Your community
Your care
Developing Buckinghamshire together

Developing out of hospital care:
Update on community hubs pilot
April 2017 – August 2017

Contents

Glossary

Term	Explanation
CGA	Comprehensive geriatric assessments
Integrated urgent care service	The new Thames Valley integrated urgent care service will help people access a wide range of clinical care through a single call, including dental, pharmacy and mental health services, ensuring patients get the right care, first time.
Integrated locality teams	Teams of staff from a range of health and care organisations working together to support patients living in that locality
Locality	Geographical division of the county defined by the registered population of a number of GP practices
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.

1.0 Executive summary

Following extensive engagement during 2016 with patients, GPs, staff, other health and social care organisations, voluntary organisations and local communities, the community hubs pilot was launched in Marlow and Thame in April 2017 to develop and test our vision of providing more care closer to home. A paper and presentation was given at the Health and Adult Social Care Select Committee in March 2017 outlining the background and context to the pilot.

The aim of this paper is to:

- Share results and learning from the pilot to date
- Communicate our intention to extend the pilot for a further six months
- Outline our plans for next steps and developing the model in the future

How have we begun to develop out of hospital services?

During the pilot the community hubs have offered the following services:

- **Community assessment and treatment services** including a frailty assessment service where geriatricians, nurses, therapists and GPs provide expert assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission.
- Additional **diagnostic facilities** such as one-stop blood tests and x-rays.
- An extended range of **outpatient clinics.**
- Support from **voluntary organisations** such as Carers Bucks and Prevention Matters ranging from clinics, drop-in sessions and information stands.

To support this work we're also developing across the whole of Buckinghamshire:

- **Locality teams** comprising of nurses and therapists working 24/7 to provide cover to those needing the greatest health and support, linking in with GPs and social care as required.
- **Rapid response intermediate care** providing short-term packages of support helping people back to independence.
- **Community care coordinators** who provide a dedicated phone and email 'single point of access' for health and care staff to arrange specialist community services, joining up care between organisations.

How are patients benefitting?

- In total nearly **700 outpatient appointments** provided for people closer to home
- **275 people referred, assessed and treated** by the community assessment and treatment service
- **310 more patients** seen in the multidisciplinary assessment service (MUDAS)
- Over **1000 patient referrals** managed through the community care coordinator
- **2645 more care contacts** a month by our rapid response and intermediate care team

Feedback

- 100% of those patients who gave feedback would recommend the community assessment and treatment service.

- Whilst feedback has been generally very positive, some patients have fed back about transport and some have been unhappy about the amount of time they have had to wait to be seen in the clinic. There have also been suggestions on how the service could be improved. For example, the option of returning hospital

equipment to their local community hub rather than having to return it to Wycombe or Stoke Mandeville hospitals.

- There has been a range of communication and engagement activity to obtain feedback and promote the pilot. This has included successful open days at Marlow and Thame, each of which was attended by c.100 people and received very positive feedback from those who went along.
- A new stakeholder engagement group, made up of local representatives, has been a key critical friend. They have shaped the terms of reference for the group and have provided suggestions for how we can improve communication and engagement. The stakeholder engagement group has also shaped the key performance indicators against which we are measuring the pilot and are supporting the broader communication and engagement.

Key learning

- We have seen increasing levels of activity, people like the services on offer and the fact that it is helping them stay independent and out of hospital. There has been an increase in referrals to the frailty assessment service overall, for example at the multidisciplinary assessment service at Wycombe. However it is too early to draw conclusions from the statistical evidence as to the impact this has had on broader performance, for example attendance at A&E.
- We must continue to raise awareness of the hubs amongst GPs to increase referrals. Whilst we have seen steady increases, the capacity for the service has not been fully utilised and the pilot has run over holiday periods which has had some impact on referral rates for the community assessment and treatment service.
- It has taken longer than anticipated to set up some of the services, particularly in terms of outpatient clinics and voluntary service involvement and more time is required to fully mobilise and evaluate these aspects of the hubs.
- We need to continue to recruit staff to support the expansion of the services.
- Our stakeholder engagement group and clinicians have recommended to us that we assess the number of referrals and the impact on patients during the winter months, when we would expect to see increased activity across our services.

Proposed next steps

- On the recommendation of the stakeholder engagement group and limited statistical evidence to evaluate and draw conclusions from, we will extend the pilot for a further six months. This would enable us to mobilise a greater range of services, increase referrals to existing services and assess the impact on referrals over the winter months.
- We will undertake a second wave of patient, public, staff and GP engagement over the next three months. We will discuss the learnings from the pilot to date with stakeholders in Marlow and Thame. In other localities, such as in Buckingham and the Chalfonts, where we have community hospital sites, as well as Wycombe and Aylesbury, we will be seeking feedback on how we could deliver more out of hospital care, building on the involvement sessions we held in 2016. We will share the learning from the pilot sites and explore what would work in other locations to best meet local needs. This engagement will inform the final proposal.
- We will continue to roll out the model for out of hospital care and community hubs across the county particularly those where we have obvious facilities in our community hospitals:
    - We plan to open up access to Amersham, Chalfont and Buckingham to our voluntary sector colleagues to enhance the offer to these localities and will continue to expand on the offer at Thame and Marlow.
    - We are also proposing to look at what other outpatient clinics can be delivered within our Amersham, Chalfont and Buckingham sites and continue to expand the outpatient offer at Thame and Marlow. This will include children's services and more chemotherapy.

2.0 Developing out of hospital care: what we have done

In line with the Five Year Forward View, our vision is to provide more care closer to home with care delivered out of hospital and in local communities, which is what our patients and clinicians have told us is important to them.

Through prevention and early-invention we want to:

- Help people to take greater control over their care and treatment.
- Ensure we meet long-term needs to help people to stay independent.
- Make it easier for people to access the right services by working more closely with GPs and other providers to join-up care and support, reducing duplication and making better use of new technologies.
- Provide a model which results in better outcomes for our patients and communities.

The idea for community hubs was formed following engagement with patients and the public in 2016. To best understand what will work for our communities, our clinicians wanted to test some of their ideas before we finalise our plans or propose permanent changes. In April 2017 we launched two community hub pilots in Marlow and Thame, towns where we already have strong community bases.

Since April 2017, and taking on board feedback from patients and other key stakeholders, we have been working on a range of service improvements in the hubs and to other out of hospital services offered across the county. £1m is being invested in expanding our community services, with an emphasis on older people and those with long-term conditions.

2.1 Locality integrated teams

As part of our investment, our adult community healthcare team (ACHT) have continued to provide 24/7 cover, working with the rapid response intermediate care team to support people to stay at home and avoid hospital admission or to provide a personalised short-term care package to help them back to independence following a stay in hospital.

In addition, we have been working with GPs and other provider organisations across Buckinghamshire to develop a blueprint that will bring together community and practice nurses, social workers, mental health staff, GPs, other health professionals and relevant voluntary organisations as multidisciplinary teams serving clusters of 1-3 GP practices, and their associated care homes, covering populations of 30-50,000 patients. They will provide a personalised plan of joined-up care and support to meet the patient's holistic needs (physical health, social care and mental health) to enable them to remain independent for as long as possible. This is building on the CCG's work on the over 75s project and the Wycombe locality integrated team that has been running for almost two years.

The new locality teams will have attached members working across clusters such as specialist nurses, rapid response and intermediate care and paramedics. As a result patients will receive better, more coordinated care in their homes. The 'blueprint' for these teams is in development with pilot areas being considered to start in the autumn.

Since April 2017, 119,842 patient visits have been undertaken by the adult community healthcare team.

