Health & Wellbeing Board
Buckinghamshire

Health and Social Care Integration Roadmap to 2020

1. Purpose of report

This report sets out the opportunities for Buckinghamshire County Council and the NHS to have more integrated working (between commissioners and providers of health services, public health and social care services and other council services) for the purposes of advancing the health and wellbeing of our residents and better managing demand.

2. National position

2.1 Sustainability and Transformation Plans

STP's articulate at a high level how local services will evolve and become sustainable over the next five years, contributing to the national 'Five Year Forward View' vision of better health, better patient care and improved NHS efficiency. STPs were announced in December 2015 as part of NHS planning guidance. There are 44 'footprint' areas for England each with a STP, a 'place based' plan. These draft plans were published in 2016 and are going through a process of assessment, engagement and further development.

2.2 Demand

Business intelligence reveals a growing and ageing population. Notably, a significant increase in the 85+ population which leads to rising pressures on health services, social care, informal care, supported housing and other services. Life expectancy is increasing, and time spent in ill health is rising as people are living longer in poor health, resulting in a growing number of people with high levels of complex need: most older people have more than one long term condition. Our current health and social care system, whilst it has made improvements, has failed to keep pace with the population's needs and expectations and is unsustainable. We face unprecedented constraints on funding and growing demand and therefore fundamental innovative changes in the design and delivery of care are needed. Integration offers an opportunity to redesign services around the needs of individuals, not organisations, and to make the best use of collective resources to manage demand more effectively.

2.3 Prevention, early intervention and care co-ordination

There is a longstanding ambition to shift more health care from hospitals to settings closer to people's homes and from reactive care to prevention and proactive models based on early intervention. By identifying risk factors to poor health and wellbeing early on, we can help people to help themselves by drawing on support in the community and by joining up local services to meet the needs of our diverse local population. However, to achieve these aims, health and social care services will need to be better co-ordinated around the individual, ensuring the right care is offered at the right time and in the right place. To support this, we will identify people with existing conditions to manage these safely with support in the community, and to co-ordinate care for those most at risk of hospital admission to keep them at home for longer. We also will create health and social care hubs that can provide a wealth of information, support and advice to support this aim to keep individuals and families healthy and well in their communities.

2.4 Collaboration and innovation

Given the rising demand on services and financial pressures all agencies are facing, there is a growing need to work together to improve performance and transform care. Whilst health and care professionals are committed to better integration, there can often be a perceived level of complexity and lack of clarity on what this means in practice which in turn reduces the pace of change. The Buckinghamshire system is developing, taking a strategic view with a set of agreed and shared outcomes and clear action plans to drive forward to reach a fully integrated care and health system by 2020/21.

3. Local position

Every health and care system across England has been asked to come together and create its own ambitious local blueprint for accelerating implementation of the NHS Five Year Forward View. As one of the 44 footprint areas, NHS organisations and local authorities across Buckinghamshire, Oxfordshire and Berkshire West (BOB) have come together and developed an STP to reduce the gaps in health and wellbeing, care and quality and finance. The STP umbrella provides transformational planning across all three areas. It is an opportunity to build on good practice, maximise opportunities, generate at scale efficiencies and avoid future costs.

The Health and Adult Social Care Select Committee and the Health and Wellbeing Board have had several discussions on STP progress in September and October. On 21 October the draft STP (2017 – 2020) was submitted to NHS England and throughout November and December public stakeholder engagement events were held. On 15 December the Health and Wellbeing Board discussed the STP and local delivery plans in detail, recognising some of the challenges and the need for better integration to advance the health and wellbeing of everyone within the footprint area.

Whilst we have made progress, we now need to move from planning to delivering our aspirations. Our current model of health and social care is in the main reactive, based upon provision of support when problems arise, creating a degree of dependency. Whilst there will always be a need to provide some level of reactive services, it is essential we shift our focus towards supporting our communities to stay healthy and well for longer, working at scale to generate new types of services and support that meet our community's needs.

4. Roadmap to 2020

In order for health and social care to become fully integrated, we must work collaboratively, with pace, to shift investment from reactive services to early intervention and preventative services, looking at the whole life cycle with particular focus on transition points. To support the next phase of development we have identified four closely interlinked areas of work (each underpinned by an action plan which is currently being reviewed by the Transformation Delivery Group).

1. Joint Commissioning
2. Integrated Provision
3. Back office (One Public Estate, Communications and Business intelligence)
4. Governance

4. 1 Key Area 1: Joint Commissioning

Joint commissioning must ensure that as a health and care system we invest in keeping people well and independent, creating the right incentives for providers to achieve these outcomes and stripping out duplication. It means working closely with communities, individuals and carers as partners in supporting people to stay healthy and independent. We need to optimise opportunities by having better alignment between health and social care; ensuring services are funded and commissioned with a whole life course approach. Commissioning has a key role to play including reshaping the way voluntary sector are funded to ensure a coordinated approach to developing and providing services. Jane Bowie, Director of Joint Commissioning, joined Buckinghamshire County Council in January and has a wealth of experience integrating health and care across both children's and adults services Work has already begun in aligning commissioning teams therefore it is anticipated further work will progress quickly. Outputs include developing a co-commissioning (health and social care) integration team and developing a commissioning vision (aligned with the STP and health and wellbeing strategy) which will use the best of all approaches from health and social care to deliver integrated provision.

