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Buckinghamshire Health and Care System Plans

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Agenda

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1. BOB STP update

2. Buckinghamshire priorities for 2017/18

3. Examples of what this will mean for residents

Background

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- **44 STP footprints across England of a scale which should enable transformative change and the implementation of the *Five Year Forward View* vision of:**
  - **better health and wellbeing;**
  - **improved quality of care; and**
  - **stronger NHS finance and efficiency**
- **STPs vary in size and complexity – from 0.3m population,1 CCG, West, North & East Cumbria (success regime) to 2.8m population, 12 CCGs, Greater Manchester (DevoManc)**
- **Buckinghamshire, Oxfordshire, Berkshire West 'footprint' 1.8m population, £2.5bn place based allocation, 7 Clinical Commissioning Groups, 6 Foundation Trust & NHS Trust providers, 14 local authorities**

THE NHS IN BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST

£2.5 BILLION
BUDGET

175
GP SURGERIES

182
DENTAL PRACTICES

MAJOR HOSPITAL TRUSTS

Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals NHS Foundation Trust and Royal Berkshire NHS Foundation Trust, providing acute medicine, surgery, maternity and paediatric services for local people, as well as more specialist services for a larger geographic area, including areas outside of BOB

37,000 STAFF

from district nurses to surgeons, porters to managers, pharmacists to physiotherapists

18,000 PATIENTS
SEEN DAILY BY GPs

400 PATIENTS A DAY
have emergency admissions to hospital

1,200
VISITS TO A&E A DAY

MENTAL HEALTH SERVICES

Provided by Oxford Health NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust

COMMUNITY HEALTH SERVICES

Provided by Buckinghamshire Healthcare NHS Trust, Oxford Health NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust

LEARNING DISABILITY SERVICES

Provided by Southern Health NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and Hertfordshire Partnership NHS Foundation Trust

AMBULANCE SERVICES

Provided by South Central Ambulance NHS Foundation Trust

BOB STP finances

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- **Resources allocated to BOB CCG commissioners for purchasing health services total £2.55bn in 2016/17 and will increase to £2.87bn by 2020/21, an increase of 12%**

- **This increase is to pay for population growth, inflation and technological advances, together with funding for new national initiatives, such as implementing 7 day working across the NHS, implementing the GP and Mental Health *Five Year Forward View* objectives**

- **Some funding for these initiatives has been retained centrally which BOB will have to compete for (transformation bids)**

- **Expenditure is growing at a faster rate than the increase in funding and there is a growing financial gap under the 'do nothing scenario' by 2020/21 of £479m**

- **Local authority partners' care budgets are under relentless pressure as a result of allocation reductions, demography, need and deprivation**

BOB STP approach

The overall approach is based on **developing STP plans in local systems where it makes sense with key partners** e.g. for integrated health and care and the Buckinghamshire transformation programme, and **collaborating across the STP footprint as necessary on cross system issues** e.g. workforce

- STP has been developed 'bottom up' and builds on plans already developed locally across the three health and care systems
- Shift the focus of care from treatment to prevention
- Access to the highest quality primary, community and urgent care
- Collaboration of the three acute trusts to deliver equality and efficiency
- Maximise value and patient outcomes from specialised commissioning
- Mental Health development to improve the overall value of care provided
- Establish a flexible and collaborative approach to workforce
- Digital interoperability to improve information flow and efficiency

Programme delivery

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- Programme management structure and process reviewed in January 2017 and will continue to be refined
- *STP Executive Board* (Chief Executive health and care system leaders) continues to drive this work
- *STP Operational Group (*lead Directors/Senior Responsible Officers) to oversee and align delivery of the three health and care system plans and BOB-wide programmes
- Aligns resources, reduces duplication and gives clear programme leadership and programme management
- Individual organisations remain accountable but approach supports planning and state of readiness to position the footprint for transformation resources

