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Developing Health & Social Care in the Community

Why Community Integration at Place

Patients and the Population

- Health and care needs increasing and changing
  - Ageing Population
  - Increased complexity/co-morbidity
- Access challenges
- Fragmented Care
- What patients want – maximising independence

Local organisations

- Financially challenged – efficiencies to be made
- BCC Better Lives Strategy
- Services built around historic care and spend and not health and care needs
- Recruitment and retention issues
- Build on what we know works – e.g. success of telehealth solutions

National context

- NHSE clearly articulated Long term Plan (LTP) ambition and implementation expectations
  - https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained
  - https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/the-nhs-long-term-plan-summary.pdf
- Nationally mandated community and PCN contractual changes
- Earmarked community investment

Fragmented Care - Patient Example

Elderly woman with dementia, who lives alone, supported by daughter found locked out of her house in the street.

Police called and daughter contacted.

Daughter contacts social care who assess a mental health need.

Mental health contacted and assess is a social care need.

GP practice contacted by daughter in distress.

Conversations between practice, social care and mental health could not resolve issue.

Patient taken to A&E as a "place of safety" overnight.

Next day psychiatric assessment agreed and respite bed required.

What Patients Want

*Commissioned by NHS England on behalf of the national collaboration for integrated care and support & co-developed with the health and care system by national voices

Buckinghamshire Care Model

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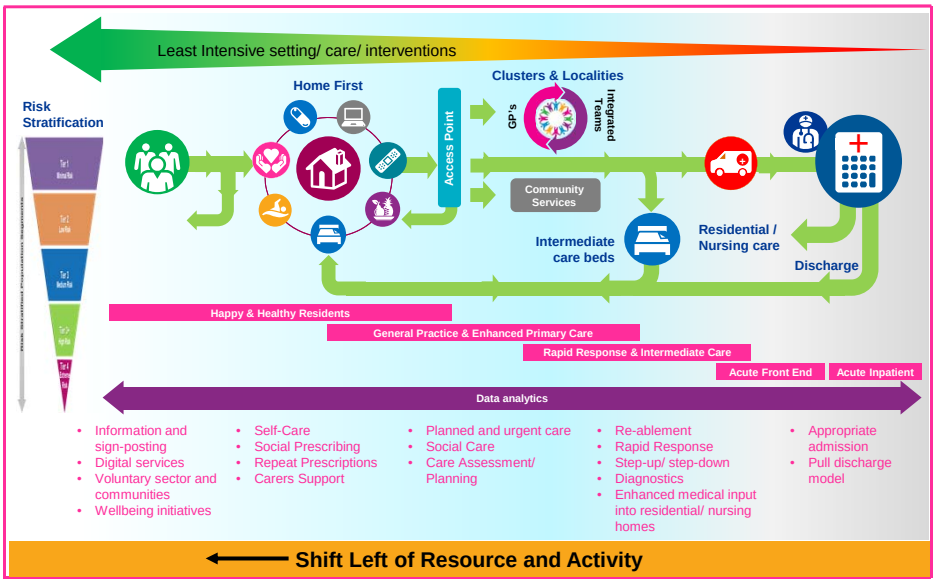


Community Integration - Ambition

"A proactive community based care model designed around local population health and care needs which through integration breaks down the historic barriers between primary, community and secondary care."

1. Scope and understand the total community services and spend for physical health, mental health, social care and community voluntary and not for profit sector by PCN.
2. Build on existing work in defining the community model by describing its future structure in collaboration with staff and local communities and developing an implementation plan for delivery over the next 2 years
3. Identify dedicated leadership for the community programme of work including clinicians who will own and drive the programme of change
4. Accelerate the national work programmes in order to achieve the expected benefits of integration and the quadruple aim of improved population health outcomes, patient and staff experience and financial balance
5. Optimise capacity to meet existing and growing demand
6. Enable PCNs to develop to lead in the system as part of a collaborative leadership model to drive service change in the system for the benefit of patients and populations
7. Strengthen the integration between physical health, mental health and wellbeing through jointly commissioned and provided services with aligned outcomes and incentives which may include risk share
8. Provide PCNs with shadow community budgets so that they can understand the service delivery components and how they can flex the model in order to optimise delivery and value for money.
9. Provide an integrated data set that establishes a baseline from which to set goals and monitor impact so that we can be assured that we are providing an effective model of care and improving health and social care outcomes.
10. Drive a model that is consistent whilst also being capable of tackling inequalities.

