Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Date: Tuesday 21 February 2017

Time: 10.00 am

Venue: Large Dining Room, Judges Lodgings, Aylesbury

AGENDA

9.15 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

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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Members

Mr B Roberts (C)
Mr R Reed (VC)
Mr B Adams
Mr C Adams
Mr N Brown
Mrs A Davies
Mr C Etholen
Ms R Vigor-Hedderly
Julia Wassell
Vacancy
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

your community, your care
developing Buckinghamshire together

Developing care in the community: pilot proposal for community hubs

February 2017

Buckinghamshire Healthcare NHS
NHS Trust

Contents

Glossary

Term	Explanation
Locality	Geographical division of the county defined by the registered population of a number of GP practices
Integrated Locality Teams	Teams of staff from a range of health and care organisations working together to support patients living in that locality
Long term conditions	A range of illnesses that cannot, at present be cured; but can be controlled by medication and other therapies. Examples of long term conditions are diabetes, heart disease and chronic obstructive pulmonary disease.

Executive summary

Every year, we care for over 600,000 people outside of hospital. We're 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've 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're 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 the care and support, reducing duplication and making better use of new technologies.

Over the next year we'll 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've been talking to GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities to understand what you want and develop plans to make this happen. You've 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.

We believe that community hubs - a focal point for health and wellbeing in local communities – could be part the solution. There is no one-size-fits-all solution but some of the services you've told us you'd 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 excellent technology
- More information shared between organisations to improve patient care

What's happening now?
We've 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 are 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.

What is the national position?

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**: according to a report by Monitor[1] as many as 50% of patients in an acute hospital could be better treated elsewhere. 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]
1. **Patient feedback**: work by National Voices in 2012 highlighted that 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. Our local communities have told us the same.
2. **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 should 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 that we heard before we finalise our plans or make permanent changes. 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 the 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 community 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'll be working closely with staff and local GPs to test these ideas for six months. We're 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

[1] Monitor: Care Closer to Home, DH, Sept 2015

[2] Kortebein et al, 2008

across Marlow and Thame. A multi-professional team of geriatrician 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, 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 for the first time 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.

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 therefore our clinicians will not admit patients overnight to 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.

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 single point of access.

<u>How will we monitor the pilot?</u>

We're 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'll 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.

1. Why do we want to change?

Our health and social care services face some big challenges. The population of Buckinghamshire is growing; we can expect another 40,400 residents by 2025, which means there are more people to care for. More importantly, the type of care that people need is continuing to change. Advances in healthcare mean that people are generally living longer, some with complex and multiple long-term conditions that previously we did not have the drugs or technology to treat.

Our system does not always deliver the joined-up care that people want or need to help them with the daily challenges they face living with multiple long-term conditions. People have told us they would like the health and care system to act as one organisation, and where they interact with multiple public services, they would like to be able to tell their story just the once.

Our services are also faced with responding to illnesses associated with the more sedentary lifestyles people now have (for example 1 in 5 adults in the county are physically inactive and 2 in 3 adults are overweight or obese). It is the long-term impact of the increase in disease related to obesity, such as diabetes, which is most concerning.

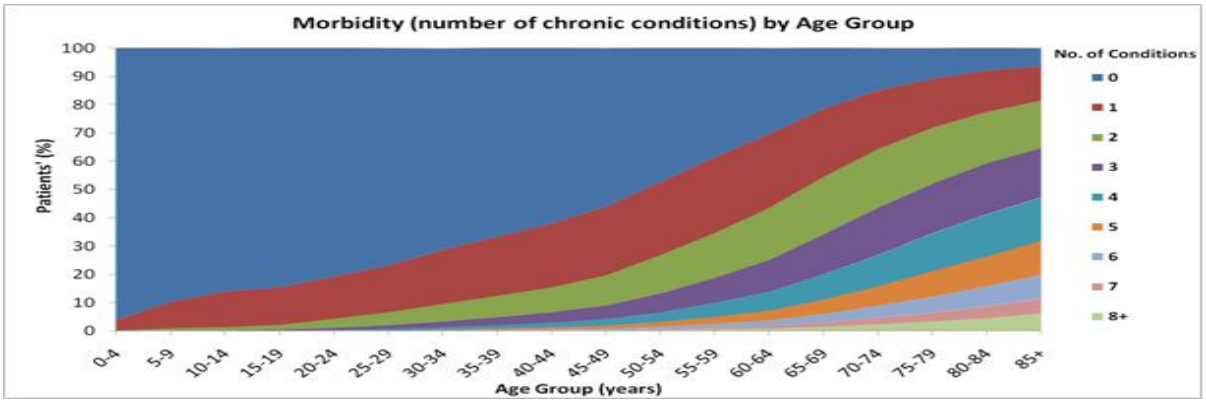
Older people generally require more health and social care. The impact of an ageing population therefore manifests as: increasing demand on GPs; pressure on hospital beds and social services; and delayed transfers of care. It is imperative therefore that we provide more care in and close to people's own homes, reducing our reliance on institutions that are expensive to run, do not always provide the right kind of support and do not allow us the flexibility to meet the needs of this growing number of older people.

The increase in the number of people aged 80 and over is very significant. They currently make up 4.9% of the population but account for 22.2% of all emergency admissions to hospital in Bucks (as of July 2016).

Numbers of people 80 and over in Bucks over the next 20 years:

2015	2020	2025	2030
26,800	32,200	38,700	48,200

The graph below shows the number of long term conditions by age group based on national data (Scottish School of Primary Care, Barnett et all, Lancet, May 2012):



So as our population ages, and the number of people living with long term conditions increases, delivering care closer to home (including access to outpatient clinics and voluntary organisations) will be critical.

Many people would prefer to be cared for in their own homes rather than in hospital or residential care and the national agenda has for some time now been encouraging more care to be provided in, or as close as possible to, people's own homes. This is in alignment with the NHS Five Year Forward View and the National Voices 'I statements':

'My care is planned with people who work together to understand me and my carers, put me in control, coordinate and deliver services to achieve my best outcomes.'

A recent report by Monitor (Monitor: Care Closer to Home, DH, Sept 2015) stated that as many as 50% of patients in an acute hospital could be better treated elsewhere. This is supported by compelling evidence that if a healthy older person is cared for unnecessarily in a hospital environment it can actually be harmful – 10 days bed rest can lead to a 14% reduction in hip and leg muscle strength and a 12% reduction in aerobic capacity. This is the equivalent of ageing them by 10 years (Kortebain, 2008).

There is also evidence that support provided from a range of professionals and a variety of organisations results in less people being readmitted to hospital both within 30 days and 18 months – by providing care at home that is holistic and promotes independence, the chances of that individual being readmitted to acute care is reduced (Caplan et al. 2004). We also know that quality of life measures improve and depression decreases for people cared for at home (Tibaldi, 2009).

Put simply, if people do not get the right care and support, their illness will get worse and they could then need emergency care in a hospital. When long-term conditions are managed well in the community – with people actively involved in choices around their own care – hospital admission should be the exception.

There is evidence that providing support and access to high quality advice enables people to take action to live healthier lives as well as provide self-care if they have a long term condition. The Self Care Forum (established in 2011 with members from a range of professional organisations) has estimated that approximately 80% of all care is self-care. Empowering and supporting this increased personal responsibility helps, they believe, to improve people's health and wellbeing, to better manage the long term condition and ultimately to ensure the long term sustainability of the NHS.