Levels of commissioning across the STP

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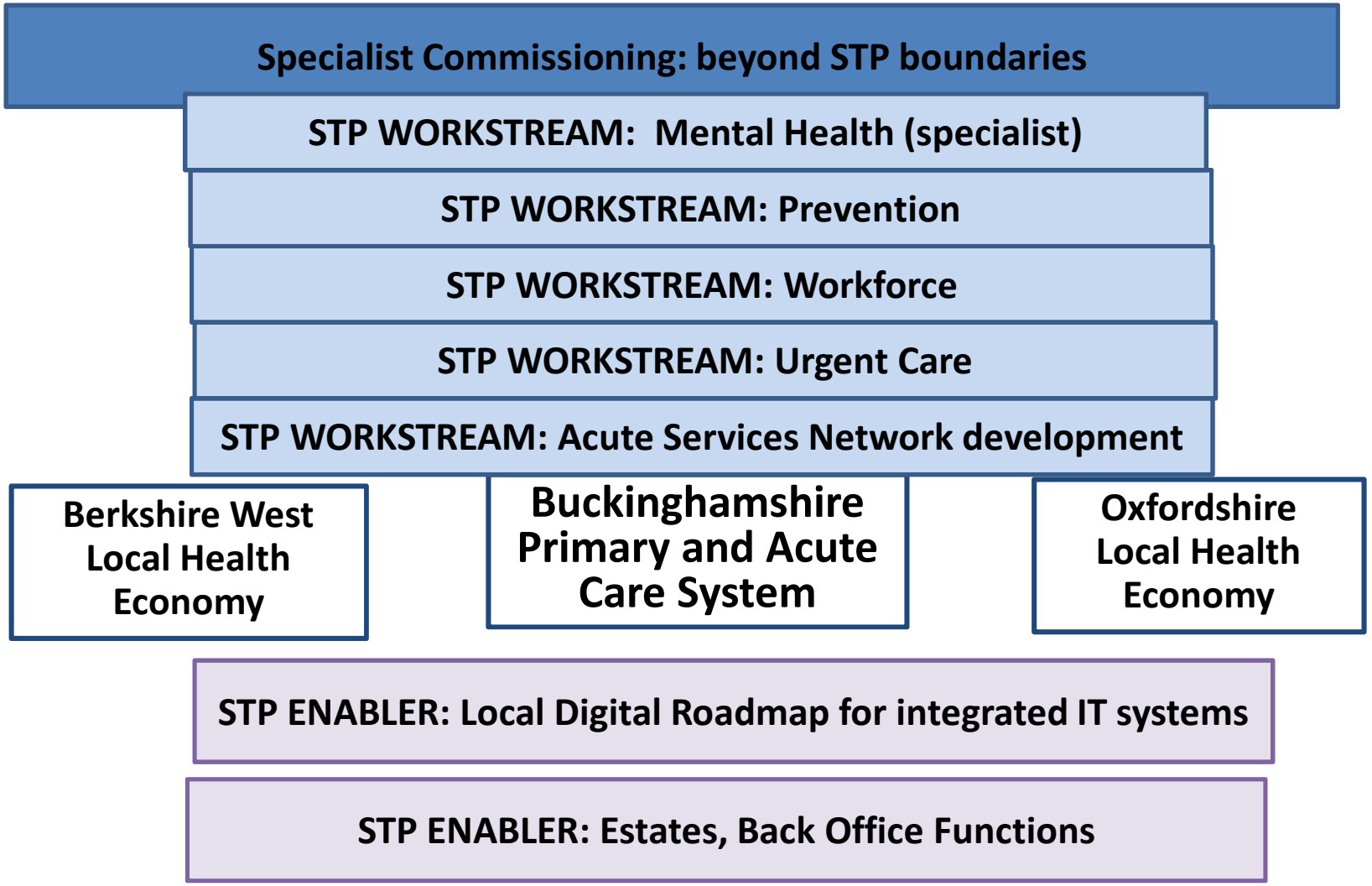