2.2 Rapid response and intermediate care service (RRICS)

A component of the community hubs pilot has been to treat more people at home with appropriate support and thus negate the need for community inpatient beds. The rapid response and intermediate care service has therefore been expanded to ensure adequate and integrated support for people at home. Therapists, nurses and healthcare assistants are now working as one countywide team with staff located geographically across the county and attached to locality integrated teams. The service provides short-term packages of support based on

clinical need (up to three times a day for up to six weeks) to those who would benefit from rehabilitation to help them get back to their level of independence. The service is available 8am – 9pm, seven days a week and is accessed through the single point of access.

Since April 2017, 29,021 patient visits have been undertaken by the rapid response and intermediate care service.

2.3 Community care coordinator team

To support both of these initiatives, and to provide a general single point of access to community services, a **community care coordinator team** has been established. This will provide GPs, hospital clinicians and other health and social care staff with a 'single point of access' phone and email to organise specialist community services for their patients, including district nursing, rapid response & intermediate care and community physiotherapy. By making it easier to access community services, we aim to help hospital admissions and avoid the delays to discharge that keep people in hospital for longer than they need to be. The service operates 8am – 5pm weekdays and 8am – 4pm weekends and bank holidays and will eventually operate 8am - 8pm 7 days a week once we have recruited the relevant staff. This service is aligning with the new integrated urgent care service across Thames Valley and will continue to grow and expand the range of services it can access.

Since April 2017, the community care coordinator team has received 2124 referrals.

2.4 Community hubs

Two hubs were established at Thame and Marlow community hospitals. They are providing a local base for community staff and help patients to access multidisciplinary rapid assessments and treatment including domiciliary visits, prevention services, primary care services (as appropriate) and hospital services (such as outpatient appointments, wound care, routine catheter changes for those who are not house bound or diagnostic testing) that people may have previously had to travel to.

- **698 outpatients appointments have taken place at Marlow and Thame.**
- **275 people have been referred, assessed and treated at the assessment service.**
- **310 more patients were seen at multidisciplinary assessment services (MUDAS) at Wycombe hospital during the duration of this pilot.**
- **2645 more rapid response & intermediate care contacts a month have taken place and an additional 13 staff have been recruited.**

The community assessment and treatment services offer includes a frailty assessment service where a multi-professional team of geriatrician consultants, nurses, therapists, paramedics and GPs provide expert assessment, undertake tests and agree a treatment plan with patients helping frail older people to stay at home and avoid an A&E visit or hospital admissions. This is similar to the model already operated by the multidisciplinary assessment services. The pilot has resulted in an increase in referrals to both services.

The table below shows the new services that have begun to be offered from the community hub pilot sites in the last six months and those services still in development.

	Outpatient clinics	Voluntary sector services	Assessment and diagnostics
Marlow	• orthopaedics • general surgery • surgery – plastics • chemotherapy and Macmillan • IAPT (psychological therapies) • Parkinson's disease • routine catheter changes	• Carers Bucks staff offering support and linking with NHS staff • Prevention Matters • Healthy Minds (IAPT)	• community assessment and treatment service (CATS). Patient's care is provided by geriatrician, nurse, GP, occupational therapist and physiotherapist. Domiciliary visits are also arranged to keep patients at home • comprehensive geriatric assessment (details in Appendix B) • additional day of plain film x-ray (3 days a week) • point of care blood testing to enable immediate results to support decision making (details in Appendix B).
	In Development		
	• *women and children* • *long term conditions management support* • *wound management*	• *Citizens Advice Bureau* • *Alzheimer's Society*	• *ultrasound service*
Thame	• general surgery • orthopaedics • care of the elderly • IAPT (psychological therapies) • plastic surgery • long term condition management support • falls assessment clinic & care of the elderly	• Carers Oxford staff offering support and linking with NHS staff • Prevention Matters • Health Minds (IAPT)	• community assessment and treatment service (CATS). Patient's care is provided by geriatrician, nurse, GP, occupational therapist and physiotherapist. Domiciliary visits are also arranged to assess and arrange care to keep patients at home • comprehensive geriatric assessment (details in Appendix B) • Point of care blood testing to enable immediate results to support decision making (details in Appendix B).
	In Development		
	• *chemotherapy* • *routine catheter changes* • *wound management* • *oral and maxillofacial outpatient clinics*	• *Alzheimer's society* • *Citizens Advice Bureau*	• *ultrasound service /x-ray*

Stakeholder involvement
To ensure we could respond quickly to patient and stakeholder feedback about the pilot we established a number of mechanisms to make certain the pilot is robust, new models of care are being properly tested and any issues or ideas for improvement could be implemented quickly. This includes quantative and qualitative research with patients, staff and GPs – both on an informal and formal basis. In addition we have been raising awareness of the pilot through traditional and social media, attendance at community events such as the Thame community market, presentations to interested groups such as the Buckinghamshire Older People Action Group along with successful open days at Marlow and Thame.

A key initiative has been to establish a stakeholder engagement group, which is chaired by our chief nurse and director of communications. Comprising of representatives from Healthwatch, Marlow and Thame League of Friends, Thame and District Day Centre, HASC, Marlow and Thame town councils and patient participation groups of local practices, the stakeholder engagement group acts as critical friend to the pilot, helping us to review how the new services are working and performing against key indicators, as well as helping us to shape how we can engage and involve people in the ongoing development (membership and terms of reference can be found in Appendix A).

This group has been key in helping us to raise awareness of the pilot at a very local level. They have made important recommendations to the governance group and the Trust's executive management committee which are shaping the pilot, including increasing outpatient clinics, more in-depth patient surveys and follow-up calls from clinicians to GPs to seek feedback and improve the coordination of care. This group has added significant value to the pilot, providing a range of perspectives as the pilot has progressed.

Most significantly the stakeholder engagement group has recommended that we should extend the pilot by a further six months to enable us to mobilise a greater range of services, increase the number of referrals and assess the impact on patients during the winter months when we would expect to see increased activity.

Clinical staff from the community teams have also been working with GP colleagues at individual practices to help them identify patients who might benefit from the new services (particularly the community assessment and treatment services element) to increase referrals and ensure that the services are being fully used.

This wide involvement has enabled the model of care to change during the pilot. For example we are bringing more outpatient services on stream with chemotherapy introduced at Marlow in August and we are looking at the possibility of being able to offer ultrasound facilities at Thame.

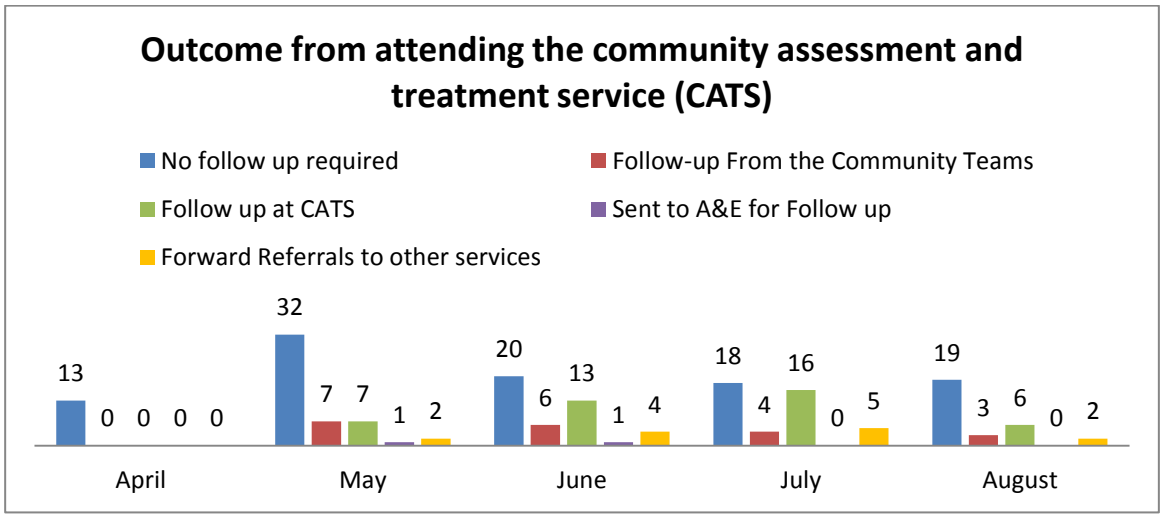
3. How have we improved patient care?

