your community, your care
developing Buckinghamshire together

Our vision for developing care closer to home: piloting community hubs

NHS
Buckinghamshire Healthcare
NHS Trust

Every year, we make over 600,000 contacts of care outside of hospital. We are working with other parts of the NHS, Buckinghamshire County Council and local organisations to make health and care services safe, sustainable and able to meet the future needs of our local population.

We want to do more to improve the care people receive and how they receive it. We have consistently heard from patients, GPs and community groups that people want their care delivered out of hospital and in local communities, and we have exciting plans to make this a reality. This booklet explains what we are doing and why.

Supporting you to stay well

Through prevention and early-intervention we want to:

- **Help you to take greater control over your care and treatment**
- **Ensure we meet your long-term needs to help you to stay independent**
- **Make it easier to access the right services by working more closely with your GP and other providers to join-up care and support, reducing duplication and making better use of new technologies**

Over the next year we will be investing over £1m to expand our community services, with an emphasis on older people and those with long-term conditions.

What you have told us

Over the past year we have been talking to GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities to understand what you want. You have told us that you want to avoid unnecessary travel, improve coordination between organisations and be given the support to manage your own health and wellbeing, and we have been developing plans to make this happen.

We believe that community hubs – a focal point for health and wellbeing in local communities – could be part the solution. Some of the services you told us you would like to see include:

- **Rapid access to testing**
- **Easier signposting to health and care services – a single point of access**
- **Joined up teams across the system**
- **Full range of therapy services**
- **Health and wellbeing function, enhancing self-management and providing education**
- **A sociable space with a café**
- **A base from which skilled staff can work in the community**
- **More outpatient clinics locally**
- **Virtual networks providing information for patients supported by technology**
- **More information shared between organisations to improve patient care**

What is happening now?

We have joined up some services already so that it is easier for you to get the right care when you need it. For example:

- Our community nurses and therapists are available round the clock to help you stay at home or get home again quickly if you have been admitted to hospital. They can provide intravenous antibiotics (via a drip) or wound care at home and, when they visit, they have the technology to monitor your improvements, access the right support for you (such as ordering equipment) and review your clinical notes.

- If you have a long term condition (such as COPD or diabetes) our specialist nurses can support you to manage your own condition. They work closely with hospital consultants to keep you independent and at home should your condition worsen.

- If you need specialist stroke care our early supported discharge team will work to provide your therapy and nursing care at home so that you don't need to stay in hospital for a long time.

Why do we need to change?

There are three main influences that challenge the way health and care services are provided across the country. These have been outlined in local NHS plans and are supported in the Buckinghamshire, Oxfordshire and West Berkshire Sustainability and Transformation Plan published in late 2016:

1. **Clinical evidence:** for many patients, there are better health outcomes if they can be treated at or close to home. For example, evidence shows that a healthy older person's mobility could age by up to 10 years if they are bed bound for just 10 days
2. **Patient feedback:** we have heard patients want to stay in their own homes, remain independent and part of the community, not be a burden to others, and continue with activities that give them meaning
3. **National direction:** the NHS Five Year Forward View outlines the long term future of the NHS. It seeks to close the:
   - *health and wellbeing gap,* focusing on prevention
   - *care and quality gap,* shifting the way care is delivered, reducing variation and making better use of technology
   - *finance and efficiency,* closing the first two gaps will have a positive impact on this, but the NHS is also looking at investing in new ways of working to join-up care and help it become more productive.

Making this a reality: our plans for expanding out of hospital care

To best understand what will work for our communities, our clinicians want to test some of the ideas we heard before we finalise our plans. Some can be implemented now but others will take longer to develop.

From April 2017, we will start to introduce the following:

- **Locality integrated teams:** we will bring together community and specialist nurses, therapists, social workers, GPs and relevant voluntary organisations. They will provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions. As a result patients will receive better, more coordinated care in their homes.
- **Rapid response intermediate care:** therapists, care staff and community nurses, working as part of a locality integrated team, will provide short-term (up to six weeks) packages of support to those who would benefit from a 'jump start' back to independence. Available 8am – 9pm, seven days a week, these teams will support people to stay at home and avoid a hospital admission, and get people home more quickly from hospital to avoid transfer to a hospital bed. The team will visit as often as required and provide a range of support including rehabilitation or help with tasks such as washing, cooking or visiting the shops.
- **Community care coordinator:** this will provide GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients (including the rapid response intermediate care service). Making it easier to access community services will help to prevent admissions to hospital and avoid the delays to discharge that keep people in hospital for longer than they need to be.

- **Community hubs:** The hubs will provide a local base for community staff and will help patients to access prevention services (Live Well, Stay Well), primary care services (as appropriate) and hospital services (such as outpatient appointments, wound care or diagnostic testing) that people may have previously had to travel to.