Our Local Plan Delivery

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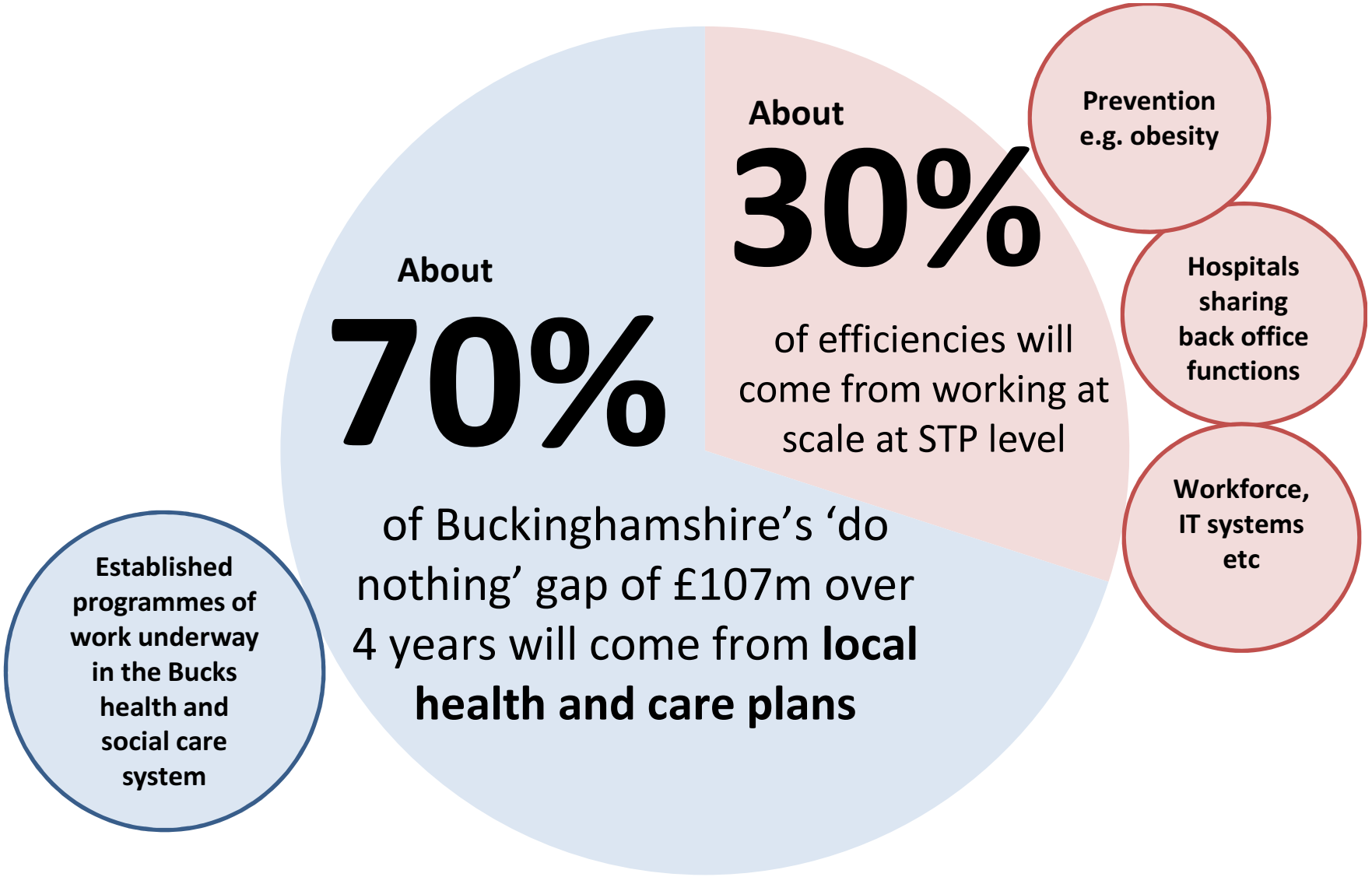

Strong record of achievement:

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- **Better Healthcare in Bucks** – transformation programme to centralise A&E and emergency services
- **Stroke and Cardiac** - innovative model of care introduced at Wycombe Hospital
- **Redesigned emergency and urgent care** including seven day medical ambulatory care facility
- **Quality and Outcomes framework** – nationally recognised innovation to increase use of Care and Support planning in Primary care
- **System wide quality improvement** – aligned monitoring and governance, e.g. Looked After Children
- **Over 75s community nursing** – delivering 'upstream' care to prevent admission and shorten length of stay for our older population

Bucks priorities 2017/18

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- **Prevention and self-care:** healthy lifestyles and Active Bucks
- **One Bucks Commissioning Team:** further developing joint health and care commissioning across NHS and the Council (adult and children's services, public health, mental health etc)
- **Key providers** are planning a formal alliance to deliver joined up care (FedBucks [GPs] + Oxford Health NHS Trust + Buckinghamshire Healthcare NHS Trust)
- **Continue investing** in rehabilitation and community services, so fewer people need hospital care
- Introducing better, simpler models of care for people with **diabetes and musculoskeletal problems** (back/neck/limb)
- **Stroke and cardiac treatment:** widen catchment, so Bucks patients don't have to travel to London; expanding services to Berkshire
- **Community Hubs:** piloting new ways of joining up health and care closer to home, tailored to the needs of local communities
- **One Public Estate:** six shared projects, using our property assets to provide better services and value to residents
- **Workforce:** increase apprenticeships for support workers, continue reducing agency spend, collaboration on temporary staffing contracts, investment in leadership
- **IT:** development of local digital roadmaps e.g. to share records across organisations

Our Roadmap….