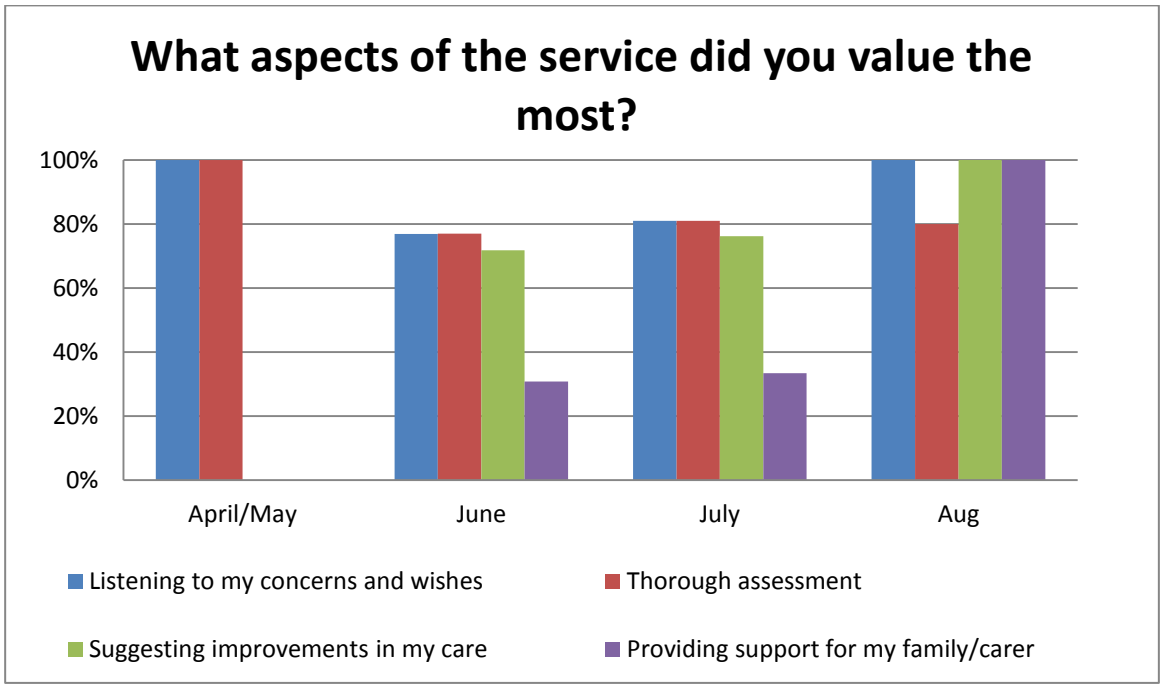
Improving patient care is at the core of what we are trying to deliver. The pilot has allowed us to closely monitor how well things are working – responding and adapting quickly as necessary. Day to day monitoring of the pilot is managed by the operational group which meets on a weekly basis. Recommendations from the operational group and the stakeholder engagement group are fed into the monthly governance group which is comprised of GPs, social care and clinicians and is chaired by the medical director, Dr Tina Kenny. Combined feedback and recommendations from these three groups are presented to the Trust's executive management committee.

To ensure the pilot has been properly evaluated a range of key performance indicators has been developed (see Appendix B) shaped by the governance and stakeholder groups described above.

By piloting these developments we are building a better understanding of what works for these communities. The triage system offered by senior clinicians is enabling patients to get the appropriate care in the right setting either from the locality integrated team, rapid response and intermediate care service, community assessment and treatment service or multidisciplinary assessment service (MUDAS), without the need for unnecessary A&E attendance or admissions. More joined up work on managing long-term illness is in development especially for

those patients who are not house bound. Whilst it is too early to draw any statistical conclusions on the hubs pilot, the numbers of patients accessing services locally have significantly increased and patient feedback has been very positive.





5. Next steps

The evidence we have gathered from quantitative analysis as well as from the patients, staff and stakeholder engagement group demonstrates that the development of community hubs is starting to make a difference.

We will continue to iterate the model, ensuring we have services in place locally that meet local needs and reflect the diversity of our towns and villages. We propose to undertake a second wave of public engagement to support the development of the model in Marlow and Thame and continue the dialogue with communities in other towns where we have community hospital sites (Buckingham and the Chalfonts) as well as in the main towns of Wycombe and Aylesbury. During October to December there will be a series of workshops with staff, GPs, people who have used the services at the hubs during the pilot to date and the wider public. All the events

will be supported by clinical staff and use an appreciative inquiry methodology that enables us to work with people to understand what is working well and what further improvements could be made to the model of care.

Given the early indications that the model is working we plan to continue the pilots in Marlow and Thame for another six months, as recommended by the stakeholder engagement group, to enable the changes to embed in the local system and for additional clinics and voluntary sector support to be introduced. We also plan to start rolling out the model to other areas, particularly those where we have existing facilities in our community hospitals and at Wycombe and Stoke Mandeville hospitals.

Voluntary sector involvement
We continue to identify and explore opportunities to work with voluntary sector partners in the hubs. As awareness of the pilot has grown, we have been approached by voluntary organisations across the county and so are beginning to discuss potential opportunities for collaboration in our other sites as well as at Thame and Marlow. We will use our second phase engagement as an opportunity to build relationships and contacts within local communities.

Outpatients
We are actively working with our clinical teams to identify further outpatient clinics that can be delivered within our Amersham, Chalfont and Buckingham sites and continue to expand on the offer at Thame and Marlow. Each of our clinical divisions has been asked to review and identify the services they could provide in local communities. We are also exploring the possibility of offering video-links from community sites to our main hospitals to offer virtual clinics, this is something we will test with patients in our second phase of engagement.

General practice hubs
As part of our strategy to work more closely with primary care, Buckinghamshire Healthcare NHS Trust is exploring with partners how primary care can be provided at Wycombe Hospital alongside the minor injuries and illnesses unit and the multidisciplinary assessment services already in place.

Integrated teams
GPs are coming together into clusters to cover a population of 30,000 – 50,000 patients. This does not mean that practices are merging but is a way that groups of GPs can work better with our integrated teams to meet the needs of their local population. Once the GP clusters have been established, the integrated teams will be aligned accordingly over the next six months.

We will review our KPIs, setting benchmarks where there are currently none to ensure that we have robust statistical data to help inform our decisions. The extension of the pilot, the strengthened KPI benchmarking and the second phase engagement will inform the final proposal.

Timeline:

Oct – Dec 2017: second phase of public, patient, staff and GP engagement
Jan – Feb 2018: evaluation of pilot, evaluation of engagement and the development of the final proposal
March 2018: final proposal presented

6. Conclusion

- The pilots have increased in activity over the 5 month period to date for both outpatients and the community assessment and treatment service.
- 100% of respondents have stated via the patient survey that they would be extremely likely or likely to recommend service, however we had some feedback on transport and waiting around that we need to review.
- The capacity for the services has not been fully utilised and the pilot has run over holiday periods which has had some impact on referral rates.
- Mobilisation particularly for outpatients and voluntary service involvement has taken longer than anticipated and more time is required to fully mobilise these aspects of the hubs.
- We have not required transitional care beds during the pilot to date.
- Stakeholder engagement has been very positive and our stakeholder engagement group has recommended that we extend the pilot for a further 6 months to enable us to mobilise a greater range of services and to see what impact the winter months have on the service model, before a final proposal is concluded.

