Your community
Your care
Developing Buckinghamshire together

Developing out of hospital care:

Community hubs pilot evaluation and next steps

Report for: Health and Adult Social Care Select Committee (HASC)
11 April 2018

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 with a further update on progress in September 2017.

The aim of this paper is to:

- Share results and learning from the pilot.
- Explain how the community hubs pilot fits in to our wider community transformation strategy.
- Communicate our intention to continue with the current model at Thame and Marlow for a further two years whilst we develop the wider out of hospital care model across Buckinghamshire.
- Outline our plans for next steps and developing the model in the future.

Top-line results

- The community assessment and treatment service at Thame and Marlow has seen **1027** people from April 2017 to March 2018 which is in line with the proposal estimate.
- **Less than 1%** of patients seen by the community assessment and treatment service were subsequently referred to A&E.
- **2,439** patients seen in the multidisciplinary day service assessment (MUDAS) at Wycombe Hospital in 2017/18 - **an increase of 25%** on the previous year.
- There have been no overnight packages of care required so far during the pilot, other than transitional beds already commissioned as part of the 'discharge to assess' project.
- There has been a **60%** increase in outpatient appointments offered at the two sites.
- We have worked with a range of stakeholders to develop and refine the pilot; they are supportive of the work achieved to date and the continued development of the hubs model as part of the wider community transformation programme.

Key learning

- Some of the elements of the hubs development were slow to mobilise and still require further work with hospital clinicians, GPs and the community to increase awareness and referrals. There have been fewer opportunities to work with the voluntary sector than had been originally anticipated, although work continues to build and develop links across communities.
- The stakeholder group has been an important part of the pilot, they have provided scrutiny and challenge to the developments, have represented views of their communities, and helped to develop links between the services and local organisations.
- Even with providing more care closer to people's homes, we have identified there is still support required for transport and access across communities.
- The feedback from those who have used the pilot sites and our broader engagement with communities have helped to inform the next steps. It is clear that a one-size-fits-all solution will not meet local needs, and therefore more specific discussion and planning will need to take place within localities.
- The full impact of community hubs will not be evident for some time, as the programme is aiming to impact prevention and early-intervention; it also requires the other complementary elements of the community transformation programme to be implemented and integrated.

Proposed next steps

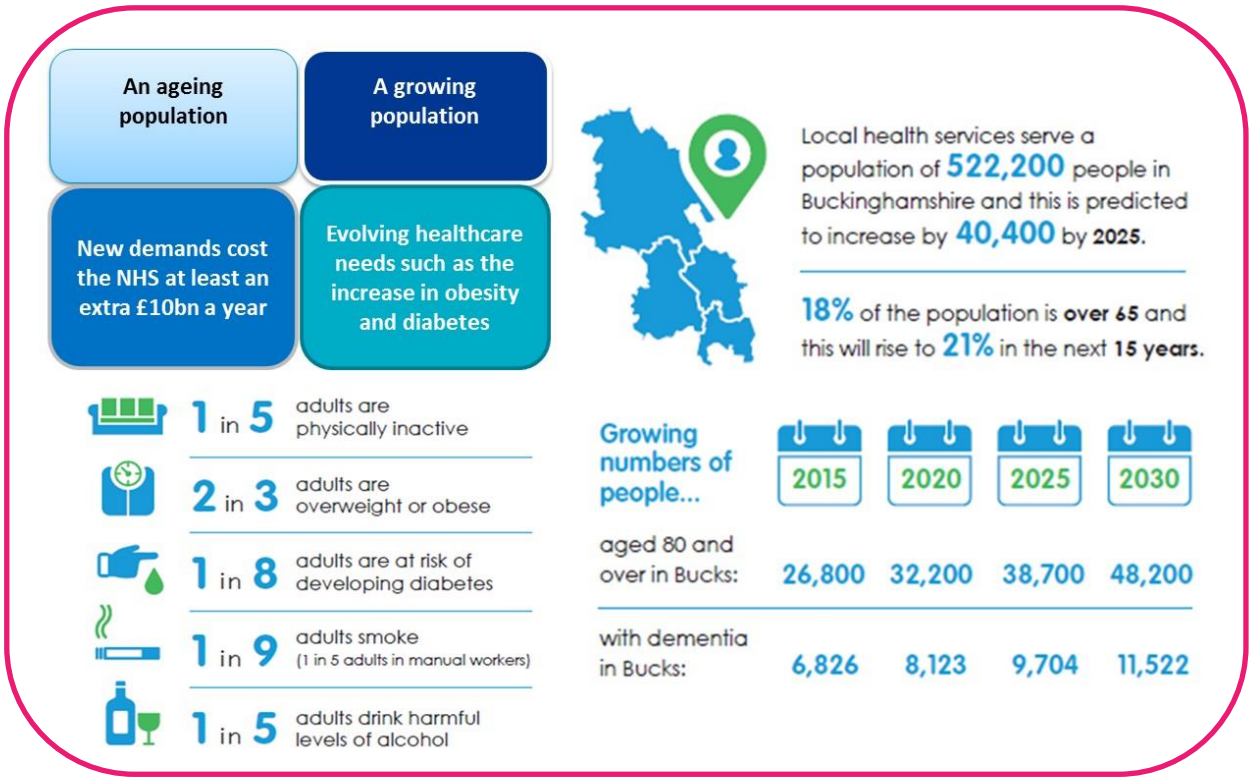
Continue with the current community hubs pilots at Thame & Marlow for another two years so that the other complementary elements of community services transformation have time to be developed, rolled out across the county and evaluated for impact. This includes developing the community hubs model across the county.

- Phase 1, April 2018: confirm the continuation of the community hubs pilot in Thame and Marlow for a further two years
- Phase 2, April - June 2018: Review out of hospital care model to understand scalability of services between the Hubs and Integrated teams.
- Phase 3, June 2018 – March 2019: Increase the scale of delivery of the hubs and integrated teams across the county.
- Phase 4, April 2019 - March 2020: Integrate the out of hospital elements into the full care model.

1. Context

The commissioners and providers of health and social care in Buckinghamshire have been working closely together to make health and care services safe, sustainable and able to meet the future needs of our local population.

Buckinghamshire population



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

Evidence from the national New Care Models programme found that by implementing a whole population care model, including hub-based care, health and care systems:

- reduced the rate of growth in non-elective admissions by approximately 4%, when compared to non-new care model systems
- emergency bed days showed a 1% reduction in comparison to a non-new care model systems which grew by 1%.

We are seeing a significant increase in the older population and increasing numbers of people with multiple long-term conditions and frailty. Long-term conditions and frailty are not an inevitable consequence of ageing, much of this is driven by unhealthy lifestyles coupled by a historic lack of investment in prevention so we must find ways to improve this too.

We also know that a frail, older person has muscle deterioration equivalent to 10 years for every 10 days in hospital. Inpatient beds are not always used effectively and can impact on a patient's ability to remain independent as their stay can be extended inappropriately. In summary, keeping people healthy and independent in their own homes is what our patients have asked for, is better for them and for the provision of services.

Our vision is to have everyone working together so that the people of Buckinghamshire have happy and healthier lives. We want to rebalance the health and social care spend to increase support for more people to live independently at home, especially older people and those with long-term conditions, by providing high quality prevention and early intervention services.

In summary, through prevention and early intervention we want to:

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

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

- People are cared for at home wherever possible and that services are focussed on this
- People will be encouraged to manage their own mental and physical health and wellbeing (and those they are care for) so they stay healthy, make informed choices about care and treatment to manage their long-term conditions and avoid complications
- We combine resources and expertise across the health and care system so that people receive joined-up care
- People can access good quality advice and care in the most suitable and convenient way possible, as early as possible, to prevent problems becoming more serious
- People have access to specialist support in their community, working with a named responsible clinician
- We will work together on prevention, not just as professionals but as communities and individuals.

2. What we've done

The care model we have been co-designing with a wide range of stakeholders, including staff, GPs, patients, general public and other health and social care providers, will deliver care closer to home in the least intensive setting and has four elements:

1. **Prevention and self-care**
   – supporting people to live healthier lives and manage their own health

2. **Integrated urgent care services**
   – including rapid community response to reduce the number of people attending A&E and admitted to hospital

3. **Enhanced primary care**
   – where access to general practice is extended and where the range of professions which can be accessed in a local hub setting including for example; community services, therapies, mental health and social care

4. **Integrated care for those with complex needs**
   – where patients are systematically identified and clinicians and patients work together to develop proactive care plans

Community hubs

A key part of the model has been the development and pilot of community hubs in Marlow and Thame community hospitals. Over the past year they have offered:

- Community assessment and treatment service (CATS) 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, including chemotherapy clinics at Marlow, community occupational therapy clinics at Marlow (and in Thame in the near future), tissue viability clinics, Parkinson's disease and falls clinics
- Support from voluntary organisations, such as Carers Bucks and Prevention Matters, ranging from clinics, drop-in sessions and information stands. There are monthly stands from Age UK in Thame and Carers Bucks are running a 'clinic' in Marlow on a fortnightly basis. Victim Support has also begun a weekly session in Thame
- Links with other public services have also been made – for example library services are now available in Marlow, providing books to support self-care and the management of mental health and long term conditions.

This is in line with what patients and clinicians told us they wanted - rapid access to testing and diagnostics and a place where they could access a full range of therapy services. Having these services based in the local community makes it easier for GPs to become full members of the multidisciplinary team that delivers the care. We have put in place a single point of access to make it easier for clinicians to refer to the multi professional, multiagency frailty assessment clinics.

To support we have invested £1m into the community services. A total of nearly 36 new posts were created in the community. We have also redeployed staff from the Community Hospitals in both Thame and Marlow to work within the community assessment and treatment service (CATS) team.

	Community care coordination team (Single point of Access recruitment (wte)	Rapid response (wte)
Band 7	1	
Band 6	4.8	7.7
Band 3	3.25	19.13
Total	9.05	26.83

Community assessment and treatment service (CATS)
The community assessment and treatment service operates from 9am to 5pm at Marlow on Mondays, Wednesdays and Fridays and Thame on Tuesdays and Thursdays. There is a geriatrician on site in the mornings and a GP in the afternoon.

The community assessment and treatment service was made possible by re-utilising the space that had previously been the inpatient ward at both Marlow and Thame. By developing the CATS service, along with the rapid response team, it was felt that more people could be supported in their own homes and therefore not require an overnight community bed. During the pilot, we ensured that overnight packages of care were still available if required – this included the other community hospital sites across the county and the ability to spot purchase local care home beds. We separately commissioned a range of services as part of the discharge to assess scheme, which had options for domiciliary care, some 24/7 care and transition beds in local care homes across the county.

Rapid response and intermediate care (RRIC)
The rapid response and intermediate care service was 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 across the county, aligned to localities. 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.

Community care coordination team – single point of access
To support both of these initiatives, and to provide a general single point of access to community services, a community care coordination team was developed. They provide GPs, hospital clinicians and other health and social care staff with a 'single point of access' via phone and email to organise specialist community services for their patients, including district nursing, rapid response & intermediate care and community physiotherapy. 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. The Trust has a wide-ranging strategy to recruit and retain the staff required to run these essential services with recruitment days held at all sites and six district nurses trained locally each year. There are excellent relationships with the university to attract newly qualified registered nurses to roles in the community and in collaboration with Bucks New University; bespoke courses are offered such as Transition to Community Nursing.

This service is now aligning with the new integrated urgent care service across Thames Valley and will be able to expand the range of services it can access.

Management and governance

To ensure quality and safety was maintained whilst these developments were implemented, the pilot has been overseen by the medical director and chief nurse of Buckinghamshire Healthcare NHS Trust. 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 BHT's executive management committee.