4.2 Key area 2: Integrated Provision

Locality working and intermediate care are two critical aspects to focus on which will provide maximum outcomes for residents.

A simpler pathway through the health and social care system is needed so professionals and residents can navigate and access the right support at the right time. Transformation into place based planning (a locality model) where a multi-disciplinary team (primary care, social care, mental health, community health services, acute expertise, public health and the voluntary sector) deliver a seamless pathway of health and social care to a designated General Practice cluster population enables a more coordinated model of care with a common vision and purpose. With a thorough understanding of a community's health and care needs, resources can be pooled and services aligned to deliver improved quality care closer to people's homes, reducing reliance on the acute sector. The locality model takes a local assets based approach, ensuring access to local voluntary and community services in multi-functional community 'hubs', as well as considering the wider infrastructure implications. By streamlining and simplifying care pathways, providing better information, advice and signposting we will reduce dependence, promote self-management and increase resilience. Each locality team will be expected to identify those most in need, and those whose needs are rising, within its population and to work together to support them.

An important part of the new integrated locality model of care and ensuring there are appropriate care solutions in the community, is the transformation of our care home and domiciliary care sectors. Approximately 15% to 18% of emergency admissions into the hospital are from care homes and the length of stay for these people tends to be higher than for average admissions. In addition, people often enter care homes following a hospital admission, with individuals and their families losing confidence in their ability to regain their independence. Yet most people want to be cared for in their own homes and we know this is best for their wellbeing. This will require good partnerships with the care home sector and the domiciliary care market – with a presumption not to assess people's long-term care needs while they are in hospital. Intermediate care is the short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or

inappropriate admission to hospital or residential care. An intermediate care strategy with a strong re-ablement ethos will be the foundation of the integrated provider programme. At the centre of the locality model approach is care that is person-centred, focused on rehabilitation and delivered by a combination of professional groups.

Local NHS providers in Buckinghamshire have agreed to form a Primary and Acute Care System (PACS) as a vehicle to transform services to this new model of care firmly based around the patient in localities. Oxford Health NHS Foundation Trust (our NHS mental health provider), Buckinghamshire Healthcare NHS Trust (our NHS acute and community provider) and FedBucks (an organisation supporting 85% of GP practices in Buckinghamshire) are the partners in this provider alliance. The alliance has prioritised four areas of service transformation to break down barriers between professionals, organisations and care pathways; urgent care, frail elderly, diabetes and mental health. The PACS will be learning from similar PACS and Multi-specialty Community Providers across the country as it develops the locality model.

4.3 Key area 3: Back office

Developing coordinated back office systems could not only lead to enhanced service development but also enable significant efficiencies. This is widely becoming acknowledged and NHS Improvement has highlighted that back office bills can result in savings of £350m over the next four years. Greater Manchester, Kent, Essex and North West London have been chosen to become back office merger pathfinders. NHS providers in the wider Thames Valley region are working on areas such as procurement, human resources and joint financial systems to generate synergies and efficiency savings for the NHS.

Building on the development of a shared service for communications and engagement, work must now mature to ensure commonly agreed narratives, consistent messages, enhancing all digital opportunities and links to national campaigns.

One public estate (OPE) partnerships across the country have shown the value of working together across the public sector. Buckinghamshire has six projects as part of a current OPE application for the county. These projects demonstrate the benefit of a strategic and collaborative approach to asset management to maximise public buildings and resources enabling service transformation and savings on running costs.

Business Intelligence will help drive integrated care across health and social care both within and between organisations. Working together and sharing information will bring together the evidence base and intelligence to inform strategic planning. It will enable integrate systems allowing better data management where health and care professionals fully understand the needs of the population they serve. It will provide a platform for better analysis prompting early intervention campaigns and encourage everyone to use technology to manage their own wellbeing. Additionally, developing integrated IT systems across health and social care organisations will support patient centred care and enhance decision making. A first step along this journey has been linking GP practice systems so that the summary care records can be viewed across organisations. This has improved the visibility of the summary patient record to both health and social care staff.

Buckinghamshire will focus on supporting the development of the workforce to ensure we can continue to recruit and retain the highest quality staff to care for our patients and communities. A workforce group across the STP is developing a plan for support workers, focussing on leadership development and using the apprenticeship levy to its full extent to train and develop new skills in our workforce for the future.

4.4 Key area 4: Governance

Strong leadership, transparency, measurable outcomes and continued scrutiny are needed to drive through improvements to this shared agenda. In Buckinghamshire, the Health and Wellbeing Board will have oversight of progress, monitor key deliverables and system wide projects.

It is essential that all local (and border) plans align to the STP and joint health and well-being strategy. Clear accountability will be required to ensure there are no duplications and a streamlined governance framework is in place. It is important that there is full visibility in relation to the decision making process. Developing a streamlined and coherent governance framework will speed up decision making and create a positive environment within which commissioners collaborate and transformation is driven forward.

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