7. Appendices

Appendix A Terms of reference for the stakeholder engagement group

Appendix B Key performance indicators and patient feedback

Appendix A Terms of reference for the stakeholder engagement group

Community hubs pilot: stakeholder engagement group

There are different elements to the pilot phase:

- Implementation
- Operational monitoring and review
- Stakeholder engagement – learning from the pilots and planning for the future

This document sets out the approach to wider stakeholder engagement during the pilot phase, through the establishment of a task and finish group to last the duration of the pilot period.

1. Purpose

The purpose of stakeholder engagement is to ensure experiences and feedback from patients, carers, service users and the public inform the development of community hubs so that they evolve in line with the needs of local residents.

To enable this we will establish a task and finish group to:

- Provide a mechanism for feedback from communities back to BHT
- Be a forum where members can share analysed patient experience, make recommendations to the operational group on improvements to the delivery of the pilots and to inform the design and delivery of future community hubs across the county and track actions to ensure they have been taken into account
- Be a critical friend to BHT throughout the development of community hubs, providing a forum for discussing updates and proposed new developments
- Inform wider engagement opportunities and support communications and engagement activities within local communities

2. Membership

The group will be chaired by Carolyn Morrice, Chief Nurse and deputised by Lee Jones, Director of Communications. A nominated representative from the operational group will also attend and provide a link between the two groups.
External members will include representatives from:

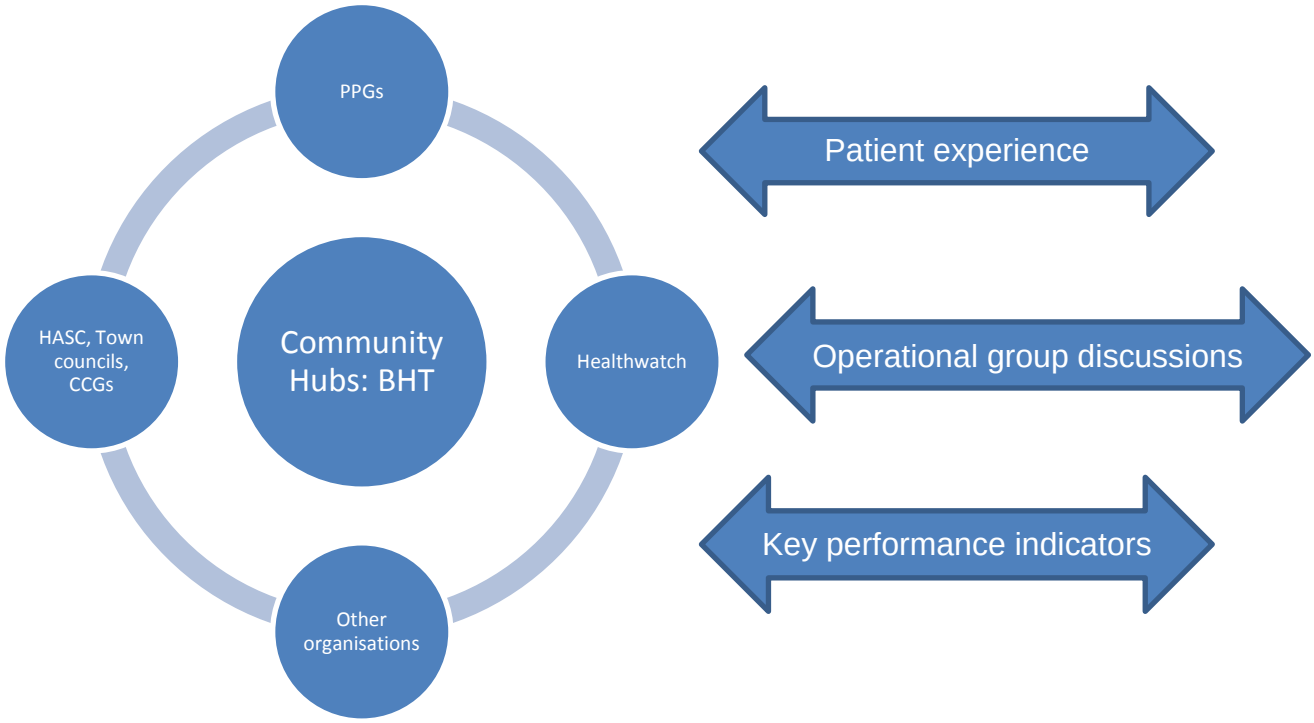
- Healthwatch Bucks and Healthwatch Oxfordshire
- League of Friends of Marlow and Thame community hospitals
- Carers Bucks
- Thame and district day centre
- Patient Participation Groups of local practices
- Health and Adult Social Care Select Committee
- Town councils in Marlow and Thame

In the first instance, one representative will be sought from each organisation. However, this could expand if the group find it to be necessary.
For a meeting to be quorate the chair or deputy, a representative from the operational group and a minimum of four external organisations will be in attendance.

3. Information to the group

It is proposed that this group will receive information on both key performance indicators (KPIs) (quantitative data) and patient experience (qualitative data). The KPIs will be provided by the BHT operational group. In addition the representative from the operational group will be able to share feedback from GP users of the services.
The patient experience data will be collected through a variety of means:

- Direct correspondence to BHT (PALS, complaints, dedicated email)
- Independent short survey to all users of the hub
- Targeted public feedback independently sought and reported
- Open days and events at the hubs



4. Ongoing engagement

This group will support the design of further engagement on the development of community hubs and community services more generally across the county.
It is proposed that in the first instance the wider GP community are engaged via their existing locality meetings with the lead executive from BHT who regularly attends.
The ongoing engagement along with the evidence and feedback from the pilot will help to inform and shape the final proposals for community hubs across the county.

5. Meeting logistics

Meetings will be held every six weeks during the pilot period. Meetings will last 2 hours. All papers, KPIs and other information and notes of the meetings will be circulated to all those present for onward distribution as appropriate and published on the BHT website once agreed.

6. Meeting protocol

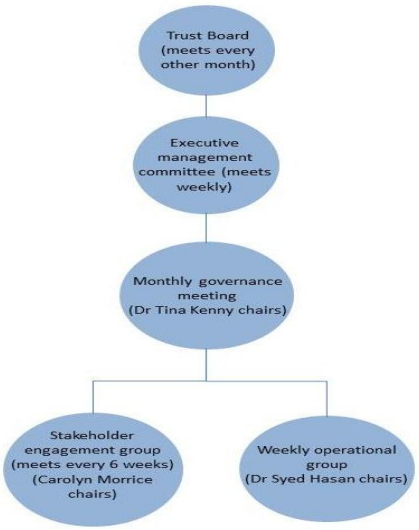
There will be clarity about the purpose of the meetings with papers circulated in advance (at least 5 days). Everyone should have the opportunity to make a contribution and put their views forward which should be as representative as possible of the groups they speak for. All members will be expected to trust, listen, respect, be flexible and focussed to create a meeting environment which is conducive to productive partnership working.

7. Decision-making, reporting and governance

The stakeholder engagement group is advisory to the Trust and does not have formal decision-making authority.
The group will feedback and make recommendations that will report into any of the following:

- Recommended for immediate consideration by the operational group
- Recorded for future consideration as part of the evaluation of the pilot
- Agreed further action by the stakeholder engagement group

Feedback and recommendations will be passed on to the weekly operational meetings and the monthly governance meetings. Feedback from the weekly operational meetings and the monthly governance meetings will also be passed on to the stakeholder engagement group. Combined feedback and recommendations from these three groups will be passed on to the executive management committee.



Lee Jones
Director of communications

Appendix B Key performance indicators and patient feedback

- As of 31st August, there have been a total of 275 patients seen by the community assessment and treatment service since commencement. However an extra 310 people per month have been seen by the multidisciplinary assessment service (MUDAS) at Wycombe Hospital during this time. 46 domiciliary visits have been undertaken by community assessment and treatment service therapy staff.

