understanding of internet and /or local services – self support

**Step two**
Patient: medium risk factors Low in motivation and/ or needs some support to identify /navigate local services or web based information

**Step three**
Patient : Complex condition/s, multiple risk factors and/or very low motivation




Underpinned with revised workforce competencies and demand management tools.
Robust technology platform, real time data feedback, community needs and asset maps

Designed by NHS South Central and West CSU

NHS
Chiltern
Clinical Commissioning Group

NHS
Aylesbury Vale
Clinical Commissioning Group

# Commissioning Strategy: Integrated Care for Frail Older People (Final)

February 2015

Report owner: Lesley Perkin

## Table of Contents

| Version Number | Purpose/Change | Author | Date |
|---|---|---|---|
| 0.1 | Initial draft programme board | L Perkin/M Dearing/T O'Connor | 05/12/2014 |
| 0.2 | Updated draft including comments from Rachael Rothero/Ali Bowman/Susie Yapp/Karen West/David Williams/Annet Gamell | L Perkin/M Dearing/T O'Connor | 19/12/2014 |
| 0.3 | Updated draft including comments from key stakeholders | L Perkin | 19/01/2015 |
| 0.4 | Changes made following Integrated Care Programme Board | L Perkin | 09/02/2015 |
| Final | Final document | L Perkin | 18/02/2015 |

*This document builds on the Integrated Care Outline Business Case – approved by CCGs, BCC (May 2014) and Health and Wellbeing Board (26th June 2014).*

*It also links with the Better Care Fund templates submitted in February 2014, September 2014 and November 2014.*

*It underpins the s75 BCF pooled budget agreement between Buckinghamshire County Council, Aylesbury Vale and Chiltern Clinical Commissioning Groups.*

# Glossary

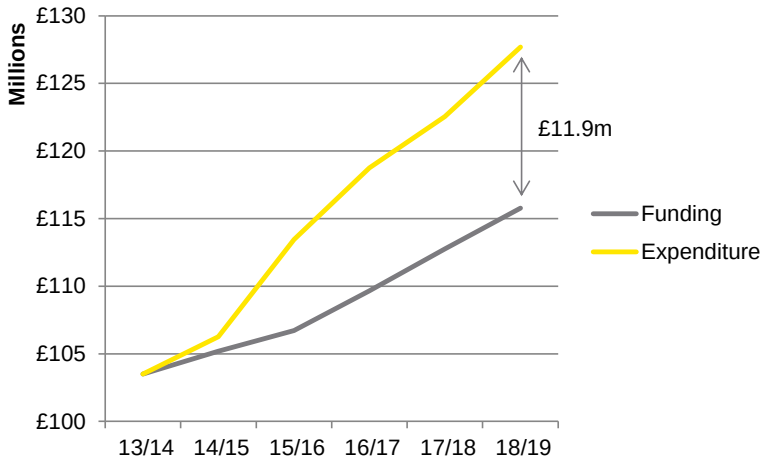
| | |
|---|---|
| ACHT | Adult Community Healthcare Team |
| AVCCG | Aylesbury Vale Clinical Commissioning Group |
| BCC | Buckinghamshire County Council |
| BHT | Buckinghamshire Healthcare NHS Trust |
| Bucks Care | Buckinghamshire Care |
| CCCG | Chiltern Clinical Commissioning Group |
| Home | Refers the place of "home" which may be another place e.g. residential home |
| MuDAS | Multidisciplinary assessment service |
| OBC | Outline Business Case |
| OPAT | Outpatients Parenteral Antimicrobial Therapy |
| Patient | Patient and service user are interchangeable terms within this document |
| Rapid Response | Provide a swift response to people's health and social care needs |
| Reablement | Services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living |
| Rehabilitation | Rehabilitation is an active, collaborative process. It uses all possible measures to help an individual to restore or maintain physical, psychological and social functioning |
| SPR | Single Point of Referral |
| | |

# Executive Summary

This Commissioning Strategy for Integrated Care builds on Buckinghamshire's Better Care Fund submission and the Outline Business Case completed in June 2014 and, along with an accompanying S75, presents the first stage of the case for change for integrated care in Buckinghamshire.

We need to commission and provide person centred care that supports people to stay independent for as long as possible. We know that continuing as we are in a disjointed and fragmented system is not sustainable for the organisations involved and is not meeting the needs of the people who use our services even if at this stage it is hard to prove that there will be significant financial benefit.

Increasing demographic and financial pressures on the health and social care system means that maintaining the status quo is not an option. The OBC reviewed £103.4m of services commissioned by BCC, AVCCG and CCCG and forecast that if these services continue to be delivered as-is, over the next 5 years, income growth will fail to match demographic growth and cost inflation and the annual gap increases to £11.9m by 2018/19, with the total deficit over the period being £41.0m (the assumptions used factor in the effect of QIPP and MTP savings plans). The whole system profit and loss project (P&L) has re-enforced the financial challenge within the system and estimated the affordability gap to be £185m by 2018/19.




We know that the context is constantly changing and evolving and we must design services that promote integrated working and are flexible enough to respond to other system wide changes. The aim is to move away from silos, not create new ones. The scope of this plan is focussed on the development of an integrated approach to commissioning the first £28m of a potential £100m of spend. It is a critical initial step on a journey to jointly finding solutions to the known challenges and developing capability and capacity of the system and the people working in it to effectively manage future challenges.

Given the data currently available and local and national experience this strategy advocates a staged programme of transition to integration supported by a pooled budget. In the first instance commissioners will work with existing providers to align capacity within the system and strengthen the system-wide approach to meeting individual need. As commissioners

and providers develop increased knowledge and understanding around the effectiveness of integrated working they will be able to further innovate to derive even greater benefits to meet the future needs of Buckinghamshire residents. In a changing health and social care economy, locally and nationally, the recommended approach provides a sustainable foundation on which to build.

## The context of a developing partnership

It is impossible for health and social care organisations in Buckinghamshire to continue with the status quo of service provision and deal with the rising tide of costs driven in part by the demographic pressure. Whilst there is no cast iron evidence that integrating commissioning and provision will solve the problem there is evidence that it improves the quality of care to the people receiving those services which in turn will yield efficiencies in the system.

The OBC identified over £100m of current expenditure that is being spent on services that operate in what would become Tiers 1 to 4 of the new model. The OBC also identified, from use of the LGA toolkit, that changes to service models in this area can yield financial benefits. For example an extrapolation of the introduction of an integrated rapid response and reablement service in Greenwich[1] suggests that savings of £9m could be made in Buckinghamshire for health and social care partners. Whilst in the first instance this strategy concentrates on the £28m that is spent on tier 3, the potential opportunity is clear.

The Five Year Forward View[2] gives a clear indication that there will be opportunities to develop new service delivery models such as Multi Specialty Community Providers and vertically integrated providers that include general practice. These models are not yet fully defined but any developments in services in Buckinghamshire must be flexible and responsive as the future unfolds.

Work on developing partnership between health and social care is aligned to recent government policies and statements outlined in the table below:

| Partnership Working Policy Context | | |
|---|---|---|
| **Policy** | **Date** | **Summary** |
| **NHS Restructuring** | Health & Social Care Act 2012 | Important background for the Better Care Fund as it established much of the current health system, giving a high degree of autonomy to clinical commissioning groups and establishing their relationship with NHS England. |
| **Deficit reduction and rebalancing the economy** | 2013 Spending Round - plans for government spending, including departmental settlements, for the year 2015 to 2016 | The government made better cooperation between local services a main objective for the 2013 spending round with the goal of maintaining the quality of services while reducing the cost to the public. It announced the Better Care Fund (then known as the Integration Transformation Fund) |
| **Local service reform - Sustainable and affordable health and** | Autumn Statement December 2013 | The 2013 Autumn Statement set out the government's intention to support local areas that want to deliver |

[1] Royal Borough of Greenwich Integrated Reablement Service
[2] Five Year Forward View, NHS, 23rd October 2014

| | | |
|---|---|---|
| **social care system** | | services differently if they can show it will save money, including by: "making sure pooled funding is an enduring part of the framework for the health and social care system beyond 2015-16". |
| **Reform of Adult Social Care** | Care Act 2014 | Under the Care Act 2014, NHS England can direct clinical commissioning groups to use and pool money to integrate health and social care services. NHS England can also impose conditions regarding plans to spend this money, and may withhold or recover payments where conditions are not met. |

Following the agreement of an initial outline business case, and agreement of the Better Care Fund submission, commissioners in Buckinghamshire have all signed up to deliver the vision of integrated for care for older residents in the county. This has been supported by the nationally prescribed requirement for local areas to progress integration across health and social care and create a pooled budget for this.

The partners in Buckinghamshire have clearly articulated in a number of forums that the current delivery model is not sustainable and needs to change to manage increasing demand. This commitment has been supported by national and local experiences demonstrating joint working across health and social care can improve patient outcomes (for example locally in mental health services). In Buckinghamshire there are already well-developed partnerships and examples of integrated care particularly in mental health services.

Nationally there is a lack of robust empirical evidence for the benefit of integration to fall back on and it is recognised that local solutions and conditions mean a local solution is always required (Five Year Forward View). The national direction of travel, as mirrored locally, is being informed by wider strategic ambition for collaboration and an intuitive knowledge that a joined up approach will deliver improved patient outcomes more efficiently.