The role of the stakeholder engagement group

Central to the development of the hubs has been the co-design with local people through the stakeholder engagement group. The stakeholder engagement group is chaired by our system wide chief nurse and director of communications. It comprises of representatives from Healthwatch, Marlow and Thame Community Hospitals' Leagues of Friends, Thame and District Day Centre, Marlow and Thame town councils and patient participation groups of local practices. The group acts as a 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 on-going development. The group has been meeting every six weeks since the pilot began, reviewing the activities of the hubs, the feedback we have had from people that have used the services and they have made suggestions to refine and improve the model. All information, KPIs and minutes from the meetings are published on the Trust's website.

3. How patients are benefitting

Community assessment and treatment service

The introduction of the community assessment and treatment service (CATS) has been the most significant development to the services provided. This service has seen **1027** people from April 2017 to March 2018 which is in line with the proposal estimate.

We have carefully monitored the impact and there have been no overnight packages of care required so far during the pilot other than transitional beds as part of discharge to assess project.

Readmissions to hospital have remained the same, which would suggest that by being cared for in the community you are not more likely to have to go back to hospital.

Outcomes

Thame community hospital

2016/17:
148 inpatient spells
512 outpatient appointments

2017/18:
459 CATS appointments
756 outpatient appointments

Over **310%** more patients seen in CATS than in the inpatient service in 2016/17

Over **48%** increase in outpatient activity

84% increase in total number of people seen in the hub Vs 2016 activity

129% increase in activity delivered to local people

Marlow community hospital

2016/17:
189 inpatient spells
444 outpatient appointments

2017/18:
568 CATS appointments
604 outpatient appointments

Over **301%** more patients seen in CATS than in the inpatient service in 2016/17

Over **36%** increase in outpatient activity

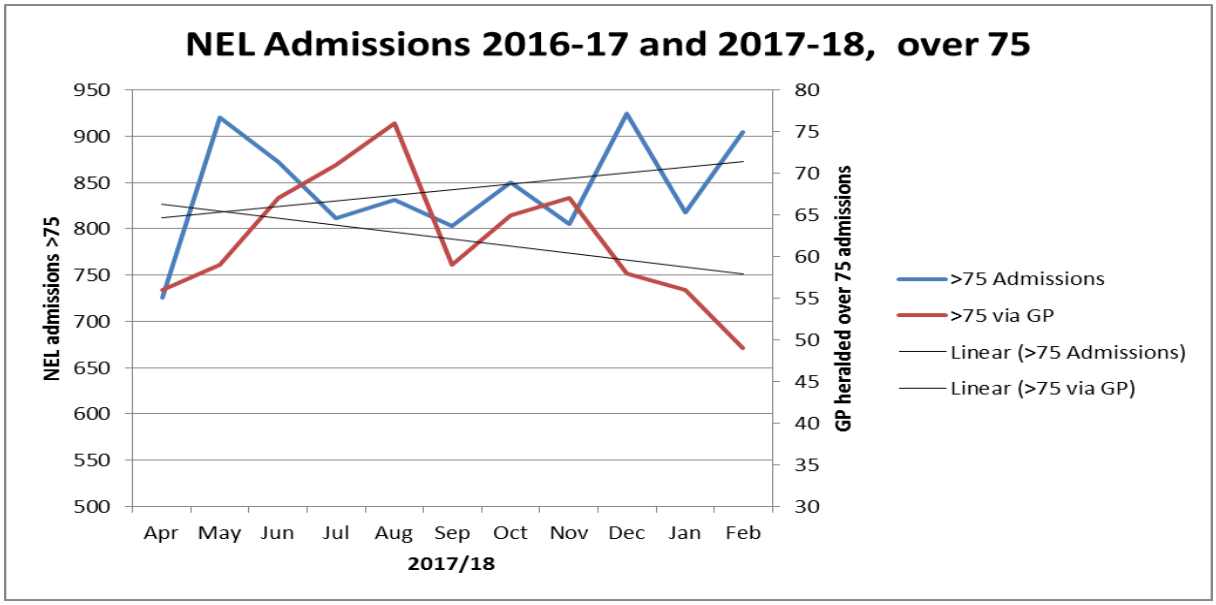
85% increase in total number of people seen in the hub Vs 2016

102% increase in activity delivered to local people

How else are patients benefitting?

- **980** patients seen in the community and **92** followed up in their own homes
- **Less than 1%** of patients seen by the community assessment and treatment service were subsequently referred to A&E.
- **2,439** patients seen in the multidisciplinary day service assessment (MUDAS) at Wycombe Hospital in 2017/18 - an increase of 25% on the previous year. This service is similar to the community assessment and treatment service at Marlow and Thame, and is referred to through the same route via the geriatricians.
- Since April 2017 **128,006** patient visits have been undertaken by the rapid response and intermediate care service.
- Since April 2017, the community care coordinator team has received **6,063** referrals.

We have seen a reduction in non-elective admissions via GP referral for people over 75 years of age when we compare 2016/17 with 2017/18. In addition, although the numbers of people over 75 attending A&E have risen throughout 2017, the trend in referrals from GPs to A&E has reduced over the last 4 months. This may be indicative of GPs referring more patients to MUDAS and CATs services. We believe that the increase in referrals to the MUDAS service is due to an increased awareness of and commitment to a more community-based model of care by general practice.



Who is being seen in the hubs?

The vast majority of patients using the community assessment and treatment service are referred from home by their GP. Only three patients were referred as part of their discharge from hospital care. **77%** of patients were seen only once, the majority of whom were discharged with no further care required or back into the care of their GP.

There were **60%** more outpatient appointments available in Thame and Marlow than in the previous year. A range of additional clinics have been offered at these sites, although we believe there is opportunity for this to be expanded further. The addition of systemic anti-cancer therapies (including chemotherapy and psychological assessments) at Marlow has been a particular benefit for those who would have previously travelled to Aylesbury and Wycombe. Following the success of these therapies we are working in partnership with Macmillan to look at how we can roll this model out across the county and Macmillan are providing funding for additional staff to support the project.

4. What our stakeholders have said

Please see Appendix 3 for the full stakeholder engagement report.

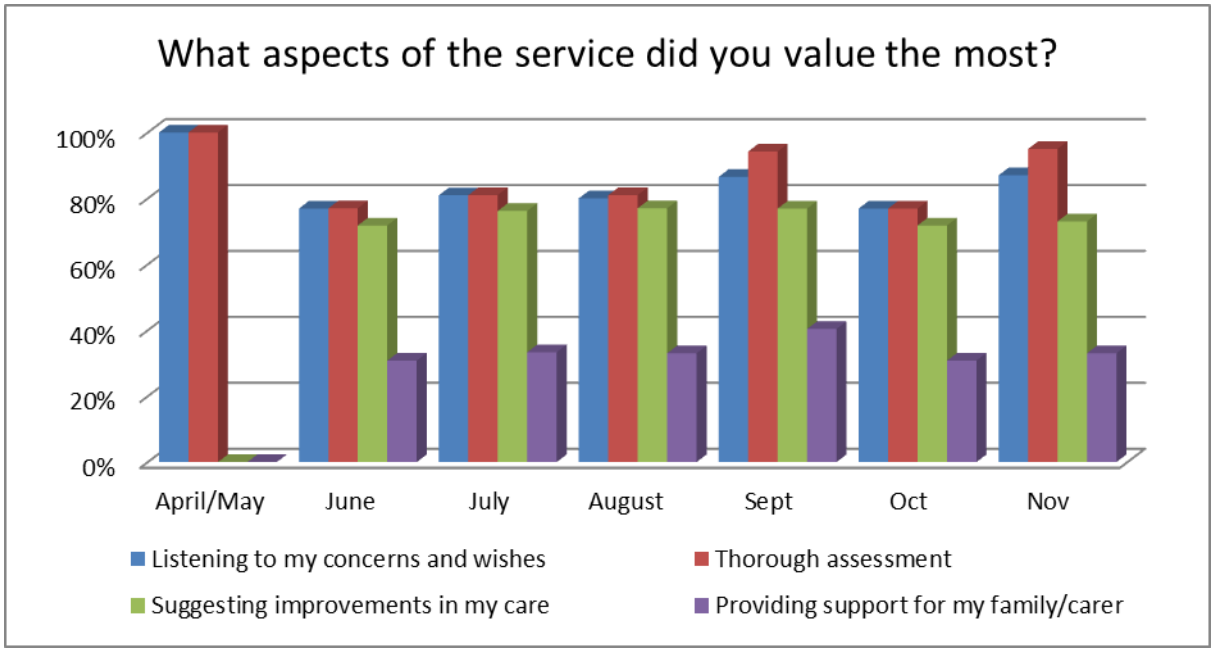
The involvement and engagement team gathered the views of 352 stakeholders, using a mixed methodology tailored to different groups:

- Focus groups with 28 hub patients
- Appreciative enquiry workshops with 7 hub staff
- 3 telephone interviews with staff from Healthy Minds, Alzheimer's Society and Age UK
- Public engagement workshops in Buckingham, Chalfont, Marlow, Wycombe, Thame, Aylesbury, and Iver, attended by 191 members of the public
- Sessions with 123 members of voluntary sector service user groups, and a patient participation group

This was in addition to the public and community group meetings the Trust was invited to present at and the open days at both hubs. The Trust engaged with over 1000 members of the public through its community hub open days, and meetings of organisations including parish councils, University of the Third Age, PPG's and stalls at community markets in which there was more general discussion and information giving.

Patients

Every patient attending the community assessment and treatment service have been asked to complete a feedback form at the end of their appointment. In this feedback people have been consistent in feeling listened to and having a thorough assessment and there are a growing number of people who report that they received improvements to their care and support for their family or carer was given as part of the package. Care has been almost unanimously rated as excellent.



**please note that, following feedback from the stakeholder engagement group, the questionnaire was revised following the November survey*

We have received feedback from some patients that parking and transport can be an issue. We are working to provide parking which can accommodate up to 10 patients attending CATS as well as patients attending other services in the community hub. We will improve turnover of parking spaces by staggering patient's arrival time and will better accommodate the parking needs of our patients by adding an extra disabled parking space at both locations with easier access to the entrance.

Patients attending a CATS appointment are encouraged to provide their own transport where possible. Flexible appointment times are offered in order to accommodate rush hour traffic.

Patients can be offered patient transport from the ambulance service with same day or next day availability. Recently the contract has confirmed a patient can be accompanied by a carer if the need arises. Patients have to be ready 2 hours in advance of the appointment time. Pick up and drop off times can vary and be unpredictable. On occasions this has led to delays in patients being picked up from the hub. This has led to reluctance in booking later afternoon appointment times.

As an alternative, a number of community voluntary transport options have been sourced. Many of these require notice to book and therefore are unable to respond to the rapid response appointment system of the CATS service. However for those appointments that can be planned in advance these transport options have been of benefit and offer a cheaper and reliable alternative to taxis. Community Impact Bucks offers signposting to transport services across the county and their number is offered to patients at the time of appointment booking.

Patients who took part in the focus groups reported that:

- The hub model, of having a range of services organised around the patient, is working well for those who have experienced it. Patients feel cared for, and the services received have had a clear positive impact on health and wellbeing, including avoiding hospital stays
- Patients benefit from being able to access outpatient appointments closer to home
- Having staff based in the hub visit patients at home to give advice and practical help was working well with a number of patients feeling their quality of life had improved as a result
- Patients feel more could be done to raise community awareness of the hub
- The key challenge for patients in accessing the hub is having transport ,most were reliant on friends or relatives, as public or community transport options were limited or unavailable
- There is still much scope for developing the hub to achieve the ambitions set out by patients and the public for a community hub

Staff

There is strong evidence to show that happy, well-motivated staff provide better quality care[1]. As a system we are committed to improving our staff's health and wellbeing.

Both clinical and support staff have been integral to the development of the model. Staff who attended our consultation events felt positive about the changes. They felt that having the time and support to offer a truly holistic and thorough assessment and work out how best to help the patients was fantastic and had really added value. They want to see the service develop further, opening for more days of the week, broadening the range of services on offer and working hard with key partners, particularly GPs to enable the service to see a larger number of patients and be more proactive.