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2016/2017

System Leadership:

Healthy Bucks Leaders establishes a system-wide Transformation Delivery Group

Building trust and transparency across the system

Commissioners:

- Working towards leaner commissioning with Bucks CC and Oxfordshire CCG
- Working through what STP means for local and at scale commissioning

Providers:

- FedBucks, a single organisation across 80% of Bucks GPs is established
- BHT, OHFT and FedBucks agree to principles of PACS

2017/2018

System Leadership: Preparing for PACS

Leaders establish a year of transition to place based services with outcomes based contracts

All transformation projects prioritised for system delivery through a common PMO

Further work to scope and share management functions

Commissioners:

Clarity on what is commissioned:

- As a single team with Bucks County & District Councils
- Across Bucks & Oxon & STP
- At larger scale (Specialist and Alliance)
- Clarity on contracting with PACS for 18/19 including social care provision

Providers:

- Strategic & Business case for provider PACS model finalised
- Clusters of GPs (30-50k populations) supported by the FedBucks 'umbrella' working with integrated multidisciplinary teams including MH

2018/2019

System Leadership: PACS to ACO

The Provider PACS becomes accountable for the primary, community and general physical & mental health needs of the Bucks registered lists of patients.

Leaders will use this year to establish what areas of commissioning may come into the PACS (as an ACO) and what needs to remain at larger scale

ACO established for 2019/2020

A Primary & Acute Care System (PACS) in 2018

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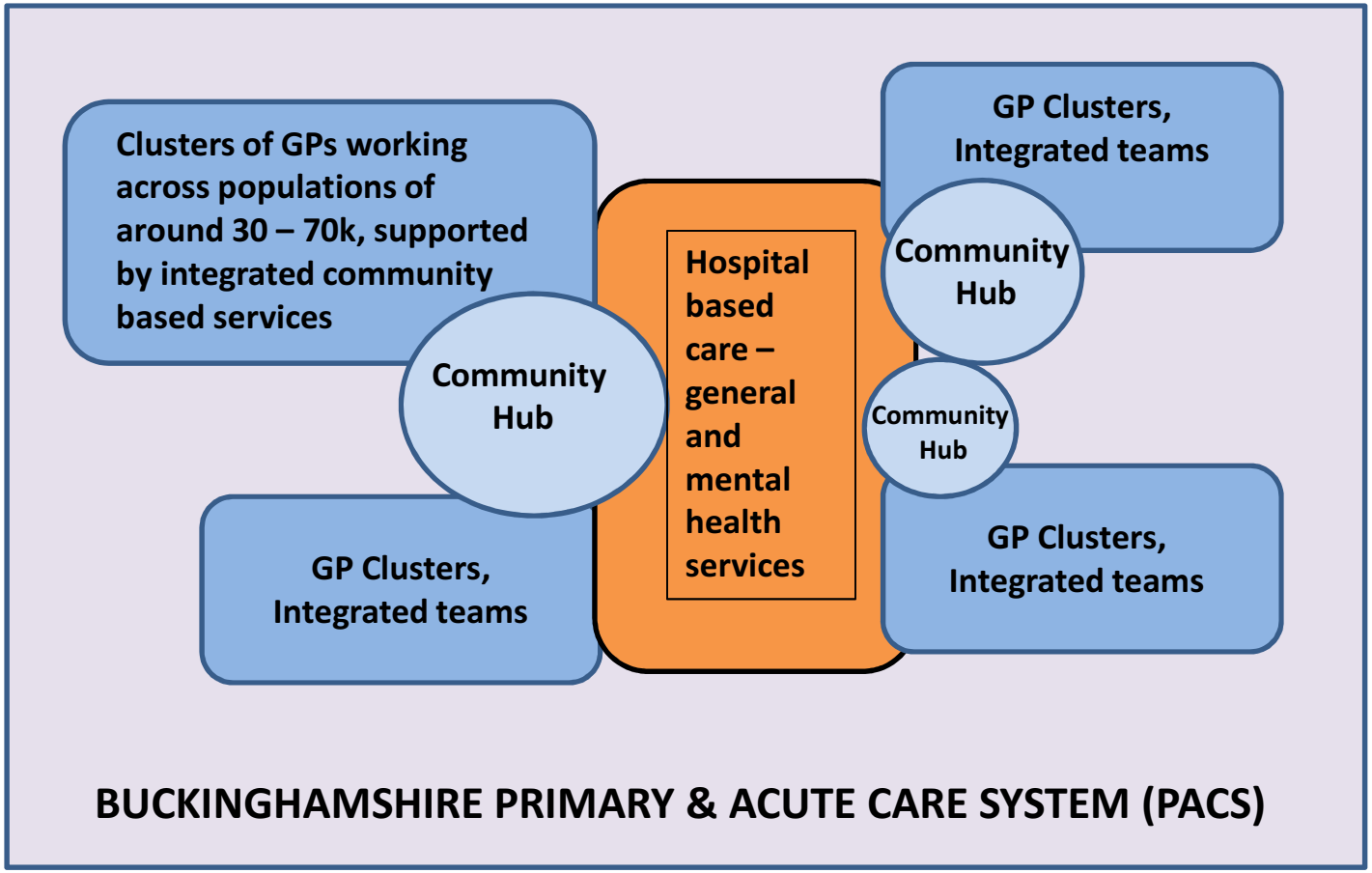
STP: commissioning at scale