Whilst at a strategic level the direction of travel is agreed, in building this case for change a number of system wide challenges have been identified which have impacted the partners ability to accelerate the delivery of a new model and evidence the benefits of implementation. These include:

- Data – at a local level there is a lack of consistent data surrounding the demands and costs across the system
- Confidence in partnerships – arguably driven in part by data, there is a lack of service performance visibility, which in turn impacts the level of trust between the partners

- Provision – existing providers deliver a range of wider services and there is a desire to maintain stability within these at a time of rising demand and there are existing contractual arrangements that need to be taken into consideration
- Knowledge – operational teams work in very discrete silos and there is a need for more alignment to allow teams to build improved knowledge of each other's operational practices
- Geography – many of the wider national evidence relates to smaller urban centres where it could be argued integration does not pose the same risk to wider operational delivery

Development of the partnership journey is already underway but current contracts for health and social care services dictate the requirement for a phased implementation approach with the first opportunity to re-commission integrated rapid response and reablement services being in 2016. In the interim period work will start on the alignment between providers of existing services, developing joint understanding of the systems and building the operational, financial and quality performance framework to drive continuous improvement. Staged benefit review points using the key indicators of non-elective hospital admissions, nursing home admissions bed occupancy and proportion of patients not requiring services after reablment will assess the impact and effectiveness of partnership working. Whist often viewed as a healthcare measure, hospital admissions are a key proxy for system wide benefit, given that reductions in hospital admissions and shorter stays are widely known to reduce dependency on health and social care services.

## Vision for integrated care in Buckinghamshire

The partners in Buckinghamshire are seeking to remove the overlap within, and streamline patient pathways across, health and social services. This will be supported by the development of joint plans and the pooling of budgets to deliver person centered care in, or as close as possible, to people's homes. Whilst older people will be the primary focus of services, many of the proposed changes will have a wider impact.

Success will be when there is:

- An all-inclusive, personalised service for the citizens of Buckinghamshire
- Service delivery without duplication
- Seamless, high quality, safe and effective pathways of access
- Users driving services and a robust and sustainable model of community engagement
- Evidenced multiagency working through integrated care pathways and excellent care navigation optimising the use of resources
- The full integration of prevention into care pathways

The key partners in delivering the vision are listed in the table below:

| Partner | Commissioner | Provider |
|---|---|---|
| Ambulance Service | | |
| Aylesbury Vale Clinical Commissioning Group (AVCCG) | | |
| Aylesbury Vale District Council | | |
| Buckinghamshire Care | | |

| | | |
|---|---|---|
| Buckinghamshire County Council (BCC) | ☐ | ☐ |
| Buckinghamshire Healthcare NHS Trust (BHT) | | ☐ |
| Chiltern Clinical Commissioning Group (CCCG) | ☐ | |
| Chiltern District Council | | ☐ |
| Oxford Health NHS Foundation Trust | | ☐ |
| Primary Care providers | | ☐ |
| Private sector organisations | | ☐ |
| South Bucks District Council | | ☐ |
| Voluntary sector organisations | | ☐ |
| Wycombe District Council | | ☐ |

Closer working across partners in the system will facilitate a model that invests more funding in lower level and wider preventative support, shifting the balance of spending and care over time. Initially the intention is to align existing service provision to develop better system wide understanding, release efficiencies, test new ways of working and monitor benefits realisation. This will allow delivery risks to be managed and as partner confidence develops this may lead to a formal recommissioining of services, which may include provider integration.

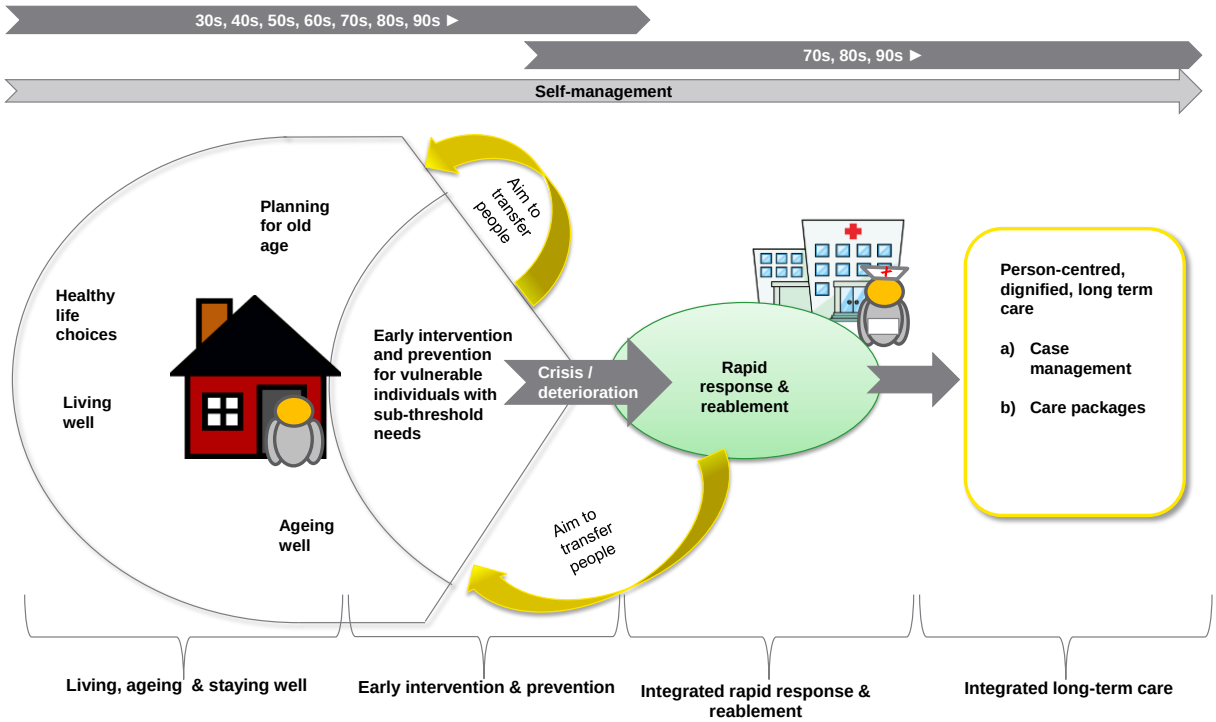
Buckinghamshire has a strong track record of collaborative working, and to ensure maximum buy-in from key stakeholders (providers, commissioners, GPs and other professionals), the integrated care programme will build on the already strong platform of joint initiatives. What this means for Buckinghamshire is optimising and growing the things that are working well, as well as radically transforming elements of provision that are not.

For Integrated Care, Buckinghamshire has used the Kings Fund model of health and social care services to help design 'what better would look like' informing the development of a new, 4-tier integrated model for health and social care in Buckinghamshire. The four tiers of the integrated service are shown in the table below:

| Tier | Objective | Components |
|---|---|---|
| **1. Living, ageing and staying well** | Providing coordinated, responsive and sustainable health promotion services, and bringing partners together to tackle negative lifestyle choices, to transform the overall health of Buckinghamshire | a. Multi-agency prevention strategy<br>b. Behaviour Change programmes<br>c. Integrated Lifestyle Service<br>d. Planning for older age |
| **2. Prevention and early intervention** | Identification of and support for individuals who are vulnerable, and at risk of requiring support in the future | a. Proactive case finding and referrals<br>b. Integrated case management<br>c. Community based prevention services<br>d. Digitalisation, adaptation, equipment and housing |
| **3. Rapid response and reablement** | Co-ordination of services to individuals during a period of rapidly escalating health or social care need, in order to | a. Rapid response<br>b. Reablement<br>Focusing on step up as well as |

| | | |
|---|---|---|
| | avoid attendance at hospital or the requirement for a long-term care package | step down. |
| **4. Integrated long-term care** | Reshaping long-term care services around a common understanding of service users' needs and establishing a single approach to market management across the health and social care economy | a. Integrated locality teams<br>b. End of life care |

The operating model will be implemented over the next five years and represents a radical shift from traditional models of service delivery. It moves away from providing services that can create dependency, discourage self-care and undermine people's confidence, to those that inform and empower individuals to manage their own health and wellbeing and make informed and personalised decisions. We will provide targeted and tailored approaches that provide individuals with effective support to take personal responsibility for their own health and wellbeing.




There are a number of underpinning national conditions in the Better Care Fund and we are seeking to use these to inform our integrated working agenda. These are:

- Plans to be jointly agreed
- Protection for social care services
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

- Agreement on the consequential impact of changes in the acute sector.

## Dependencies and developments

Since the original vision was agreed as part of the outline business case there has been a need for things to develop as the local health and social care system was unable to sit still. There is a need to ensure that these developments and their implications are factored into future delivery plans.

