Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Minutes

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

Minutes from the meeting held on Tuesday 21 February 2017, in Large Dining Room, Judges Lodgings, Aylesbury, commencing at 10.00 am and concluding at 12.50 pm.

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

MEMBERS PRESENT

Buckinghamshire County Council

Mr B Roberts (In the Chair)
Mr R Reed, Mr B Adams, Mr C Adams, Mr N Brown, Mrs A Davies and Julia Wassell

District Councils

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

Members in Attendance

Mr M Appleyard

Others in Attendance

Mr G Betts, Interim Managing Director - CHASC
Mr N Dardis, Chief Executive, Buckinghamshire Healthcare Trust
Dr G Jackson, Chairman, Aylesbury Vale CCG
Dr T Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust
Ms L Patten, Chief Officer, Aylesbury Vale Clinical Commissioning Group
Dr M Thornton, GP, Trinity Health
Ms C Morrice, Chief Nurse and Director of Patient Care Standards, Buckinghamshire Healthcare NHS Trust

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies: Mr Carl Etholen

Changes in membership: Wendy Mallen is no longer on the HASC.

2 DECLARATIONS OF INTEREST

Julia Wassell confirmed that all her declarations of interest were up to date.

3 PUBLIC QUESTIONS

None received

4 BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST SUSTAINABILITY AND TRANSFORMATION PLAN NHS ENGLAND SOUTH BOBW

Lou Patten, Chief Executive, Clinical Commissioning Groups, Neil Dardis, Chief Executive, Buckinghamshire Hospital Trust, and Graham Jackson, Clinical Lead for Aylesbury Vale attended the meeting to give an update on the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan. The presentation in full can be found here (will attached presentation to notes)

The Committee discussed the individual work streams contained in the STP.

The following points were discussed:

- How the finances would be set out across the footprint and the debt inherited that would be factored into the baseline
- The 70/30 split referred to the Bucks “chapter” with 70% efficiencies coming from local plans and that this would be monitored through progress checks
- The assurances needed that the STP would not result in reductions for Bucks residents and the confidence that the plans would build services locally for residents
- Assurances relating to the Governance of the decision making process
- Ensuring key stakeholders were involved so have a whole system integrated working
- The need to ensure services were accessible to all including those in deprived areas or that did not have access to digital solutions and the requirement to give people options

Prevention
The following points were discussed:

- The link between the STPs project plans, how they were broken down to a County level and if timescales would be included in the project tracker. It was confirmed that the plans would be shared with key stakeholders in May
- Assessing would the success of the agenda for patients and ensuring the patient voice was heard. Examples were given of engagement happening already and feedback used from patients to inform the plans

Urgent Care
The following points were discussed:

- Who decided if a request put through by a GP was urgent or put on the routine list
- The need for the treatment pathway to be communicated to patients and put in place so that delays were minimised.

- The requirement to maximise the use of technology between departments and the GP
- How extended GP services could be put in place to prevent patients visiting A&E
- How Wexham Park Hospital/Frimley were integrated into the plans to overcome the current disjointed nature of provision. It was confirmed that there were links with Wexham Park discharge planning and links between the teams. It was also confirmed that some capital funding for GPs had been sought in order to be able to talk digitally with the hospitals
- The need for engagement with the ambulance service. It was confirmed that the South Ambulance Service has been heavily involved

Acute Care
The following points were discussed:

- The Committee questioned whether the £7.2m saving from Acute services included procurement and sought reassurance that savings would be made from procurement. Members were assured that numbers in the STP were realistic and if not made would present challenges

Mental Health
The following points were discussed:

- Concerns were raised about what needed to be done for Mental Health in Buckinghamshire and the feeling that the County was behind what others were doing
- The need to think differently about how we provided services and that this would be picked up as part of the Community Hubs initiative

Specialised Commissioning
The following points were discussed:

- Substantial savings could be made in this area and the need to have the expertise to ensure breadth of knowledge. It was discussed that this was a specialised end of health care and expensive
- Areas of savings suggested had included having diagnostic tests carried out locally and liaising with the specialist clinicians to ensure joined up working

Workforce
The following points were discussed:

- The option to move towards 7 day working, which mean there would be less contrast between weekday and weekend patient experiences and if this would be sustainable. It was noted that there was already a lot of work in Buckinghamshire that was proving successful

Digital
The following points were discussed:

- Historically communications within the NHS had not been good. It was confirmed that all Aylesbury Vale clinicians were now on the same system and more digital solutions were being used across the sector
- Work was ongoing between the Adult Social Care and GPs in order to better access information

A 12 month update was requested to come back to the Committee on the developments in this particular area.

Action: Lou Patten

Primary Care
The following points were discussed:

- The development of Community Hubs, their location and the resources that would be used
- How services were going to be delivered closer to home for patients

5 DEVELOPING CARE IN THE COMMUNITY

Dr Tina Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust, Dr Martin Thornton, GR, Trinity Health and Carolyn Morrice, Chief Nurse attended the meeting to give a presentation on their vision for developing care closer to home. The full presentation can be found here.