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What does this mean for Patients, Clients, Carers and the Public?

What's happening now?

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- Community nurses and therapists available round the clock
- Specialist nurses supporting patients with long term conditions
- Early supported discharge for stroke patients providing therapy and nursing care at home reducing hospital stays

What the public told us

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- GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities have informed plans

Themes

- avoid unnecessary travel
- improve coordination between organisations
- support to manage own health & wellbeing

- Consistent feedback from our hubs engagement…

- Rapid access to testing
- Easier signposting
- Joined up teams
- Full range of therapy services
- Health and wellbeing - enhancing self-management, providing education
- sociable space with a café
- base for skilled staff working in the community
- More local outpatient clinics
- Virtual information networks
- Information shared between organisations to improve care

Patient experience:
GP Consultations

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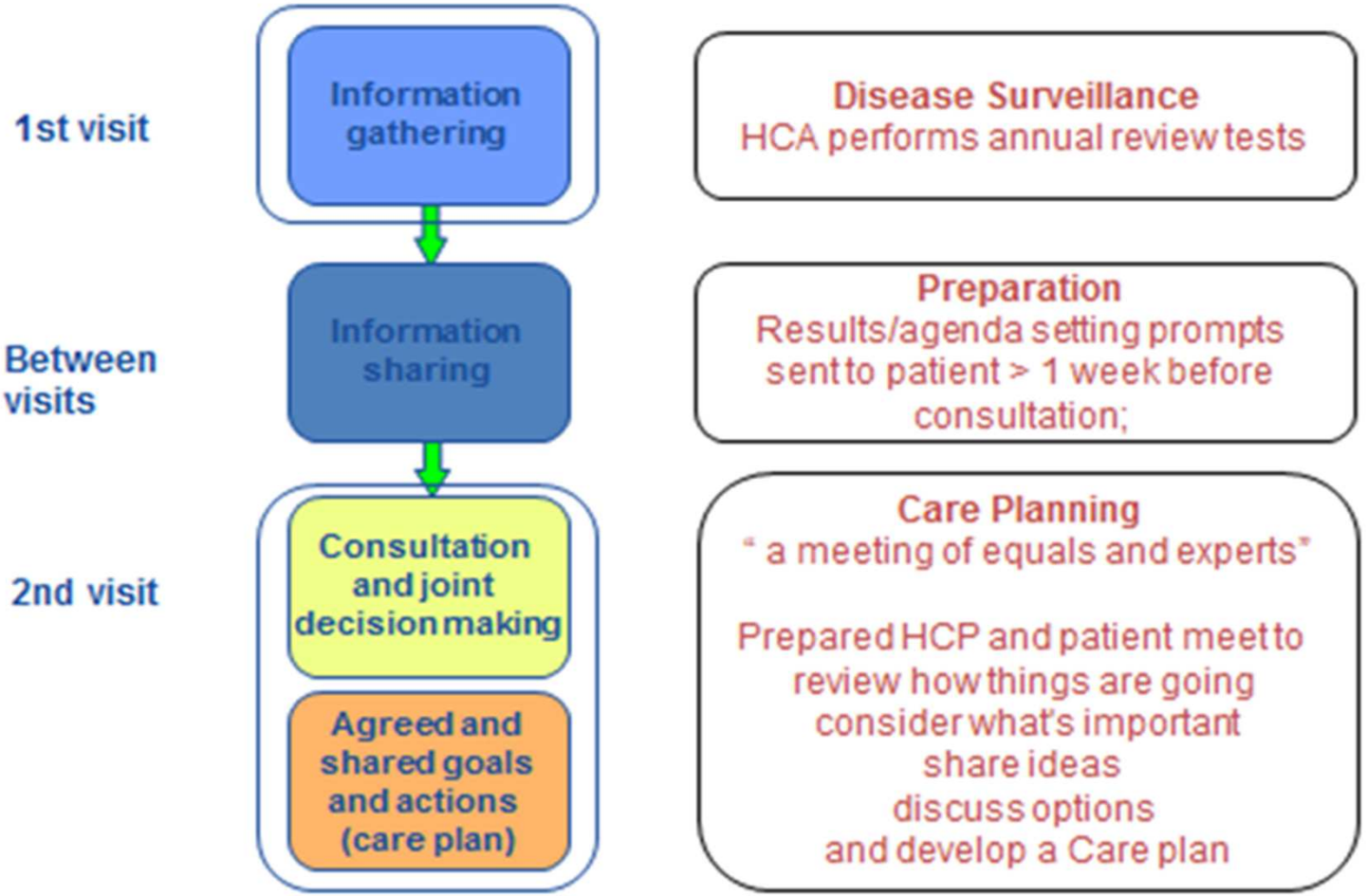