What will this mean to patients

- Those 'at risk' patients will be identified early and proactively managed with non medical interventions and care where appropriate
- Those with Complex comorbidity will be managed by a single community based multidisciplinary team lead by a complex care manager
- Care services will be developed that are tailored to local need based around PCNs or groups of PCNs – form will follow function.
- Patients will be supported to live independently at home but not isolated
- Patients will tell their story once
- Patients will be proactively pulled out of the hospital setting back to their homes once medically fit
- Health inequalities will be reduced so that patients should expect to have the same health outcomes as the top 10% of the country
- Medicines optimisation in at risk groups

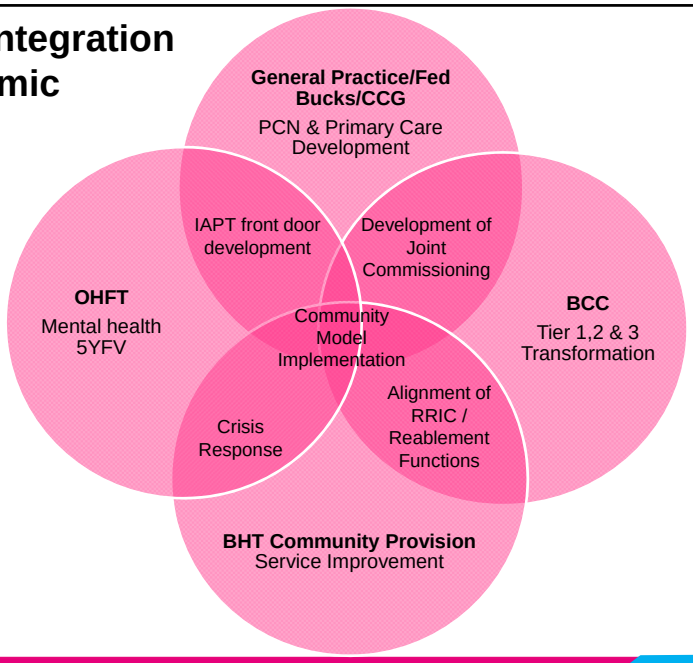
What will this mean to staff

- Practice and community nurses will work collectively with a single caseload where appropriate
- There will be read / write access to care records by multiple professionals
- Single templates will be used across the system agreed by the health and care e.g. advanced care plans
- There will be single operating processes
- Pathways of care will be standardised
- Staff will act as if they are in one organisation with shared values, learning and culture (including third sector)
- New workforce roles will be created supporting community based services
- Information to be easily available to staff and readily shared when appropriate

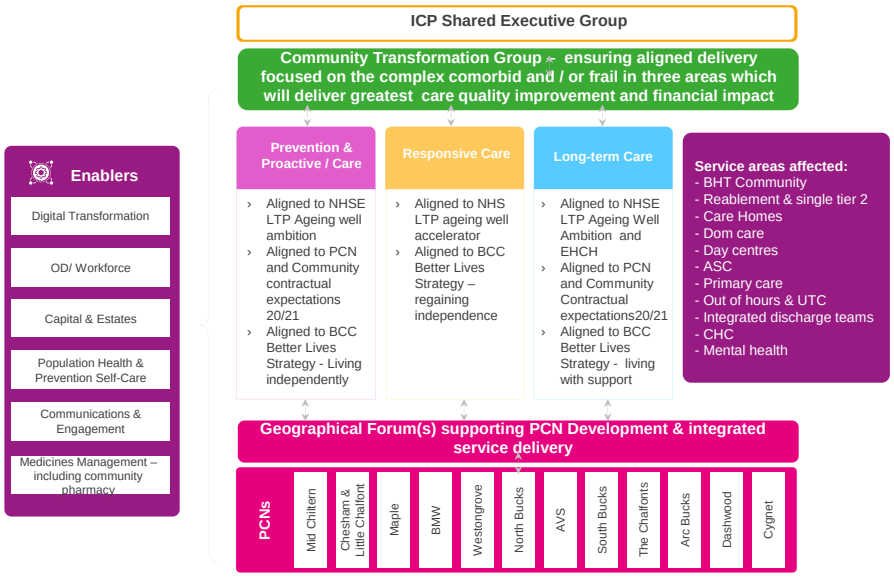
What will this mean to the Organisations