GPs

GPs are integral to the new model of care, which was co designed with some local GPs. As part of the CATS service two GPs work as members of the multidisciplinary team undertaking assessments, developing care plans and arranging on-going care. The wider community of GPs, who refer into the service, also participate as part of the stakeholder group. To ensure a wide range of views are taken into account as the service develops, meetings with locality leaders have taken place, and some sessions with GPs in the localities.

Referrals to the new CATS service have been made by almost every practice in the county although the majority have come from those closest to the hubs themselves. There has also been an increase

[1] *The quadruple aim: care, health, cost and meaning in work Sika et al (2015) BMJ Quality and Safety*

in referrals to MuDAS (multidisciplinary day assessment service) at Wycombe Hospital as awareness of this new model of care has increased generally.

The GPs have been relatively consistent in describing how they would like to see the service develop. They want it to become more proactive and hold responsibility for the patients for longer. In addition, care co-ordination has been identified by GPs as one of the areas on which we could improve as well as access to a single IT system to increase ease of communication. To this end EMIS, the preferred GP computer system, has gone live in both Thame and Marlow allowing CATS staff to both see and enter information directly into the GP record. We are working with clinicians to understand what other benefits we could get from the system e.g. taking away the need for the GP to make a separate referral.

Voluntary sector partners

Voluntary sector organisations have been engaged in the process of community hub development both in the stakeholder group and by providing services in the hubs themselves. These services have not yet been as well used as everyone had hoped. Their views were sought as part of this review to inform the development of the hubs programme.

Key findings:

- All interviewees found the Hubs staff friendly and helpful
- All had expected to receive referrals to their service through CATS, but this has not happened to the extent they had hoped.
- Interviewees felt that the different organisations operating in hub could work together in a more co-ordinated way.
- The VCS organisations felt that the environment within the hub was too clinical and could be redesigned to be more patient friendly.

Senior health professionals

In November 2017 Professor Don Berwick (one of the founders of the Institute of Health Improvement and adviser on health to President Barack Obama) and Chris Ham, (Chief Executive of The King's Fund) visited Buckinghamshire as part of the support package for ICSs. We shared with them our vision for transforming care in Buckinghamshire by creating an integrated hub based model of care. Their reflections were that this model of care matched the Whole Population Health model developed by the New Care Models programme and the wider international direction of travel for health and social care.

General public

314 service users and members of the public took part in engagement sessions across Buckinghamshire. Participants were shown an assessment of how the hubs had progressed in relation to the model developed in 2016 following public engagement:

They were then asked to discuss this vision and its relevance now, taking into account the learning from the pilots. They continue to support the vision of community hubs developed through the public engagement in 2016, though a café was no longer viewed as essential to the model. They wish to see the current hubs continue and for the model to be rolled out across Buckinghamshire, taking into account local need. They raise concerns about the lack of awareness amongst the public and GPs of the current hubs. Lack of access to public and community transport was also raised as an issue. They wish to see a wider range of referral routes including self-referral, higher levels of awareness of the hubs, and an increase in the range of clinics available at the current hubs.

Conclusions from the stakeholder engagement

The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review. Patients and the public wish to see the current hubs continue and the model rolled out across Buckinghamshire, with provision tailored to different needs in different areas

All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential. Levels of awareness of the hubs was low amongst both patients and GPs. Transport was highlighted as an issue, with concern expressed that the lack of community transport to the hubs could potentially be a barrier to access for many patients.

Key recommendations

Current hubs

- Raise awareness of the current hubs with public and GPs, in part through clearer branding.
- Increase the service to at least five days per week at both sites.
- Review the current referral process with GPs, and consider expanding the process to self-referral.
- Ensure better co-ordination of the different services operating within the hubs.
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic-like, to provide better facilities for partner organisations to provide their services, and to be dementia, mental health and learning disability friendly.
- Mobilise a wider range of outpatient clinics.

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units and other public sector estate.
- Ensure effective joint working across health and social care and with voluntary sector.
- Consider how pubic and community transport to hubs could be improved.
- Provide signposting to other public and voluntary sector support services.

5. What we have learnt

- The pilot has tested the model for 12 months and found that it is supported by both users of the services and clinicians.
- Outcomes demonstrate that we are moving in the right direction in terms of reducing the need, particularly for people over 75 years of age, to make unplanned visits to A&E.
- Engagement with local people in communities across the county show that there is support for replication of the model across the county.
- Key Performance Indicators which have been developed with the stakeholder engagement group and used to monitor and challenge performance during the pilot is outlined in Appendix 1; it shows that the services have grown over the year and they continue to grow.
- Unfortunately the uptake of the voluntary sector was not as large as we had hoped. Having listened to the local voluntary organisations we realise that for many it would require new investment and this made it difficult for some 3rd sector organisations to work within the Hub, as they had already established bases elsewhere or had restricted funding.
- Feedback from service users is that someone based in the hub to signpost people to the service they need and to encourage those reluctant to accept help, for example the lonely, to contact services would be more helpful than co-location.
- Work more closely with acute clinicians to facilitate earlier patient discharge with support provided by the community hubs.
- Work closely with GPs to proactively identify patients who may benefit from being referred to the community assessment and treatment service.
- Explore the option of greater direct access for patients.

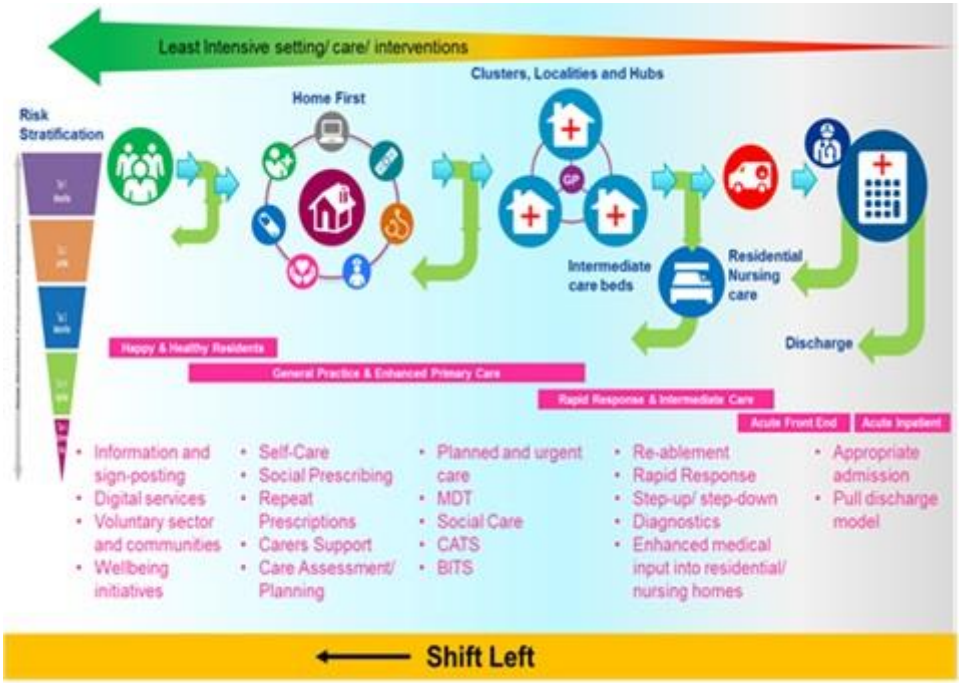
6. How community hubs fit with our wider transformation strategy

In July 2017 Buckinghamshire was announced as one of the 8 shadow Integrated Care System (ICS) nationally, in recognition of the strength of the relationships between commissioners and providers across the system and the innovative new care models it was piloting.

NHS England, through the Integrated Care System programme, has committed to support Buckinghamshire with both capital and transformation funding in 2018/19. This will help us develop general practice at scale to increase resilience, extend access by driving collaboration between practices and develop the estate which would allow this to happen.

The development of community hubs is only one part of our wider transformation strategy to deliver more care closer to home and out of hospital across Buckinghamshire.

Whilst the evidence shows that community hubs are already making a significant contribution to achieving our vision, they can't be viewed in isolation. The real impact will only be seen once the other elements are fully operational.



GPs and provider organisations across Buckinghamshire have been working 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. These, together with the community hubs and locality-based community services will be the building blocks for the integrated teams.

This model of care is in line with the findings of the NHS England New Care Model programme. The evidence points to each individual element having a small impact; but the aggregation of the impacts of each intervention being greater than that of the sum. As a consequence community hubs will not reach maximum effect until all elements of the model reach maturity.

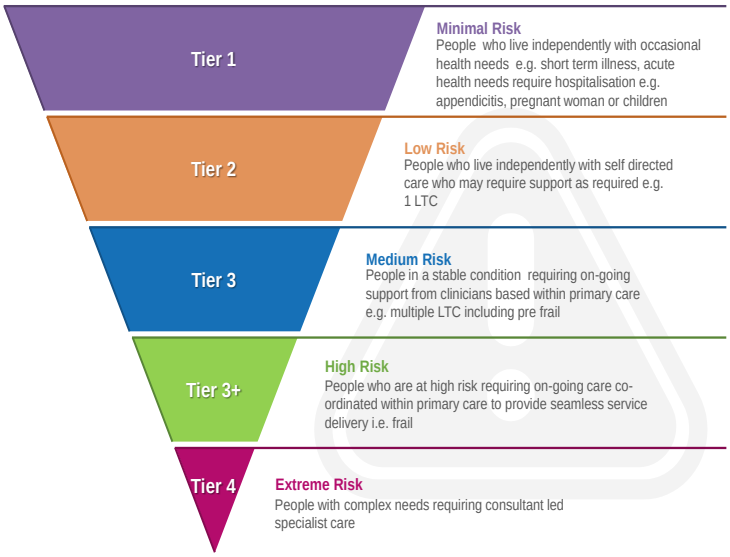
Success of the programme will be measured by the delivery of high quality and sustainable care. It aims to slow the growth in non-elective (NEL) activity by between 1% and 3% (A&E attendances, NEL admissions) and reduce variation in elective care. It also aims to improve the experiences of patients, their families and carers as well as the health and social care workforce.

Key work streams

Population Health Management

The Public Health Department of Buckinghamshire County Council is leading population health management work. It aims to improve the health of the entire population and to reduce health inequalities among population groups and reflects a shift in thinking about how health and care is defined. Care, in particular healthcare, is traditionally organised into relatively siloed specialties or services.

A practical alternative is to segment or risk stratify populations into groups with sufficiently similar characteristics and arrange supports and services to meet their expected needs. For instance we can identify groups ranging from healthy people, mothers and children, to people with multiple long-term conditions, frail people or people at the end of life for the whole county as well as at a local level (localities and groups of GP practices).



By identifying the people in each of the risk segments we can design services to meet their needs and target those services at those most likely to benefit.

Locality Integrated teams

Building on the CCG localities, GP practices are grouped together in their geographies around populations of 30,000 to 50,000 to form 13 integrated teams.

In the first phase, 4 teams are being established that consist of GPs supported by a community nurse, practice nurse, mental health practitioner, community practice worker, occupational therapist social workers, and input from acute clinicians. The workforce for integrated teams may change over the implementation phase depending on the needs of the population.

Rapid response and intermediate care (RRIC)

The two re-ablement teams of health and social care are being merged to form one countywide offer. The service is designed to increase the level of care and support provided in people's homes to avoid admissions and also to support early discharge after a stay in hospital so that people can be as independent as possible at home for as long as possible

Community hubs

Community hubs will serve a population between 100,000 – 150,000. They are intended to improve access, via a single point of contact, to a wide range of services. These include preventative, primary and specialist care from a range of providers working in multidisciplinary teams made up of representatives from the voluntary sector, social services and NHS organisations.

