Health and Social Care Integration – Community Care Model

1. Introduction

As laid out in Next Steps of the NHS Five Year Forward View (2017), Integrated Care Systems are partnerships between all NHS organisations and local authorities in a local area which take collective responsibility for resources and population health. They are expected to make faster progress than other System Transformation Partnerships in transforming the way care is delivered, to the benefit of the population they serve.

Their stated objective with regard to integrated care is:
To integrate services and funding, operating as an integrated health system, and progressively to build the capabilities to manage the health of the ICS' defined population, keeping people healthier for longer and reducing avoidable demand for healthcare services.

In Buckinghamshire we have been working with all the ICS partners to integrate all the elements of care into one cohesive care model. (Appendix 1). Evidence from the NHS E New Care Model programme shows that no one single element will make care sustainable into the future, but rather the implementation of a population health model.

This paper describes the progress we have made in integrating services and the timeline for delivery to March 2019.

2. The community care model

The aim of a population health model of care is to:

- Improve outcomes
- Reduce inequality
- Address the wider determinants of health across the population.

It uses data to develop a deep understanding of the population and uses this understanding to predict, and then deliver the interventions that will be required by sub-populations and individual patients. In addition this understanding will support the system to identify where it can make quality and efficiency improvements to tackle unwarranted variation and better align resources to needs.

3. Elements of the care model

3.1 Population Health

Planning and tailoring services based on population segmentation; better population health through community engagement; supporting self-care and patient activation.

When fully mature you would see:

- Local services designed to meet the needs of the local population
- Easy access to specific prevention services and an understanding within the locality of the barriers to uptake
- Strong community engagement with all community resources mapped and connected
- Network of community champions in place
- The population is segmented and stratified within each segment to ensure that patients most likely to benefit from an intervention are proactively identified
- People with long term conditions and low knowledge and confidence are identified and supported to take control of their own health and wellbeing
- Carers are identified and support is embedded

Our Successes so far

a) Designing services to meet needs of local population

The Public Health Team undertook an **analysis of the burden of ill health** for the ICS population and presented it at the ICS Partnership Board in Aug 2018. This allowed the Board to compare the different localities within Buckinghamshire and also across the System Transformation Partnership. In addition, to help the ICS Partnership Board understand urgent care, the team analysed usage by age, diagnosis, volume of activity.

Locality profiles have been prepared as part of the Buckinghamshire Joint Strategic Needs Assessment by Public Health and are accessible by each locality to help them understand the needs of the local population. In addition the Public Health Team have piloted a deep dive methodology with the North Aylesbury Vale locality and is in the process of preparing a similar pack for each locality.

b) Access to preventative services

In Buckinghamshire, partners are already working together to deliver specific actions related to the Health and Wellbeing strategy. A **consistent approach to prevention**, behaviour change and self-care, which builds on the strengths of individuals and communities, will enable the system to identify priority areas for joint working with the potential to deliver solutions at scale and avoid duplication.

It will enable individual organisations to plan their own projects and programmes with reference to the wider system and identify support available outside their own organisation for example joint training.

Following extensive engagement, a stakeholder workshop was held on 27th September to begin the design of a shared approach to prevention, which will be presented for approval to the Health and Wellbeing Board (HWB) and the ICS Partnership Board. A key outcome from this workshop was that a priority should be tackling **social isolation.**

The next step is that organisations take the final draft of the shared approach for prevention through their own internal processes, including the proposal for social isolation to be adopted as a priority.

The population health analysis drawn up by public health shows that the risk of social isolation (65+ years) in parts of **Aylesbury Vale North** are among the highest in the county. There is a clear evidence of the link between loneliness and poor mental and physical health.

Building on the pre-existing enthusiasm for community involvement, the locality has used local volunteers, or community champions, to map the **community assets** in each parish. This has allowed an up to date resource list to be developed and shared with the voluntary and community sector to engage people in local events. It focusses not on the big, national voluntary sector support but on the small local initiatives which are led by local people e.g. Knit and Natter clubs, local coffee mornings.

The involvement of the **local community champions** is crucial to the success of this work, as it is only through them that the grass roots knowledge to keep such a resource up to date is available.

The locality has also developed the **Patient Support Service** which initially focussed on the elderly but has broadened its remit over time to remove the age barrier.