2.0 Our vision for integrated care in the community

All NHS organisations, Buckinghamshire County Council and other local organisations are working closely together to make sure that health and social care services continue to be safe, sustainable and delivered close to home in the face of these challenges. This is outlined in the Sustainability and Transformation Plan published in late 2016. Healthy Bucks Leaders (made up of health, care and council leaders in Bucks) has ensured that individual organisational plans are informed by and consistent with this wider, long term vision.

Our vision is to have everyone working together so that the people of Buckinghamshire have happy and healthier lives. We want to rebalance the health and social care spend to increase support for more people to live independently at home, especially older people and those with long-term conditions, by providing high quality prevention and early intervention services. The development of community services will be concerned with adults and children, physical and mental health needs and virtual and real service provision models.

Through prevention and early intervention we want to:

- Support people to keep themselves healthy and live, age and stay well
- Enable more people to live independently for longer
- Create the right health and support in the community in order to reduce pressure on our hospitals and GPs

The Clinical Commissioning Groups model shows the relationship between community and hospital based care which will be reflective of local circumstances and population need:

The principles of the vision that have and continue to shape changes are:

- People are cared for at home wherever possible and that services are focussed on this.
- 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 long term conditions and avoid complications.
- We combine resources and expertise across the health and care system so that people receive joined-up care.
- 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.
- People have access to specialist support in their community, working with a named responsible clinician.
- We will work together on prevention, not just as professionals but as communities and individuals

Our next step, having considered what we could do to tackle the challenges we face in these three areas, is to test our proposals in a range of ways, of which this proposed pilot is one. We want patients, carers and local people to be involved in the key decisions we will need to take. We want to work more closely with local councils and the voluntary sector who are also key to helping us to make the necessary changes.
Starting in April 2017 we will begin 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.
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In addition to these transformational changes to the services provided, there is also work ongoing by providers (particularly Buckinghamshire Healthcare, Oxford Health and FedBucks) to consider other ways of aligning our organisations to ensure that we create an environment within which integrated teams and new ways of providing care and support can flourish.

3.0 Pilot proposal

The development of community hubs and this proposed pilot sits within this context of wider system integration – developing integrated teams, increasing self-care support - that will support a shift in the emphasis of our services so that more self-care and prevention support is available and that people are able to be independent for as long as possible.

The community hubs pilots will be the first step towards providing a facility within which services and support can be provided that will achieve our goals but the journey will continue beyond this pilot and be informed by it and other service improvements.

3.1 Engagement to inform the development of community hubs

This compelling case for change and vision for community hubs was developed through engagement that has explored how we could provide more care and support closer to home.

3.1.1 Public events

Events were held in April – May 2016 across the Buckinghamshire localities. The aim of the events was to create an early opportunity for patients, carers, relatives, members of the public, partners and key stakeholders including voluntary and charitable organisations to inform the development of our plans for future models of care and devise a vision for community hubs. The involvement and input from a broad range of participants, perspectives and views was comprehensive and informative.

At each event, there were presentations to set the context and then facilitated group work with participants to identify what services could be delivered closer to home, how a hub might work and priorities for development.

Across all 6 sessions 183 participants attended and feedback was also provided online. There was good representation from key stakeholders, partners, voluntary and charitable groups.

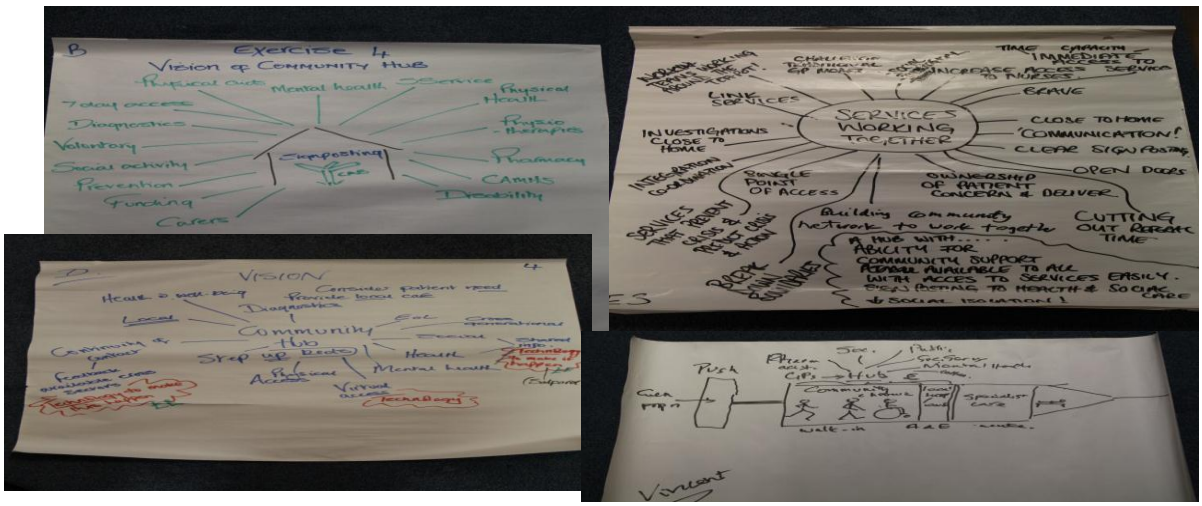
There were 9 subjects that were suggested in every location:

- Rapid access/local diagnostics/near home testing
- Signposting/navigation to health and care services – a single point of access?
- Integrated 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 could outreach in to the community
- More outpatient clinics locally
- Virtual networks providing information for patients supported by excellent technology
- More information shared between organisations to improve patient care

The general vision was a physical multifunctional space, with a multidisciplinary integrated model providing key services in the local community with a drop-in capacity. People described a one-stop-shop and a base for clinical staff to work within and to outreach from.

Key services suggested included rapid access to assessment, intervention and diagnostics. The provision of outpatient services, therapies and rehabilitation, health and wellbeing services with prevention, health education and information also featured strongly. Services to improve support for dementia and dementia cafes were also seen as important. (Full summary Appendix C).

A selection of 'vision' drawings from the public events:



In addition to the events held in spring 2016, the Buckinghamshire Clinical Commissioning Groups have held public events in all seven localities in late 2016 as part of their ongoing public dialogue about the development of services. They described the concept of locality teams and a community hub which was well received by the public present and provided additional input to the design of the pilot.

Meetings have also been held with representatives of the League of Friends organisations that support Marlow and Thame community hospitals. They have been supportive of the need to change service models and pleased that the vision sees a crucial role for these community facilities.

3.1.2 GP engagement and clinical engagement

Several GPs and staff attended the public events and engaged with patients in robust debate about access and support. In addition, specific and ongoing conversations have been held with GPs both directly related to the provision of services in the community hospital but also more widely in relation to the longer term vision and model of integrated community services. Discussions with the GP localities (starting with Wooburn Green and Aylesbury South within which Marlow and Thame Community hospitals are located) have considered the wider vision to ensure that the model for community hubs evolves appropriately in each locality.

