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Your community, your care

Our vision for developing care closer to home

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Health and Adult Social Care Select Committee

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Buckinghamshire Healthcare NHS
NHS Trust

Our plans

- 600,000 people cared for outside of hospital annually
- Working with partners to make health and care services safe, sustainable and able to meet the future needs of our local population
- Investing over £1m to expand our community services

Helping you to stay well

Through prevention and early-intervention we want to:

- help patients to take greater control over their care and treatment
- ensure we meet patients' long-term needs to help them to stay independent
- make it easier to access the right services

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Context

- Clinical evidence
- Patient feedback
- National direction – Five Year Forward View

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What's happening now?

- Community nurses and therapists available round the clock
- Specialist nurses supporting patients with long term conditions
- Early supported discharge for stroke patients providing therapy and nursing care at home reducing hospital stays

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What you told us

- GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities have informed plans

Themes

- avoid unnecessary travel
- improve coordination between organisations
- support to manage own health & wellbeing

- Consistent feedback from our hubs engagement…
  - Rapid access to testing
  - Easier signposting
  - Joined up teams
  - Full range of therapy services
  - Health and wellbeing - enhancing self-management, providing education
  - sociable space with a café
  - base for skilled staff working in the community
  - More local outpatient clinics
  - Virtual information networks
  - Information shared between organisations to improve care

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What we're doing

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

Teams that will support frail older people …

Locality integrated teams
Integrated teams, which will include nurses, therapists and social workers, 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

Rapid response intermediate care
Therapists, care staff and community nurses will provide short-term packages of support to those who would benefit from a 'jump start' back to independence

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

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What we're doing – community hubs

- Will provide the following:
  - **NEW** frailty assessment clinics
  - **MORE** outpatient clinics
  - **NEW** voluntary sector and signposting
- Expanding the support available to people in the community will help to maintain a person's health and independence, reduce need for bedded care
- Pilot to launch at Marlow and Thame hospitals for six months
- During the pilot patients will not be admitted overnight to the inpatient wards at Marlow (12beds) and Thame (8beds) hospitals.

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Patient story…

GP is concerned that Mr Jackson is getting frailer and seems a bit less able to cope

Previously – GP concerned but can't pinpoint anything specific that needs treating. The only option is to admit to hospital.

Now – GP calls the community care coordinator and talks to the community matron, part of the integrated locality team. The team visit and provide Mr Jackson with appropriate treatment and support.

Outcome – Mr Jackson's health is stabilised. His care is organised and structured around his needs and he remains at home.

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How will we monitor the pilot?

- Piloting to give us a better understanding of what works for these two communities
- Medical director and chief nurse will oversee
- Range of measures
- **Responsive & able to quickly adapt**
- Discussions will continue with patients, staff, GPs, other health & social care professionals, and communities
- Will finish pilot with a clear proposal – based on what we've tested and what we've heard

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Over the next six months we will…

- Manage almost **20,000 referrals** through the community care coordinator
- **Double** the number of outpatient appointments offered at Marlow and Thame
- See **350 patients** through the one-stop frailty assessment clinic
- Provide rapid response intermediate care to over **3000 people**
- **Avoid** almost **300** hospital **admissions,** reduce delayed discharges
- Improve **patient experience**

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Thank you

Any questions?

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