Tina Kenny highlighted the following developments:

- The clinical evidence and patient feedback and the themes that had emerged
- Community Hub pilots to start from April 2017 which would see the introduction of locality integrated teams, rapid response intermediate care and community care coordinators

The Committee discussed the following points:

- The details of the community hubs were discussed including their locations and how they would work. It was confirmed that although the term 'hub' alluded to them being a physical entity, the hubs were in fact the combination of integrated teams working together to manage referrals, coordinate outpatient appointments, assessment clinics, rapid response in order to avoid hospital admissions and improve patient experience
- The importance of communications relating to the pilots and the services that would be offered, for example the messages to older people to understand that having contact with health professionals did not necessarily mean hospital or a care home
- The Committee discussed self-funders and how they would access the service. It was confirmed that assessments would be carried out in the same way they were now and would only depend on treatment or service required
- The Committee discussed community engagement and how this was achieved. Support from Healthwatch Bucks was offered

The Committee thanked colleagues for their informative update and asked that they provide a further update on progress on the pilots at the September HASC Select Committee meeting.

6 DATE AND TIME OF NEXT MEETING

There will be a special HASC meeting on Tuesday 14 March at 2pm to discuss and agree the Hospital Discharge Inquiry report.

The next Committee meeting will be on Tuesday 28 March at 10am. Both meetings will take place in the Large Dining Room, Judges Lodgings.

CHAIRMAN

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Buckinghamshire Health and Care System Plans

Louise Patten
Chief Officer, Aylesbury Vale and Chiltern Clinical Commissioning Groups

Agenda

1. Recap strategy and objectives

2. Key priorities for 2017/18

3. Examples of what this will mean for Bucks residents

Our strong record of achievement:

- **Better Healthcare in Bucks** – transformation programme to centralise A&E and emergency services
- **Stroke and Cardiac** - innovative model of care introduced at Wycombe Hospital
- **Redesigned emergency and urgent care** pathways
- **Nationally recognised innovation to transform primary care**
- **System-wide quality improvement** – aligned monitoring and governance, e.g. Looked After Children
- **Over 75s community nursing** – delivering 'upstream' care to prevent admission and shorten length of stay for our older population

Our Buckinghamshire System Plan

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To ensure the people of Buckinghamshire have happy and healthier lives, supported by a sustainable health and care system

To do this, we must work **as a system** to rebalance the health and social care spend by increasing support for living, ageing and staying well, and prevention and early intervention initiatives.

Our main area of transformation for the next two years is to achieve **joined up primary care and community based services**

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Our focus is to…

- **Improve** patient outcomes and experience
- Shift spend on bed-based care into **prevention and care at home**
- **Join up health and care services**, to reduce waste and duplication
- **Deliver cost and productivity improvements** by implementing best practice
- Provide urgent and emergency care in the **right place at the right time**
- **Use technology** for rapid access to advice, care and support

How our plans align:

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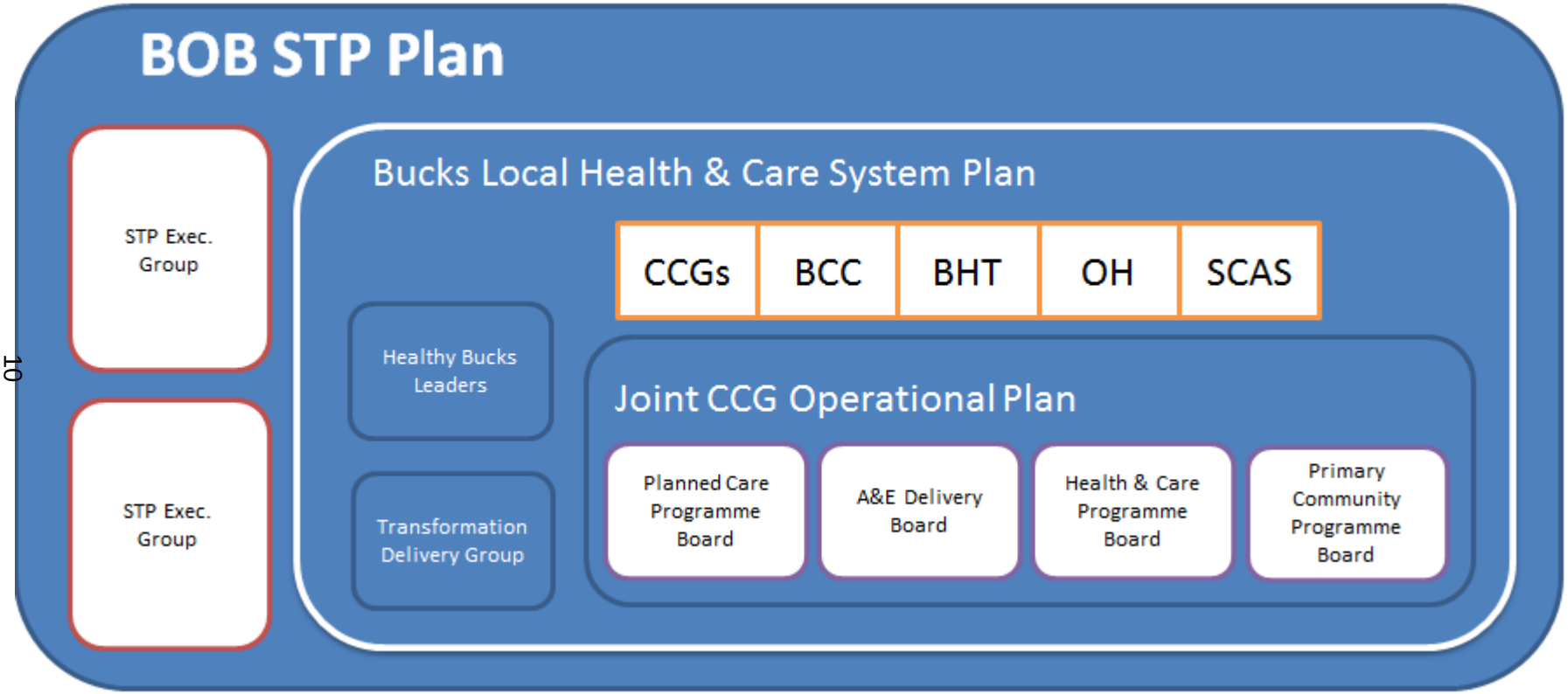