- Activity has increased slightly for the community assessment and treatment service during August but the outpatient activity reduced.

Community hub indicators

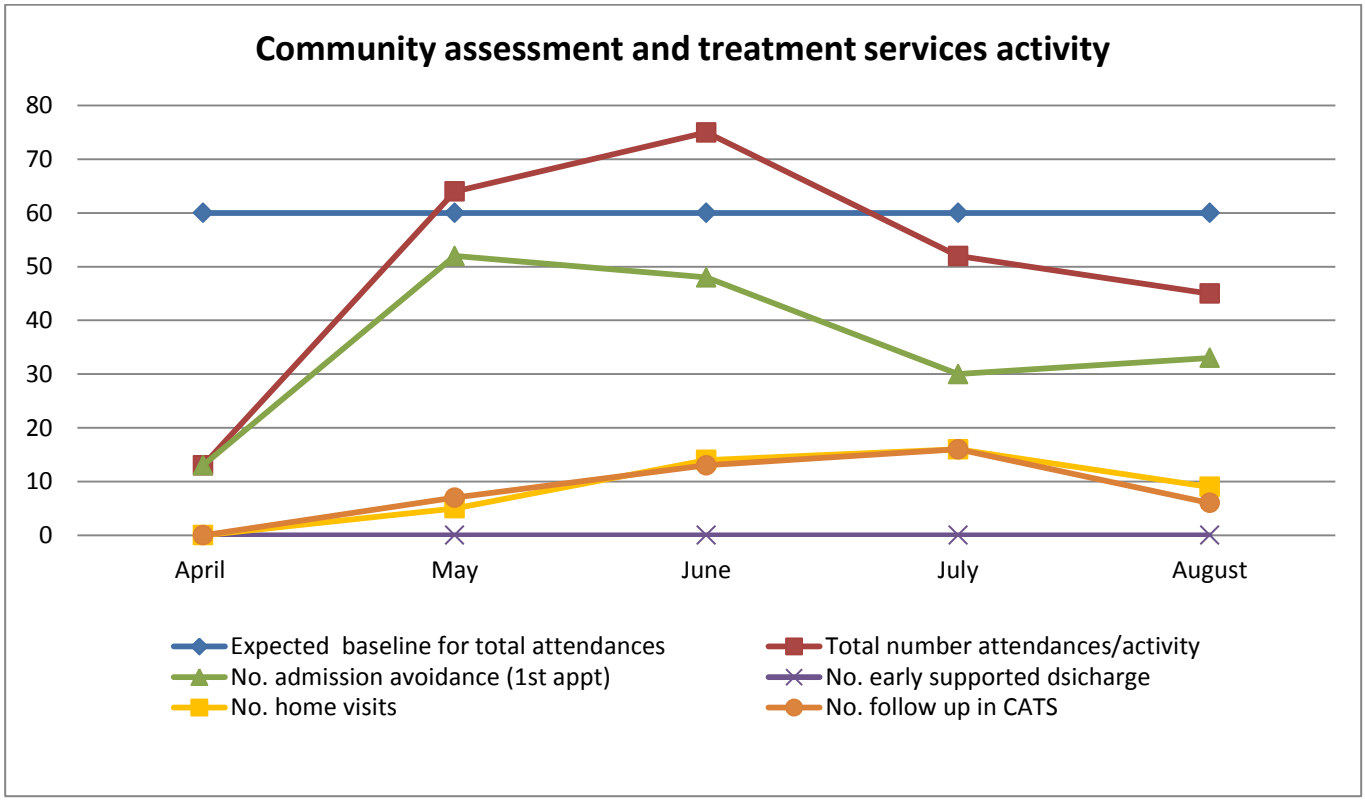
Measure	Baseline	Expected improvement	April	May	June	July	Aug
Number of patients accessing outpatients at community sites (across both sites)	**83 /month**	**167 / month**	83	140	175	152	148
Number of patients accessing outpatients at community sites (Marlow)			31	79	68	58	69
Number of patients accessing outpatients at community sites (Thame)			52	61	101	94	79
Number patients seen in community assessment and treatment service across both sites (1st appointments and follow up incl dom visits)	**No Baseline**	**60 per month**	13	64	75	58	65
Number of patients seen in community assessment and treatment service (Marlow)					37	29	35
Number of patients seen in community assessment and treatment service (Thame)					38	29	30
Number people seen in community assessment and treatment service as admission avoidance MUDAS (1st appointments)	**125**		111	202	224	202	196
Number people seen in community assessment and treatment service as admission avoidance across both sites (1st appointments)	**No Baseline**	**Monitor**	13	52	48	30	40
Number people seen in community assessment and treatment service as admission avoidance (1st appointments Marlow)					24	19	18
Number people seen in community assessment and treatment service as admission avoidance (1st appointments Thame)					24	11	22
Number people seen in community assessment and treatment service as early supported discharge across both sites (1st appointments)	**No Baseline**	**Monitor**	0	0	0	0	0
Number people seen in community assessment and treatment service as early supported discharge (1st appointments Marlow))					0	0	0
Number people seen in community assessment and treatment service as early supported discharge (1st appointments Thame)					0	0	0

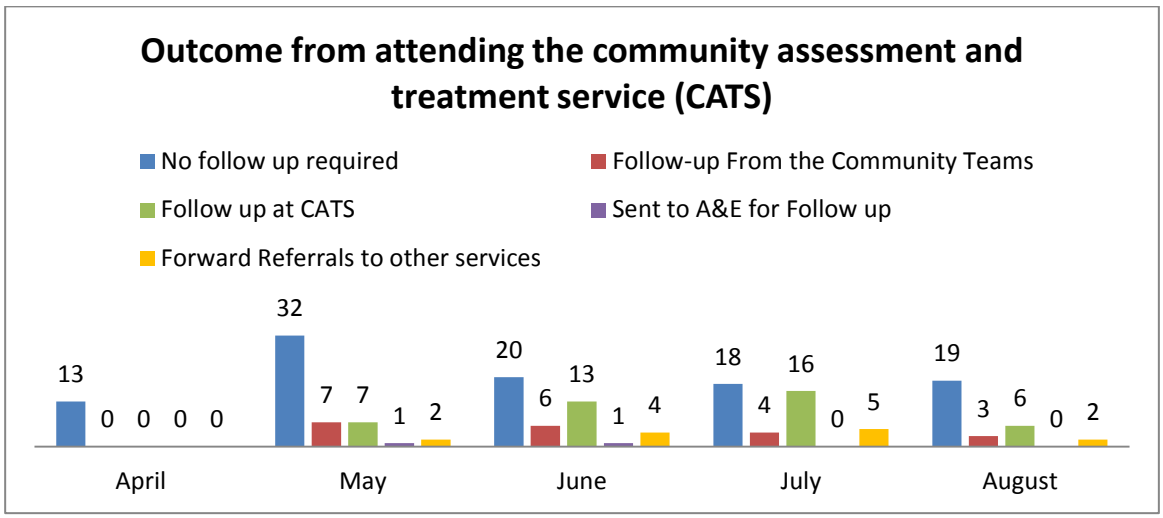
Number of domiciliary visits from community assessment and treatment service across both sites	**No Baseline**	**Monitor**	0	5	14	16	11
Outcomes from community assessment and treatment service – Number of people discharged home – no follow up required (across both sites)	**No Baseline**	**Monitor**	13	32	20	18	25
Outcomes from community assessment and treatment service– Number of people discharged home – Follow up required from community teams (across both sites)	**No Baseline**	**Monitor**	0	7	6	4	4
Outcomes from community assessment and treatment service– Number of people discharged home – Follow up required from the community assessment and treatment service (across both sites)	**No Baseline**	**Monitor**	0	4	11	16	10
Outcomes from community assessment and treatment service - Number of people sent to A&E (across both sites)	**No Baseline**	**Monitor**	0	1	1	0	0
Outcomes from community assessment and treatment service - Number of people referred onto other services (across both sites)	**No Baseline**	**Monitor**	0	2	4	5	3
Number of patients over 75 seen within community assessment and treatment service after 28 days discharge from SMH (across both sites)	**No Baseline**	**Monitor**	1	2	2	3	3
Community assessment and treatment seam. Patient related experience measures (across both sites)	**No Baseline**	**% Rating community services as good or excellent**		100% (30 patients)	100% (50 patients)	100% (18 patients)	100% (32 Patients)
Community assessment and treatment service friends and family measures (across both sites)	**No Baseline**	**% extremely likely or likely to recommend service**		100% (30 patients)	96% (50 patients)	100% (18 patients)	93.3% (34 patients)
Number of patients on waiting list for Community Hospital all sites (as of last day of the month)	**No Baseline**	**Monitor and reduce**		30	12	17	17