- System costs will be reduced by identifying and removing nursing and care duplication and identifying opportunities to use resources better
- Services will be Improved value by enhancing the cost effectiveness and quality of interventions
- Improved coding and data management
- Realisation of systematic telehealth solutions

The Integration Dynamic



Delivering Rapid Community Change at Place



Prevention and Proactive Care

Achievements 19/20

- Introduction of complex care managers – Senior health care professionals who specialise in helping patients with multiple long-term conditions to stay in their own homes. In addition to current district nursing staff, these roles will support patients who need a high level of care in the community.
- Extension of the Community Assessment and Treatment Service to Amersham. This service assesses frail elderly patients in the community and puts in place additional support to enable them to remain independent and at home, avoiding a hospital admission.
- Extension of specialist geriatrician to enable health care professionals to receive immediate advice and support in order to help patients receive appropriate care in the community.
- MDTs for comorbid complex patients, diabetes and children

Expectation 20/21

- Focus on comorbidity
- Full roll out and embedding of complex care nurses
- Full roll out of integrated teams and further MDT meetings appropriate to the population
- Sites to receive population health management support to enable identification of at risk patients and proactive care
- Medicines optimisation
- Embed social prescribing
- Introduce patient activation measures
- Introduce proactive patient assessment – mental health, falls etc

Outcome Measures

- % of people signposted to early help and prevention services
- % reduction in non elective attendances and admissions (ACS Conditions)
- % reduction in DTOC

Responsive Care

Achievements 19/20

- Award of Ageing Well Crisis Response Accelerator site – National pilot with £800k investment to deliver crisis response locally
- Provision of comprehensive rehabilitation and delivery of therapy at weekends - increasing capacity through the recruitment of therapists, rehabilitation support workers and physiotherapists.
- Increased therapy available to patients in their homes
- Maximising patients' independence at home through the Community Physiotherapy Service and RRIC Teams
- Elderly care consultant in A&E to identify those patients who do not need to be admitted and to ensure the relevant support is put in place to enable them to go home.

Expectation 20/21

As part of the Crisis Response Accelerator

- Develop delivery plan
- Ensure community health data set collected – form baseline
- Work with 111 to develop single point of access to community services

Outcome Measures

- % of people accessing 2 hour urgent community response services
- % of people able to access intermediate care/reablement within 2 days.
- % increase in people successfully re-abled

Long-term Care

Achievements 19/20

- Roll out of Red Bag scheme - Initial Pilot showed that it reduced length of stay in hospital by up to 10 days per care home resident
- NHS Mail for social care providers – To date 21 care homes using NHS Mail enabling closer digital links with health and social care and reducing an average of 10 hours a week of nurses admin time per home
- Immedicare - 37 Care Homes (2000 beds) shown to reduce hospital admissions and demands on primary care (full analysis in progress).