The team consists of 6 individuals (3.5wte) supported by 32 befriending volunteers. All of the team have received training in motivational counselling and patient activation. The team visit patients in their homes and assess a wide range of health and social needs, signposting people to relevant agencies. The range of support is broad and includes, for example, access to mobility aids and personal alarms, health interventions and benefits advice.

Currently the team have an active case load of 37 cases, with a further 219 people who are supported through an occasional follow up call or are supported by befrienders. Since January 2018 the service has been supported by EMIS clinical services which enables the Patient Support Team to record their interventions on the patient's General Practice clinical record. This is a first step in developing an integrated care record.

Across the county 81 non- clinical members of staff from practices have been trained in **signposting patients** to help them access directly the support they need, which often is not a health response. 26 of these have had further training to use health coaching skills to support individuals to identify and achieve their own goals. Implementing signposting in practices is one of the national 10 high impact changes for general practice which is recognised as releasing more time for clinicians to care.

3.2 Urgent care needs and integrated rapid response

Proactive community based approach to urgent care; joined up rapid response service and integrated urgent care.

When fully mature you would see:

- Patients can make a single call to get an appointment out of hours, including being directly booked into in-hours general practice
- Care plans and patient notes can be shared between providers
- Capacity for community services operating 24/7 is jointly planned
- A rapid response service that can meet the health and social care needs of patients 24/7 and avoid admission to hospital
- Patients are able to access booked appointments in general practice in line with the national standards

Our Successes so far

a) 24/7 primary care access

From April 2018 the primary care out of hour's service and the urgent care centre at Wycombe Hospital have been provided through the Buckinghamshire Provider Collaborative, bringing together South Central Ambulance Service, FedBucks, Buckinghamshire Healthcare Trust and Oxford Health NHS FT. This has led to development of an **Urgent Care Treatment Centre** in High Wycombe.

An increased staffing model for winter months has been put in place supported by an escalation framework linked to a homeworking resilience policy which can rapidly deploy capacity as required.

A **Multi-Skilled workforce** model is emerging and has resulted in increased rota fill including GPs, Advanced Nurse Practitioners and paramedics.

In Aylesbury the primary care Out of Hours base has been co-located with the GP streamer in A&E to provide a more integrated service.

A new Out of Hours centre will be set up in the Southern locality to support patients along the M4 corridor, and reduce the activity at Wexham Park A&E. Patient representatives and

an engagement group is being put in place to support the development of a more holistic service model and supported by social marketing.

b) Improved Access

In order to support winter planning each locality has implemented the national guidance to provide an **additional half an hour of bookable appointments** per 1,000 weighted population in general practice by 1st October 2018.

The national guidance sets out the aim to develop which not only face to face appointments but more innovative methods of delivering care including, for example, digital appointments and group sessions. The service is commissioned for the county from the GP collaborative FedBucks and is delivered on a locality foot print. This has proved to be a successful driver to encourage collaborative working between practices, and to support localities in developing their transformation skills.

The service offers approximately 270 hours of additional access to general practice a week. A number of multi-skilled key transformational workforce models are emerging, for example the use of Physiotherapists and Paramedics are being piloted along with virtual consultations (Qdoctor). Building on the experience that localities have gained through working together to deliver improved access, practices are beginning to see tangible benefits from working in a more collaborative manner. The next steps are to use the development of the locality plans to further encourage this collaboration.

c) Personalised Care Service

There are a number of people across the county who frequently contact services, including ambulance, A&E, general practice, because they do not know how else to get help. Many of these people are reluctant to engage fully with services. **The Personalised Care Service** is in place in three localities (Aylesbury Central, High Wycombe and Southern) and employs care co-ordinators who have time to build up trust between them and the service user and help the service user work out what is driving their frequent requests for help.

The service works in partnership with all providers. Currently it has received 52 referrals and is actively supporting 26 clients. The intention is that as the service develops it becomes an integral part of the integrated team within the locality, but retains its focus for supporting a small number of clients who have complex needs and require a high level of input.

d) Development of integrated short -term response

Integrating and improving **short term support** across Health and Social Care is a priority for the Integrated Care System.

It will support people and their families to avoid crises, or to manage them better when they occur and accelerate people's recovery following a crisis helping them regain as much confidence and independence as possible. For both professionals and service users and their families it will reduce duplication and inefficiencies and, most importantly, improve the experience of going through the service.