The following table lists the key developments and their leads.

| Ref | Development | Impact/Risk | Date | Lead |
|---|---|---|---|---|
| D1 | Primary Care Strategy | Overarching strategy considering future models with impact on activity in Tier 1, 2, 3 and 4<br>Maintain a programme approach to ensure models of care are aligned | March 15 | Dr Chris North, Dr Malcolm Jones, Nicola Lester, Louise Smith |
| D2 | Public Health Strategy | Developing model for Tier 1 and part of Tier 2<br>Maintain a programme approach to ensure models of care are aligned | March 15 | Tracey Ironmonger |
| D3 | Care Act implementation | Implementing early advice activities which links to Tier 1<br>Maintain a programme approach to ensure models of care are aligned | April 15 | Susie Yapp |
| D4 | Profit and Loss | Finance model being developed for the whole system<br>Harder to see system wide impact of changes with model | Ongoing | Robert Majilton |
| D5 | System Resilience Planning | In year service changes<br>Ensure re-commissioning decisions account for future plans | Ongoing | Dr Becky Mallard-Smith, Dr Kevin Suddes |
| D6 | Over 75 Fund | In year service changes<br>Ensure re-commissioning decisions account for future plans | 14/15 & 15/16 | John Lisle, Colin Thompson |
| D7 | Single Point of Referral | Developing interim SPR to support in-year development | Feb 15 | Jeanie Brown (PM) |
| D8 | Estates Review | Review of estate across the system (including community hospital provision)<br>Maintain a programme approach to ensure milestones are aligned | Mar 15 & ongoing | David Williams |
| D9 | IT Interoperability | Enabling integrated IT across the system<br>Maintain a programme approach to ensure milestones are aligned | April 15 | Colin Thompson |

# Section 2 - Operating Model

# Tier 1 and 2 – Living well, prevention and early intervention

## Preventative services

### Introduction to the pathway

Tier 1 comprises a universal, community based primary prevention and self-management offer to all residents of Buckinghamshire. Notably, as demographics vary across the county, delivery of locality based services need to be flexible and where necessary, tailored to particular groups and/or needs.

The key components of this tier will be:

- A multi agency prevention strategy
- Behaviour Change programmes and tools through online support
- An integrated lifestyle service
- Planning for old age

Tier 2 services are for those that have gone beyond the services of Tier 1 but currently drop below the threshold for the crisis response, reablement and long term care services of Tiers 3 & 4. We believe those people include older people with escalating health needs, adults identified as having a moderate to high risk of developing a long term condition, adults with established long term conditions but current social care needs are sub-threshold and residents who have received a period of reablement but do not currently require long term care interventions.

The key components of this tier are:

- Proactive care referrals
- Integrated case management (Link to Tier 4)
- Community based prevention services (including Prevention Matters)
- Digitalisation, adaptations, equipment and housing

The Joint Strategic Needs Assessment identifies the challenge facing Buckinghamshire related to the level of unhealthy behaviours among the adult population. Factors such as a sedentary lifestyle, smoking, obesity and drinking alcohol above recommended levels are fuelling increases in preventable long term conditions such as heart disease, stroke and diabetes. These conditions are contributing to rising social care needs.

### Future model for preventative services

The Public Health team in BCC is developing the Buckinghamshire Public Health Strategy for March 2015. This will encompass the key elements of Tier 1 and some of the elements of Tier 2 as well as encompassing the key elements of the Care Act. The following section outlines their initial thinking in developing this approach.

The Care Act identifies prevention as a key component in managing demand for social care services and three levels of prevention defined within the Care Act:

1. Primary prevention – this is aimed at individuals with no current care needs. It includes universal services to promote healthy lifestyles and action to tackle the wider determinants of health
2. Secondary prevention - this is aimed at individuals at higher risk of developing disease, disability and care needs. It includes screening and early case finding and action to prevent deterioration
3. Tertiary prevention – this is aimed at minimising the effects of disability or deterioration in people with existing health and care needs

Primary and secondary prevention require a whole system approach to prevention and multi-agency responses to tackling the wider determinants of health. It aims to enable individuals to be encouraged and where required supported to self manage and take personal responsibility for their health. The action of partners on the wider determinants of health should aim to make healthier choices the easier choices. Tertiary prevention requires prevention activities to be fully integrated into care pathways. The integration activities for all tiers will draw upon the existing County Council responsibilities for public health, the prevention priorities in the new 5 year plan for the NHS, the existing multi-agency strategies and work programmes and be coordinated by the Healthy Communities Partnership.

Buckinghamshire aspires to deliver large scale access to behaviour change support for all and targeted activities to enable those at greatest risk of poor health to improve their health and wellbeing. Work is currently being undertaken to develop a public health strategy and a model for living, ageing and staying well which provides coordinated behaviour change services. The approach for this model will incorporate:

- Action throughout the lifecourse - This recognises the impact of health pre-birth and in early years on health in adult life
- Proportionate universalism – This requires the provision of universal services, but with targeted action where the scale and intensity is proportionate to the risk of poor health.
- Acknowledging and working with the role of communities and social networks – these factors shape social norms. Work will include engaging communities and social networks in the planning and implementation of key programmes and through this shaping social norms and behaviours. This should include innovative approaches to engage communities who are ‘seldom heard’
- Tackling the wider determinants of health

Prevention programmes will focus on a number of key priorities:

- A focus on healthy pregnancy and early years
- The Big 4 lifestyles (being physically active, reducing smoking, maintaining a healthy weight and drinking alcohol within recommended limits)
- Promoting mental wellbeing (including preventing loneliness and social isolation)
- Falls prevention and bone health
- Drugs misuse and alcohol treatment services

A summary of the key components of the prevention programme are provided below:

| Level | Objective | Components |
|---|---|---|
| **3. Primary Prevention - Living, ageing and staying well** | Providing coordinated, responsive and sustainable health promotion services, and bringing partners together to encourage and make healthy choices the easier choices, to transform the overall health of Buckinghamshire | a. Integrated lifestyle services, including effective use of digital tools and social media<br>b. Multi agency prevention programmes<br>c. Planning for older age |
| **4. Secondary Prevention early intervention** | Identification of and support for individuals who are vulnerable, and at risk of requiring support in the future | a. Proactive case finding and referrals<br>b. Use of behaviours such as being more physically active, stopping smoking and losing weight therapeutic approaches to reduce the progression of long term conditions<br>c. Integrating prevention into the management of long term conditions<br>d. Community based early intervention services such as Prevention Matters |

In addition to the existing prevention work programmes, action will be taken within the next year to:

- Commission a web and app based digital personal health management tool to support residents to assess their current lifestyles, identify personal health goals and tools to support lifestyle changes
- Work with the CCG's and Social Care to integrate prevention into care pathways and front line activity. The Making Every Contact Count training programme will be a key aspect of this activity.
- The development of a model for integrated behaviour services to inform a longer term commissioning and resourcing strategy

### Proactive case finding and referrals

Buckinghamshire has invested in the development of MAGs (multiagency teams) that operate at almost every GP practice in the county. The model involves key members of all relevant teams coming together to identify and discuss the most vulnerable people on their caseloads that they believe would benefit from a more holistic approach to enable them to maintain their independence.

Early evaluation both qualitative and quantitative has shown benefits from this approach including improved working across teams and reduced hospital admissions. Work will continue in the following areas:

- refine the model

- ensure that all teams can be fully involved for the benefits of all the patients whether known to them or not
- make best use of technology to support team engagement
- support patients who live in boundary areas and evaluate the impact on individuals.

MAGs will be a key component of the future model in terms of supporting the identification of people at risk. It is further expected that the model will develop to link appropriately to Integrated Locality Teams and community geriatricians.

## Integrated case management (delivered by Integrated Locality Teams)

The integrated case management element of Tier 2 will be to ensure early interventions are taken which will minimise the risk of a crisis developing that requires a rapid response & reablement response, a hospital admission and/or an increase in long term care packages. This element of care will be delivered in practice by the Integrated Locality Teams who will also be operating at Tier 4. They will be linked to GP practices and attend MAGs, undertake early interventions and support people with long term care needs. The teams will be supported by specialists operating from secondary care to maximise the benefits from long term condition management in the community.

**Future enhancements**

In the first instance these teams will be created by co-location and alignment but in future we would expect to see the creation of synergies realised between domiciliary care providers, the ACHTs, practice nurses, mental health staff and social workers as well as the integration of various voluntary sector providers.

# Tier 3 – Integrated Rapid Response and Reablement

## Current model of service delivery

### Introduction to the pathway

The focus of this tier is to coordinate the delivery of a range of services to support individuals to remain independent at home with reduced admission of the frail elderly to, and accelerated discharge from, hospital settings and reduced demand for social care support with improved outcomes and reduced costs across the system. Whilst the patient may be deemed as "not in need of acute services" their individual circumstances mean that their ability to function safely at home cannot be assured. As such some form of intervention is required which would traditionally be covered by community health and/or social care. It is well established that a frail elderly person starts to decompensate after 4 hours in a hospital setting which affects both their health and social care needs from then onwards.

This cohort is in part common to health and social care partners and if unmanaged they will become a pressure for all service commissioners. To address this the Rapid Response and Reablement services are intended to put in place support on a time-limited basis to support independence. The preference is for these services to be delivered in the home, but in limited cases it may be appropriate to be provided in a bed based facility.

Overall the outcome is to minimise unnecessary hospital stays and/or delay the requirement for social care packages. This not only improves patient life outcomes, but also reduces costs in terms of acute hospital bed days and a lower complexity of care packages.