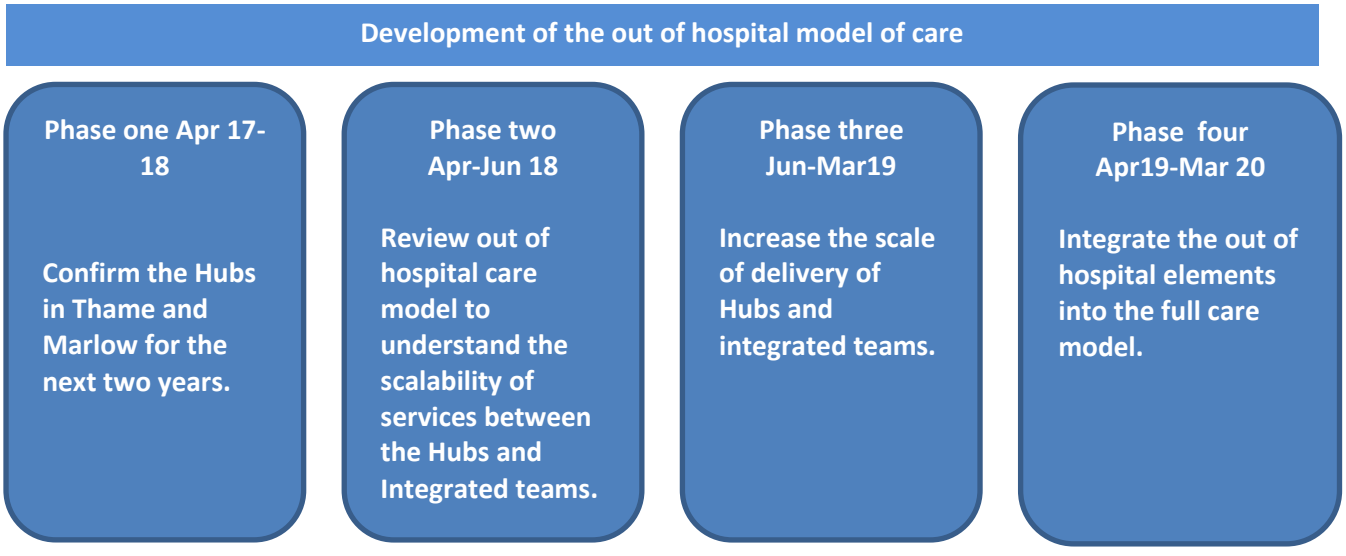
24/7 minor injuries unit and out of hours primary care services

The Buckinghamshire provider collaborative - made up of Buckinghamshire Healthcare NHS Trust, South Central Ambulance Service NHS Foundation Trust (SCAS), the local GP federation 'FedBucks' and Oxford Health NHS Foundation Trust – took over the provision of the 24/7 minor injuries and illness unit (MIIU) at Wycombe Hospital (WH) and the primary care GP out-of-hours services operating at WH, Stoke Mandeville Hospital (SMH), Buckingham Hospital and Amersham health centre from 3 April 2018. The MIIU is intended to be designated to become a first-wave urgent treatment centre (UTC) very soon after service mobilisation.

7. Next steps

- Continue with the current community hubs pilots at Thame & Marlow for another two years so that the other complementary elements of community services transformation have time to be developed, rolled out across the county and be properly evaluated. This includes developing the community hubs model across the county.
- Work with general practice localities to further integrate services and to support the proactive identification of patients who are likely to benefit from the CATS service e.g. through risk stratification.
- Work with care homes to ensure that residents in a care home, who would benefit from the CATS service, have access to it.
- Explore further development of the referral model potentially widening the range of people who can refer directly to the services within the hub including self-referral.
- Review the discharge from A&E and acute inpatient care pathway to ensure that CATS is recognised as a viable alternative to a 'bedded 'option, developing a local concept of the virtual ward.
- Work with local GPs to increase the capacity of the CATS by increasing the number of days of operation in line with demand.
- The Integrated Care System will set up local stakeholder engagement groups aligned to the integrated team localities – building on those in place for Marlow and Thame - to co-design the local detail of the out-of-hospital care model, including the hubs, ensuring that they meet the needs of the local community.
- Identify the target population cohorts and care professionals that the new model of care will apply to
- Define the service combinations that will comprise the future model and the level at which services will be delivered across Buckinghamshire.
- Drawing on the base lining of all existing projects, identify the financial contribution of the services and change projects in scope to meet the system's 2018/19 financial requirements.
- Provide suggested timeline for implementation and outline workforce projections.
- Review the care model to strengthen prevention and self-care and ensure that it maximises the care delivered locally and focusses on health and wellbeing in line with the design principles in Appendix 5.
- Development of a robust communication plan with the public and professionals to raise the awareness of the hubs and increase the productivity and value of the services for the local community.
- Review outpatient services to ensure that the shift to local provision is transformational, meets the local health population needs and not just utilising space.
- Local services for local people to minimise travel and have a home first approach where possible.
- Put in place signposting, education and care navigation in hubs.

Timeline



Appendix 1: Performance KPIs

Key performance indicators measures and indicators dashboard

The adjusted baseline has been calculated using an average of the first 6 months data. RAG rating is against expected baseline.

Measure	Baseline at start of pilot	Adjusted baseline	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients accessing outpatients at community sites (across both sites)	**83**	**143**	83	140	169	152	148	157	103	155	95	125	182	240
Marlow			31	79	68	58	69	83	53	71	30	38	81	123
Thame			52	61	101	94	79	74	50	84	65	87	101	117
Number patients seen in Community assessment and Treatment service across both sites (1st appointments, follow up and dom visits)	**No baseline**	**58**	16	52	75	52	57	85	113	121	72	119	87	131
Marlow			4	31	37	30	23	51	65	70	44	71	62	62
Thame			12	21	38	22	34	34	48	57	28	48	25	69
Number people seen in Community Assessment and Treatment Team **as admission** avoidance across both sites (1st appointments)	**No baseline**	**41**	16	52	48	30	40	65	78	88	47	80	67	83
Marlow			4	31	24	19	18	38	45	50	25	48	45	41

Thame			12	21	24	11	22	27	32	38	22	32	22	42
Number people seen in Community Assessment and Treatment Team as **supported discharge** across both sites (1st appointments)	**No baseline**	**>1**	1	1	0	0	0	0	0	1	0	0	0	
Number of people Discharged Home – no follow up required (across both sites)	Outcomes from Community Assessment and Treatment Team		16	32	20	18	19	34	68	63	38	67	38	47
Number of people Discharged Home – Follow up required from community teams (across both sites)	Outcomes from Community Assessment and Treatment Team		0	7	6	4	3	5	11	6	2	5	7	43
Number of people Discharge Home - Follow up required from Community Assessment and Treatment Service (across both sites)	Outcomes from Community Assessment and Treatment Team		0	7	13	16	6	26	18	22	19	28	18	13
Number of people sent to A&E (across both sites)	Outcomes from Community Assessment and Treatment Team		0	0	1	0	0	0	0	0	1	2	1	1
Number of people referred onto other services (across both sites)	Outcomes from Community Assessment and Treatment Team		0	2	4	5	2	13	8	17	12	7	6	2

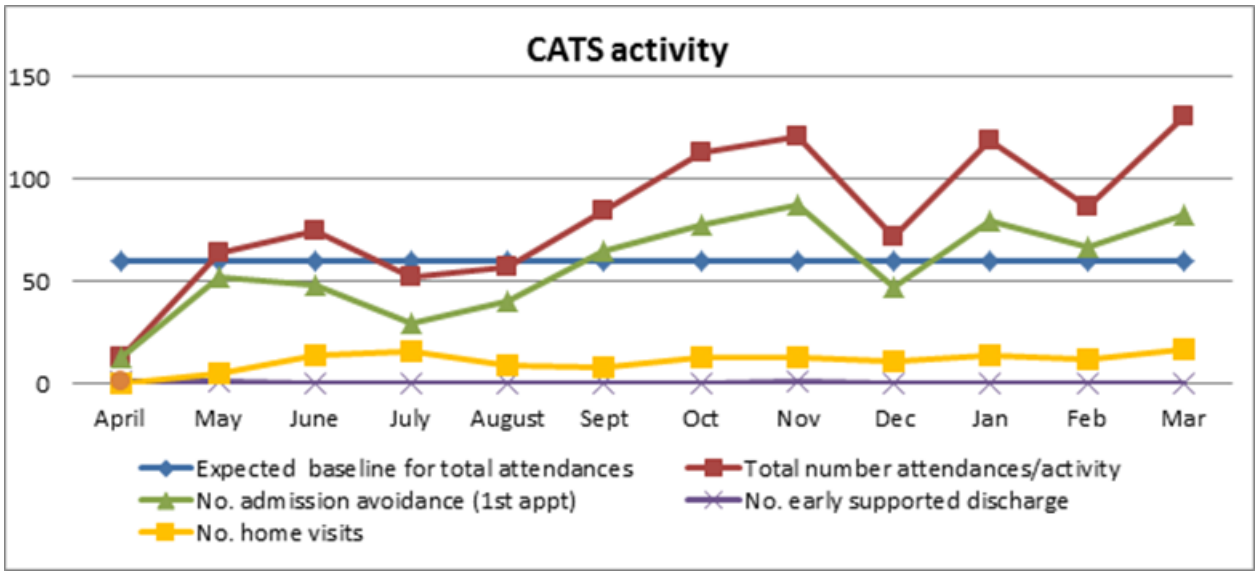
Number of patients over 75s seen within Community Assessment and Treatment Team after 28 days discharge from Stoke Mandeville Hospital (across both sites)	**No baseline**	**Monitor**	1	2	2	3	3	0	2	10	7	4	3	8
Community Assessment and Treatment Team Patient related experience measures (across both sites)	**No baseline**	**80% Rating community services as good or excellent**		100% 30/52 1st appts only	100% 48/48 1st appts only	100% 18/30 1st appts only	100% 32/40 1st appts only	100% 58/65 1st appts only	100% 67/78 1st appts only	100% 79/79 1st appts only	97% 34/35 1st appts only	100% 65/65 1st appts only	100% 61/61 1st appts only	Data not available yet
Community Assessment and Treatment Team friends and family measures (across both sites)	**No baseline**	**95% extremely likely or likely to recommend service**		100% 30/52 1st appts only	96% 48/48 1st appts only	100% (18/30) 1st appts only	93% 32/40 1st appts only	100% 58/65 1st appts only	100% 71/78 1st appts only	99% 74/75 1st appts only	100% 43/43 1st appts only	96.7% 60/60 1st appts only	94.3% 70/83 1st appts only	
Number of patients on waiting list for Community Hospital all sites (as of last day of the month)	**No baseline**	**Monitor**		30	12	17	17	28	3	20	29	33	16	38