The GP practices co-located with the community hospitals in Marlow and Thame are supportive of the proposed pilot and keen to work together to see how services could develop collaboratively to provide the best care and support to local patients.

The GP discussions have played a key part in developing the assessment and diagnostic services element of the pilots. The discussions are ongoing to ensure that we bring together GPs and consultants to provide a high quality frailty assessment service, supported by a range of expertise. It is planned to have GPs working as part of the service which will support the provision of seamless care for the patient.

Staff engagement sessions were also held in Spring 2016 and January 2017. A wide range of staff both from acute and community settings shared their visions for community hubs which resonated very closely with the views of patients.

GPs and staff remain critical to the development of plans for this pilot and wider developments and the dialogue will be continued throughout the pilot period.

3.2 Vision for community hubs

We have ambitions for community hubs and would like to see them become a genuine focal point in communities to support people to lead happier and healthier lives with a range of organisations and professionals working together to achieve that objective.

The views of the public, staff and other key stakeholders have helped us to define an early vision for community hubs. They would be real and virtual service offerings, multifunctional spaces (ideally in light and airy buildings) where a broad range of services would be provided by a wide range of organisations. The focus would be on prevention and self-help as well as offering services that traditionally people would have had to travel to a large hospital for.

The services would be coordinated and offered seamlessly to patients and include the following:

- prevention and self-help services (smoking cessation, pre-diabetes education, pulmonary rehabilitation)
- services that are currently provided in some GP surgeries (ECGs, minor surgery, travel immunisations)
- traditional hospital based services such as outpatient appointments for long term conditions, DVT care, IV antibiotics, other infusions, tests (with immediate results where necessary and appropriate),
- multidisciplinary assessment for frail people
- services provided by the voluntary sector such as Carers Bucks and Prevention Matters.

The hubs would provide a base for staff who mostly support people in their own homes to work together as integrated teams to enable them to provide a seamless, holistic and patient-centred service.

The range and scope of services that can be operated from a hub will be limited by the space available (so alternative sites may need to be considered in the long term), the viability of offering a service on that scale and the availability of interdependent services.

3.3 Community hubs pilots in Marlow and Thame

It is proposed to run pilots of the emerging community hubs model in the Marlow and Thame localities. We want to run a pilot so that we can learn from it – hear the experiences of patients, GPs and staff and inform how the model could iterate and grow to determine the right mix of services for their locality in the future. We will carefully monitor the impact of these changes during the pilot – from a clinical, operational and patient perspective and will make changes during the course of the pilot if that is

necessary. Our ambition is to create hubs across all localities, shaped to meet the needs of that local area and the pilot will help to inform these developments.

As a result of what we heard from the public and our research from elsewhere in the country we are proposing to trial changes in six areas:

- Outpatient services
- Voluntary sector and community services
- Assessment and diagnostic services
- Signposting
- Integrated teams
- Inpatient services

The table overleaf provides an indication of the services currently provided at Marlow and Thame community hospitals, our proposals during the pilot and other services that are currently being worked up to go in to the hub environment. It is anticipated that the model for community hubs will evolve through the life of this pilot and beyond as we work with local people, patients and clinicians on what works best for their locality. Some of the services we would like to put in might not work and others that we have not yet started to scope may.
Further detail on the model and current activity information can be found at Appendix A and B.

3.3.1 Marlow pilot

Service area	Now	Pilot	Additions being planned
Outpatient clinics	• Rheumatology • Physiotherapy • Urology • Heart failure • Diabetes • Speech therapy	In addition to current clinics: • Palliative care • Orthopaedics • Care of the elderly • Falls assessment clinic	• Chemotherapy • Respiratory • Oral surgery • Other clinics supporting long term conditions management
Voluntary sector	• None	• Carers Bucks staff offering support and linking with staff • Prevention Matters	• Wide range of organisations using space regularly to provide services and support
Inpatient care	• 12 beds • 85% step down from acute hospitals (see Appendix B)	• Care in people's own homes through investment (rapid response and intermediate care) • Transitional care beds and overnight packages of care (night-sitting) if required • Community hospital beds in Amersham/Buckingham (if required)	• Integrated locality teams supporting care at home. • Virtual support via technology particularly for those with long term conditions
Assessment/ Diagnostic services	• Plain film X ray 2 days a week • Blood tests	In addition to current services: • Frailty assessment service accessed via telephone and provided by geriatrician, nurse, GP and therapist to assess and arrange care to keep patients at home • Point of care blood testing to enable immediate results to	• Ultrasound service • Increased range of point of care testing

		support decision making.	
Base for staff who work across the locality	• Adult Community Healthcare Teams (nurses, therapists) • Health visitors	In addition to current staff: • Prevention Matters	• New base for staff from across health and social care working as part of integrated locality teams
Signposting	• None	• Prevention Matters • Citizens Advice Bureau	• Integrated signposting to support people to access the right service at the right time.

3.3.2 Thame pilot

Service area	Now	Pilot	Additions being planned
Outpatient clinics	• Rheumatology • Respiratory • Physiotherapy • Heart failure • Diabetics • Urology • Dermatology • ENT • Speech therapy	In addition to current clinics: • Palliative care • Orthopaedics • Care of the elderly	• Chemotherapy • Respiratory • Other clinics supporting long term conditions management
Voluntary sector	• None	• Carers Bucks offering support and linking with staff • Prevention Matters	• Wide range of organisations using space regularly to provide services and support
Inpatient care	• 8 beds • 85% step down from acute hospitals (see Appendix A)	• Care in people's own homes through investment (rapid response and intermediate care) • Transitional care beds and overnight packages of care (night-sitting) if required • Community hospital beds in Amersham/Buckingham (if required)	• Integrated locality teams supporting care at home. • Virtual support via technology particularly for those with long term conditions
Assessment/ Diagnostic services	• Plain film X ray 2 days a week • Blood tests	In addition to current services: • Frailty assessment service accessed via telephone and provided by geriatrician, nurse, GP and therapist to assess and arrange care to keep patients at home • Point of care blood testing to enable immediate results to support decision making.	• Ultrasound service • Increased range of point of care testing
Base for staff who work across the locality	• Adult Community Healthcare Teams (nurses, therapists) • Health visitors	In addition to current staff: • Prevention Matters	• New base for staff from across health and social care working as part of integrated locality teams
Signposting	• None	• Prevention Matters • Citizens Advice Bureau	• Integrated signposting to support people to access the right service at the right time.

3.3.3 Outpatient clinics

What we have heard
We provide a range of outpatient services from across our hospital and community sites but at the public engagement sessions we heard that people believed they would benefit from not having to attend acute hospitals as often for routine appointments where it may be possible to provide them closer to home.

What we are planning to do
There is considerable work ongoing to modernise how outpatient services operate across the county – ensuring we make best use of technology in particular to minimise travelling and patients having to spend time in clinics for interactions that could have been managed differently. The community hubs will however see an expanded number of clinics available with a particular focus on support for those with long term conditions. It is expected that double the number of appointments will be available in the community over the course of the pilot. This will be aligned with work already ongoing to transform care for patients with diabetes, which will also reduce the number of visits required at acute sites with more care and support available in the community.

We are also exploring with other specialities the possibility of their providing outpatient clinics within these hubs. It is likely that we will be able to provide more respiratory services in community settings and are working up the feasibility of providing some chemotherapy at community sites for cancer patients.