Key: CCGs – Clinical Commissioning Groups, BCC – Buckinghamshire County Council, BHT – Buckinghamshire Healthcare NHS Trust, OH – Oxford Health NHS Foundation Trust, SCAS – South Central Ambulance Service, BOB STP – Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan

Our shared challenges

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An ageing population

A growing population

New demands cost the NHS at least an extra £10bn a year

Evolving healthcare needs, such as the increase in obesity and diabetes

Our strategy:
We need to put care in the best place

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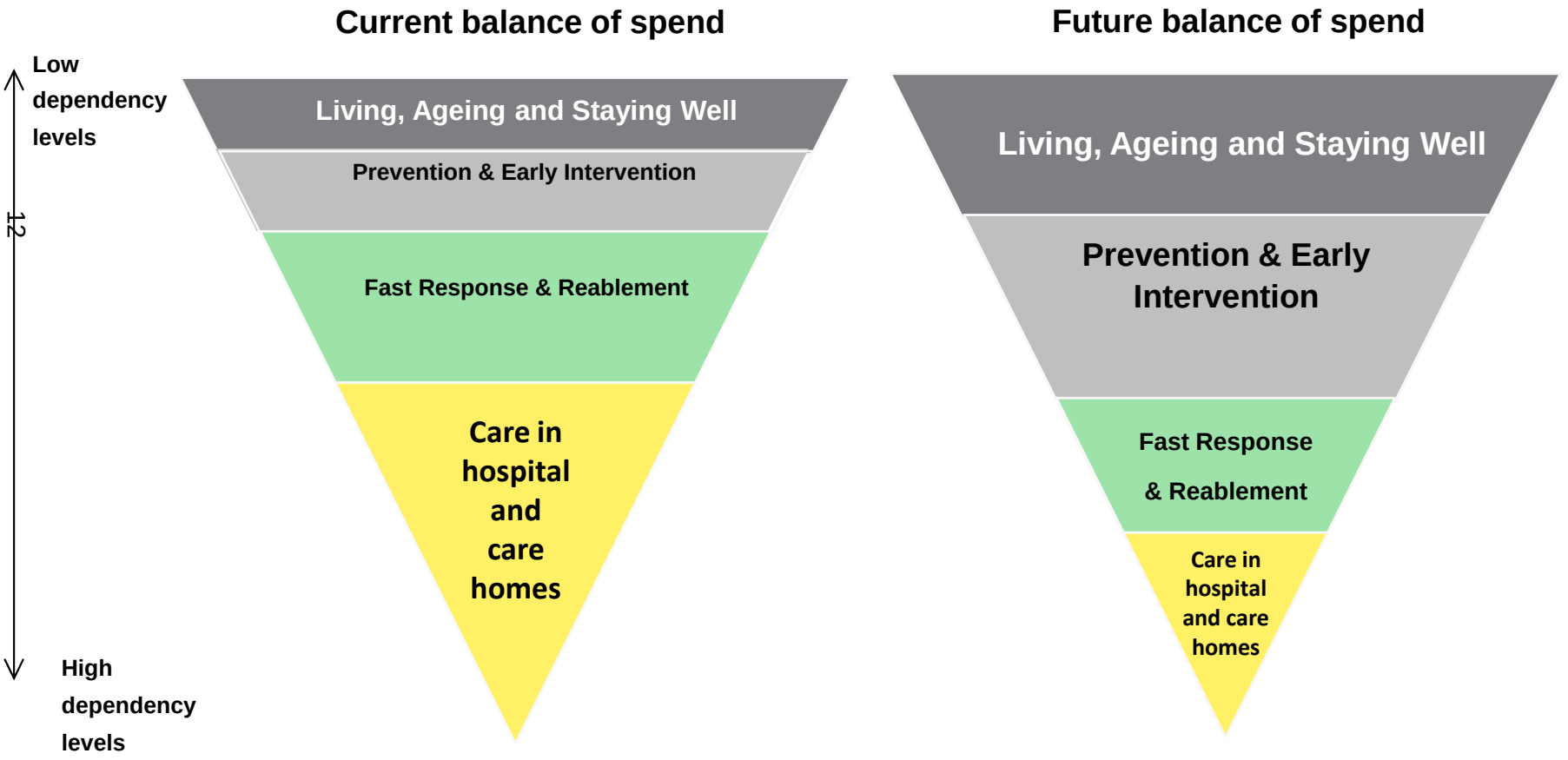
If we do nothing to meet these challenges, our costs will exceed our funding by about £107million over the next four years across the Buckinghamshire health system.