The tier is considered from two perspectives:

A. Avoidance (of additional long-term social care services and/or hospital admission – Step-Up) – a range of interventions to support people with health and/or social care needs to stay at home to avoid additional service needs, admission to hospital or other long-term care. The service would apply to people in their own homes or at a hospital
B. Discharge (Step-Down) – Enabling discharge from hospital settings, ideally returning to home

It is the expectation from commissioners that the emphasis is increasingly on the avoidance element of service to use facilities to 'step up' care for an individual to avoid a hospital stay or need for more permanent social care services.

### Current model of Admission Avoidance (step-up) services in Buckinghamshire

The entry point is for patients in the community. Patients may self-refer in, but it is more common to be referred in by a professional to either the: Locality ACHT (including rapid response); Hospital via Ambulance; or directly to Social Care (CR&R). The patient undergoes an assessment by the receiving organisation who determine whether a service is required to meet the identified needs.

Where necessary the assessing organisation will seek to put in place a support service or refer on to another organisation – currently the service provided may vary depending on the

organisation and their service contracts. Rapid Response services are currently only Nursing led, whilst there are two different reablement focused services available: one health therapy led service provided by the ACHTs; and one social care led service provided by Buckinghamshire Care (Bucks Care). Whilst there are different service provision arrangements to meet individual needs (e.g. meal preparation vs meals on wheels), there is a recognised level of similarity and service overlap.

Services are intended to be short term, normally 2-3 weeks for ACHT and up to 6 weeks for Bucks Care, (and are not subject to financial eligibility issues), after which the intention is that patients are able to care for themselves at home. Where a patient is not deemed fit for discharge, supporting services continue to be provided, impacting capacity, whilst an assessment for longer-term services (typically social services) is undertaken.

Patients can be referred from a GP into a 'step up', bed which is almost always a community hospital facility. This is arranged by registering the patient on the Strata (electronic referral) system. The community hospital beds are managed by the Elderly and Community Directorate at BHT. At present approximately 15% of the community hospital beds are used for step up services.

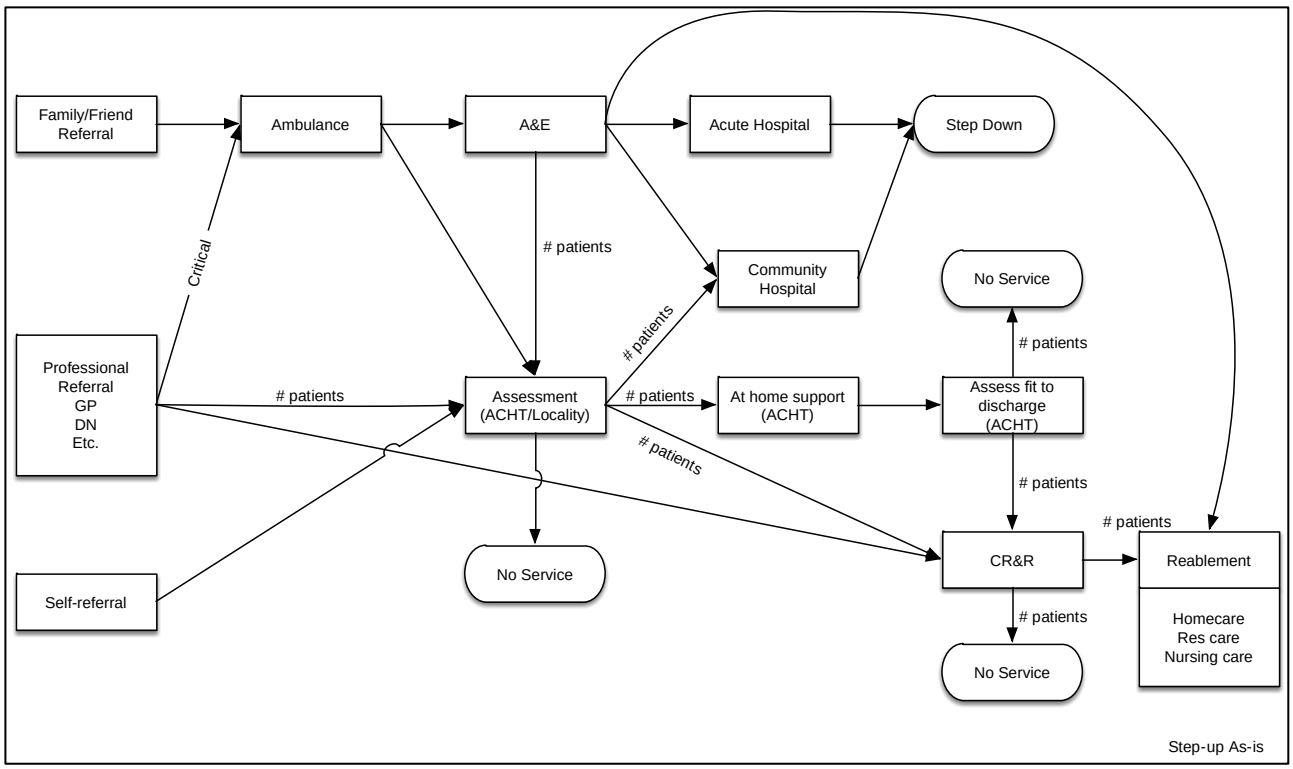



**Figure 1 - Hospital Admission & Long-term care avoidance**

## Current model of Discharge Support (step-down) services in Buckinghamshire

The entry point is for patients in a hospital setting. When the patient is declared medically fit for discharge on the ward (agreed at daily meeting) they are currently either discharged, transferred to a community hospital (referred via the Strata system) or referred for an assessment for support to enable discharge.

The assessment may be undertaken by ward based staff, the Community Transfer of Care Team or for more complex cases the Complex Discharge Team. For routine cases within the acute setting, the ACHT will assess the patient and put in place a package of rehabilitation support to enable the patient to return home. If following intervention, further support is deemed necessary then a referral will be made to the Local Authority for access to reablement and / or a formal assessment for social care.

In the case of a complicated discharge, the Complex Discharge team co-ordinate a range of assessments within the acute setting to review the specific needs of the patient. This could include a continuing healthcare assessment, mental health assessment and local authority assessment (hospital social work team).