Community county wide services indicators

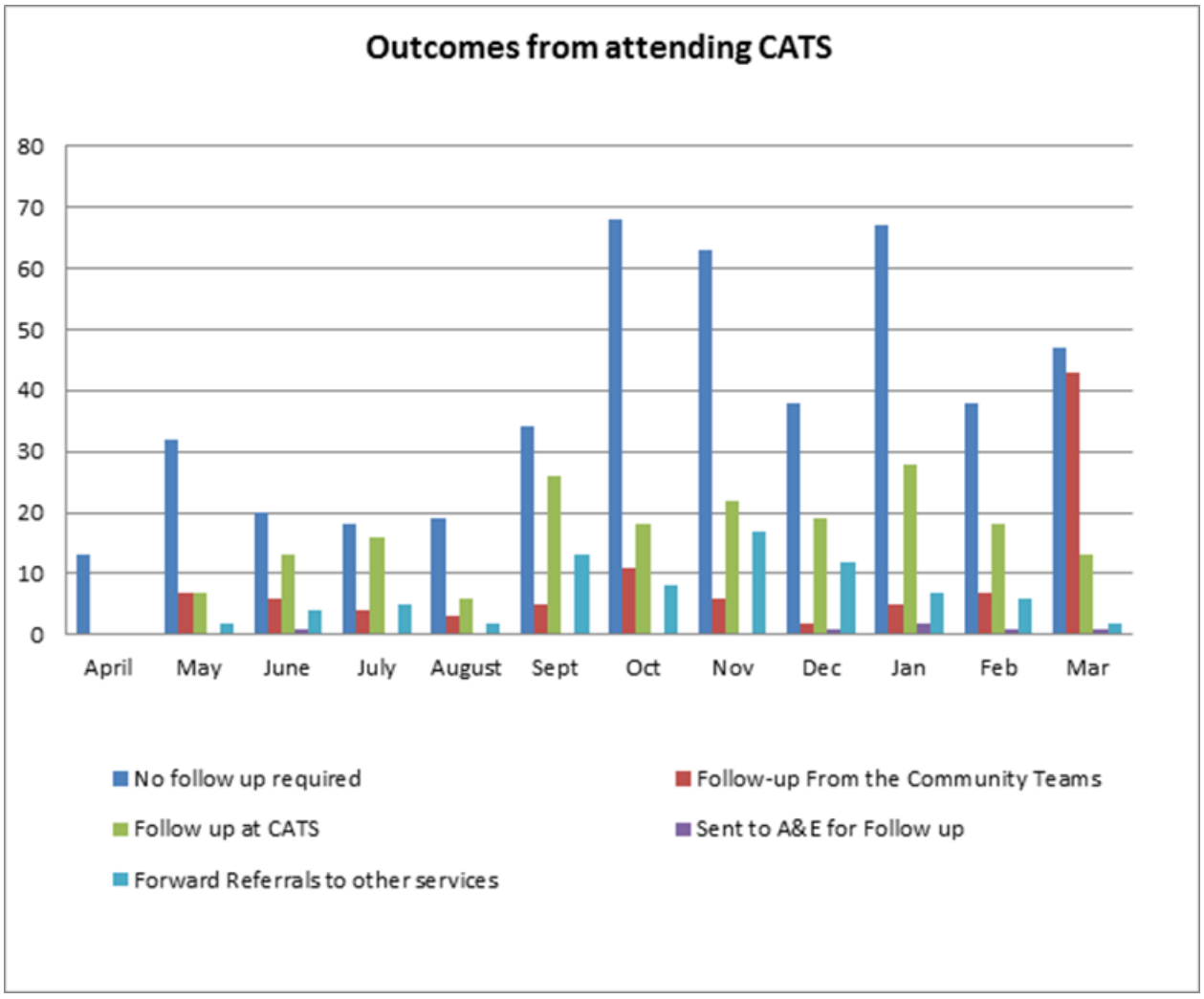
Measure	Baseline at start of pilot	Expected baseline	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of admissions avoided (Adult Community Healthcare Team & Rapid Response and Intermediate Care Team)	**800**	**850**	805	935	1020	971	897	838	888	1095	970	996	897	825
Number referrals managed through community care coordinator	**500 (not including GP referrals)**	**Expect to achieve baseline as services uptake referral pathway**	154	331	398	499	575	533	599	592	604	673	540	565
Rapid response intermediate care & therapy contacts	**7900 contacts**	**16600 contacts when fully recruited**	9750	10758	11559	11556	12439	11601	10729	11592	9991	11486	9886	9602
Rapid response intermediate care & therapy contacts	**Expected total contacts in relation to % staffing recruited - contacts are RAG rated against these**			3984	6806	8300	8300	10126	12719	10790	11288	11288	11288	11288
Rapid response intermediate care & therapy contacts	**% staff recruited**		10%	24%	41%	50%	50%	61%	68%	65%	68%	68%	68%	68%

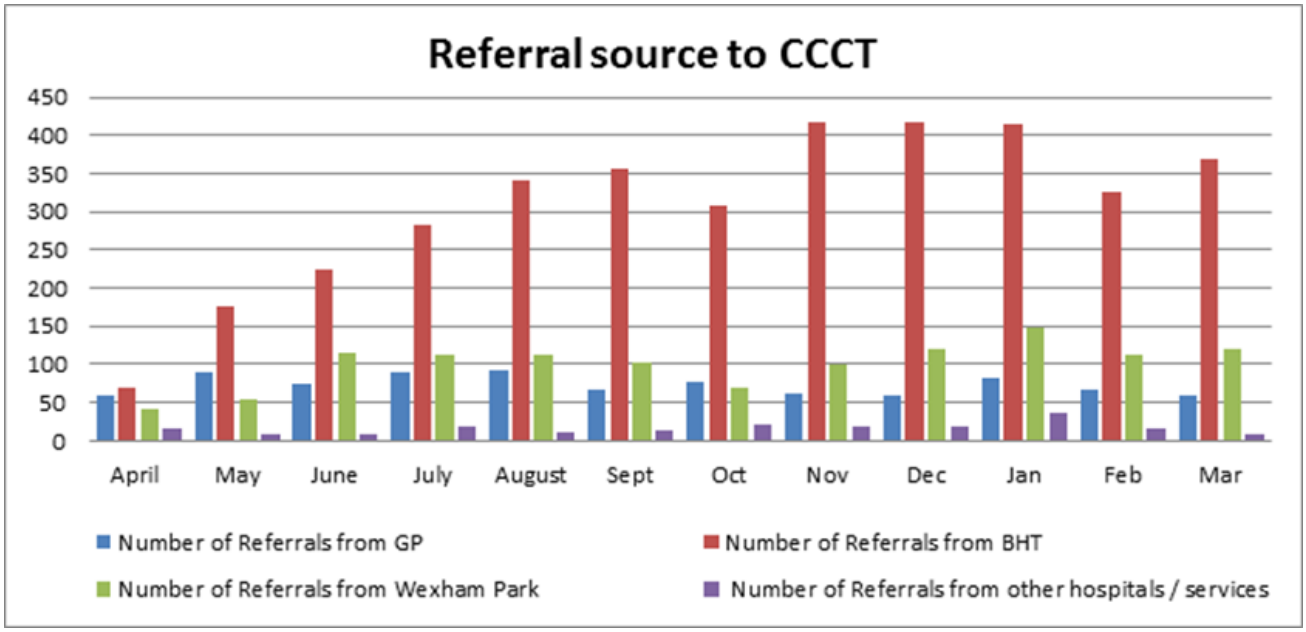
Adult Community Healthcare Team & Rapid Response and Intermediate Care Team Patient related experience measures	**80% rating good or excellent**	**Demonstrate improvement**	97% 62/62	93% 82/82	100% 74/74	97% 109/109	95% 40/40	100% 120/120	98% 93/93	99% 110/111	100% 77/77	100% 55/55	98% 57/57	Data not available yet
Adult Community Healthcare Team & Rapid Response and Intermediate Care Team friends and family test measures	**95% extremely likely or likely to recommend service**	**Demonstrate improvement**	95% 62/62	97% 82/82	97% 74/74	100% 109/109	98% 71 /71	99% 69/69	93% 112/112	98% 50/51	97% 60/62	96.7% 29/29	100% 28/28	Data not available yet
% of people discharged from acute care to normal place of residence	**92%**	**94%**	90%	91%	91%	92.7%	90.6%	91.1%	89.7%	89.5%	90.1%	95.1%	96.2%	90.1%
% of patient Readmissions of over 75s within 28 days	**21%**	**Reduction in overall admissions**	Reported in May	21%	22%	19.7%	18.9%	24.4%	18.1%	19.58%	18.1%	17.8%	Data not available yet	17.35%

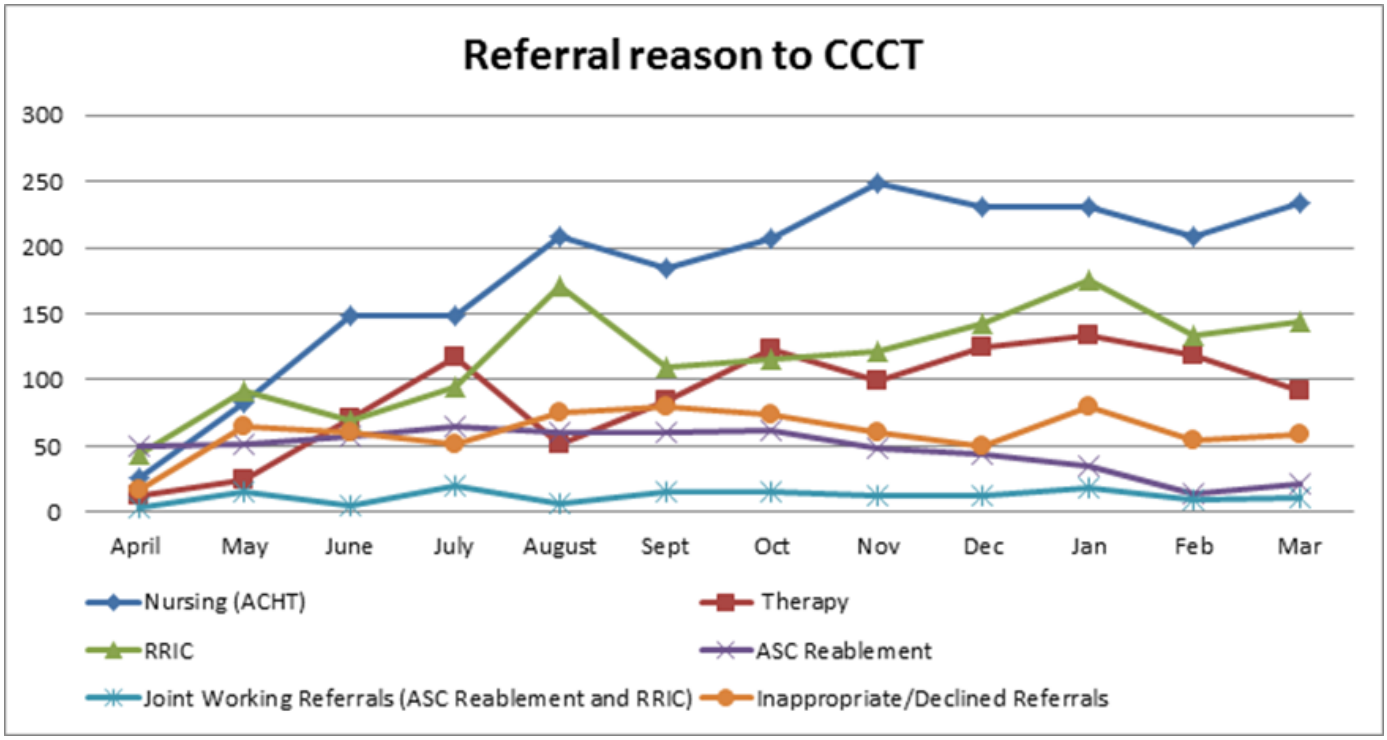
Community Assessment and Treatment Service (CATS)



Outcomes from attending CATS show that most patients do not need a follow up appointment.







A selection of answers from the questionnaire asking what patients didn't like about their visit or care that day:

- We liked everything and the arrangements which have been made.
- Waiting around
- It would have been nice to know that this I was a long appointment we had only reckoned on 30 minutes and we were here for 3 hours.
- The long wait
- Had to wait two hours for patient transport to collect me from home and then from 12 noon to 1.30pm to take me back another 1 and a half hours wait.

- The length of time not expected
- Too cold
- My visit was very satisfactory. Seen on time and looked after for every stage of my stay
- No complaints everything was very impressive.
- Nothing. It was spotlessly clean and no one else about! A few people crept in later in the morning.

Appendix 3

Your community Your care
Developing Buckinghamshire together

Bringing care closer to home.

Stakeholder views on community hubs

'They turned me from being a patient back into being a person'

Executive summary

Introduction

Buckinghamshire Healthcare NHS Trust, working with its health and social care partners, launched the community hubs programme in April 2017, at two pilot sites in Marlow and Thame. This followed an extensive public and patient engagement exercise in 2016 to find out what people wanted from a community hub. The findings informed the development of the pilot hubs.