Community county wide services indicators

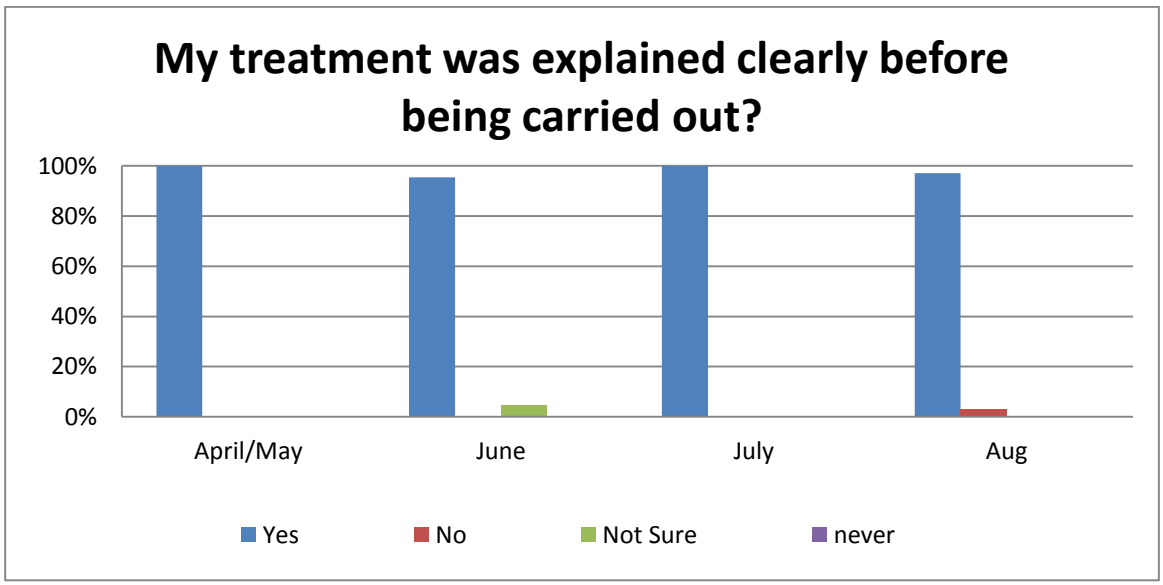
Measure	**Baseline**	**Expected improvement**	**April**	**May**	**June**	**July**	**August**
Number of admissions avoided (adult community healthcare team & rapid response and intermediate care team)	**800/month**	**850/month**	805	935	1020	971	897
Number referrals managed through community care coordinator (Note: tbc if roll out for CCCT commences yet to GPs for DN referrals as GPs may refer within the integrated teams)	**500 referrals/ month not including GP referrals**	**Expect to achieve baseline as roll out to all areas**	137	305	398	499	575
Rapid response intermediate care & therapy face to face contacts (Note: expected improvement includes additional 8700 above baseline)	**7900 FTF/ month**	**16600 FTF/ month as staff recruited**	8779	9718	10475	10155	11424

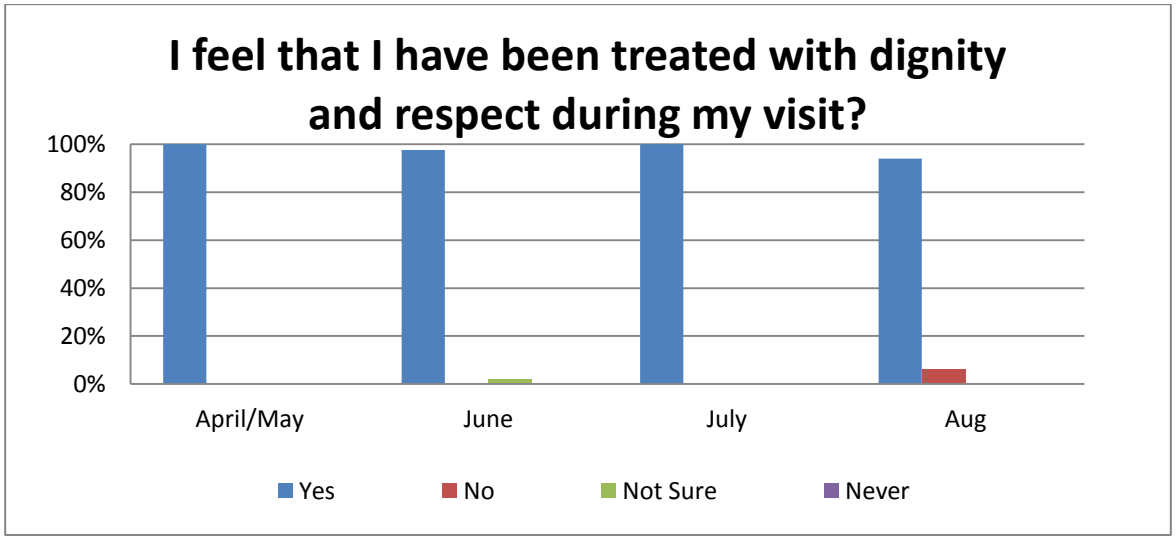
Adult community healthcare team & rapid response and intermediate care team patient related experience measures	**80% rating community services as good or excellent**	**Demonstrate improvement**	97% (62 patients)	93% (82 patients)	100% (74 patients)	97% (109 patients)	95% (40 patients)
Adult community Healthcare team & rapid response and intermediate care team friends and family test measures	**90% extremely likely or likely to recommend service**	**Demonstrate improvement**	95% (62 patients)	97% (82 patients)	97% (74 patients)	100% (109 patients)	98% (71 patients)
% of people discharged from acute care to normal place of residence	**92%**	**94%**	90%	91%	91%	92.7%	90.59%
% of patient readmissions of over 75s within 28 days	**No baseline**	**Reduction in overall admissions**	Reported in May	21%	22%	19.7%	18.9%
Numbers of patients requiring additional overnight support to maintain safe at home e.g. assistance getting to toilet (domiciliary care)	**No Baseline**	**Monitor**	0	0	0	0	0
Commissioning arrangements – social services nursing home beds weekly	**No Baseline**	**Monitor**	0	0	0	0	0
Commissioning arrangements – socials services care home beds weekly	**No Baseline**	**Monitor**	0	0	0	0	0
Commissioning arrangements – BHT spot purchasing care home beds weekly	**No Baseline**	**Monitor**	0	0	0	0	0