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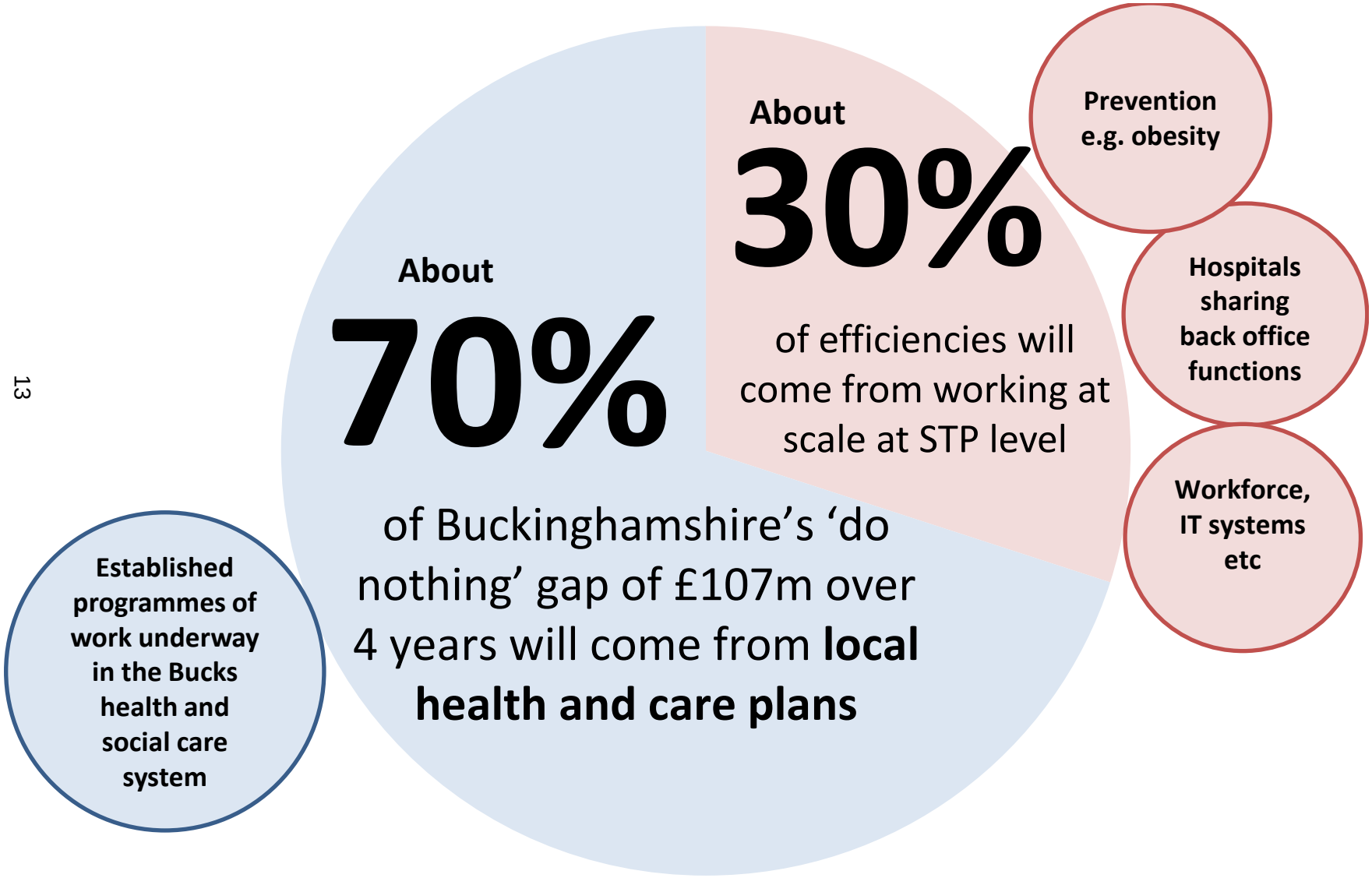