YEAR OF CARE PARTNERSHIPS

Encouraging self management

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House of Care model

The House of Care emphasises that effective care and support planning (CSP) consultations rely on four elements working together in the local healthcare system

CASE STUDY:
The Airedale approach

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- Airedale, in Yorkshire, has **reduced A&E attendances from care homes by 45%** and **emergency admissions to hospital from care homes by 37%**.

- They've done this by offering people in care homes the opportunity to talk to a doctor and other clinicians over the phone 24 hours a day. This has helped to make sure that people are directed to the most appropriate health service, be that a pharmacist, their GP or a hospital.

- We have been piloting this service in two test sites in Aylesbury; the early indications are positive, so **we are planning to roll it out to cover 30 care homes.**

Community services

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From April 2017, we will have further developed services in the community that will support frail older people …

Locality integrated teams
Integrated teams, which will include nurses, therapists and social workers, will provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions

Rapid response intermediate care
Therapists, care staff and community nurses will provide short-term packages of support to those who would benefit from a 'jump start' back to independence

Community care coordinator
This will provide GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients

Community hubs

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- Will provide the following:
  - **NEW** frailty assessment clinics
  - **MORE** outpatient clinics
  - **NEW** voluntary sector and signposting
- Expanding the support available to people in the community will help to maintain a person's health and independence, reduce need for bedded care
- Pilot to launch at Marlow and Thame hospitals for six months
- During the pilot patients will not be admitted overnight to the inpatient wards at Marlow (12beds) and Thame (8beds) hospitals.

Patient story…

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GP is concerned that Mr Smith is getting frailer and seems a bit less able to cope

Previously – GP concerned but can't pinpoint anything specific that needs treating. The only option is to admit to hospital.

Now – GP calls the community care coordinator and talks to the community matron, part of the integrated locality team. The team visit and provide Mr Smith with appropriate treatment and support.

Outcome – Mr Smith's health is stabilised. His care is organised and structured around his needs and he remains at home.

Monitoring the pilots

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- Piloting to give us a better understanding of what works for these two communities
- Medical director and chief nurse will oversee
- Range of measures
- **Responsive and able to quickly adapt**
- Discussions will continue with patients, staff, GPs, other health and social care professionals, and communities
- Will finish pilot with a clear proposal – based on what we've tested and what we've heard

Over the next six months we will…

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- Manage almost **20,000 referrals** through the community care coordinator
- **Double** the number of outpatient appointments offered at Marlow and Thame
- See **350 patients** through the one-stop frailty assessment clinic
- Provide rapid response intermediate care to over **3000 people**
- **Avoid** almost **300** hospital **admissions,** reduce delayed discharges
- Improve **patient experience**