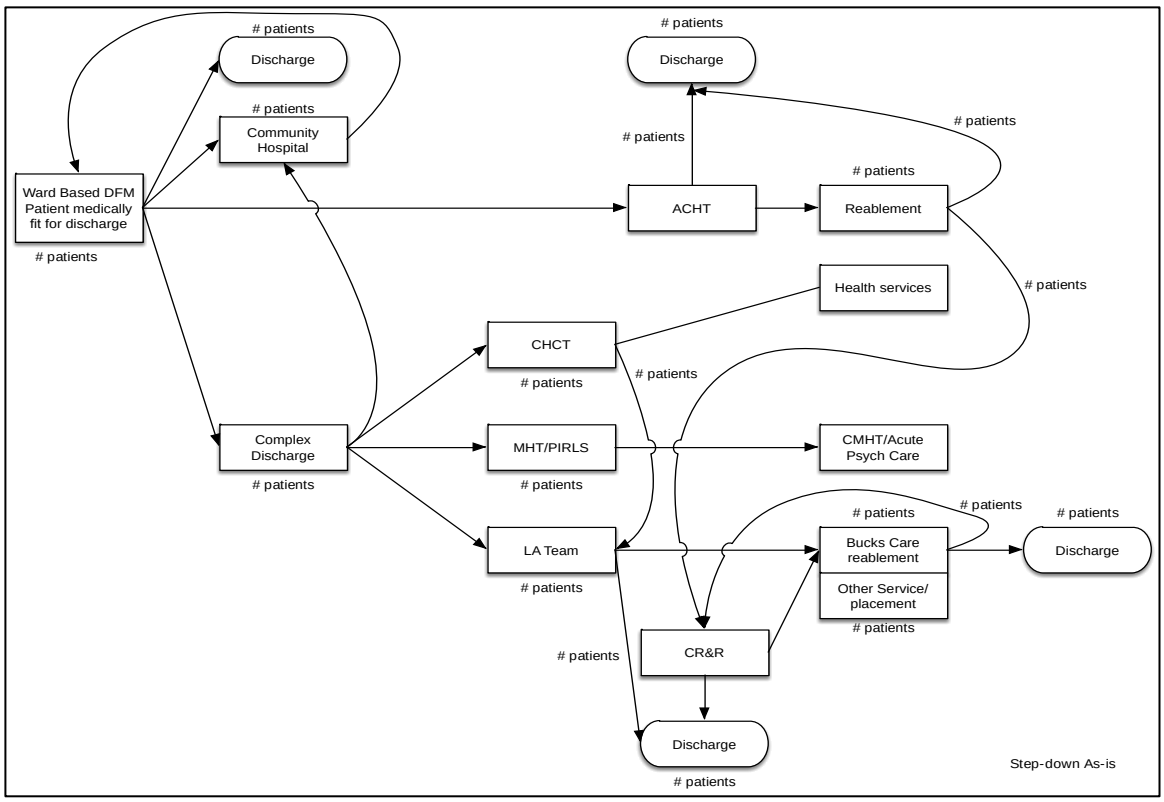



Figure 2 - Discharge support as-is process

## Establishing the opportunity and improvement potential

### Key opportunities in the As-Is process

| Current Model | Improvement Opportunity |
|---|---|
| Duplicated points of entry for reablement services within ACHT and Bucks Care (reablement assessors). Both go on to assess for entry into respective services, in addition to in hospital assessments. | • Single contact and co-ordination point<br>• Single multi-disciplinary assessment process to streamline care need planning<br>• Confidence in service to deliver services in a timely fashion<br>• Assessment carried out as part of service delivery where possible |
| Some commonality in service provision across ACHT and Bucks Care – in addition there are some differential service standards between the two providers. | • Pool collective reablement resources to increase access to a range of services available for all patients through the pathway<br>• Ensure most appropriate resource is utilised based on patient need |
| Professional skills are not optimised – some tasks may be undertaken by overly skilled staff | • Optimise use of professional capacity and maximise available resource |
| Services are operated from different bases with ACHT's operating from 7 sites across the county and Bucks Care operating a field based delivery model | • Collaborative working and co-location exploited to enable knowledge sharing and joint working (e.g. joint assessments)<br>• Technology used to maximise access to relevant patient insight |
| Multiple points of referral for ward based teams | • Single point of referral to co-ordinate response<br>• Faster response for patients |
| Several hand-offs in process to manage transfer from hospital into reablement services | • Reduce handoffs and improve patient experience |
| Fit for discharge from reablement patients remain in service whilst further assessments and services are being arranged (ACHT/Bucks Care) | • Consider onward service requirement earlier and align start of onward services with the end of reablement<br>• Increase capacity |
| In-built delay as a result of adherence to statutory timeframe (e.g. section 2s and 5s) | • Application of lean principles to manage demand as it arrives and reduce ongoing dependency |
| Community hospital/bed based provision used predominantly for step down capacity | • Shift the focus to prevention by putting the control of the beds into the Rapid Response and Reablement team to support the avoidance element of the service |
| Different operating hours and entry points: limited hospital social work and CR&R at evenings and weekends. ACHT operate 24/7 | • Align and extend operating hours to maximise outcomes for patients |
| Patients can receive duplicate assessments – hospital and community clinical staff, hospital and community social workers | • Establishment of common assessment processes |

## Future model of Avoidance and Discharge Support services in Buckinghamshire

### Overview

The future model will provide an integrated service pathway coordinated and triaged by a single clinically led point of referral. The entry points will be from community and ward based professionals, but at its core will be a common rapid response and reablement function delivered through aligned rehabilitation and reablement services with a focus on preventing the need for admissions to hospital and minimising the need for long term care packages. The services will initially be delivered through an alignment of the existing providers. The principle of continual assessment will be used throughout the reablement service pathway to allow follow-up services to be arranged, enabling a seamless transfer of care as appropriate.

The Reablement service will be directed following the referral depending on need. The most appropriate response and intervention lead will be identified so that the initial response has the best chance of meeting initial needs. The following figure provides a matrix to exemplify the multiple different options which may apply and as a patient progresses they may move from one lead to another.

| | | Intervention lead | | |
|---|---|---|---|---|
| | | Nurse | Therapist | Social care |
| Response | Rapid (<3hrs) | Y/N | Y/N | Y/N |
| | Fast (<1 day) | Y/N | Y/N | Y/N |
| | Normal (<3 days) | Y/N | Y/N | Y/N |

Figure 3 - Response / Intervention Lead matrix

The service will be operated as an aligned county wide multi-disciplinary team. However there would be at least 3 bases for the staff across the county from which field based resources can be co-ordinated. This would support a person centred approach that is rooted in a locality. The professionals in the multi-disciplinary team will include: nurses, occupational therapists, physiotherapists, social assistants, and multi-skilled healthcare assistants (drawn from ACHTs) and reablement workers and assessors (from Bucks Care). Some existing social workers will be embedded into the team to reduce hand-offs, facilitate better quality assessment reflective of longer term needs and minimise risk of delay in arranging care.

The multi-disciplinary team could be developed further in the medium term to include consultant geriatrician, pharmacists, older adult mental health, GPs (inc. out of hours) and paramedics. This may then lead in the longer term to the option for the integration of services within a single entity responsible for the multi-disciplinary team.

The rapid response and reablement pathway will be common to both admissions avoidance and discharge processes. The entry points will be from professional referees and is outlined in Figure 4 below.

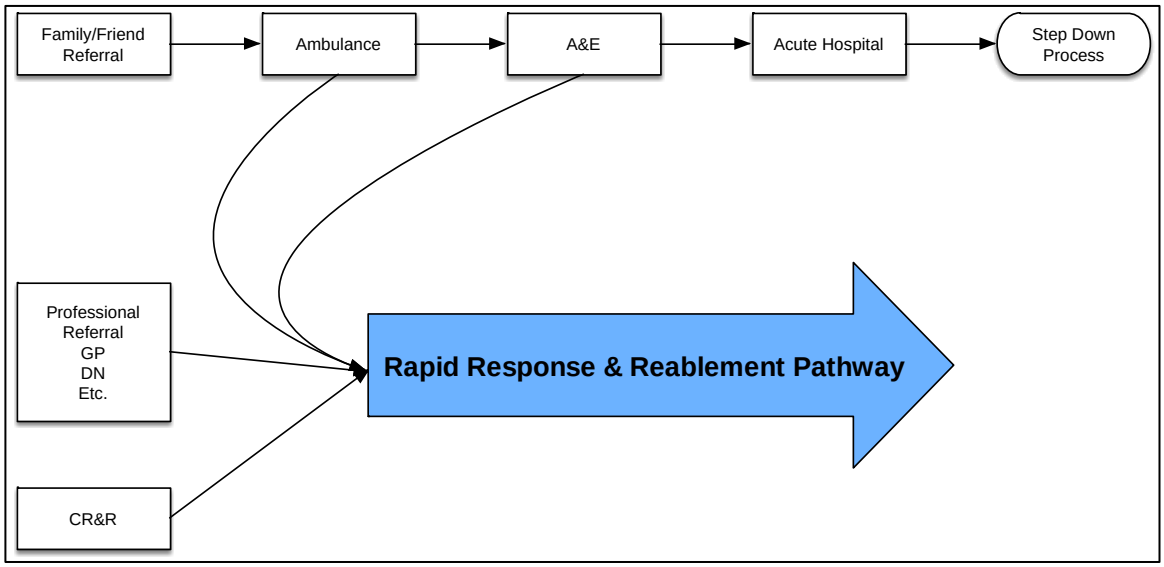



**Figure 4 - Avoidance and discharge To-Be pathway framework**

The rapid response and reablement pathway (see Figure 5) is delivered through a multi-disciplined approach and comprises three principle steps: a single point of referral (SPR), common assessment and aligned service interventions.

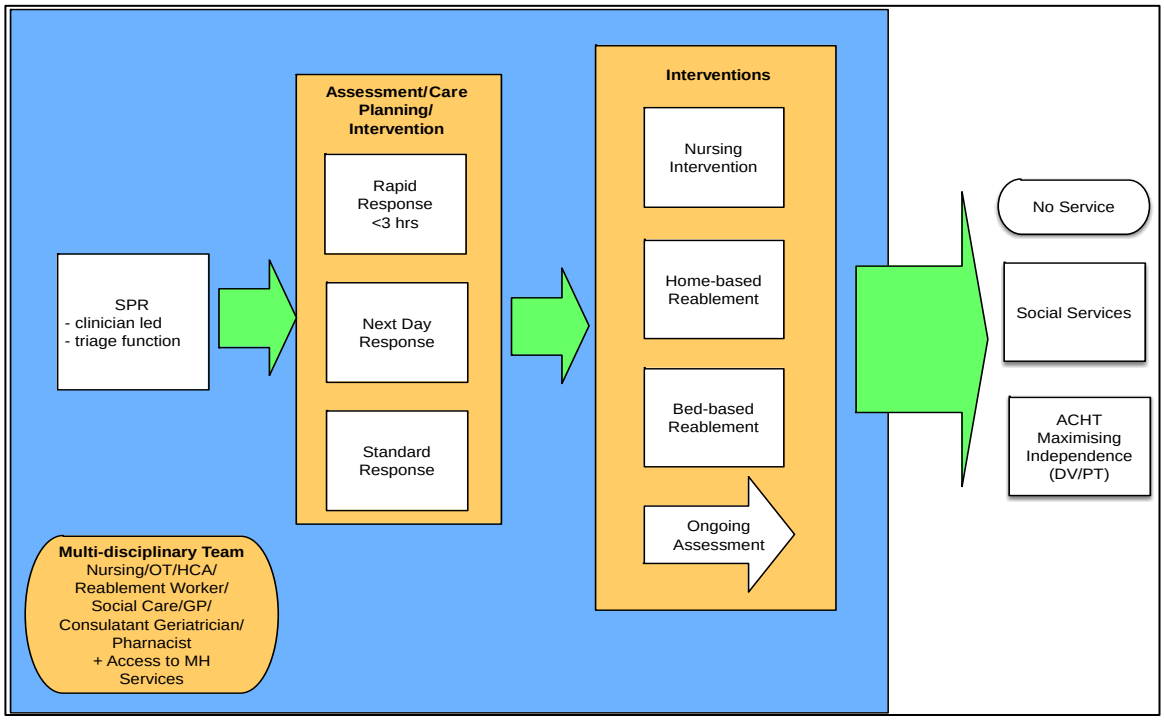



**Figure 5 - Rapid Response and Reablement To-Be pathway**

## Key elements

### *Single Point of Referral*

- Single countywide telephone based referral coordination point to ensure all onward assessment and rehabilitation needs are met. This access point may not be the same contact point for patients once known and in a service.
- Clinically led service with administrative support.
- The service will be operational 24h/7d. To maximise existing operational cover requirements it is proposed that the 21:00-7:30 response will be provided by the ACHT Night Teams to ensure that appropriate rapid response can be mobilised.
- The teams will have access to relevant Health and Social Care systems to ensure all patient records are reviewed.
- GP maintains accountability for the patient, but the SPR team is responsible for getting access to appropriate rapid response and rehabilitation service. (which may include bed based care). Update on action taken will be provided at the end a rehabilitation episode. A future development will be realtime progress updates on the shared patient file.
- Home from Hospital (Red Cross) service would continue to be used to enable supported discharge as part of triage services.
- The service would manage referrals for community hospital beds to support the emphasis moving to step up provision.