3.2.4 Assessment and diagnostic services

What we have heard
We know from public events and from feedback every day to individual staff from individual patients that people would like to be cared for at home as much as possible and avoid coming in to hospital if at all possible. This is no less true for our frail, elderly patients.

GPs and hospital clinicians have said that keeping people out of hospital is a priority as it helps them to maintain their independence.

At the moment people often have to travel to Wycombe, Stoke Mandeville and Amersham hospitals for various diagnostic tests and investigations. We heard from attendees at the public events that it would be beneficial to travel only as far as a community setting for a test or investigation if that were possible.

What we are planning to do
To support more care to be provided at home and to facilitate more frail older people avoiding admission to hospital it is proposed during the pilot to provide an assessment service for frail patients. This will be a community based service that enables patients to be seen as a day patient (ie not admitted to an inpatient facility) and have access to assessment and a wide range of services from preventative and primary care through to specialist care.

This model will involve a geriatrician, nurse, paramedic and therapist working with GP colleagues to identify and support patients who, without a quick intervention, might soon require a hospital admission. This service will operate 5 days a week between Marlow and Thame as required and allow same-day access. It will work in tandem with, and enhance the service currently provided by, the MuDAS (multidisciplinary assessment service) at Wycombe Hospital which already supports approximately 1000 patients per year. We expect an additional 350 patients a year would be seen, assessed and supported through this model. The model has been co-developed with local GPs to ensure it can support them to meet the needs of their patients. In some cases home visits will be facilitated too.

Technological advances mean it is now possible in some cases to use equipment that provides test results immediately (point of care testing). We will use this technology to support the clinicians providing the frailty assessment service so that their ability to make quick decisions on the best course of action for a particular patient is enhanced and will increase the likelihood of them being able to remain at home.

The assessment service will get blood results immediately, be able to undertake ECG tests and give intravenous medicines such as antibiotics and other drips. They will also have access to the full range of community services that a patient might need so for example if they have had a fall, they will seamlessly ensure they have access to the experts in that service or if they have a wound that needs dressing that care will be arranged too.

X-ray is currently offered at Marlow hospital and we are investigating the possibility of providing other radiology services in hubs such as ultrasound.

What will this mean for patients?

Mrs S is not feeling at all well and has become more forgetful than normal
Previously - Mrs S 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 S 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.

3.3.5 Base for staff working across the locality

What we have heard
GPs and the public have been very clear that the wide range of organisations delivering health and care services in the community are hard to understand and navigate. There appear to be gaps and duplication between services and people do not believe that they are receiving seamless, or indeed joined-up care.

What we are planning to do
There is significant work ongoing across Buckinghamshire to develop integrated community services. This will involve aligning teams from all organisations across health and social care, supported and facilitated to work together, reducing gaps and duplication. Building on the pilots already established in Wycombe and Aylesbury Vale, it is proposed to develop multi-disciplinary teams that work with the person and their carer/wider family to agree and deliver a personalised plan of joined up care and support designed to meet their holistic needs and enable them to remain independent longer.

The teams will access rapid response intermediate care if required as well as work closely with all organisations and teams supporting an individual even if they are not formally part of the team. Referral processes will be streamlined and care coordinators will be identified for each patient. There will be no 'wrong door' for referrals – the team will pass referrals on as appropriate. The team's key functions will be:

- Identifying patients at risk of increased frailty
- Working with patients to develop individual care plans
- Coordinating care for individuals to minimise confusion, gaps and duplication
- Providing treatment, care, support and review

The work that is ongoing triailing different ways of supporting care homes will be incorporated into this workstream as the response should be the same regardless of where you live (although tailored if you have nursing care already).

These teams will probably be based in community hubs and by sharing a base will be better placed to join up the care and support offered to patients. Staff currently being aligned more closely, include district nurses and social workers, as well as therapists (council and health occupational therapists in particular) and GPs. These staff spend much of their time visiting people in their own homes but our

pilot will enable us to use some space in the existing community hospital buildings to create flexible bases where staff can begin to meet and work together.

What will this mean for patients?

GP is concerned that Mr Y is getting frailer and seems a bit less able to cope
Previously – the GP is concerned but can't pinpoint anything specific that needs treating. He's worried that Mr Y 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 **integrated locality team.** The nurse will go and visit, assess Mr Y and 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 company.

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

3.3.6 Inpatient services

What we have heard
We know that, particularly for older people, hospital-based care does not deliver the benefits we would like to see in terms of returning people to independence after a period of ill health. We heard from the public that more care is required to support people to remain as independent as possible, for as long as possible, in their own homes. Inpatient beds in community hospitals are not always used effectively and can impact on a patients' ability to remain independent as their stay can be extended inappropriately.

The patients currently cared for across the four community hospitals in Buckinghamshire (80 beds) have a range of needs but audits show that at any one time approximately 24 patients' would have their needs better met in an alternative setting.

What we are planning to do
Given these factors it is proposed to trial caring for patients previously who may have been traditionally admitted to Marlow and Thame community hospitals in alternative environments. The frailty assessment service (described in section 4.4) will enable admission avoidance – by supporting GPs with the assessment and care planning for frail older people. This pilot will also help enable the cultural shift that is required to ensure that hospital staff are supported (through a single point of access and increased investment) to facilitate discharge to the most appropriate place with the most appropriate care.

During the pilot therefore our clinicians will not admit patients overnight to 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.

In addition, there is significant investment in and development of the rapid response intermediate care services that are required to support patients in their own home either to avoid a hospital admission or facilitate discharge from hospital. At present there are several services offering reablement services and the plan is to combine the current REACT team (at the front door of A&E) with the reablement capacity in the ACHT locality teams and Bucks Care to create a single **Rapid Response Intermediate Care Team** that offers:

- Short-term packages of support (for up to six weeks)
- Multi-disciplinary assessment and rapid response from 8am-8pm, 7 days a week at Stoke Mandeville Hospital
- Multi-disciplinary assessment and treatment in patients own homes for admission prevention and supporting hospital discharge
- Intermediate care support at home 8am-9pm 7 days a week
- Daily in-reach and outreach presence on hospital wards and at the front door
- Community physiotherapy for ongoing rehabilitation needs to maximise independence
- Integrated with other services, both existing and being developed, as part of wider service alignment

It is expected that this investment and alignment of services will create an additional 50% contacts for intermediate care with the number of contacts rising from 12764 to 19145 per annum to enable an additional 300 admissions to be avoided.

To support and enable appropriate and efficient access to these services, a full single point of access will be established to include all referrals of those patients ready for discharge from acute services but who require some additional support as well as those at home who require some additional support to avoid a hospital admission.

In time this referral point will be expanded in line with referrer needs and it likely to become the access point for all specialist community services (eg falls/bone health services), elements of continuing health care services and perhaps some social care services.

What will this mean for patients?

Mrs J has a fall and is taken by ambulance to A&E
Previously – Mrs J 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 J 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 J 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.

3.3.7 Voluntary sector and community services

What we have heard
We know that the needs of the population are rarely met by one individual or organisation and increasingly, as we heard at the public events, the voluntary sector are providing invaluable services that support people to maintain their independence.