We have a strong track record in Bucks of improving outcomes & saving money

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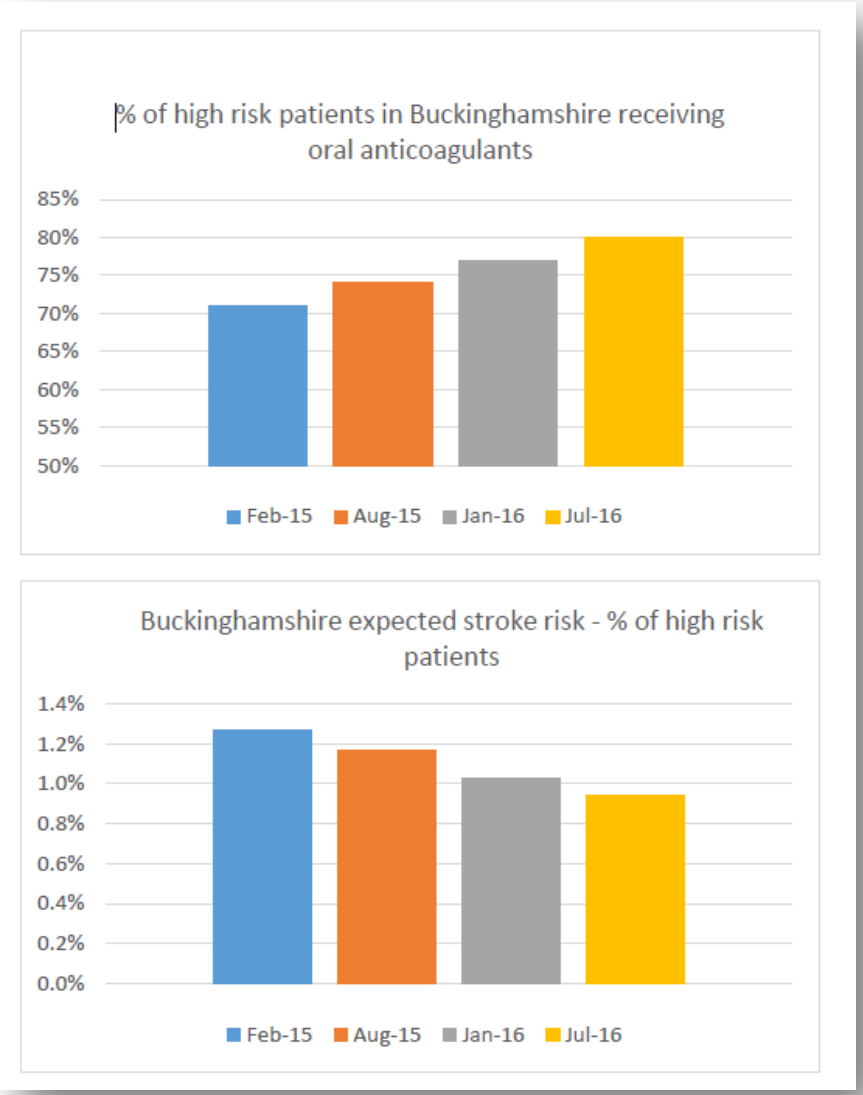
Atrial fibrillation project

(AF = irregular heart rate = much higher risk of stroke)

- Screening means **600 more high risk patients will get medicine** to help prevent blood clots
- **20 fewer strokes every year** (at a care cost of £25,000 per stroke)
- **Net savings of £220,000 a year for the local NHS** (plus long-term care savings)



Plans are based on feedback from public, patients and stakeholders:

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Key priorities 2017/18

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- **Prevention and self-care:** healthy lifestyles and Active Bucks
- **One Bucks Commissioning Team:** further developing joint health and care commissioning across NHS and the Council (adult and children's services, public health, mental health etc)
- **Key providers** are planning a formal alliance to deliver joined up care (FedBucks [GPs] + Oxford Health NHS Trust + Buckinghamshire Healthcare NHS Trust)
- **Continue investing** in rehabilitation and community services, so fewer people need hospital care
- Introducing better, simpler models of care for people with **diabetes and musculoskeletal problems** (back/neck/limb)
- **Stroke and cardiac treatment:** widen catchment, so Bucks patients don't have to travel to London; expanding services to Berkshire
- **Community Hubs:** piloting new ways of joining up health and care closer to home, tailored to the needs of local communities
- **One Public Estate:** six shared projects, using our property assets to provide better services and value to residents
- **Workforce:** increase apprenticeships for support workers, continue reducing agency spend, collaboration on temporary staffing contracts, investment in leadership
- **IT:** development of local digital roadmaps e.g. to share records across organisations

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Patient education

Moving care upstream

Prevention:

All health and care staff look out for early warning signs and give brief, evidence-based advice

- Obesity
- Blood pressure
- Falls etc

Earlier diagnosis:

Lung diseases

Heart failure

Diabetes etc

Symptom-based clinics

Effective primary care:

Reducing variations in treatment and care

Managing referrals

Community hubs: more tests & treatment locally, specialists in community

Avoiding hospital admissions:

Rapid intervention to avoid problems escalating

More services at/near home

Support in care homes e.g. video links to specialists

Effective, efficient hospital care:

Earlier discharge with effective support and follow-up care to avoid readmission

Reducing the inequality gap

Community Hubs: co-ordinating services & support

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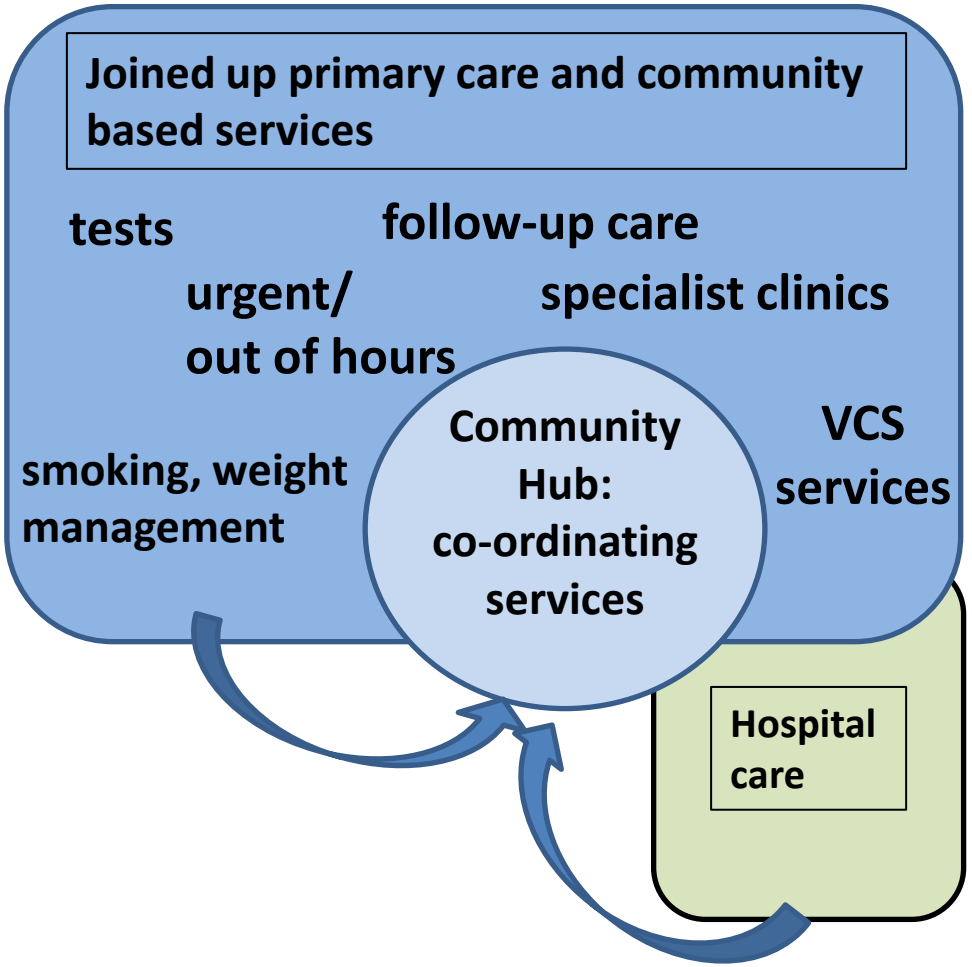
Community hubs will vary (services tailored to local population's needs)

Some services will be in a building, others may be virtual e.g. video outpatients, information and tools

All services co-ordinated across the area, to respond quickly to local patients' needs

Faster, easier access to hospital based specialist advice, through local appointments or video conferencing



A Buckinghamshire Primary & Acute Care System (PACS) in 2018

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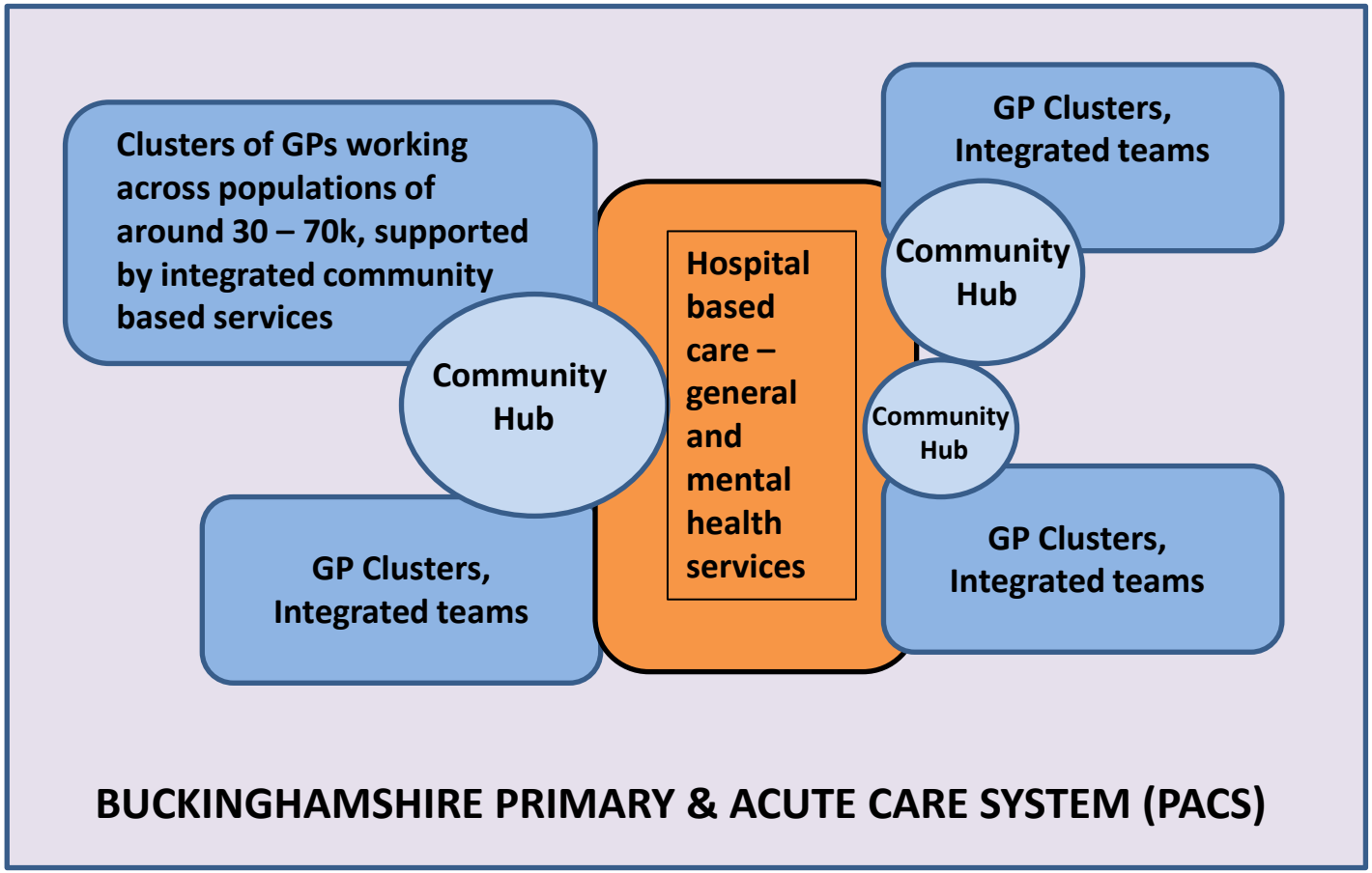
STP: commissioning at scale