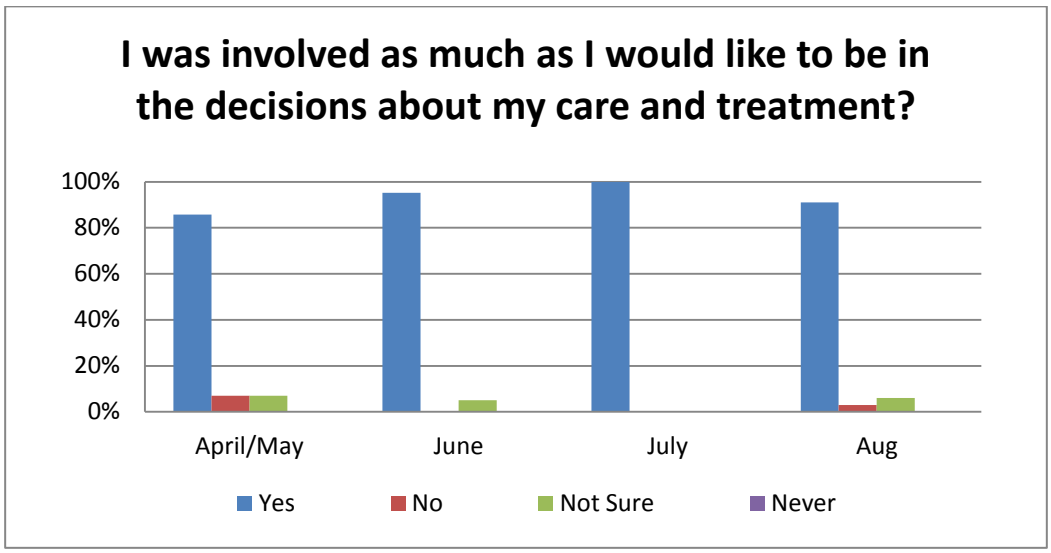


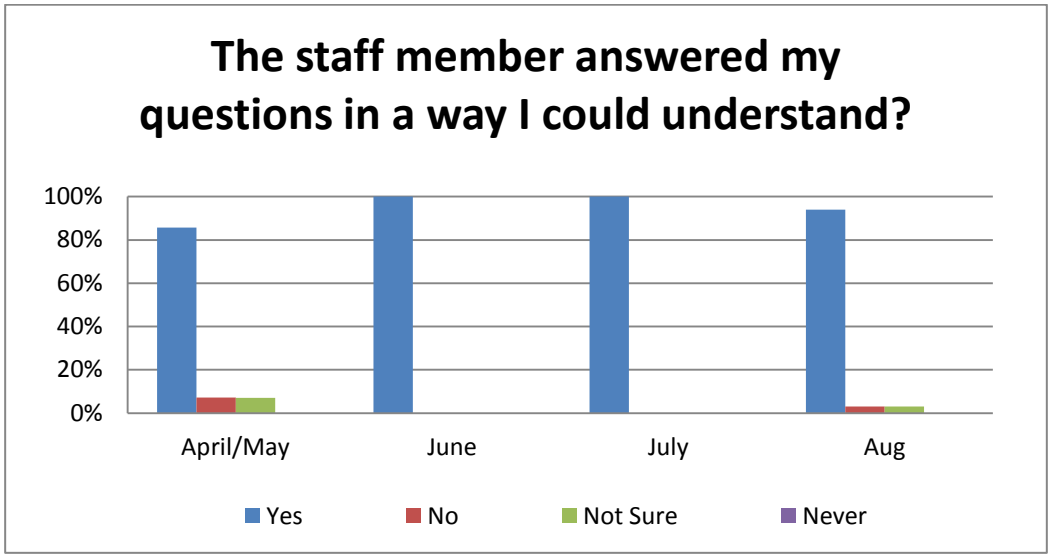


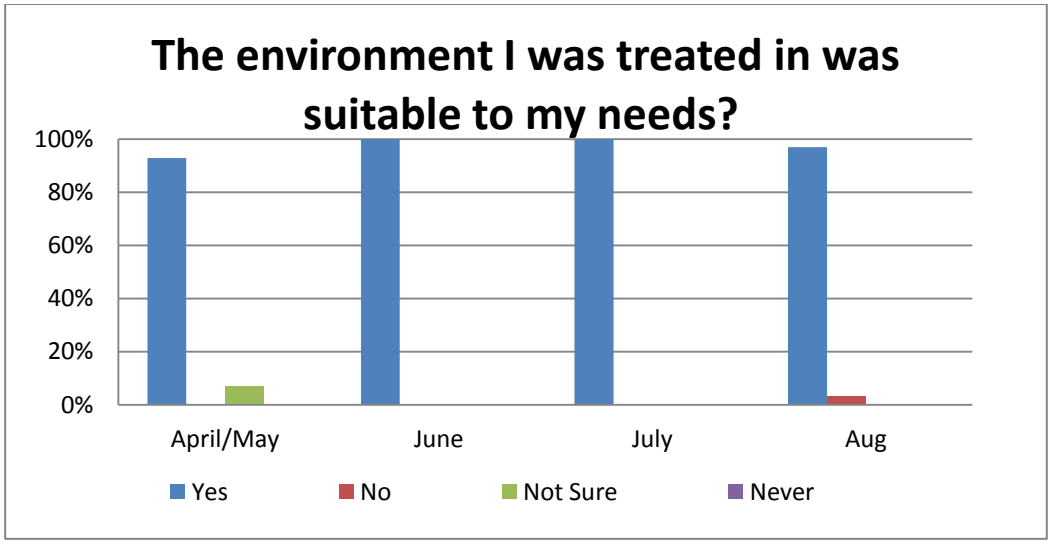
Community assessment and treatment service patient survey results