What we are planning to do
We will work with voluntary sector partners to offer opportunities to run services from the community hub buildings. We plan to trial this with Carers Bucks and Prevention Matters during the pilot. It is proposed that they will have a presence at both sites most days of the week and be available to offer guidance and support and signpost to other services as appropriate. The service could be 'drop in' or by appointment but exact details are still being finalised.

3.3.8 Signposting

What we have heard
A key message from the engagement events was that the public felt they could be more self-sufficient if they had access to better signposting advice to help them navigate complex and complicated health

and care systems. We also heard of the important work that many voluntary organisations and charities already provide in localities to support local communities in this way. Many felt it would be beneficial for these organisations to work more closely with health and care to improve the advice and guidance offered.

What we are planning to do
We are keen therefore to develop in these community hubs the right support to people to ensure they receive the right care from the right person at the right time. Developing a full signposting service will take time but we are proposing to trial some new models in the first phase of the community hubs development including working with Patient Participation Groups from GP practices (Healthmakers project) and the Citizen's Advice Bureau.

4. Learning from the pilot

By piloting these developments we will have a better understanding of what works for these two communities. This approach will allow us to both closely 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 be monitoring, using a range of measures, how well things are working on a daily basis – this will range from how many people we have helped to stay independent and not be admitted to hospital, to the patient experience of the new services. Our medical director and chief nurse will be overseeing this pilot to make sure the quality and safety of our care to patients and staff is maintained. By doing this we will be able to quickly make any changes or adaptations as or when we need to.

During the six month pilot we will also be continuing 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 want to know the impact on the care and experience of users of the hub. We will therefore ask a range of patient representative organisations, including Healthwatch, Practice Participation Groups, League of Friends, to share with us feedback that they receive about the services at the hubs and/or in their own homes. We will want to know specifically about the range of services offered, ease of access to services, impact on travel time and the quality of the service received.

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.

We will know that this change has worked if frail, usually older people are staying in their homes for longer. This is not easily quantified or measured but is the expectation based on what national and international evidence there is.

In addition to these qualitative measures, we believe that there will be specific things we can measure to help us assess the impact. We believe the benefits of this shift in care model would include:

Measure	Baseline	Expected improvement
Increased numbers accessing outpatients at community sites	1000 outpatients/annum	2000 appointments/annum
Admissions avoided (all sites)	800/month	850/month
Rapid response intermediate care contacts	12764 per annum	19145 per annum
Patient related experience measures		Demonstrate improvements across a range of measures
Number of people discharged from acute care to normal place of residence	92% (all patients)	94%
Numbers seen in frailty	N/A	15 per week across both

assessment service		locations
Referrals managed through community care coordinator	N/A	765 per week
Readmissions of over 75s	TBC	To see a reduction in overall admissions
Numbers of patients requiring additional overnight support	N/A	To monitor as part of pilot to inform future

As part of our quality assurance processes, the chief nurse and medical director have reviewed these proposals and the measures described above and will monitor the impact on patients throughout the pilot. As well as daily monitoring, a group has been established that will meet bi-weekly and has operational and clinical staff attending.

5. Summary and timeline

This pilot proposal has been built up over time with considerable engagement with the public, GPs and other key stakeholders. It is part of the ongoing, system wide development of integrated community care that will ensure our health and care system is high quality and sustainable to cope with the pressures it currently and will continue to face.

The service will iterate and grow during and hopefully after the pilot, informed by our learning and ongoing dialogue with the public and GPs to determine the right mix of services for their locality. Depending on the shape and scope of the future service model, it may well be that further engagement or consultation is required before permanent changes are made.

The proposed timeline is outlined below and demonstrates the ongoing commitment to learning from the pilots to inform development of the model for community hubs within the context of wider system change.

Date	Activity
End January – 14th February	• Stakeholder communications • Further iteration of pilot proposal • Ensure baseline data collated
21st February	• HASC meeting
Feb - March	• Staff consultation to support pilot
1st April	• New clinics established • Frailty assessment service commences • Investment in rapid response intermediate care and additional staff recruited • No new admissions to community inpatient beds at Marlow and Thame
June – September	• Ongoing discussions with patients and GPs in localities • Fortnightly meetings to evaluate ongoing impact and iterate if required • Development of plans for future model across the county
September / October	• Measure expected benefits
October / November	• Share proposals to determine next steps for countywide hubs

Appendix A

MARLOW COMMUNITY HUB

Outpatients

Currently:
Speech and language therapy (weekly)
Heart failure (weekly)
Diabetes (weekly)
Rheumatology (weekly)
Urology (monthly)
AAA screening (weekly)
Physiotherapy
Dental
Speech and language therapy (weekly)

In addition:
Palliative care (weekly)
Care of the elderly (weekly)
Trauma and Orthopaedics (monthly)

Inpatient services

Currently:
12 inpatient beds

In future:
Frailty assessment service –
Geriatrician, nurse and therapist 3 days a week (flexible) focussing on assessments to avoid hospital admissions

Transitional care beds and overnight packages of care available if required

Investment in rapid response intermediate care and other community services

Staff bases

Currently:
Adult Community Healthcare Teams (district nurses, therapists, health care assistants)
Health Visitors
Macmillan Nurses

In future:
Bucks County Council occupational therapists
Base for integrated locality teams

Voluntary organisations services

Currently:
None

In future:
Carers Bucks clinics
Alzheimers Society advice point
PPG Expert patients advice point
Prevention Matters Community Development Worker
Library link
Citizens Advice Bureau

Ambulatory/diagnostic services

Currently:
Xray (Tues & Thurs am)
Blood tests

In addition:
Ultrasound (3 x week)
Point of care testing

NB: Descriptions in *italics* are those that are not yet completely in place but discussions are ongoing.

BACKGROUND INFORMATION: Marlow

NB: Some figures are different as different time frames used for the 12 month analysis

The hospital provides the following services:

- 12 inpatient beds (in 3 and 4 bed bays)
- Outpatient clinics
- Musculoskeletal physiotherapy
- Staff base for ACHT, Health visitors

On the inpatient ward the current staffing issue is 6.52 band 5 vacancies against a wte budget of 10.53 ie a 60% vacancy rate.

Average age of inpatients	
CH	**Age**
Marlow	83

Admissions

ADMISSIONS TO MARLOW - 1ST APRIL 2016 TO 31ST OCTOBER 2016												
Community Hospital	Total Admissions	Step-up source					Step Down Source					
		GP	other provider	Elective booked	A&E /Bed bereau	Totals Step UP	Other/CH	Other Comm hosp	Wycombe	AGH	SMH	Total Step down
Marlow	127	5	8	2	6	21	2	2	17	0	85	106

Vast majority of admissions are step down from acute hospitals (Wycombe, Stoke Mandeville and Wexham Park).

Medical cover is provided by GPs from Marlow practice as commissioned by BHT.

Number of admissions per CCG locality (Oct 15 – Oct 16)

Total number of admissions	**182**
High Wycombe	78
Marlow	45
Amersham & Chesham and Southern Chiltern localities	35
Aylesbury CCG Localities	15
Out of county	9

Discharges

The average length of stay was 22.0 days.

A spot audit of all community hospital beds in 2015 showed that 30% of patients were fit for discharge (38% of those awaiting a package of care, 25% awaiting reablement at home). These are all patients who are discharged home but with this additional support.