Roadmap across the STP…

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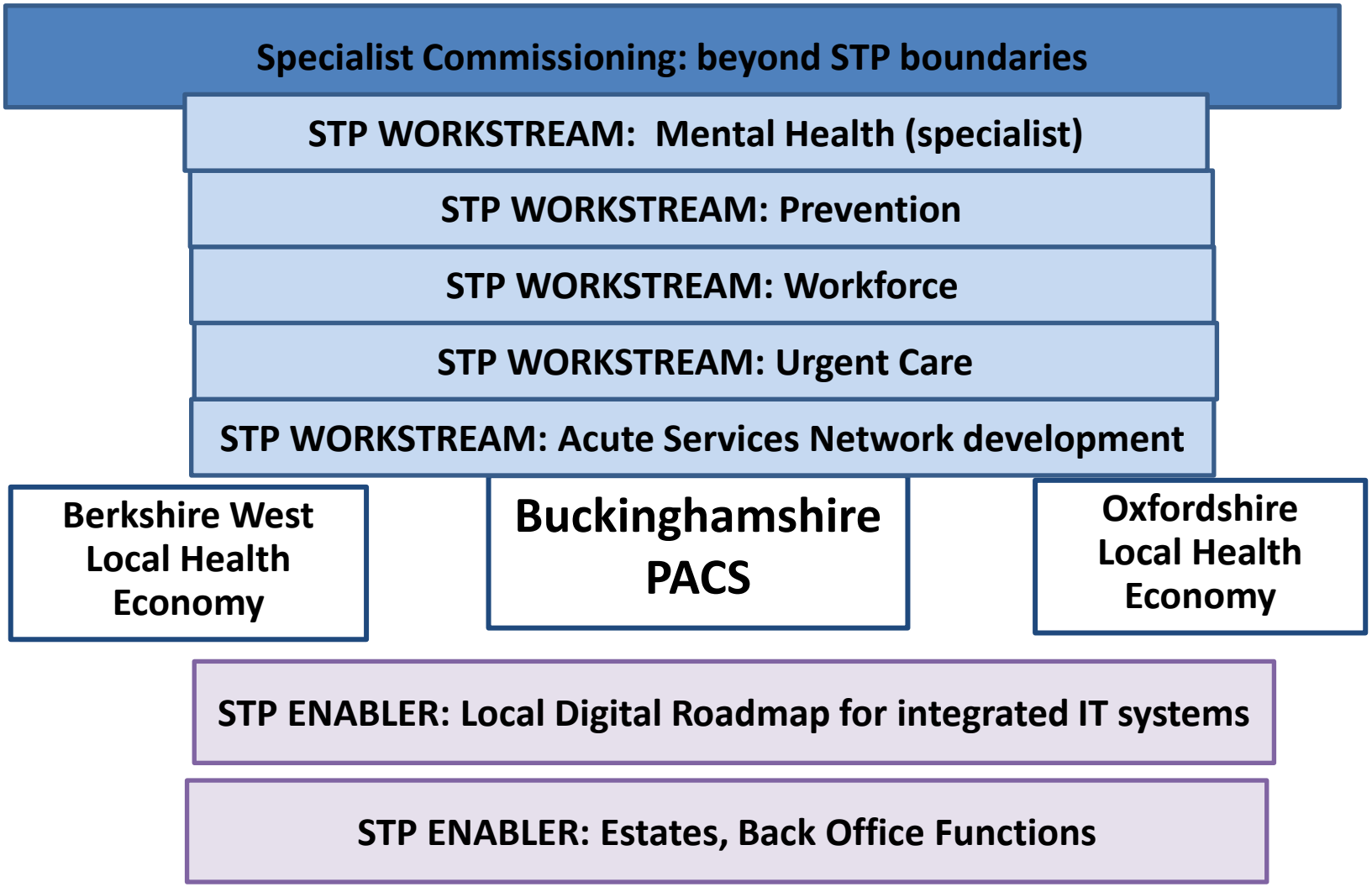