Between September 2017 and March 2018 the Trust conducted further public and stakeholder engagement. The objectives were:

- To engage with and involve the local community to ensure their views and experience inform future decision making around the pilots both in Marlow and Thame and more widely across the county
- To review the criteria for community hubs that the public had developed in 2016 to see what progress had been made and to test their continued relevance
- To get feedback from staff and patients, and partner organisations involved in the pilots to inform on going service development

Methodology

The involvement and engagement team gathered the views of 352 stakeholders, using a mixed methodology tailored to different groups:

- Focus groups with 28 hub patients
- Appreciative enquiry workshops with 7 hub staff
- 3 telephone interviews with staff from Healthy Minds, Alzheimer's Society and Age UK
- Public engagement workshops in Buckingham, Chalfont, Marlow, Wycombe, Thame, Aylesbury, and Iver, attended by 191 members of the public
- Sessions with 123 members of voluntary sector service user groups, and a patient participation group

This was in addition to the public and community group meetings the Trust was invited to present at and the open days at both hubs. The Trust engaged with over 1000 members of the public through its community hub open days, and meetings of organisations including parish councils, University of the third age, PPG's and stalls at community markets in which there was more general discussion and information giving.

Key findings:

- The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review
- Patients and the public wished to see the current hubs continue and to see the model rolled out across Buckinghamshire, with provision tailored to needs in different areas
- All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential
- Levels of awareness of the hubs was low amongst both patients and GPs
- Transport was highlighted as an issue, with the lack of community transport to the hubs potentially a barrier to access for some patients

Key recommendations from public and stakeholder engagement:

Current hubs

- Raise awareness of the current hubs with public and GPs, in part through clearer branding
- Increase the service to at least five days per week at both sites
- Review the current referral process with GPs, and consider expanding the process to self-referral
- Ensure better co-ordination of the different services operating within the hubs
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic like, to provide better facilities for partner organisations to provide their services, and to be dementia and learning disability friendly
- Mobilise a wider range of outpatient clinics

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units
- Ensure effective joint working across health and social care and with voluntary sector
- Consider how pubic and community transport to hubs could be improved
- Provide signposting to other public and voluntary sector support services

1. Introduction

In April 2017 Buckinghamshire Healthcare NHS Trust working with its health and social care partners, launched the community hubs programme, at two pilot sites in Marlow and Thame. In 2016 the Trust conducted an extensive public and patient engagement exercise to find out what people wanted from a community hub. The key findings were that patients and the public wanted:

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

The findings informed the development of the pilot hubs. Between September 2017 and March 2018 the Trust conducted further stakeholder engagement. The objectives were:

- To engage with and involve the local community to ensure their views and experience inform future decision making around the pilots both in Marlow and Thame and more widely across the county
- To review the criteria for community hubs that the public had developed in 2016 to see what progress had been made and to test their continued relevance
- To get feedback from staff and patients, and partner organisations involved in the pilots to inform on going service development

Methodology

The involvement and engagement team gathered the views of 352 stakeholders using a variety of methods:

- Focus groups with 28 current hub patients
- Appreciative enquiry workshops with 7 hub staff
- 3 telephone interviews with staff from Healthy Minds, Alzheimer's Society and Age UK
- Public engagement workshops in Buckingham, Chalfont, Marlow, Wycombe, Thame, Iver and Aylesbury, attended by 191 members of the public
- Sessions with 123 service users from the following organisations; Alzheimer's Society, Bucks Vision, Haddenham Carers, Macular Degeneration Society, Talkback, and Rectory Road patients group

This report details the views and recommendations of the above stakeholders. In addition to the engagement sessions with stakeholders detailed in this report, the Trust and the Buckinghamshire clinical commissioning groups held information and discussion sessions to keep the public informed of progress with the community hubs, reaching over 1000 members of the public.

2. Patient views of the community hubs

Introduction

Views of patients who had used the hub were sought as part of the wider stakeholder engagement exercise to inform the Trust's plans for bringing care closer to home across Buckinghamshire. The aim of the patient engagement was to get feedback from patients involved in the pilots to inform on going service development

Methodology

All patients who had used the community assessment and treatment service in Marlow and Thame community hubs in its first 6 months of operation, and a sample of patients who had attended outpatient appointments were contacted. Two focus groups were held, one in Marlow and one in Thame. The following questions were asked:

Could you briefly describe your experience of being a patient at the hub? What went well? What went less well?

- What could we do that would have improved your experience?
- Did life at home become easier after the service you received at the hub?
- From your experience of being a patient here, do you think the hub is doing what it set out to do?
- What other services would you like to see provided at the community hub?

Participant profile

There were 28 participants in total, 21 at the Marlow event and 7 at the Thame event. 23 of the 28 people who attended completed and returned their equality monitoring form. Of those:

- 7 were males and 16 females
- The ranged in age from 65 – 80 years plus groups with the larger number being in the 65-79 age groups.
- 21 of those who responded classified themselves as white British

Discussion results

Could you briefly describe your experience of being a patient at the hub? What went well? What went less well?

In Marlow the experience of being a patient at the hub had been a very positive one for all of the participants. The holistic, 'one-stop-shop' nature of the service, being given the time to see a range of clinicians, and talk their case through, was seen to have great benefit.

- *'I was extremely satisfied with everything, I thought the team were brilliant, the comprehensive review of my condition, made me understand what was going on, after months of pain and restricted mobility. I have nothing but praise. It brought it all together, in the round. Up to then it was ad hoc, you went to the doctor when you needed a doctor, you went to minor injuries, you went to A&E if you had a fall. I felt I was a person, not a patient'*

- *'A one stop shop as mum said, we came in we saw a doctor a nurse, a physio you had an x-ray while you were here you got the results while you were here'*

- *'What was really nice was to be able to talk to them, be told things I've been trying to find out for weeks'*

- *'Everybody was so good, they had brought in a doctor who specialised in my condition, and other people coming in and saying how could they help me, escorted everywhere, whereas at Wycombe you go to one department then you are sent downstairs, here it was all compact'*

- *'They turned me from a patient back into being a person'*

Patients appreciated the speed with which they were able to be referred in to the service

- *'I was asked, can you get to Marlow 2 o'clock on Monday. You'll get a letter tomorrow, this was Friday, I did get the letter and we were here on Monday'*

- *'The paramedic came to see me on Thursday and I was here on Friday'*

Patients felt the attitude and care delivered by staff was excellent, both to patients and to carers

- *'The nurse took me everywhere to the x-rays and everything, as we sat there different people came in, physio came in, I found it absolutely incredible'*

- *'The service I received from the receptionist through the doctor and all the nurses were first class. I was so impressed. I went away very boosted up'*

- *'Usually they don't care about you,(the carer) but here it was lovely they kept asking how I was'*

For some participants in Marlow there was a clear sense that the service had helped to avoid hospital admission, for example:

- '*There is always the fear of being admitted to hospital, to come here and essentially get everything in one hit is much better, even if you went into hospital you wouldn't get things sorted out as quickly and efficiently as we have here, you spend so much time waiting in A&E and go to ward and nothing actually happens, here in just a few hours we got a lot sorted out, we got referred to the speech and language lady who came to see dad at home, for us it probably saved a hospital admission'*

In Thame patients who had attended outpatient appointments appreciated being treated closer to home, in terms of convenience, speed, and for one participant to avoid a hospital stay:

'I came to outpatients to see the chest doctor. I'm obviously in Thame, I don't have to travel. I've also used district nurses that come in, because normally I have to go into hospital, I stayed in 5 days the last time. They came to my home twice a day. But yes the outpatients bit is brilliant'

'I was here for all of 10 minutes I came to see my surgeon following surgery in March found it easy to park , I wasn't kept waiting at all I was in and out in 10 minutes'

Patients appreciated the full assessment they received:

'Very good came to improve to not fall down there was a physio they were all excellent especially the physio, it was all very good. Very good all of it'

'I thought it was super. At least they assessed me'

In Thame a number of patients spoke about not knowing why they had been referred to the hub. It had not been explained by the GP. They simply received an appointment in the post and only understood what the appointment was for once they attended.

'I didn't know what I was coming to when I came here; I have an on-going muscle condition for last 20 odd years. I'd seen my doctor because I had a lot more problems then I got a call about coming here so I thought there was somebody here a specialist, to look at some other forms of the muscle problem. I didn't know what it was until I got here. I didn't know it was a collective assessment so to speak, going around lots of people. Nobody was a specialist but they were all interested and took notes. I didn't get much advantage from it.'

'Thame rang me and said aren't you coming? I said where and they said I was booked for Thame, no communication. I didn't realise what I was coming for. Halfway through the assessment I realised what it was for, although I had severe falls it was to assess what I could do , with my brain especially. I thought it was to see what was wrong with my bones, I have osteoporosis you know'

'Were the doctors made aware of all of these things going on here, it just seems odd that several of us didn't know why we were coming here? It wasn't like someone at the surgery said do you want to see somebody about falls or anything like that, I just had a letter'

What could we do that would have improved your experience?

In Marlow having access to transport to the community hub was the main thing that would improve some patients' experience of the community hub. Most were reliant on friends or relatives as public and community transport options were very limited or unavailable.

- *'In time transport may become an issue for most of us'*
- *'My neighbour was able to drive me, but transport is an issue'*
- *'Transport is the biggest problem, it is a nightmare'*

One patient had to be transferred to Wycombe as she needed an IV. Her experience would have been improved if the hub was open all week and had the correct equipment to allow her to be treated closer to home.

In Thame participants felt that more could be done to make the community in Thame aware of the hub:

'I didn't know this was here, I mean I live on the doorstep'

'How would people get to know that it was here? There's no information anywhere, not even in the doctor's surgery, to tell you this kind of thing is available. If you are seriously ill the doctor will put himself out to tell you what is available, but people on the sort of borders of things, this sort of thing would help them not get any worse than they are if they knew it was available'

Did life at home become easier after the service you received at the hub?

Many of the patients had seen a significant improvement to their quality of life in the time since they had been seen at the hub. One of the things that had an impact was the opportunity to have someone review all of their medication, in several instances leading to a reduction or change in medication, that the patient felt had been very beneficial.

- *'Within a month Dr Johnson had changed all my medication and I felt on top of the world'*

- *'The change of medication made such a difference'*

- *'Medication, having a second opinion, they said, you might not need this anymore. They took me off two lots of drugs'*

Several patients had someone visit them at home to assess their need for aids and to provide practical advice following their visit to the hub. This had improved their quality of life.

'A lady came to my house she asked how I got off the loo I said I just hang onto the door, she said you don't want to do that, she got me a handle'

'The aids around the bathroom, they have been so helpful, my wife knows I can be left safely'

'Sometimes I can't walk at all and problems getting up and out of chairs so she gave me a loo seat with a handle that was helpful, which they delivered the next day actually'

'The two nurses came down and they brought me a wheel about trolley so I could wheel my meals around. I don't know what made me fall, I fell in the garden, they told me to do away with my rugs you know, because you can trip over them of course, that and the handle for my loo, it was very useful'

'The advice I received from the nurses, they were concentrating on my arm which I broke, they gave me quite a few exercises I hadn't done before. I had my plaster off at Wycombe and they said I could go there for physio, but of course I can't get there every day, you can't get to' Wycombe unless you have transport and of course I don't have transport. The nurses told me extra bits which they hadn't told me at Wycombe which was a great help'

From your experience of being a patient here, do you think the hub is doing what it set out to do?
Patients were asked how they felt the hub was performing in relation to the 10 criteria that patients and public had identified as what they wanted from a community hub in the original 2016 public engagement events.

Marlow:

Criteria	**Patient experience**
Rapid access to testing	Patients felt this was working well. Participants had had blood tests and x-rays and received results on the day
Earlier signposting to health and care – single point of access	Participants had not experienced this
Joined up teams across the system	It was felt the teams within the hub worked well together.
A full range of therapy services	Patients had felt they received a range of interventions. One patient felt she would have benefitted from seeing a podiatrist experienced in dealing with complications from diabetes
Health and wellbeing function enhancing self-management and providing education	Patients had not seen evidence of this, one participant who had diabetes felt control of her condition had been taken out of her control since she used the hub, with nurses visiting her at home to test her and provide insulin
A sociable space with a café	This was not seen as a priority by those present. It was felt

	that Marlow had enough cafés and that a number of organisations also provided this kind of service for older people.
A base from which skilled staff can work in the community	Participants had experience of this working well, with staff coming to their homes to assess their need for aids and providing advice
More outpatient clinics locally	As CATS patients, participants had not experienced this but could see from the list that it was happening. Questions were asked about whether people could be referred by their doctor to the clinics
Virtual networks providing info – supported by excellent technology	Participants did not see this as a priority
More info shared between organisations to improve patient care	It was felt this could be done better. It was felt that more could be done to publicise the hub.