The discharge destinations of the patients were as follows:

Discharge Destination	Marlow
Local authority residential accommodation	3
N/A- patient deceased	3
NHS other General Hospital	4
NHS run care home	3
Private Care Home	0
Temporary place of residence	6
Usual place of residence	78
Care Home (probable)	13
Grand Total	**110**

Outpatients

Shows total number of outpatients Oct 15 – Oct 16 with idea of where patients came from.

Total number of appointments	488
Number patients referred by GP practices in local vicinity	323

Diagnostics

Plain film Xray is provided two mornings a week and there are approximately 650 undertaken in 6 months.

Appendix B

THAME COMMUNITY HUB

Outpatients

Currently:
Speech and language therapy (weekly)
Heart failure (weekly)
Diabetes (fortnightly)
Rheumatology (monthly)
Urology (monthly)
Audiology (monthly)
ENT (monthly)
Dermatology (monthly)
Respiratory (fortnightly)
Physiotherapy

In addition:
Palliative care (weekly)
Care of the elderly (weekly)
Trauma and Orthopaedics (monthly)
Respiratory

Inpatient services

Currently:
8 inpatient beds

In future:
Frailty assessment service –
Geriatrician, nurse and therapist 2 days a week (flexible) focussing on assessments to avoid hospital admissions

Transitional care beds and overnight packages of care available if required

Investment in rapid response intermediate care and other community services

Staff bases

Currently:
Adult Community Healthcare Teams (district nurses, therapists, health care assistants)
Health Visitors

In addition:
Bucks County Council occupational therapists

Voluntary organisations services

Currently:
Smoking cessation

In future:
Carers Bucks clinics
Alzheimers Society advice point
PPG Expert patients advice point
Prevention Matters Community Development Worker
Library link
Citizens Advice Bureau

Ambulatory/diagnostic services

Currently:
Blood tests

In addition:
Ultrasound (3 x week)
Point of care testing

NB: Descriptions in *italics* are those that are not yet completely in place but discussions are ongoing.

BACKGROUND INFORMATION: Thame

NB: Some figures are different as different time frames used for the 12 month analysis

The hospital provides the following services:

- 8 inpatient beds
- Day hospital
- Outpatient clinics
- Staff base (ACHT, health visitors)

On the inpatient ward there are currently no vacancies at band 5.

Average age of inpatients	
CH	**Age**
Thame	84

Admissions

ADMISSIONS TO THAME - 1ST APRIL 2016 TO 31ST OCTOBER 2016												
Community Hospital	Total Admissions	Step-up source					Step Down Source					
		GP	other provider	Elective booked	A&E /Bed bereau	Totals Step UP	Other/CH	Other Comm hosp	Wycombe	AGH	SMH	Total Step down
Thame	95	2	11	0	3	16	0	0	1	1	77	79

Vast majority of admissions are step down from acute hospitals (SMH).

Medical cover is provided by GPs from CV Health as commissioned by BHT.

Number of admissions per CCG locality (Oct 15 – Oct 16)

Total number of admissions	172
Thame (Haddenham, Long Crendon, other villages)	87
Aylesbury (and surrounding villages)	52
Chiltern CCG localities	33
Out of county	3

Discharges

The average length of stay was 22.2 days.

A spot audit of all community hospital beds in 2015 showed that 30% of patients were fit for discharge (38% of those awaiting a package of care, 25% awaiting reablement at home). These are all patients who are discharged home but with this additional support.

The discharge destinations of the patients were as follows:

Discharge Destination	Thame
Local authority residential accommodation	1
N/A- patient deceased	3
NHS other General Hospital	10
NHS run care home	1
Private Care Home	3
Temporary place of residence	2
Usual place of residence	51
Care Home (probable)	12
Grand Total	**83**

Outpatients

Shows total number of outpatients Oct 15 – Oct 16 with idea of where patients came from.

Total number of appointments	608
Number patients referred by GP practices in local vicinity	345

Appendix C

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD MEETING
Wednesday 27 July 2016

Details of the Paper

Title	Your care, your community – Feedback from community hub engagement
Responsible Director	David Williams – Director of Strategy and Business Development
Purpose of the paper	• To provide a summary and overview of 'Your community, your care', our recent public engagement programme on developing community hubs. • To provide an outline of overall key feedback • The Trust Board is asked to note and accept this paper as a summary record of the engagement process
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note and accept this paper as the report on the Your community, your care public engagement exercise.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
Quality and patient safety
Integrated Care

Please summarise the potential benefit or value arising from this paper:
Patient centred change resulting in more effective use of resources avoiding errors in change that later need correcting, better patient experiences, improved joint management of care and sustainability.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	*If you need advice on completing this box please contact the Director for Governance)*

Author of paper: Tracey Underhill, Head of Membership, Engagement, Equality and Diversity-*(operational)*

Presenter of Paper: David Williams Director of Strategy and Business Development

Other committees / groups where this paper / item has been considered:

Date of Paper: 15 July 2016

Buckinghamshire Healthcare NHS
NHS Trust

Your community, your care
Feedback from community hub engagement
July 2016

1.0 Purpose

- To provide a summary and overview of 'Your community, your care', our recent public engagement programme on developing community hubs.
- To provide an outline of overall key feedback
- The Trust Board is asked to note and accept this paper as a summary record of the engagement process.

2.0 Executive Summary

The subject of this paper is our recent programme of public engagement, Your community, your care (YCYC). This was a series of 6 public and 2 staff engagement sessions that took place across April and May of this year led by Buckinghamshire Healthcare NHS Trust (BHT). The six engagement sessions took place starting on the 7th April 2016 at Thame and concluded on the 12th May in Buckingham. Other locations included, Marlow, Chalfont, Aylesbury and Wycombe.

Each session worked to a set programme and sessions were 2.5 hours and were designed to have three stages e.g. information giving, group work and a plenary.

The aims of this programme are listed below and this paper seeks to provide assurance to the Trust Board and the public that early conversations have taken place about the potential of developing community hubs and delivering more care closer to home. In addition, this paper offers assurance to the board that the aims of the, Your community, your care engagement programme have been met.

In total, 26 different groups of people across the 6 sessions have provided feedback. The information we have as a result of analysis is represented below summarising with a vision of a community hub that seems to be the most commonly supported from the feedback we have received.

This is a summary report of the process and feedback from patients and stakeholders; it does not seek to report on potential plans, options or changes. In thinking about the potential of moving more care closer to home, the Trust felt it was very important to have an early dialogue, without pre-defined models or ideas. We wanted to first listen to the views of local people, in the current climate, to see if the concept of care closer to home is supported. Having the dialogue early means that feedback can genuinely help to inform the shape of future services as we try to develop the ideas and suggestions received along with our partner organisations who will need to be involved. Much of the feedback spanned more than the remit of just health.

3.0 Introduction

As a result of a shift to delivering care closer to home, BHT committed swiftly to a programme of early engagement with the local community. In February 2016 the BHT Board with the support of partners agreed to run a series of public engagement events with a focus on the development of community hubs in line with national direction. BHT wanted to create an early opportunity for patients, carers, relatives, members of the

public, partners and key stakeholders including voluntary and charitable organisations to inform the development of our plans for future models of care. The feedback received will be used to help inform decisions around health and social care changes within local communities. Feedback will also help to inform projects as they emerge from the future Sustainability and Transformation Plan. This will be a regional plan that involves key partners such as social care, local authorities and mental health across the Buckinghamshire, Oxfordshire and West Berkshire footprint.

