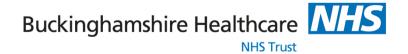


# Your community, your care

Our vision for developing care closer to home

Dr Tina Kenny, Medical Director

Health and Adult Social Care Select Committee 21 February 2017



## 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

### **Context**

Clinical evidence

Patient feedback

National direction – Five Year Forward View



## 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





## 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



## 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.



## 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.



## 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

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 Will finish pilot with a clear proposal – based on what we've tested and what we've heard
 your community,

## 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





# Thank you

Any questions?