On September 18th, a workshop took place with staff to launch the vision for short term intervention and recovery services and start to co-design the improvement plan and its elements

e) Developing the reablement services of BCC and BHT

Buckinghamshire County Council and Buckinghamshire Healthcare Trust have developed a single service specification with a focus on optimising resources and outcomes for patients. This will mean there are common pathways across the service which enable us to utilise collective capacity more efficiently.

A countywide workshop was held on 26th October to work with staff to design options for the future delivery of the service. As part of the model we will be developing a trusted assessor model and shared competency framework.

f) Discharge to Assess (D2A)

Discharge to Assess focuses on assessing patients for their ongoing care needs outside of hospital, so reducing the length of time a person is in hospital. Assessment for any longer term care and support is then carried out in the most appropriate setting and at the right time for the person.

A detailed action plan is in place covering:

- Tailored short-term Home Care support with a reablement/outcomes-focused approach
- Intermediate care beds – specific residential or nursing beds to provide time limited care and support with reablement focus which could also prevent admission to hospital
- Brokerage support in hospitals to help self-funders of care identify the most suitable placements for their care needs – to operate across Buckinghamshire, starting in Stoke Mandeville Hospital
- Red Cross Care Navigators – 6 month pilot, started in September, providing "at home" support to facilitate discharge and settle people back at home
- Alignment with Enhanced Recovery at Home programme being run by Frimley Health Trust at Wexham Park Hospital to support people in the South of the county.

3.3 Ongoing care needs – enhanced primary and community care

Scaled up enhanced primary and community care teams; multidisciplinary teams for those with long term and life limiting conditions; rapid clinical advice and guidance is available; services traditionally delivered in hospital are delivered in community settings; ongoing care in the community is enabled by technology.

When fully mature you would see:

- Integrated care teams including health, social care and voluntary sector working together to deliver care
- The competencies required within multi-disciplinary teams are designed to meet the needs of the local population
- General practices working to together to manage resources effectively across a cluster
- General practices has services in place to specifically target avoidable admissions
- Patients are offered a choice of methods of consultation – email, phone, face to face
- Electronic referral is in place between providers
- Patients understand how to manage exacerbations and how to access help
- Enhanced care in care homes framework is in place

Our Successes so far

a) **Long term conditions model**

The partners across the ICS have developed the care model to support those with long term conditions. Diabetes is the first condition to be fully implemented and has been short listed for the Health Service Journal Improving Patient Digital Participation in Diabetes Education awards.

The model begins with **prevention**, supporting practices to identify those at risk of getting diabetes and have early conversations about maximising wellbeing, for example by weight management and diet change.

For those **newly diagnosed** with pre-diabetes and type 2 diabetes, locality based programmes are in place to help people understand their condition, how best to manage it and how to access support.

Each patient has an annual **Care and Support Planning** meeting in their general practice where they can discuss their condition and how their care plan is working for them. This standardised approach has reduced variation in care between practices.

In addition, this structured approach across all partners, allowed the specialist service to review their need to manage patients with type 2 diabetes. As a result approximately 800

extra patients now have their care managed in the community releasing 1100 outpatient appointments.

The next step is to implement **virtual clinics** where consultants and GPS jointly review the care of patients with greatest need.

We are now exploring how this model can be implemented for respiratory and cardiac pathways and those with co-morbidities.

b) Enhanced health in care homes

Evidence shows that frail elderly people are best cared for in their usual setting. Transferring such a patient to hospital can, in itself, cause deterioration and disorientation. In order to reduce the need for such transfers we have in place a **24/7 telehealth advice** line, implemented in 30 homes across Buckinghamshire. This allows care home staff to access advice about a patient they are concerned about, without the need for the patient travelling to A&E or a surgery. We are extending the roll out to target those homes with the highest rate of hospital admissions.

Where a patient does need to attend hospital we are piloting a hospital transfer pathway called the **'Red Bag'** The staff in the care home use a red bag to transfer the patients current care plan, personal information and their belongings e.g. glasses, hearing aids and their clothes. This red bag signals to all staff along the pathway that the patient is a care home patient. The transfer of the care plan facilitates clinicians in diagnosis of the problem but also helps care staff understand the needs of the patient, particularly where the patient has difficulty in communicating. When the time comes for discharge back to the home all the patients belongings and updated care plan are again transferred in the red bag

c) Integrated teams

The development of multi-disciplinary integrated teams is core to the Buckinghamshire Community Care model. As an **integrated team** we would expect to see the team members working together to a common set of goals, regardless of the organisation which employs them. By managing their case load as a team, rather than a set of individuals, team members will discuss how they can together meet the needs of the patient, no longer referring patients from one team member to another. Three areas are testing the model for an integrated team for those with co-morbidities – Westongrove, Aylesbury central, North Aylesbury Vale.