Aims of the engagement programme included:

- An early opportunity to explore with local communities how we might develop community care hubs and what that might look like locally
- To better understand what patients and carers identify as the services that could be provided closer to home and the benefits to local people and the quality of their care
- To identify those services that people feel they don't need to travel to an acute hospital site for
- To understand how we might be able to support different people's needs in different areas via a community hub
- To establish a list of priorities from each session
- To provide an opportunity to gather feedback from individuals on their vision of what a hub might look like as well as the collective view from group work
- To deliver meaningful engagement sessions for patients, carers, partners and stakeholders to attend.

The participation and input from a broad range of participants, perspectives and views has been very comprehensive and informative. More detail is provided below.

4.0 Process

At each event, opening presentations were delivered by our Chief Executive, Neil Dardis and our Chief Nurse, Carolyn Morrice, with the exception of Thame when our Director of Strategy and Business Development presented on behalf of the CEO. The presentations focussed on setting the context, explaining the national drivers for care closer to home, with a few examples from elsewhere. They included some of our achievements and challenges to date and highlighted our wish to seek people's views early.

Facilitated group work followed with participants responding to specific questions via a range of exercises using a set format and method to maintain consistency across the sessions. Following the group work individuals were offered the opportunity to record their own personal vision. Group work included identifying what services would people like delivered closer to home, how a hub might work, priorities and creating a vision of what a community hub might look like.

Sessions concluded with a plenary and closing comments. Participants were informed of how their feedback would contribute to informing developments. All participants were asked to complete evaluation forms and equality monitoring sheets.

Each participant was informed that they would receive a report of the session they attended and they would be able to verify the accuracy of the report ahead of any analysis.

All 6 reports have been completed, circulated for comment and verified by participants and are available on request. All reports are consistent in format and approach and carry the branding that we have developed for this programme. Responses have been positive and the reports have been welcomed with some minor amendments.

Finally, following acceptance of this paper and it's content by Trust Board, our promise to participants is to develop an overall report drawing on all 6 reports and this will then be circulated to all participants and staff.

5.0 Summary of key outputs
Following collation of all the feedback there is a significant amount of information to analyse. From the 6 sessions, we had feedback from 26 groups across several exercises. Our analysis has looked at comments provided by frequency, by location, the priorities groups decided at each session and we have developed key themes. Still to analyse are the individual personal visions of what a community hub looks like. We received 113 of these which is very positive and these will further add to the richness of information collected.

5.1 Attendance
Across all 6 sessions

- 183 participants attended
- 281 people actually booked which demonstrates the level of interest
- 66 people did not arrive
- 32 people cancelled

There has been good representation from key stakeholders, partners, voluntary and charitable groups.

Evaluations have been collected from each session along with equality monitoring forms. Of the 183 attendees 117 completed evaluation forms some examples of responses include:

- 112 of a 117 responses said they valued the opportunity to discuss with others, ideas about community hubs
- 111 of 117 responses valued the facilitation of the group work positively
- 107 of the 117 responses said they valued clinical staff being present.

5.2 Analysis of top ten points of feedback resulting from collation of:-
- priorities identified by groups across all 6 sessions – exercise 3
- analysis of feedback by frequency – exercise 2
- analysis of feedback by site – exercise 2

It is important to note that where ** is shown this indicates a skew of data due to one location identifying the topic as significant for them so this needs to be interpreted with great care and does not reflect the overall list which is listed further below. However, it is important to note that there are some differences about local needs between different locations and some variation between what people feel is important. The data below is shown for all 6 locations.

Top ten priorities identified by the groups in all 6 locations via exercise 3	Top ten services people identified as wanting to see delivered closer to home by frequency via exercise 2	Top ten services people would like to see delivered closer to home by site. Cross analysis exercise 2
Integration of services i.e health, social care, voluntary and charitable sectors	Rapid access to assessment, diagnostics (lab in the bag example strongly supported)	Rapid access local diagnostics near home testing (LAB in a bag example strongly supported)

Hub seen for health wellbeing and prevention including training and education opportunities for patients Providing a range of services	Therapies, rehabilitation, and physiotherapy mentioned frequently as a service would like to access closer to home. Could see in a hub	Signposting / navigation to services – would like a single point of access to contact for information and signposting. to health and social care services Citizens advice bureau mentioned frequently for model and ? could they help to deliver?
Rapid Access to diagnostics/ assessment	Step up / step / down / transition bed provision locally **Skewed listing position Thame heavily weighted barely mentioned elsewhere. See left hand column.	Integrated teams/Integrated skills and integrated working with health and social care.
Navigation and signposting to services across health and social care. Central single point of access wanted eg. Telephone line / online. Which services provided where and how to access.	Better communication, 24 hour access to records / record sharing/ sharing of information between care providers more joined up	Dementia services Dementia Café Other services for those in need of mental health support
Diagnostics	Technology – Telemedicine, Skype, remote access to care, telephone for remote advice for follow up. Etc	Local access to rapid advanced level first aid – The message is – would help with demand on A&E “help us to help ourselves” Key message – want face to face – most just need reassurance anxiety and uncertainty drives people to A&E unnecessarily can’t access GP quickly enough.
Technology – care skype/telemedicine /virtual information & sharing of information and 24 hour access to records and for general information.	More personalised care **Skewed listing position Chalfont Cited strongly in Chalfont see also below - continuity	Rehabilitation services Therapies Physiotherapy mentioned frequently
Information	Radiology /Imaging /Ultrasound **Skewed listing position Thame heavily weighted	Prevent social isolation need services/action to help
Communication across services and care providers.	Outpatients A broad range of out patient clinics cited. Most strongly desired in Buckingham but not skewed and eyes and ear care came up most	Step up/down/transitional beds **Skewed listing position Thame heavily weighted barely mentioned elsewhere. Beds not necessarily in hub or even the hospital but

	frequently along with podiatry	provision needs to be kept local. Access matters.
Transport to hub make hubs accessible. Good public transport access. Transport issues generally	Continuity of care **Skewed listing position Chalfont. See above personalised care.	24 Hour access to patient notes/information/record sharing
Joint 10th Reduce social isolation – health deteriorates.	*Joint 10th* Carers support	Community Hub with health, wellbeing and prevention centre / function Integrated services with social care Drop in facility Voluntary groups and charitable groups either present, input, or signposted to from hub Most mentioned, Citizen's advice bureau Carers Bucks, Age Uk / Age concern
Joint 10th Step up / step / down / transition beds **Skewed listing position Thame heavily weighted barely mentioned elsewhere. Beds not necessarily in hub or even the hospital but provision needs to be kept local. Access matters.	*Joint 10th* Childrens and Family Services	Telemedicine/Skype/Remote advice

5.3 Analysis of the feedback by showing which themes were brought up at every one of the 6 locations

i.e these are the only 9 subjects that were mentioned by every location:

- Rapid access / local diagnostics near home testing (LAB in a bag example type approach)
- Signposting / navigation to health and social care services /a single point of access
- Integrated health teams/Integrated health and social care teams/skills
- Therapies / Rehabilitation services and in particular physiotherapy
- All locations saw the hub as also having a health and wellbeing function a wellness centre promoting exercise and weight loss, enhancing self management providing health education and helping with prevention of ill health as well as having a social space most also saw a café as being part of the space.
- Skilled staff needed and idea to use hub as base to outreach into the community from.
- Outpatients – opportunities to run outpatient clinics more locally
- Virtual networks providing information for patients, sharing records, technology for improving better communications between teams and organisations
- Information sharing – includes records to improve care for patients moving from one care provider to another.