Thame:

Criteria	**Patient experience**
Rapid access to testing	Participants had not experienced this
Earlier signposting to health and care – single point of access	Not experienced this
Joined up teams across the system	Not experienced this
A full range of therapy services	Those who had a CATs assessment had experienced this
Health and wellbeing function enhancing self-management and providing education	Not experienced this
A sociable space with a café	Participants did not see this as a priority as there were a number of cafes in the town
A base from which skilled staff can work in the community	Participants had experienced this, with community staff visiting them at home
More outpatient clinics locally	Participants had seen the benefits of having outpatient appointments closer to home
Virtual networks providing info – supported by excellent technology	This was not viewed as a priority for this patient group
More info shared between organisations to improve patient care	Participants felt this was not happening effectively

What other services would you like to see provided at the community hub?

- Access to public or community transport for those living outside Marlow in South Buckinghamshire
- Equipment and extended opening days to allow for IV treatment

- Pain clinic
- Podiatrist
- One patient suggested having a range of consultants with different specialities
  '*Specialist for a particular thing so if people who needed a particular specialist could make appointment, something like neurologist, or rheumatologist'*

Conclusions

- The hub model, of having a range of services organised around the patient, is working well for those who have experienced it. Patients feel cared for, and the services received have had a clear positive impact on health and wellbeing, including avoiding hospital stays
- Patients had benefitted from being able to access outpatient appointments closer to home
- Having staff based in the hub visit patients at home to give advice and practical help was working well with a number of patients feeling their quality of life had improved as a result
- In Thame a number of patients referred by their GPs were unaware of why they were being referred
- Patients felt more could be done to raise community awareness of the hub
- The key challenge for patients in accessing the hub is having transport ,most were reliant on friends or relatives, as public or community transport options were limited or unavailable
- There is still much scope for developing the hub to achieve the ambitions set out by patients and the public for a community hub, though having a café was not viewed as a priority**.**

3. Staff views of the community hubs

Introduction

The aims of the staff engagement were:

- To find out staff views on service delivery to patients since the hub was set up
- To explore how the community hub could develop to continually improve the patient experience

Methodology

All staff from the community hubs were invited to take part in workshops. Workshops were held in Marlow and Thame each attended by three members of staff. The following questions based on the principles of appreciative enquiry were explored:

- What has been your best experience of the community hub, a time when you felt that it worked well for everyone involved?
- What made that possible?
- Imagine we are a year into the future and the hub is working perfectly based on these ideas and principles. What would that look like?
- What would need to happen to get us there?
- Staff were asked to rate out of 5 how far they felt each of the 10 criteria for community hubs set out by patients in the engagement events in 2016 had been met.

Participant profile

Six participants took part in the workshops. This was made up of five nurses and one healthcare assistant

Discussion results

What has been your best experience of the community hub, a time when you felt that it worked well for everyone involved?

Staff in Marlow had a very positive view of the service to patients; one mentioned that if it was her mum she would want her to have this kind of service. The hub provides a 'one stop shop' for patients, having access to doctors, nurses, OT and physio at one site. Patients receive a comprehensive service without having to attend lots of different appointments potentially at different sites. Patients have thorough frailty assessments and longer appointment times. Their GPs are only able to see them for ten minutes so referring them onto the hub means that the patient can be checked thoroughly and leave knowing what their next steps need to be. They have access to consultants therefore diagnosis for some patients is quicker. Having a range of professionals together meant they could spend time discussing the patient's case and take a joint approach to best way forward. It makes life much easier for carers. The CATs team can refer patients to other services like Prevention Matters and social services. In one case social services had seen a patient at the hub.

Staff in Thame were also very positive about the benefits of the service to patients. Patients themselves were very happy with the service; one patient had spoken about 'feeling loved'. The benefits to patients included, being able to see a number of clinicians in one day instead of a series of different appointments, they can be seen by an OT at the clinic who will then visit them in their home, so more continuity in service, it was a more personal service with more time for patients and patients did not have to wait to be seen.

What made that possible?

- Having a range of services in one place
- More joint working
- Thorough assessment of clients situation and needs

Imagine we are a year into the future and the hub is working perfectly based on these ideas and principles. What would that look like?

Marlow:

- Hub would be open 5 days a week
- It would have a clearer mission statement that potential referrers such as GPs would be more aware of. Clarity about where hub fits with community and acute services
- Referral pathways working effectively. GPs educated in how to refer and to what.
- Hub would have its own doctor available whole time it was open
- There would be cover for staff when people on annual leave/sick
- There would be an administrator so nursing staff can focus on more nursing
- There would be a dedicated transport service for patients and better signage at the hub
- More varied menu available to patients, currently only able to offer soup
- More services available for patients

Thame

- The hub would be open 5-7 days a week to provide a truly preventative service and allow for consistency, for example being able to provide IV antibiotics in one place on consecutive days.
- The hub would have a clearer remit or brand, providing unique service not just taking bits from others
- It would be much busier, with potential referrers such as GPs more aware and knowledgeable about the service
- There would be additional services available such as podiatry, and ultrasound
- Administrative and reporting systems would be more streamlined and there would be an administrator, potentially working across both pilot sites
- Services would be more joined up
- BHT doctors and consultants would have access to GP patient records on EMIS
- There would be more consistency in doctors attending hub, ideally one doctor for the hub
- The environment would be more clinic like
- The hub would have the right equipment available for the work being done there
- The staff skill mix and level would be more appropriate to the service being provided, staff would feel their skills are being utilised and developed rather than feeling deskilled

- There would be cover for staff if they are sick or on annual leave

What would need to happen to get us there?

<u>Recommendations applicable to both sites</u>

Brand and marketing

- There is a need to create a clearer USP for the community hubs. This can then be used to market the hubs more effectively to potential referrers particularly GPs and increase referrals

Services

- Linked to the above is the recommendation that services are mobilised as quickly as possible into the hub, so there is clarity about what is on offer. Staff recommendations included, podiatry, ultrasound, dietician, and more third sector organisations like Age Concern
- Consideration should be given to increasing the service to 5 days per week at both sites

Staffing and administration

- The skills mix and level of staff should be reviewed taking into account what patient needs have been during the pilot to date.
- An administrator role should be created, potentially shared across both sites
- There should be cover for holidays and sickness
- Have more consistency of doctors
- Access to records: Look into how BHT doctors can have access to GP records

Governance and reporting

- Review the reporting needs with view to streamline processes and avoid duplication. Have clearer project management approach to programme development, potentially involving service improvement team

Recommendations specific to Thame

- Environment: Invest in changing to a more clinic like environment so is more functional and feels less like hospital ward that is not being fully utilised. Better use of space downstairs , including more office space and power points
- Equipment: Review and provide appropriate equipment, taking into account use over the pilot so far. For example hub has two underutilised blood testing machines, physio requires mats and parallel walking bars

Recommendations specific to Marlow

- Environment: Provide better signage. Provide wider range of food options, patients often waiting a while and current options not substantial enough
- Transport: Explore options for dedicated transport for patients
- Signposting: Develop list of available services and contact details

How far have criteria developed in the public and patient engagement sessions been achieved? 0 being not achieved and 5 being completely achieved:

Staff agreed a rating between them for each criterion.

Marlow

Criteria	Rating	Comments
Rapid access to testing	4	Need basic blood testing, echo and CT scans to complete the service
Earlier signposting to health and care – single point of access	3/4	
Joined up teams across the system	3	
A full range of therapy services	4	
Health and wellbeing function enhancing self-management and providing education	1	Would like to see cancer care and diabetes here. Already used by Parkinson's group

A sociable space with a café	0	
A base from which skilled staff can work in the community	5	
More outpatient clinics locally	3	
Virtual networks providing info – supported by excellent technology	0	We do provide this service by using our own PCs to get information for our patients
More info shared between organisations to improve patient care	2/3	

Thame

Criteria	**Rating**	**Comments**
Rapid access to testing	3	
Earlier signposting to health and care – single point of access	4	
Joined up teams across the system	2	
A full range of therapy services	4	If no annual leave
Health and wellbeing function enhancing self-management and providing education	5	
A sociable space with a café	0	
A base from which skilled staff can work in the community	5	
More outpatient clinics locally	3	
Virtual networks providing info – supported by excellent technology	1	We do go online for some of our patients and print them information off for them to take away
More info shared between organisations to improve patient care	1	

4: Partner organisations' views of the community hubs

Introduction

A number of VCS and health organisations provide services within the hubs. Their views were sought as part of this review to inform the development of the hubs programme.

Methodology

Telephone interviews were conducted with representatives from the following organisations:

- Healthy Minds
- Alzheimer's Society
- Age UK

They were asked what had gone well, what had gone less well and their recommendations for the development of the hubs.

Discussion results:

- All interviewees had found the CATS staff friendly and helpful
- All had expected to receive referrals to their service through CATS, but this has not happened to the extent they had hoped. Healthy Minds were seeing their own clients who were able to get to the hubs
- Interviewees felt that the different organisations operating in hub were working quite separately, and not in a co-ordinated way
- The VCS organisations felt that the environment within the hub was not designed in a way that supported the services they wished to deliver. The presence of day beds, lack of adequate chairs and tables, lack of space to display materials, and limited access to tea and coffee making facilities were mentioned.

Recommendations made by interviewees:

- A regular meeting of all organisations operating in the hub to facilitate better co-ordination of the services
- Ensure environment is dementia friendly and develop facilities to support group sessions, and for display of leaflets
- Both Healthy Minds and Alzheimer's offered to provide training for hub staff.
- Healthy Minds recommended the following:
    - Consultation sessions with CATS team to look at their caseload and see who might benefit from Healthy Minds service
    - Healthy Minds to provide training to CATS staff. Two courses available one on detection of common mental health problems, second '10 minute CBT' giving intro to CBT framework
    - Falls prevention classes, Healthy Minds could attend to talk about role of anxiety in falls and way to address it
    - Healthy Minds are able do home visits

5: Service user groups views of community hubs

Introduction

The Involvement and Engagement team met with a number of service user groups to ensure the views of those less likely to attend the Trust's public events were sought as part of the review.

Methodology

The Involvement and Engagement team attended group meetings and presented on progress with the hubs in Thame and Marlow, and were then asked the following questions:

- What do you like about what you have heard?
- What concerns you?
- What does the Trust need to consider in order to ensure that the hub model meets the needs of your community/group?

Participant profile

- Alzheimer's Society - 25 participants made up of people with Alzheimer's and their carers
- Bucks vision - 36 participants made up of people with visual impairments and their carers
- Haddenham Carers - 8 carers
- Macular Degeneration Society - 16 participants made up of people with macular degeneration and their carers
- Rectory Road patients group - 34 participants
- Talkback - 4 members of Talkback's management committee all of whom had learning difficulties

Discussion results

What participants liked:

- The hub model of holistic care in one place was supported by all groups
- For carers the idea of care closer to home was important as they often delayed or did not deal with their own health problems because of their caring responsibilities. If they did attend appointments at the main hospitals they either had to take the person they cared for or arrange emergency cover. One participant talked of the difficulties of having chemotherapy and having to bring his wife who had Alzheimer's. Having a hub close by would make it easier for carer's to maintain their own health
- The large hospitals could be very disorientating for people with Alzheimer's, visual impairments and learning difficulties, so small hubs closer to home would be preferable

What concerned them:

- Local transport was an issue for all groups. Many had to pay for taxis to get to appointments
- Many participants had not been aware of the hubs existence and some did not think their GPs knew about them
- People with learning disabilities were concerned about any change in the services they were used to, and particularly concerned about the risk of GPs not passing on relevant information to specialists.