  Commencing first in Marlow and Thame, where we already have strong community health bases, we will be working closely with staff and local GPs to test these ideas for six months. We are planning to provide the following services in these hubs:

  Frailty assessment clinics: GPs can refer patients to specialist clinics in the community to help frail older people to stay at home and avoid an A&E visit or hospital admission. The new one-stop same-day or next-day clinic, will be available 9am – 5pm, five days a week across Marlow and Thame. A multi-professional team of elderly care consultants, nurses, therapists, paramedics and GPs will provide expert assessments, undertake tests and agree a treatment plan with patients. If required they can refer patients to the right community or hospital team to provide on-going support or treatment. These clinics are already available at Stoke Mandeville and Wycombe hospitals, and their introduction in Thame and Marlow will reduce the need for patients to travel for support.

  Outpatient clinics: Five more clinical specialties – palliative care, orthopaedics, care of the elderly, falls and oral surgery - will offer outpatient clinics in the community. We aim to further increase the number of outpatient clinics and specialities over the pilot period, with a focus on supporting people with long term conditions.

  Voluntary sector and signposting: We are working with Prevention Matters, Carers Bucks and the Citizen Advice Bureau to offer a range of advice, support and signposting services in the first step of creating a single point of access to health and care services for the public. Carers Bucks will help carers access additional support such as benefits advice, practical and emotional learning, and emergency planning. Prevention Matters will support people to regain confidence and independence by finding suitable social activities and community services in their area.

Case study

GP is concerned that Mr Jacks is becoming more frail and seems less able to cope

Previously – the GP is concerned but can't pinpoint anything specific that needs treating. He's worried that Mr Jacks might need longer term care, possibly in a home and so sends him to hospital where he stays several weeks before transferring to a care home.

Now – the GP calls the community care coordinator and talks to the community matron, part of the locally integrated team. The nurse will visit and assess Mr Jacks, as well as talk to him about his life. She will then be able to talk to other members of the team, including social care, frailty assessment, intermediate care etc to put in place a variety of support that enables him to maintain his independence maybe some help with meals, someone to help with cleaning and some companionship.

Outcome – Mr Jacks' health does not deteriorate. His care is organised and structured around his needs and he remains at home.

Over the next six months we will:

- **double the number of outpatient appointments offered at Marlow and Thame**
- **see 350 patients through the one-stop frailty assessment clinic**
- **provide intermediate care to over 3000 people**
- **avoid almost 300 hospital admissions**
- **manage almost 20,000 referrals through the community care coordinator**

Our clinicians believe that significantly expanding the support available to people in the community will help to maintain a person's health and independence, which would otherwise deteriorate if admitted to hospital for a length of time. In particular, by introducing a rapid response service and specialist frailty assessment clinics in the community, we will reduce the need for bedded care in hospital. During the pilot our clinicians will not use the inpatient wards at Marlow and Thame hospitals, as these are our smallest inpatient units (12 and 8 beds respectively). Instead the space will be used to run the new frailty assessment clinics. On the rare occasion that a patient may need additional overnight support, which cannot be provided by the locality integrated teams, local transitional care home beds and overnight packages of care (night-sitting support for people in their own homes) will be available to our clinicians.

Case study

Mrs Smith is not feeling well and has become more forgetful than normal

Previously - Mrs Smith attends A&E and is admitted to hospital where she has a raft of tests and gets progressively more forgetful and weak.

Now – her GP sends her to the **community hub** for a **frailty assessment**. The geriatrician, nurse and therapist do a full assessment as well as taking bloods (and use their point of care testing machine to get the result immediately). They diagnose a urine infection and so give Mrs S some antibiotics into a vein over six hours.

Outcome – Mrs Smith does not go to A&E. She is treated at the community hub and is able to go home later. She has follow-up visits at her house for a couple of days.

How will we monitor the pilot?

We are piloting these ideas to give us a better understanding of what works for these two communities. We will monitor how well things work - responding and adapting quickly if we are not demonstrating improvements for our patients and communities – and use our learning to inform our final plans.

We will look at how well things are working on a daily basis including how many people we have helped to stay independent and not admitted to hospital, and the patient experience of the new services. Our medical director and chief nurse will oversee this pilot to make sure the quality and safety of our care to patients and staff is maintained.

During the six month pilot we will also continue discussions with our staff, GPs, social care, other health and care providers, patients and the public in order to learn from their experiences of these new services and to further develop care in the community.

We will take this learning and have similar discussions in other communities across the county so that by the end of the pilot we have a clear proposal about how we wish to provide more care in the community in the future.

Case study

Mrs Johnson has a fall and is taken by ambulance to A&E

Previously – Mrs Johnson is admitted to hospital, spends several days as in inpatient and loses her confidence to be at home by herself. Social care is involved and it takes several weeks to arrange suitable alternative care accommodation.

Now – the rapid response intermediate care team have staff in A&E so Mrs Johnson can go home. They arrange for a member of the team to visit her at home later that day to organise her care whilst she gets over the fall and gets her confidence back.

Outcome – Mrs Johnson is able to return home and recover much more quickly. With a short-term package of support in place she maintains her confidence and independence.

Where can I find out more?

Visit www.buckshealthcare.nhs.uk/communityhubs

If you want to get involved, have any questions or wish to feedback on these plans you can contact us on:
Email: community.hubs@buckshealthcare.nhs.uk Phone: 01494 734959

your community, your care
developing Buckinghamshire together