5.4 Common themes from the visions groups produced

There were some common key themes to the visions of participants in their groups. A few of these are listed below:

- People generally saw the concept of a hub as a physical space but there were discussions about whether it could be a virtual rather than a physical framework so virtual networks, remote telecare, telephone advice, electronic signposting, others suggested a hub which they saw as a mobile similar to the screening vehicle that could outreach to rural areas. Some liked the idea of a combination of a physical hub combined with some potential for a mobile as outreach from the hub
- Interestingly, there were several visions drawn of physical spaces but in round buildings.
- Majority of feedback for the vision showed a hub as a physical multifunctional space for health and social needs. There is strength in the feedback regarding the need to have a social space, drop in function and skilled clinical members of staff on site.
- It should offer co-location of services and there should be a multidisciplinary approach. Some saw it with GP present but more saw it without and many wanted any plans to develop a hub to avoid duplication.
- Voluntary and charitable groups are included in the vision either within the hub to provide input and support or, to signpost from the hub
- It is seen as a one stop shop
- It houses and delivers integrated services from health but also with social care services (joined up care)
- Signposting and navigation is seen as very important
- It needs to provide services that meet the needs across all ages including children and young families as well as older people.
- The hub is seen to offer a health, wellbeing and prevention function helping to keep people well, keep fit classes, falls prevention, cardiac and stroke rehabilitation classes rather than just treat illness, empower people to better manage long term conditions.
- People see it as providing a social space to help reduce social isolation nearly all visions created had a café in this space.
- Dementia services and a dementia café and making any facility dementia friendly as well as accessible for those with physical or sensory impairments.
- Phone access or drop in for advice people want to see someone quickly for advice and reassurance some said they don't always find NHS 111 helpful or appropriate for their needs and get directed inappropriately to care they don't need people want to see a trained professional – have confidence in the advice.
- We also heard of good experience of 111. People advised avoid making things any more complex
- It is seen as being in either a central location or an area with good footfall potential, must have good access via public transport, utilising an area already established that needs to be better used some community hospitals were suggested for this or other community established buildings that could be shared or developed. One comment suggested co locating fire, health and police together as a community hub.

To provide a flavour of the services that participants saw the hub providing spans a range of outpatient clinics with ophthalmology and audiology services being mentioned quite frequently. Telemedicine remote service provision, diabetes, therapies, podiatry, rehabilitation, rapid assessment and diagnostics, advanced first aid, dementia care,

children and young people and young family services are also clearly identified as are others.

5.5 Summary and Conclusions.
To complete our process, our plan is to draw together a wider overall report, mentioned earlier, along with the analysis of the personal visions received, the staff feedback (which is very similar) and views collected from our digital online feedback facility.

Despite the breadth of feedback, there are some common broad themes that can be established to help inform an overall view:-

The general vision appears to be a physical multifunctional space, with a multidisciplinary integrated model providing key services in the local community with a drop in capacity. It is seen as a one stop shop facility. Additionally, it is seen as a base for clinical staff to work within and to outreach from. A key element of feedback has been the need for better integration across health but also with social care. A hub is seen as needing to be accessible and on good routes for public transport.

Key services include rapid access to assessment, intervention and diagnostics, the lab in the bag example shown in the presentation appears to be well received and supported. The provision of outpatient services, therapies and rehabilitation, health and wellbeing services with prevention, health education and information also feature strongly. This includes services such as falls prevention, cardiac and stroke rehabilitation, and dietry advice. A form of advanced first aid for face to face reassurance is seen to potentially helpful to prevent people attending A&E unnecessarily and could be accessed via the hub. Services to improve support for dementia and dementia cafes were also seen as important.

Other elements strongly supported is improved use of technology e.g. Skype, telemedicine for remote access to clinical advice and information and some follow up appointments whilst remembering those that may not be able to access or use technology.

It was also felt that a hub would provide an additional function of helping to reduce social isolation which can lead to ill health thus preventing further need of care.

6.0 Recommendations

- The Board is asked to note and accept this paper as the report on the Your community, your care public engagement exercise
- Note that this engagement exercise will inform future discussions and care model development within Buckinghamshire
- Support continued engagement and communication with our communities on the development of health and social care services
- Feedback has demonstrated many similarities but also differences between locations and any future models may need to take account of local needs.

Tracey Underhill
Head of Membership, Engagement, Equality and Diversity *(operational)*
On behalf of
David Williams
Director of Strategy and Business Development.

SUMMARY

Your community, your care – our vision for developing care in the community: piloting community hubs

Every year, we care for over 600,000 people outside of hospital. We're 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've 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're 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 the care and support, reducing duplication and making better use of new technologies.

Over the next year we'll 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've been talking to GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities to understand what you want and develop plans to make this happen. You've 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.

We believe that community hubs - a focal point for health and wellbeing in local communities – could be part the solution. There is no one-size-fits-all solution but some of the services you've told us you'd 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 excellent technology
- More information shared between organisations to improve patient care

What's happening now?

We've 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 are 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.

What is the national position?

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:

Quick facts

- 1,250 people in Buckinghamshire live with multiple complex conditions
- In 5 years' time the number of over 65s will have increased by 10%
- By 2025 we will have seen a 44% increase in over 85s

1. **Clinical evidence**: according to a report by Monitor[1] as many as 50% of patients in an acute hospital could be better treated elsewhere. 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]
1. **Patient feedback**: work by National Voices in 2012 highlighted that 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. Our local communities have told us the same.
2. **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 should 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 that we heard before we finalise our plans or make permanent changes. 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.

[1] Monitor: Care Closer to Home, DH, Sept 2015
[2] Kortebein et al, 2008

- **Rapid response intermediate care**: Therapists, care staff and community nurses, working as part of the 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 community 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'll be working closely with staff and local GPs to test these ideas for six months. We're 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 geriatrician 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, 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 for the first time 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.

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 therefore our clinicians will not admit patients overnight to 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

Quick facts

- At any one time 24 patients are in a community hospital bed waiting for other packages of care and support to be put in place
- Patients stay on average for 22 days whilst waiting

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.

Box:

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.

How will we monitor the pilot?

We're 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'll 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.

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 DETAILS TBC

Case studies

GP is concerned that Mr Y is getting frailer and seems a bit less able to cope
Previously – the GP is concerned but can't pinpoint anything specific that needs treating. He's worried that Mr Y 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 **integrated locality team.** The nurse will go and visit, assess Mr Y and 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 company.

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

Mrs S is not feeling at all well and has become more forgetful than normal
Previously - Mrs S 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 S 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.

Mrs J has a fall and is taken by ambulance to A&E
Previously – Mrs J 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 J 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 J 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.