The referral point is aimed at professionals including:

- Ward based team (for step-down)
- GPs and practice nurses
- GP out-of-hours service
- A&E and other hospital staff
- Community health and social care services
- Ambulance crews
- Nursing and residential care homes

An initial triage conversation will be undertaken with the professional referee to inform and agree the most appropriate pathway for intervention and assessment. Following this the appropriate service response will be mobilised in line with the options in Figure 3.

The service will be operational 24h/7d to ensure rapid response can be facilitated. The core hours for maintaining a full service will be 15h/7d. Currently there are approximately 24,000 referrals to ACHT, 4,500 to the Hospital Social Work teams and 600 to Bucks Care (in addition to Hospital referrals).It is estimated that 33% of ACHT referrals relate to rapid response and reablement, and 100% of referrals to Hospital Social work and Bucks Care will be seeking a reablement assessment. As such the it can be assumed that the number of referrals to the SPR will be c.13, 000 per year. The staff cover for telephone and electronic referral needs to be sufficient to meet this demand without excessive wait times for professionals and the rota needs to be developed to account for call profile and annual variation in demand.

**Experience from elsewhere**

Sunderland[3] has created a single point of referral, known locally as the Intermediate Care Hub. This provides a triage function to ensure people are redirected onto the right pathway.

- Currently operational up to 8pm seven days a week, the next step is to take it to 24/7
- Collects and compiles the data on referrals as well outcomes which allows analysis to be undertaken
- Staffed by Band 6 Nurses and Social Care staff, with admin support

Feedback from a range of Health and Social Care professionals indicate that the hub has helped to simplify the supported discharge pathway into intermediate care and reablement services.

- The service deals with 400 – 500 referrals per month, 74% are for step down from hospital and an increasing number of referrals are coming from GPs for prevention to admission into hospital
- Feedback from providers of services indicate they are better informed and are not receiving numerous requests for services or inappropriate discharges

**Future considerations/enhancements**

- Development of closer operational links with GPs (including out of hours) and CR&R
- Technology used to enable e-referrals from the ward or professionals whilst in the home (reducing need to relay the requirement by phone), options may include web chat
- Technology to enable triage assessment to be undertaken by referring professional to enable automatic allocation to reablement professional
- Development of a single staff scheduling system
- As part of wider service offer commission a single organisation to provide SPR

[3] Integrated Care Hub: A Sunderland Approach, 2012

***Multi-disciplinary delivery team***

- Countywide aligned team of professionals drawn from a range of providers with a manager to coordinate deployment to respond to needs of patients to provide: nursing and therapy interventions, care planning, short term support and care.
- Professional accountability lines will remain in place and where the whole team is not aligned to the new service, individuals will need to be identified to be part of the team and its operational rotas.
- Operational availability 24h/7d for rapid response, with majority of planned service interventions undertaken between 7:00 and 22:00
- The initial triage screening by the SPR will be used to direct the most likely profession to lead the first response. This professional lead will have access to the wider team to discuss options whilst in the patients home.
- Working to a single rehabilitation assessment and planning tool.
- Able to offer a range of services delivered by different disciplines which could range from: nursing interventions to manage health conditions, therapy interventions to support mobility, reablement to support daily tasks of independent living and an enhanced diagnostic assessment (e.g. MuDAS)
- Combined team will enable resources to be allocated to maximise the utilisation of skills and experience available
- Professionals will have easier access to appropriate support from other disciplines to seamlessly manage the issues presented in more complex cases
- Home based services will be the primary model of care with the same pathway being used for all patients
- Bed-based support could be utilised for part of a patient's pathway where they are not able to safely remain at home or where part of the response is more effectively delivered in a care setting. This could be through utilisation of existing bed capacity across the county (both public and private facilities).
- Where initial assessment and patient response suggest ongoing care is likely to be required the social workers within the team will undertake a care assessment and plan care as required

To illustrate how this would work a couple of fictionalised scenarios have been developed.

**Reg's story**

*Reg lives on his own and is 77 years old. He had an entirely appropriate admission to hospital following a short illness. The ward team decide that he probably can't manage at home and so discuss him at the ward based MDT meeting.*

*What would have happened before…DFM met, agreed need for ongoing support and send referrals to both the ACHT and the social care team at the hospital. 5 days after the medics had said Reg was medically fit he went home. The ACHT therapist visited and developed a rehab plan for him. After about 10 days they decided that he would probably struggle to fully care for himself at home so referred him to social care (CR&R). It took a week before*

*Reg was referred to the Reablement service during which tome the ACHTs continued to provide his care. Once the reablement service took over they saw him for a further 6 weeks but during that time they realised that although he wouldn't need four visits a day he would need some long-term care so made a referral back to social care. CR&R completed the full assessment within a week but then it took a further two weeks for the care package to start during which time the reablement service continued to visit.*

*What will happen in future…with new services in place, the ward would have referred him straight to the Rapid Response and Reablement service who would plan his care. If there were complicating factors they would have sent someone up to the ward to do an assessment but ideally that would have been completed once he was home. He would have gone home under their care and received support to regain as much independence as possible with input from therapists and reablement workers. Throughout his reablement journey the team would have been assessing his ongoing care needs and once it became apparent that he would be unable to manage fully on his own in the future, the social worker in the team would have started the full assessment process and care would have been arranged to start as his reablement pathway came to an end.*

**Ethel's story**

*Ethel lives on her own and has been coping since the death of her husband two years ago. She's 81 and has no children living nearby. She felt a bit under the weather last week and didn't go on any of her usual excursions to bridge or the shops. She's now feeling much worse to the extent that she called the GP practice. The GP made a house call a few hours after her call to the surgery. He was concerned that she would deteriorate even further left at home on her own although unable to pin point a particular new medical issue.*

*What would have happened before…her GP called the medical registrar at the hospital and requested an ambulance to take Ethel to the hospital.*

*Ethel was admitted with dehydration and put on CDU. Whilst in hospital Ethel was kept in bed and lost confidence in her ability to look after herself.*

*She stayed in hospital for 6 days and then came home with support from the ACHT. They provided care and support with visits 3 times a day for a fortnight and then referred her to social care via CR&R. Five days later she was transferred to the care of the Bucks Care Reablement Service. They provided visits twice a day for a further 3 weeks and then discharged her.*

*What will happen in future…with new services in place, the GP would have made a call from Ethel's house to the Rapid Response and Reablement team where a clinician would have made a decision about who to send to see Ethel. That professional would have, provided some immediate support, made an assessment and arranged care from the wider team. If Ethel's dehydration*

*could not have been managed at home, she could have gone to a bed based reablement service for 24/48hrs which would also have been arranged by this team. She would then have received some reablement support at home for a few days or a week and then returned to normal.*

The different disciplines would support the provision of three principle service responses: Rapid (<3hrs), Fast (<1 day) or Normal (<3 days). The most appropriate professional (based on patient need and issues identified by referee/SPR) will be deployed to undertake the initial response and assessment. This will then be used to inform the future reablement care planning and service mix. If when assessed or whist receiving services, it is determined that the primary need would be better served by another discipline then the patient will be transferred to another professional without referral.

It is proposed that the multi-disciplinary team is resourced by aligning staff from ACHT, OPAT, MuDAS, Bucks Care and BCC. This will initially be undertaken without formally changing contracts and providers will be asked to agree to a Memorandum of Understanding to facilitate open and effective improvement and information sharing.

***Delivery settings***

The intention is that the majority of care is delivered in the person's own home to support continued independence. It is recognised that for a small number of patients a bed-based reablement service will be more appropriate. This may be as a result of an inappropriate home setting or the need for diagnostic services alongside reablement. Whichever setting is used it is intended that broadly the same service response is put in place where appropriate.

The level of bed-based services available for rehabilitation and reablement needs to be appropriately scaled and work is ongoing by BHT to inform this process. The recent acuity audit suggests 50% of the existing community hospital beds in Buckinghamshire are being utilised by patients who could be supported in an alternative residential/nursing care setting – Appendix 1 (Estimating capacity of community beds to support step-down/step-up) includes additional information).