Expectation 20/21

- Delivering on enhanced health in care home agenda
- Every care home to be aligned to a single PCN
- Identification of those at the end of life and their proactive management
- Introduce multidisciplinary support to care homes
- Strengthen mental health support in care homes
- Evaluate and potentially roll out immedicare to wider number of care homes
- Continue NHS mail roll out – care homes and hospices

Outcome Measures

- % of emergency admissions to hospitals from care homes
- % reduction in DTOC
- % reduction in residential and nursing care placements
- % reduction in length of stay in residential and nursing care
- % increase in people successfully re-abled

Role of Primary Care Networks

What are PCNs

- PCNs are still very new, but in time networks will consist of **groups of general practices working together with a range of local providers**, including across primary care, community services, social care and the voluntary sector, to offer more personalised, joined up care to their local populations.
- Relationships will be key and PCN Accountable Clinical Directors (ACD) have a key leadership role
- One of these relationships will be with the Unitary Community Boards

19/20 Achievement - See next slide

20/21 Expectation

- Additional roles reimbursement
  - first contact physiotherapist & physician associates
  - paramedics (21/22)
- Recurrent organisational development funding to support PCNs to progress and mature
- New nationally mandated services proposed but there remains uncertainty over provision of these
  - Anticipatory Care
  - Personalisation
  - Structured medication reviews
  - Early Cancer Diagnosis
  - Enhanced Health in Care Homes
- Review what local services could be provided by a PCN
- Improved Access review

PCN 19/20 Progress

PCN	Social Prescriber	Pharmacist	PPG Engagement	OD Events	Other PCN Project
North Bucks PCN	√	√	√	√	DMARD research project
Westongrove PCN	√	√		√	NA
Central BMW PCN	Recruiting in New Year	√	√	√	Respiratory project, Acute Pathways project and the Paediatric Hub project.
Central Maple PCN	√	√	√	√	Care Homes Patient Online project, High Intensity User project and the Paediatric project
AVS PCN	Staring 02/01/2020	√	√	√	NA
Chesham & Little Chalfont PCN	Not recruiting in 2019/20	Not recruiting in 2019/2020		Date tbc	NA
Mid Chiltern PCN	√	√	√	√	Development of a Social Prescribing Community Network / Pathway
Cygnet PCN	√	Starting 06/01/2020		21/01/2020 & 11/02/2020)	NA
Dashwood PCN	√	√	√	Awaiting proposal	Thames Valley Cancer Quality Award Scheme [CQAS] project
South Bucks PCN	√	√	√	04/02/2020 & 05/02/2020)	Mapping of local services
Chalfonts PCN	√	√		√	NA
Arc Bucks PCN	√	Starting 06/01/2020	√	√	PCN Community Social Activation Model (based on Frome) intended to improve outcomes for patients related to the wider determinants of health.

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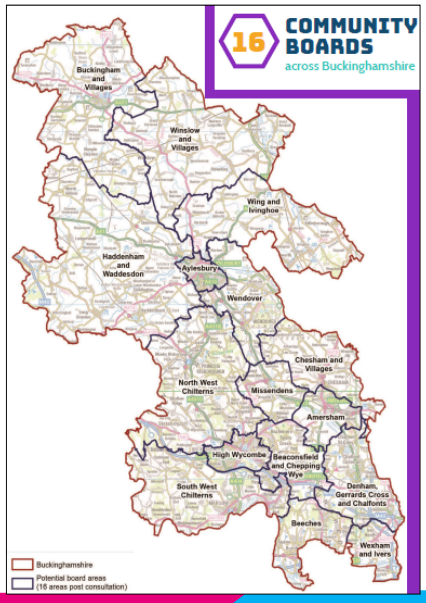
PCN & Community Board Alignment

Community Board	PCN
Buckingham and Villages	North Bucks
Winslow and Villages	North Bucks
Wing and Ivinghoe	North Bucks
Haddenham and Waddesdon	North Bucks/AV South
North West Chilterns	AV South
Aylesbury	BMW/Maple
Wendover	Westongrove
Chesham and Villages	Chesham and Little Chalfont
Amersham	Mid Chilterns
Missendens	Mid Chilterns
High Wycombe	Dashwood/Cygnet
Beaconsfield and Chepping Wye	Arc Bucks
South West Chilterns	Arc Bucks
Denham, Gerrards Cross and Chalfonts	Chalfonts/South Bucks
Beeches	South Bucks
Wexham and Ivers	South Bucks



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Challenges and support required to deliver

Challenges

PCN Specific Are the expectations too high?