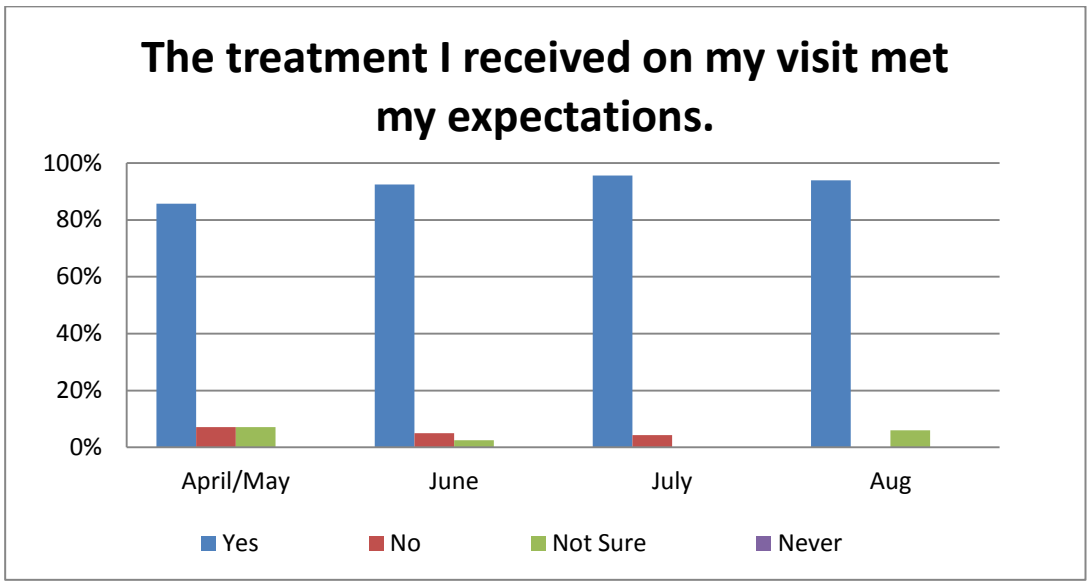


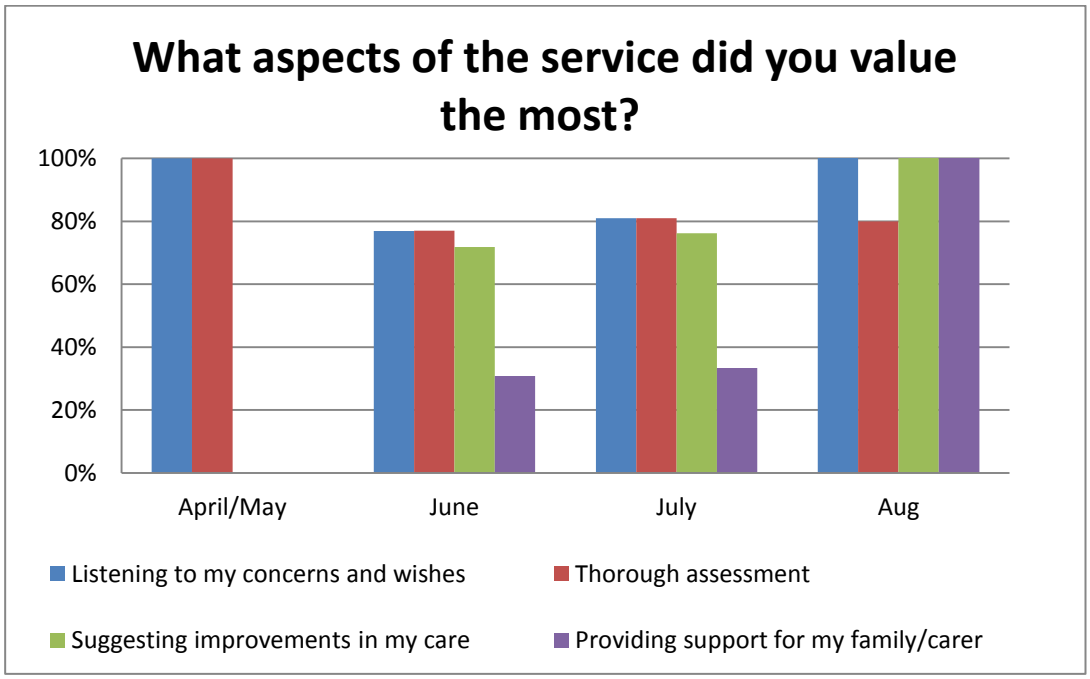


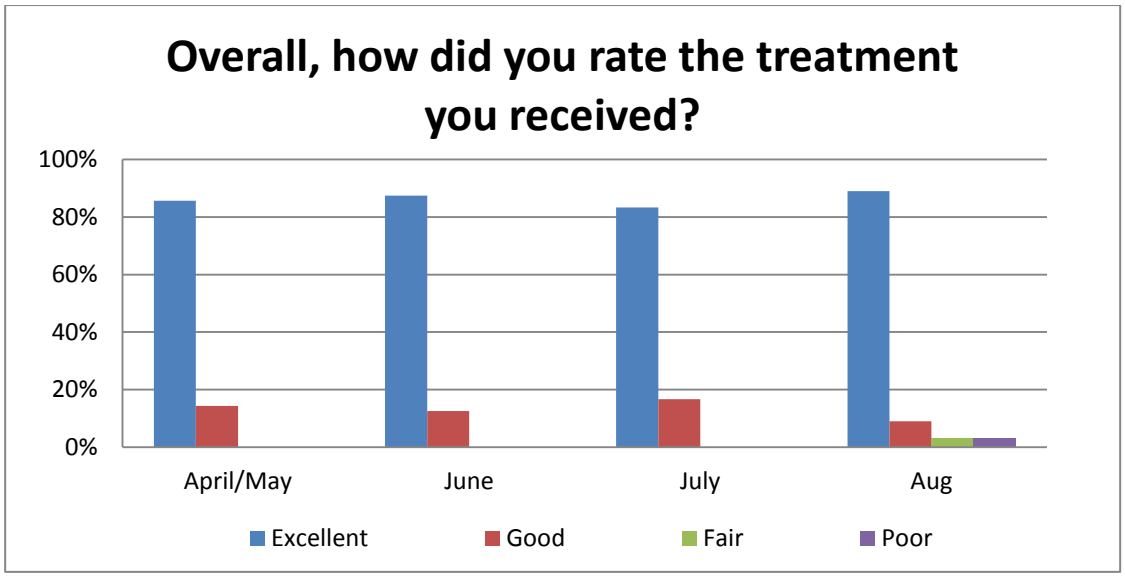

I was involved as much as I would like to be in the decisions about my care and treatment?
100%
80%
60%
40%
20%
0%
April/May
June
July
Aug
Yes
No
Not Sure
Never


The staff member answered my questions in a way I could understand?
100%
80%
60%
40%
20%
0%
April/May
June
July
Aug
Yes
No
Not Sure
Never


The environment I was treated in was suitable to my needs?
100%
80%
60%
40%
20%
0%
April/May
June
July
Aug
Yes
No
Not Sure
Never


The treatment I received on my visit met my expectations.
100%
80%
60%
40%
20%
0%
April/May
June
July
Aug
Yes
No
Not Sure
Never


What aspects of the service did you value the most?
100%
80%
60%
40%
20%
0%
April/May
June
July
Aug
Listening to my concerns and wishes
Thorough assessment
Suggesting improvements in my care
Providing support for my family/carer

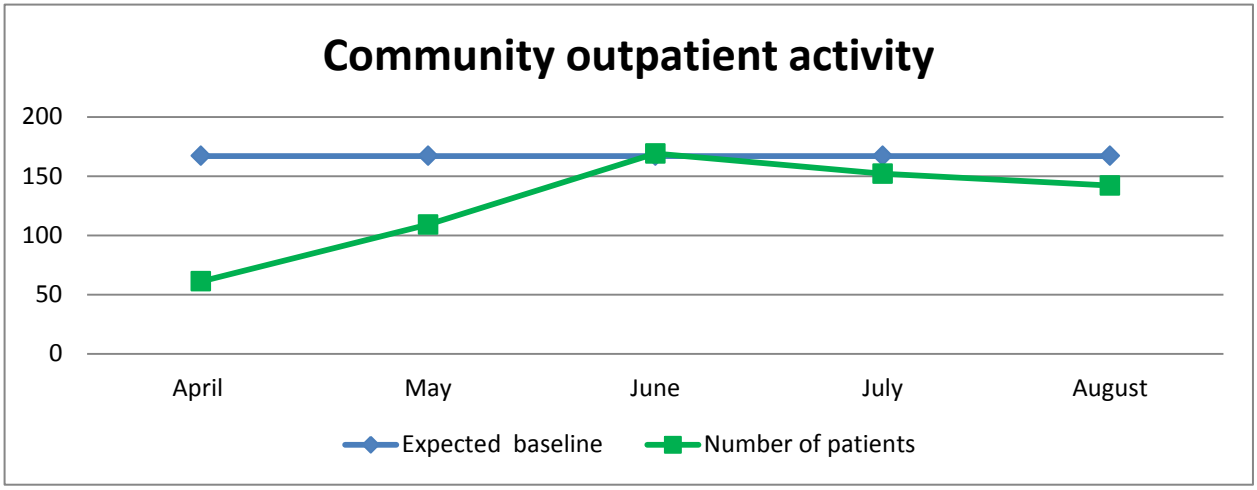

Overall, how did you rate the treatment you received?
100%
80%
60%
40%
20%
0%
April/May
June
July
Aug
Excellent
Good
Fair
Poor

Patient experience free text

- Excellent service met my expectations
- I can't find fault on this service
- Very happy with the service received
- Can't fault the service
- Great difficulty getting up the slope outside
- Thank you very much
- Wonderful service

Community outpatient appointments

The number of outpatient appointments has increased since the pilots began but have not yet reached anticipated levels. Work is ongoing to increase further the range available and discussions at the stakeholder groups have provided insights into the types of clinics that could be provided in the community setting.



Rapid response and intermediate care (RRIC)

To ensure we could continue to support people in their own homes and enable them to remain as independent as possible for as long as possible, we planned to increase staffing in the rapid response and intermediate care team. We are currently ahead of our planned trajectory and are optimistic that this will be sustained.

The teams have expanded and therefore been able to care for more patients in the community. Although we have not yet achieved the full number of face-to-face contacts we had planned, the number continues to rise.