For example in Westongrove, a cluster footprint within the Aylesbury Central locality, the profile of the patients focussed on is those living in their own home, with more than 4 long term conditions and those taking more than 8 oral medications, particularly where there is concern that medication could be causing symptoms e.g. confusion or low blood pressure.

The community nursing team and the cluster Westongrove multidisciplinary team, meet together fortnightly to discuss patients common to both caseloads. This has allowed the teams to ensure that the care provided is integrated, identify areas of duplication, and prioritise the workload.

One of the benefits of this model is that the Westongrove team is able to carry out a comprehensive geriatric assessment in the patient's own home, rather than the patient having to attend another venue for this. As a consequence the assessment takes into account the home layout, individual circumstances etc

Currently the team has an active case load of 56 clients, 23 more being supported through telephone calls and 74 on the case load but not with any current need for intervention.

3.4 Highest care needs – co-ordinated community based and in patient care

Proactive, co-ordinated care in place for most vulnerable people; admission and discharge to bedded options is integrated into community care package.

When fully mature you would see:

- Integrated service within locality to support highest care needs
- Patients are proactively identified through the combined use of clinical expertise and a systematic risk stratification
- All patients identified have a named clinician who ensures there is a single care plan in place which is regularly reviewed and owned by the patient
- Where an admission to a bedded option is required there is community in reach in place to maintain continuity of care
- Early supported discharge models/ step down models are in place and best practice discharge planning is implemented to ensure as short a stay in hospital as possible

Our Successes so far

Integrated service within locality to support highest care needs

The Multidisciplinary Day Assessment Service (MuDAS) in Wycombe has, over the years, been developed as the blue print for **co-ordinated community based care for elderly people** with the highest needs. It focusses on older people and provides a 'one stop shop' for patients to have an intensive, comprehensive assessment of their condition and treatment plan. Most patients are seen the next day, although urgent, same day appointments are also available.

In order to deliver this package of care closer to patient's homes we have been working on developing the **Community Assessment and Treatment Service (CATS)** in Marlow and Thame hospitals. Patients are referred to the service either by a phone call to a geriatrician

or electronically through the GP clinical record. The latter speeds up the referral process and allows the CATS team direct access to the full clinical record. The multi-disciplinary team includes a consultant or GP, nurse, physiotherapist and occupational therapist who have time, in one appointment, to discuss and assess the medical needs, mental wellbeing, social and functional abilities, home environment and rehabilitation needs with the patient and carers. Patient centred goals, onward support, plans for further medical appointments or rehabilitation are agreed with the patient as required. The service provides pre-hospital management to support patients at home and post-hospital care to support discharge to assess.

Pilots are testing the delivery of a model where the bedded option is in the patient's own home or in a local care home and where patient care is delivered through a Community Assessment and Treatment Service (CATS) and the community nursing and reablement teams. The number of patients has increased from 143 from Apr –June 2017 to 411 from Apr-June 2018 with a saving of £1m against the bedded option.

There is still work to be done to fully integrate this model of care into the locality structure and to develop ownership across all partners.

4. Next Step Priorities

As set out in the Buckinghamshire ICS Operating Plan in March 2019 we will have achieved:

- Risk stratification in general practice to support integrated team in identifying those at greatest risk of admission and focusing interventions on those mostly likely to benefit.

4.2 Urgent Care

- Discharge to assess will be operational
- Integration of the rapid response and reablement service with a view to going live on 1st April 2109
- Direct booking of appointments by 111 into Improved Access

4.3 Ongoing Needs

- Further development of the 24/7 primary care service including implementation of an Out of hours centre in South Chiltern locality
- Development of primary care networks or clusters – 50% of the population covered by level 2 Primary Care Networks
- Development and roll out of integrated teams – three integrated teams managing a case load

- A hospital transfer system for care home patients, based on the Red Bag Model, across the county.
- Pathway groups in place to lead the transformation of respiratory, cardiology and co-morbidity pathways.
- Interoperable solutions will be deployed to support integrated te4ams working from a single record (CareCentric & Careflow)

At the time of writing the operating plan for 2019/20 is under development and will set out the subsequent milestones

Appendix 1: Care Model

Your community
Your care
Developing Buckinghamshire together

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