Case study: Complex health issues

- **Angela, 56, has asthma, diabetes and depression**
- **Lives with daughter Sue, but often home alone as Sue works shifts**

NOW

- Carers visit twice a day, but Angela only allows them to help with food prep and won't discuss her personal care
- Angela and Sue aren't sure who to contact about specific health issues e.g. worsening asthma, pain

They phone 999 for urgent advice and services

Angela has had several unplanned admissions to hospital

This has reduced her mobility

Case study: Complex health issues

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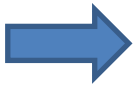
FUTURE

- Angela has a key worker from the **'integrated locality team'** based in the **community hub,** and working with local GP practice
- The team review her care 'package': medicines, equipment and specialist support to help manage her asthma and mental health
- They agree with the local pharmacy to 'blister pack' Angela's medicine to help her take the right dose, and make rescue packs of steroids available
- They also arrange a carer's assessment for Sue



Angela can manage her own health better, and feels more supported

She's less anxious and her pain levels are OK as she's taking her pills; she now allows care workers to help with her personal care

Instead of calling 999, Angela or Sue call her key worker to sort out appropriate support at home or in the local area

Angela makes fewer trips to A&E and doesn't end up in hospital. Sue no longer has to take time off work; she feels better knowing that her Mum can easily get help when she needs it

Case study: Frail older person

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When Ethel's husband Albert died, she thought it would mean giving up and moving into a home.

Ethel has arthritis and breathing difficulties, so Albert had done most of the housework, walked his beloved dog Jack and made sure Ethel took her pills and ate well.

Emma, a nurse, part of the integrated locality team, called in a few days after Albert died:

- Emma made sure Ethel's care needs were assessed and got her some benefits advice and home help
- The team assessed her treatment and made sure they understood what Ethel wanted out of life and how they could all work together to make it happen
- Emma even found a local charity which offered volunteer dog walking services
- **Now every day Ethel has a visitor who takes Jack and Ethel out for a walk, a trip to the shops or just for a cup of tea and a chat**

Case study: Prevention

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Mrs Smith is 75 and has a history of heart failure

NOW

- Multiple admissions to A&E for falls
- Eventually fractures her hip

Long hospital stay

Pressure ulcer

Institutionalised

Loss of confidence

Weakness

Long stay in rehab unit

Needs social care

NHS bill: £50k

Case study: Prevention

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Mrs Jones is 75 and has a history of heart failure

FUTURE

- Aware of her risk of falls and has considered home hazards through local falls campaign
- GP has optimised her medication for heart failure and educated her on falls
- Has been signposted to join local Simply Walks group and Active Bucks exercise class
- Tells friends about falls risks

Happy

Independent

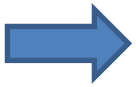
No falls

Case study: Community hubs - referrals

- **Robert, 68, has been referred to see a specialist for a respiratory problem**
- **Lives in Marlow**

NOW

- Travels to Stoke Mandeville Hospital for an appointment
- Has tests and is seen by the consultant



Robert takes his medication, as prescribed by his consultant

Robert takes no other action to improve his health

Robert's condition is managed only up to a point; he makes frequent visits to his GP for additional advice, support and reassurance

Case study: Community hubs - referrals

FUTURE

- Robert has an appointment at the local **community hub**
- While at the hub, Robert is able to talk to the 'Health Maker' – a volunteer from the local GP practice who has information on a variety of activities that might help him
- She is also able to put him in touch with a local support group

Robert has support as well as a diagnosis and feels well supported

He is seen locally, so avoids unnecessary travel

He makes connections with other people locally who have the same issues as him who are able to provide first hand advice and support

Robert takes control of managing his long term condition and so goes to the GP less often. His disease is better controlled so he is less likely to have a crisis as time goes on.

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Any questions?

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Your community, your care

Our vision for developing care closer to home

Dr Tina Kenny, Medical Director

Health and Adult Social Care Select Committee

21 February 2017

Buckinghamshire Healthcare NHS Trust

Our plans

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

Helping you to stay well

Through prevention and early-intervention we want to:

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

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Context

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

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What's happening now?

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

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What you told us

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

Themes

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

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

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What we're doing

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

Teams that will support frail older people …

Locality integrated teams
Integrated teams, which will include nurses, therapists and social workers, will provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions

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

Community care coordinator
This will provide GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients

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What we're doing – community hubs

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

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Patient story…

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

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

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

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

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How will we monitor the pilot?

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

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Over the next six months we will…

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

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Thank you

Any questions?

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

NHS
Buckinghamshire Healthcare
NHS Trust

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

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

Supporting you to stay well

Through prevention and early-intervention we want to:

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

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

What you have told us

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

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

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

What is happening now?

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

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

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

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

Why do we need to change?

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

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

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

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

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

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

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

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

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

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

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

Case study

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

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

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

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

Over the next six months we will:

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

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

Case study

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

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

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

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

How will we monitor the pilot?

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

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

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

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

Case study

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

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

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

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

Where can I find out more?

Visit www.buckshealthcare.nhs.uk/communityhubs

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

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