Service user group recommendations for how the hub programme could take their needs into account:

- Provide a wide range of clinics
- Effective signposting to other organisations who provide support
- Assessment in the home
- Focus on supporting health and well-being including mental health services
- Being able to self-refer to the hub
- Ensure information is shared effectively with GPs
- Dementia friendly and taking into account needs of people with earning difficulties for example with signage
- Somewhere quiet to relax
- More partnership working with the voluntary sector

6. Public views of community hubs

Introduction

Buckinghamshire Healthcare NHS Trust held a series of public workshops across the county between January and March 2018 to engage with members of the public to report back on what had been achieved in the pilot hubs in Thame and Marlow and gather their views on what care closer to home could look like across Buckinghamshire.

They followed on from the public events held in 2016 the findings from which informed the pilot hubs. One of the aims of the events was to revisit and update the ideas the public had developed in 2016 for what a hub could look like in their area.

Methodology

Public meetings were held in Buckingham, Chalfont, Marlow, Wycombe, Thame, Iver and Aylesbury. The meetings were led by members of the Trust's executive group, Carolyn Morrice, Chief Nurse and Tina Kenny, Medical Director. Participants were shown a presentation detailing the work of the pilot community hubs including how the hubs fit into the wider community care provision. This included the assessment below, based on the discussions with hub staff and patients detailed earlier in this report, of how far the hubs had progressed against the original criteria developed from the 2016 engagement sessions:

They then worked in facilitated groups to answer the following questions and answers were recorded on flipcharts:

- What did you like about what you have heard?
- What concerned you?
- In light of what you have heard about the pilot hubs, what's working, the challenges, and local circumstances in your area in 2018, we want to know what your vision for a community hub is now

The results from the discussions were collated and themed.

Participant profile

The events were attended by 191 people in total. Of the 191, 161 completed an equality data monitoring form.

- Gender: 105 of those who completed the form were female and 54 were male
- Age:

0 - 15	
16 - 24	
25 - 34	2
35 - 44	8
45 - 54	14
55 - 64	26
65 - 79	79
80 +	27
I do not wish to declare	5

- Disability: 43 of those who completed a form considered themselves to have a disability or long term condition. 112 did not and 5 did not wish to declare
- Ethnicity

White British	136
Irish	5
Other white background	1
I do not wish to declare	5

Discussion results

What did you like about what you have heard?

There was broad support for the hub model of holistic care across all of the public events, participants particularly liked:

- Rapid access
- Access to multidisciplinary teams
- The range of services available
- Access to treatment at home
- The one stop shop nature of the service
- Access to diagnostics
- Same day results
- Reduced hospital stays/visits
- Outpatient appointments closer to home
- Work with the voluntary sector

What concerned you?

Concerns emerging across the public engagement sessions were:

- The lack of awareness of the hubs amongst the public, GPs and other organisations
- There was a need for better signposting to other public and voluntary sector support

- Voluntary sector involvement not as effective as should be
- Patient information not being shared effectively between GPs and the hub staff, and the referral system via GPs not seen as robust
- Transport was a problem, unless one had access to their own transport or support of friends and family, the lack of public or community transport options was a barrier to access to the hubs
- Following on from this limited access to parking locally was an issue
- The difficulties of accessing services across county borders
- There was concern in Buckingham about the future of the beds in their community hospital

Recommendations for how the community hub programme should be developed:

Members of the public wished to see the current hubs maintained and developed and to have the programme rolled out to where they were. In particular they wished to see:

- Self-referral, or through a wider range of services, including faith based organisations
- More effective work with voluntary sector, including social prescribing
- Effective links between health and social care
- Better public or community transport options available to access hubs
- A higher level of awareness of the hubs within the community
- Evidence based services appropriate to each community
- An increase in the range and volume of outpatient clinics
- Provision of mental health services
- An increase age range catered for
- Having a café was not a priority but having the capability to provide sociable events with a defined purpose such as a dementia café ,or death café was supported
- More focus on prevention/health and well being
- The cross border issues addressed
- A physical space, in some areas this was about making better use of community hospital facilities, but did not have to be hospital based, in Wycombe participants raised the option of a mobile unit.

7. Public information sessions

Introduction

In addition to the engagement sessions with stakeholders detailed in this report, the Trust and the Buckinghamshire clinical commissioning groups held information and discussion sessions to keep the public informed of progress with the community hubs.

Methodology

The Trust held open days at both of its community hubs. Senior staff also presented at a range of events, and answered questions on the community hubs from the public. Over 1000 members of the public were reached through the information sessions.

Event details

Event	Date	Number of attendees
Open Day Marlow	06/07/2017	87
League of Friends from Buckingham visited Marlow and Thame	11/07/2017	6
Buckingham Older People's Action Group	17/07/2017	20
Buckinghamshire County Council	20/07/2017	approximately 100
Age UK	10/08/2017	12
Meeting with Rycote Practice GPs	15/08/2017	8
Thame Community Market	22/08/2017	50
Open Day Thame	13/09/2017	92
Buckingham League of Friends	14/09/2017	12
Winslow and district local area forum	28/09/2017	15
Rectory Meadow PPG	03/10/2017	87
Thame League of Friends AGM	04/10/2017	
Older persons action group Lane End	05/10/2017	33
Marlow League of Friends AGM	09/10/2017	7
Simpson Centre PPG	12/10/2018	90
University of the Third Age AGM	02/11/2017	approximately 100
Chalfont League of Friends AGM	06/11/2017	
Stokenchurch Parish Council	18/10/2017	17
The Ivers Parish Council	06/11/2017	18
Wendover Parish Council	07/11/2017	16
Ivers Women's Institute	08/01/2018	31
Aylesbury University of the Third Age	10/01/2018	200
University of the Third Age Wendover	22/01/2018	55
Buckingham League of Friends AGM	22/03/2018	approximately 30

8. Conclusions and recommendations

Conclusions

- The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review
- Patients and the public wished to see the current hubs continue and to see the model rolled out across Buckinghamshire, with provision tailored to needs in different areas
- All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential
- Levels of awareness of the hubs was low amongst both patients and GPs
- Transport was highlighted as an issue, with the lack of community transport to the hubs potentially a barrier to access for many patients

Key recommendations from stakeholders:

Current hubs

- Raise awareness of the current hubs with public and GPs, in part through clearer branding
- Increase the service to at least five days per week at both sites
- Review the current referral process with GPs, and consider expanding the process to self-referral
- Ensure better co-ordination of the different services operating within the hubs
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic like, to provide better facilities for partner organisations to provide their services, and to be dementia and learning disability friendly
- Mobilise a wider range of outpatient clinics

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units
- Ensure effective joint working across health and social care and with voluntary sector
- Consider how community transport to hubs could be improved
- Provide signposting to other public and voluntary sector support services

Amarjit Kaur
Head of Involvement and Engagement

Appendix 4

Support statement from Patrick Land on behalf of the Marlow Hospital League of Friends

In relation to the Community Hubs Pilot, on behalf of the Marlow Hospital League of Friends I would like this statement of support to be taken into account when considering the future steps in relation to the Community Hub Pilot Scheme. In the Marlow community there has been great anxiety following the closure of the beds in the Marlow Community Hospital some while ago. This was followed by the appearance of the "closure" of the Hospital, which caused very significant local concern. I, together with fellow representatives of the Marlow Hospital League of Friends, and other representatives of the Marlow community including the Mayor have attended regularly at the Community Hubs Pilot Stakeholder Group meetings, at which we have been able to be appraised of the latest developments through the course of the Pilot Scheme, and have been able to be involved in discussions in relation to the Community Hubs Pilot. As far as we have been able we have reported back to the local community.

The view of the Marlow Hospital League of Friends is that the Community Hub Scheme is a positive step which has the potential to be developed considerably, and as such also has the potential to be welcomed widely by the healthcare professionals involved in the delivery of the services, and also by the community will be able to recognise the constructive use of the much valued Marlow Community Hospital as an integral part of the delivery of a modern healthcare service in the locality.

The Marlow Hospital League of Friends very much hope that it will soon be possible to remove the word "Pilot" from the Community Hub Scheme, and for there to be significant ongoing progress in the rolling out of the various services that can be provided from the Community Hub in Marlow, together with the co-ordination with and mobilisation of additional sectors including the voluntary sector to maximise the potential for the services that can be delivered from the Community Hub, and to support the scheme in ways which are appropriate to the Marlow Hospital League of Friends as a local charity.

We await news of the outcome of recent discussions with anticipation.

Support statement from Sarah Taylor, Chair of Thame Hospital League of Friends

The establishment of the pilot scheme for the Health Hub in Thame means that, for the first time in years, the League of Friends of Thame Community Hospital is feeling cautiously optimistic about the future of their hospital. Indeed, there is growing enthusiasm for the project in the wider Thame community.

The hospital had always been associated with beds, originally used for a mixture of respite and patients needing overnight monitoring. Over the years, the number of beds had dwindled to a level that was not financially viable and the small number of beds meant that, more often than not, they were occupied by patients from outside Thame: they couldn't be kept free on the off chance that a Thame patient might need one. Although there was a lot of activity at the hospital, we lived in constant fear of the place being closed altogether.

The growing consensus that frail elderly patients should be kept out of hospital and at home for as long as possible has in fact potentially given our hospital a new lease of life.

What we want is a hospital that is there for the people of Thame and surrounding areas and is, in modern parlance, sustainable. That is, it should have a role that is genuinely useful and affordable for the long term. The current pilot scheme offers the vision of just such a role, combining as it does: the excellent CATS (community ambulatory treatment service) which assesses vulnerable patients and provides solutions to keep them at home and prevent admission to A&E; the existing physiotherapy service; the Day Hospital providing rehabilitation and preventative treatments; an increased number of clinics provided by consultants and other healthcare professionals coming from Stoke Mandeville and the John Radcliffe Hospital; input from the voluntary sector such as Carers Buckinghamshire and Oxfordshire; support from the neighbouring GP practices; more diagnostic services in the community; facilities for the Day Centre. The Buckinghamshire Healthcare Trust that runs the Hospital is working closely with stakeholder groups to adapt to local needs and break down barriers between Hospital and the Community.

Of course, these are early days and all is by no means perfect. We must work hard to ensure that all the GPs in the locality use the services to help make them viable and that patients are aware of what is on offer and push to be referred to the hospital rather than have to go further afield for assessment and treatment. The hospital needs investment in better IT and better equipment. Recruiting staff in an area where housing is so expensive remains a perennial problem. The GPs next door are bursting at the seams and need bigger premises. The transition between healthcare and social care is desperately short of the mark. Keeping people at home only works if there is support for them and their carers. We all must work towards finding solutions to these problems.

We have been given a commitment that, should the pilot fail, the beds will be restored and the hospital returned to what it was. However, we all know that that is not viable in the long run. Therefore, as a League, we are keen for the pilot to be successful and to be confirmed as the policy for the future.

Appendix 5

ICS design principles

1. **Standardised processes** to deliver safe and high quality care - evidence-based clinical decisions informed by peer support and review.

2. **Co-ordinated across a whole system** – ensuring coordination of care for patients across services eliminating unnecessary treatment or duplication.

3. **Population orientated** - focused on the needs in a location, and/or population groups such as those with specific long term conditions or the frail.

4. **Person-centred and holistic** – supporting patients to live independently at the centre of decision making about their care.

5. **Maximising care in the community setting** when care can be more effectively delivered closer to home.

6. **Comprehensive** - access to multi-disciplinary teams to meet patient's health and social care needs; to include wellbeing and prevention, acute and chronic care.

7. **Accessible** - responsive to the patient's needs with appropriate waiting times for advice, diagnosis and care; maximising the use of technology.

8. **Sustainable** - ensuring financial and staffing resources are used effectively to deliver best value.