**Future enhancements**

- Single contract for delivery of multidisciplinary team achieved by either provider collaboration towards an alliance contract or formal recommissioning
- Ensure community bed based facilities are profiled effectively to appropriately meet the needs of patients at the lowest cost
- Community bed based facilities are used as bases for the multidisciplinary teams.
- Night sitting service developed to enable more patients to be supported to live in their own home particularly those on a non-weight bearing pathway
- GP out of hours services to be fully linked in and aligned
- Addition of other professions, e.g. pharmacists

**Experience from elsewhere**

Greenwich has put in place integrated health and social care teams to provide a whole-system response to intermediate care, hospital discharge, urgent care, and community rehabilitation. The service is configured around three integrated teams:

- Community Assessment & Rehabilitation Teams (CARs) to provide rehabilitation, social care and manage intermediate care beds
- Joint Emergency Team (JET) - Fast immediate multi-disciplinary responses works in A&E, Ambulatory Medical Unit and in the community to prevent ambulance service call-outs and reduce admissions 7 days a week
- Hospital Integrated Discharge Team (HID) - Facilitates discharge by maximising use of the re-ablement services and intermediate care beds

These changes has been achieved with no changes made to the staff employers or contracts, where there is a health team manager, there is an assistant manager from social care, and vice versa.

The operational model has seen improvements across the system including:

- On average, 64% of people entering the new pathway require no further services after completion of the pathway
- Reduction in A&E admissions - 147 prevented in Q1 2013 by working with GPs to refer to JET rather than hospital
- Reduction in hospital admissions - 172 prevented in Q1 2013 by maintaining a presence in A&E and AMU, 8am-8pm, 7 days
- 7% reduction in admission to care homes per annum
- In the first 12 months, the redesign enabled an immediate 5.5% productivity saving on the health services alone. The social care budget was reduced by £900,000

No new investment has been required to achieve the change as savings were made through shared management arrangements.

# Tier 4 – Integrated Long Term Care

## Current model of service delivery

### Introduction to the pathway

There is a disparate range of professionals operating across the county. Some are deployed at a county wide level, whereas others operate at a locality level to provide services across Tiers 2, 3 and 4. Whilst there are some formal interfaces only a limited amount of this activity is currently coordinated.

The main professional groups are:

| | |
|---|---|
| **ACHTs** | There are seven multi-disciplinary teams offering rapid response, reablement and maximising independence pathways. Maximising independence is the most relevant pathway for Tier 4 and is delivered predominantly by District Nurses. The service ranges from annual visits to three times per day and is mainly for people that are housebound.<br><br>Referrals are made from GPs where the patient is at home or from the hospital ward if there has been an in-patient stay to each localities referral access point. |
| **Social Care** | There are three teams of Social Workers and Assistants covering the north, middle and south of the county. The teams are responsible for reviewing and changing care packages. Packages are setup by the CR&R team based out of BCC offices at County Hall or hospital social workers – ideally after a period of reablement. The packages of care are provided by private domiciliary care providers and supplementary services such meals on wheels.<br><br>Referrals from GPs and ACHTs for new packages are sent to CR&R who undertake and assessment and set up services before handing over client to the community team.<br><br>GPs and other health care professionals contact the social work team via CR&R if they need to discuss a client and their changing needs. |
| **Mental Health** | There are two teams for Older Adults Mental Health based in the north and the south of the county. The teams are responsible for providing community based adult mental health services |
| **GPs** | GPs are an integral part of this pathway and use MAGS as the mechanism to coordinate all of the above teams around the needs of the patient |
| **Specialist Nurses** | In some specialities there are integrated nursing teams , with access to consultant support, supporting GPs and ACHTs to care for people at home, e.g. respiratory and heart failure |

| | |
|---|---|
| **Primary Care Team** | Each practice has a wide range of staff supporting the GP, in particular practice nurses |

The current model of care is not patient centric and given the direction of travel towards a multidisciplinary approach to reablement (see Tier 3), the current delivery model needs to change to ensure sustainability.

## Establishing the opportunity and improvement potential

### Key opportunities in the As-Is process

| Current Model | Improvement Opportunity |
|---|---|
| Services are operated from different bases with ACHT's operating from 7 sites across the county and social care operating from three bases | • Collaborative working and co-location exploited to enable knowledge sharing and joint working (e.g joint assessments)<br>• Technology used to maximise access to relevant patient insight |
| Duplication of ongoing care in health and social care | • Ensure that a patients care is being managed to account for wider interventions "health leg vs. social care leg"<br>• Joined up patient experience – not having to repeat condition updates to different professions |
| Some commonality in service provision across ACHT and Domiciliary Care Providers. | • Account for Health interventions when planning Dom Care<br>• Consider expansion of packages to meet wider needs |
| Some commonality of assessment across ACHT and Social Care | • Common assessment approach and sharing of data |
| In new model of Tier 3 – creation of an integrated rapid response and reablement service reduces the size of the remaining delivery organisations | • Merge remaining functions to increase operational scale and associated efficiency benefits |

## Future model of Integrated Locality Teams in Buckinghamshire

### Overview

The future model will see integrated teams operating across the County providing coordinated, person centric care to individuals in their own homes. These teams will be comprised of resources managed at an area level (likely to be three teams). Depending on need they will be assigned to one or more locality bases from which they will provide a seamless service based on the needs of individuals.

It is important that the professionals are able to operate effectively at a locality level and build a sense of team around the patient and GP practices, but they do not need to work or be managed solely at this level. Through the use of technology the field based workers will be enabled to work with their patients and maintain effective links with their teams and managers. For management and synergy purposes three locality teams are proposed but the staff within those teams would be aligned at least to the level of the 7 localities and in some cases to smaller groupings within those where population and geography supports that.

### Key elements

***Integrated Team***

- Three area aligned teams of professionals drawn from a range of providers with a manager in each to coordinate deployment.
- Professional accountability lines will remain in place and where the whole team is not aligned to the new service, individuals will need to be identified to be part of the team and its operational rotas.
- Day time only service with 'roving professionals' being assigned to patients in line with need.
- Streamlined access to local services with a strong sense of local place to build patient trust, facilitate voluntary and community sector involvement and build on wider local opportunities to improve outcomes.
- Clear oversight of all patient interactions (health and social care) to coordinate provision, reduce duplication and exploit wider opportunities for optimising service interactions as part of a wider package and reduce the level of specialist input (e.g. using existing home care to support low-level nursing interactions).
- Individuals will have simpler access to appropriate support to seamlessly manage the issues presented when care needs change.

To illustrate how this would work a couple of illustrative scenarios have been developed, see below.

**Mary's story**

*Mary lives on her own and is 83 years old. Following a stay in hospital and a period of reablement she continues to require ongoing nursing and home care support to manage her diabetes, medicines and tasks of daily living.*

*What would have happened before…numerous different people from different organisations have assessed Mary's changing needs. Then a variety of workers visit throughout the week to facilitate Mary's different needs. There seems to be little recognition by each visitor of the various other services and Mary can get quite confused and agitated as to whom is due to visit and for what reason.*

*What will happen in future…a key worker undertakes an assessment for all Mary's needs and arranges with colleagues a holistic package of care. The main care provider agrees to undertake the majority of the requirement, including monitoring Mary's self-medication compliance. This reduces duplication and enables the nurse to visit less frequently. However, when the nurse does visit she is fully briefed on Mary's progress and the services she has been receiving.*

It is proposed that the integrated locality team is resourced by aligning ACHT, Oxford Health and BCC staff into three teams. Locality hubs will be created in existing buildings (link to estates review work) with the ability to be public facing and support the development of wellbeing centres (Tier 1).

**Future enhancements**

- Potential to create integrated access points which take responsibility for contacts within a given area. This would need to be assessed in more detail to establish the synergies with the existing CR&R service and ACHTs.
- Opportunities to use technology to enhance long term condition management.
- Development of organisational efficiency associated with new way of working.
- Consider links to practice nurses as they are experts in managing long term conditions and so there are synergies in working practices.
- Examine skill sets across existing silos particularly in nursing (practice nurses, district nurses and specialist nurses).
- Different organisational models for service delivery.

**Experience from elsewhere**

Torbay[4] have operated an integrated delivery model for some time with community staff ultimately transferring to the NHS. It is recognised that there is no 'best way' of integrating care. As such the model is reflected in local relationships, structures and networks, but with the following attributes:

- Teams based on GP registration and not home address to enable allocation of work, simplify access and make co-ordination of effort easier.
- Sound, joint governance and shared leadership and single management arrangements for all professionals

[4] Integrating health and social care in Torbay, The King's Fund, 2011

- Flexible use of pooled budgets with prioritisation of continuity of care at home

The operational model has seen improvements across the system including:

- Inter-professional trust and shared assessments – improved relationships with stronger capacity to do their jobs, clear professional identity, improved training opportunities and employment security within a changing health and social care landscape
- Single point of contact within zones improve access and speeded up responses which GPs found invaluable
- Emergency bed day use has fallen on average by 28% for age groups from 75+ and is the lowest in the SW region against a rising national trend
- Reduction in the use of nursing home and care home beds
- Quicker decisions and arrangements for care to be put in place with no arguments on funding responsibility
- Improved performance of the LA against national benchmarking data/CQC

your community, your care
developing Buckinghamshire together

# Appendix: Local Plan Planning for Engagement

Author: Sophie Payne

Buckinghamshire Healthcare NHS Trust
NHS Chiltern Clinical Commissioning Group
NHS Aylesbury Vale Clinical Commissioning Group
Buckinghamshire County Council

## Approach to developing engagement plan

- **We are developing a comprehensive engagement plan for public, patients and stakeholders across Bucks:**
  - supported by an overarching narrative about the cross-cutting work happening at BOBW-level
  - aligned with and informed by STP engagement planning both at BOBW-level and in neighbouring footprints e.g. Bedfordshire and Milton Keynes
- **Rationale:**
  - A 'locality-based' approach fits better with how many of our local patients and public use services (i.e. 'crossing borders' to Frimley and elsewhere) and therefore what they will want to know about and to influence.
  - Working at Bucks level allows us to move at pace and easily join up engagement across the CCGs, BCC and BHT as major provider.