- Pace of delivery versus strengthening of relationships & collaboration
- New services specs – considerable challenge

- How prepared are they
- Are they sufficiently resourced
  - Management support

Integrated Working

- Varied progress by groups of practices and community partners in integrating
- Lack of capacity to develop above BAU
- Persistent 'tricky' issues that are never resolved such as single system wide templates and process e.g. access to records/ACPs, trusted assessor

Community Engagement

- How do we meaningfully engage with our communities

Support

Support for PCNs and Community Providers

- Time
- Management support to PCNs
- Specialist expertise
- Transparent funding arrangements and fair funding allocation in line with local need
- Focused implementation plan
- Targeted support to deliver
- Reliable data and BI support
- Commitment to meeting community investment allocations
- Community engagement in codesign of services - unitary council / community boards

Commissioning Support

- The ICS, aligned to national guidance, to set out direction of travel – high level deliverables/outcomes
- Aligned service outcomes across community providers
- The Health and Social Care Joint Commissioning function to be strengthened at place through ICET
- At Place providers to become self regulating informed by reliable data and BI support
- Utilisation of any alternative funding arrangements to maximise collaboration and integrated delivery

The Future of Core Primary Care Provision

The BOB primary care strategy (now part of the Long Term Plan) sets out the actions that will be taken across the three Integrated Care Partnerships to invest the new resource identified to deliver a transformed model of primary care. The outcomes for our patients will be:

- Improved access to care;
- a stronger focus on population health and prevention;
- access to a wider range of practice staff, appropriate to clinical need;
- services delivered from modern buildings, co-located with community and preventative services, hospital specialists and mental health care;
- more services delivered in the community, including in people's usual place of residence, that are currently delivered in hospital;
- primary care delivering key components of broader clinical pathways e.g. cancer, urgent care, and mental health.

Community Integration to Tackle Inequality

Objectives (2019 to 2023)

1. Hypertension - Target support to identify and treat those with hypertension who are BME and/or live in quintile 5. Demonstrated by improvements in prevalence rates and % of hypertensive patients treated to target by 2022 from the 2018 baseline.
2. Mental Health – Promote good mental health and improve access to mental health services for those that need it, with an additional focus on children and young people who are more vulnerable to poor mental health. Current activity to be baselined across schools, colleges and health in order to identify which catchment areas should be targeted with support in the areas that have the highest levels of deprivation.
   - **Measure 1:** Increased number of Mental Health Support Teams (MHSTs) against targeted schools and colleges in catchment areas that have the highest levels of deprivation (DQ5)
   - **Measure 2:** Increased numbers of children and young people from schools within DQ5 accessing mental health services in 19/20 (compared to 18/19 baseline)
3. Long Term Conditions (LTC) (including mental health) - Reduce the gap between the experience of BME and White British patients to manage their LTC. Evidenced by improved experience of Care and Support Planning for these cohorts from the 2018 baseline and by improved recording of ethnicity in the Primary Care Record from 2018 baseline.
4. To reduce the prevalence of smoking generally and to see the greatest reduction in smoking prevalence in GP Practices in DQ 4&5.

Achievements 19/20

- TB outreach Screening
- Children's Hubs
- Trailblazer - Mental Health Support Team
- Breast Screening for patients with Learning Disability

Expectation 20/21

- Each CCG portfolio to identify a health inequality project - economic studies have shown that addressing health inequalities not only brings better outcomes for patients but also reduces pressure on the health and social care budget)
- Agree one key objective to deliver on at place as a collective - this can be taken from the equality objectives i.e. tackle smoking so all system partners can work together towards meeting that objects.
- Each PCN Clinical director to focus health inequalities – that could be just getting better recording on EMIS – but using this system intelligence to target populations that need better health interventions – see below PCN project that is being worked on now - the aim of this exercise is to increase the recording of carers & ethnicity coding so that identification of needs of the said group.