***Note**: NHS England guidance is clear that 'STP footprints are not statutory bodies – but discussion fora – so individual organisations within each remain accountable for ensuring their legal duties are met during the STP design, delivery and implementation process.'*

# Overarching engagement and communication aims

**Aims:**

- Ensure we can demonstrate appropriate engagement with, and input from, the public and stakeholders, to inform the conclusions reached during the development of local plans for health and care services
- Ensure that we operate transparently ('no surprises') and prepare for any formal consultation

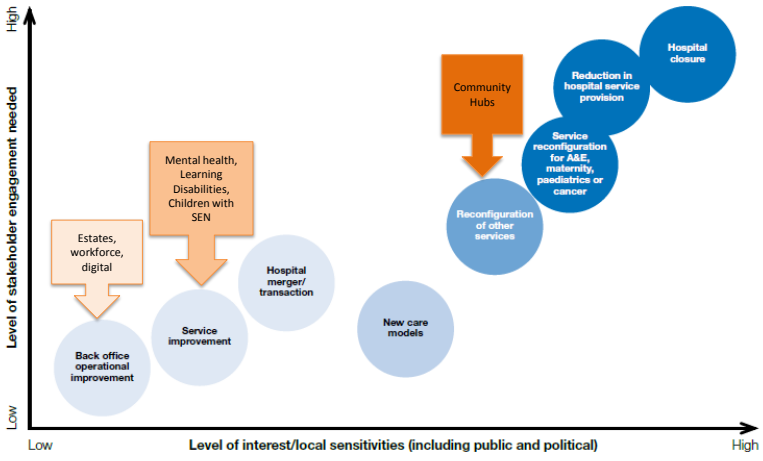
### Engagement

- Engage key stakeholders around each phase of work to ensure they are aware of, understand and contribute to the local plan
- Ensure the local plan hears from and understands stakeholder requirements and feedback, and these are taken appropriate account of
- Build relationships, dialogue and awareness in preparation for any formal consultation

### Communications

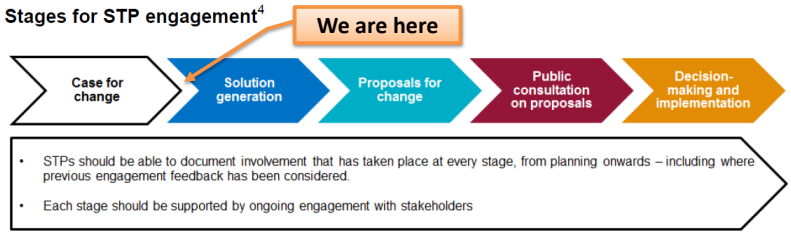
- Align communications and engagement messaging and activity across organisational boundaries
- Support the onward cascade of messaging and bring back audience insights and reactions
- Develop and refresh messaging based on feedback from Engagement Steering Group, Healthwatch and others

# What level of engagement is proportionate?




**Source: NHS Improvement** (with addition of Bucks-specific considerations in orange; darker = more extensive public engagement)

# When should we be engaging?

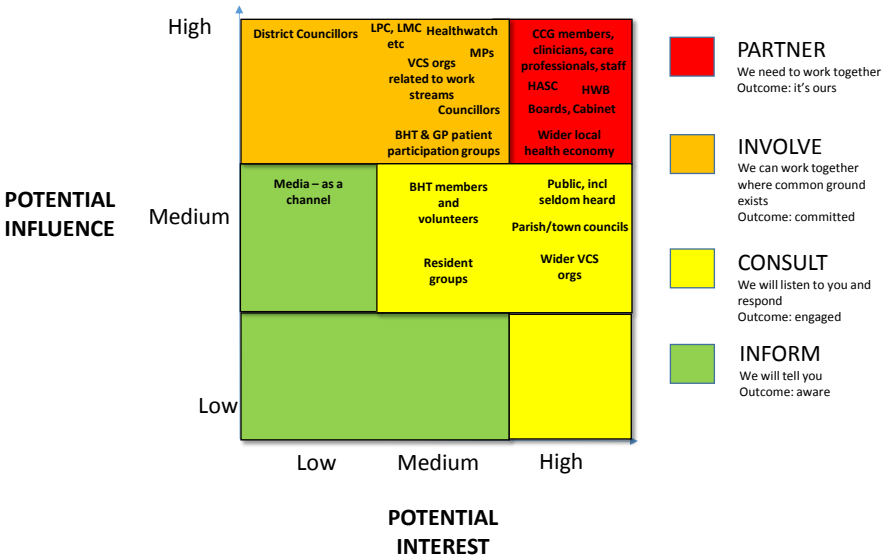



We are building on extensive prior insight and engagement about integrating care, especially community care. Next steps:

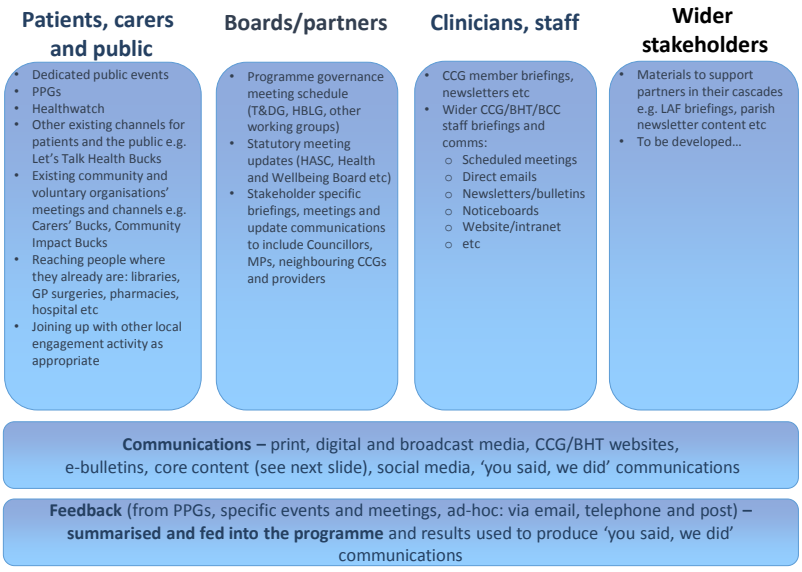
- Engagement across the 7 localities
- Potentially followed by formal consultations, dependent on nature of proposals

**4 Source: NHS England engagement guidance** (with addition of Bucks-specific considerations in orange)

# Stakeholders (in development)



# Channels (in development)



| Health & Adult Social Care Select Committee | | | | |
|---|---|---|---|---|
| 24 Jan 2017 | Inquiry recommendation monitoring | For Members to receive an update on the progress on the recommendations made during the "Accessibility and Promotion of Services for Adults with Learning Disabilities" Inquiry which went to Cabinet in May 2016. | Kelly Taylor, Commissioner | |
| 24 Jan 2017 | Active Bucks | For Members to review the Active Bucks programme and to hear the plans for future activity. | Sarah Mills, Public Health Principal | |
| 24 Jan 2017 | Joint Strategic Needs Assessment | For Members to receive and discuss the refreshed JSNA. | Jane O'Grady, Director of Public Health | |

| To be timetabled | | | |
|---|---|---|---|
| | **Dementia Services** | • A report went to Cabinet in May 2011 which reviewed identifying the benefits of early diagnosis and service in place to support dementia. A series of recommendations were made to Cabinet with monitoring on the progress of the recommendations at 6 and 12 months'.<br>• HASC to consider looking at how well these recommendations have been embedded and the progress made to support the increased numbers of people with dementia. | • CCG<br>• BHT<br>• Adult Social Care |
| | **Diabetes** | • For Members to review the services people with diabetes receive across BHT.<br>• To include a review of podiatry services for patients with diabetes | • BHT<br>• CCG |

| | | | |
|---|---|---|---|
| | **Pharmacy Services** | • To keep an eye on the Government's plans for pharmacy services and timetable a review of the impact of these plans on Buckinghamshire residents. | • Pharmaceutical Council |
| | **Better Care Fund** | • The Better Care Fund – update and impact of national funding locally, report back on the BCF risk register and the inclusion of action against red and amber residual risk. | • CCG<br>• Adult Social Care |
| | **Delayed Discharge** | • For the Committee to review how well the integrated community teams are working. | • BHT<br>• Adult Social Care |
| | **Adult Social Care** | • A focus on quality assurances processes | • Adult Social Care |
| | **111 services** | • How is it working locally? | • CCG<br>• SCAS |
| | **Buckinghamshire Care** | • Overview of overall performance | • Bucks Care<br>• Adult Social Care |