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Health and Wellbeing Board update report

Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership (STP) and the Buckinghamshire integrated care system

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Buckinghamshire County Council
NHS Oxford Health NHS Foundation Trust
NHS South Central Ambulance Service NHS Foundation Trust

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Buckinghamshire, Oxfordshire and Berkshire West STP

STP: background and context

- Three local health and care economies – which include two first wave integrated care systems
- The emphasis on place is strong and the approach taken across the STP is to do things at the footprint that makes sense to local stakeholders and local populations
- STP's focus is on strategic collaboration and shared learning when more can be achieved by working together on a larger scale e.g. workforce, specialised services

STP facts and figures

- **Total 1.8m population**
- **£2.5bn place-based allocation**
- **3 Clinical Commissioning Groups**
- **6 Foundation Trust and NHS Trust providers**
- **14 Local Authorities**

The way forward:
2018/19 planning guidance

Accountable Care Systems become integrated care systems:

- robust cross organisational arrangements to tackle challenges facing the NHS
- integration of services focused on populations that are at risk of developing acute illness and hospitalisation (population health management)
- more care through re-designed community-based and home-based services, in partnership with social care, and the voluntary sector
- systems taking collective responsibility for financial and operational performance and health outcomes
- “bottom up” development with a variety of models
- voluntary roll out of integrated care systems

Progress

- STP leaders have reviewed and redefined the role of the STP
- The STP has identified the importance of working with neighbouring STPs as some programmes straddle STP boundaries
- Fiona Wise STP Executive Lead from 5 March 2018
- Lou Patten joins Oxfordshire CCG as Interim Chief Executive Officer, and continues leadership of Buckinghamshire CCG
- Plans to further strengthen the governance and programme management arrangements

Draft programme

Programmes led by STP:

- **Cancer:** aim is for a further 1,400 people in Thames Valley to survive cancer for 10 years or more by 2020. Major upgrade in diagnostic capacity, preventative interventions (screening and healthy living), workforce. STP has secured over £9m transformation funding for this work
- **Prevention:** working closely with Public Health, delivering STP-wide 'Making Every Contact Count' programme (using day-to-day interactions to support people in making positive changes to their physical and mental health and wellbeing); priorities are obesity, physical activity and smoking, use of technology to promote self care
- **Population health management (PHM):** the adoption of a single systematic approach to PHM, closely linked to the Digital programme, will support the identification of "at risk" individuals and identify opportunities to redesign pathways at a system level
- **Capacity planning**: new work stream, being scoped
- **Digital**
- **Estates:** development of STP-wide estates strategy to make best use of capital funds
- **Workforce**

Draft programme

Programmes where the STP shares best practice and provides assurance:

- **Urgent and emergency care:** brings together the 3 A&E Delivery Boards to share learning and maximise system resilience. New 111 service and Ambulance Response Programme launched 2017
- **Mental Health:** reviews progress in local systems on delivering the Mental Health Forward View
- **Primary care:** supports the delivery of GP Forward View in local patches, especially in relation to workforce and international recruitment. Key deliverable is 8.00 – 8.00 access to bookable GP appointments 365 days a year
- **Maternity:** established a Local Maternity System to ensure capacity for additional 3,000 births with a focus on new models of care, workforce and safer care

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The Buckinghamshire integrated care system

Louise Watson

Integrated care system overview

Vision:

Everyone working together so that the people of Buckinghamshire have happy and healthy lives

Objectives:

- People supported to live independently;
- Care integrated locally to provide better support closer to home;
- Improved urgent and emergency care services;
- Improved resilience in primary care services;
- Improved survival rates for cancer;
- Improved outcomes for people suffering mental illness;
- Reduced unwarranted variations in quality and efficiency of planned care;
- Digital transformation creating IT platforms that support integrated care;
- Long term operational and financial sustainability.

Delivered through:

Population Health: Working with localities to define and segment populations, understand their needs and monitor outcomes of interventions (including prevention and self-care).

Integrated Care: Improving access to services for people with long-term conditions and frailty in particular. This will support people to live independently and reduce reliance on emergency and acute services.

Five Year Forward View: Progress against national priorities including improving outcomes for cancer, improving resilience in primary care, improving access to urgent care and improving mental health outcomes.

Professional Support Services (Enablers): that ensure we have the support, expertise and technology to operate as an effective integrated care system.

Our transformation so far

Population Health

- Population Health programme focusing on local variation, aligned to national priorities e.g. growth in population aged 80+, prevalence of high cost diseases (COPD, coronary heart disease, dementia, diabetes, obesity, stroke)
- Finding cases using risk stratification and links to 'high volume' users
- Increasing patient education and supported self-care through the Live Well Stay Well programme

Integrated Care

- Community hubs pilots, providing community assessment and treatment services, extended range of outpatient clinics, more diagnostic testing e.g. one-stop blood tests and X-rays, and support from voluntary organisations
- Working together to transform reablement and social care services to help more people to live independently at home for longer
- Series of events with staff, stakeholders, members of the public and community groups to share the vision and seek views

Five Year Forward View

- New integrated musculoskeletal service for people with health conditions that affect their joints, bones, muscles and soft tissue – fully rolled out across the county by 2019
- Delivery of cancer strategy including Thames Valley Cancer Alliance funded project
- Making it easier to get GP appointments at evenings and weekends, and developing new 24/7 primary care service which will include 'primary care hubs'
- Diabetes service transformation: over 1,000 Type 2 patients now being managed in primary care; successful bid for funding for structured education and training for diabetes
- Improving and increasing access to mental health services

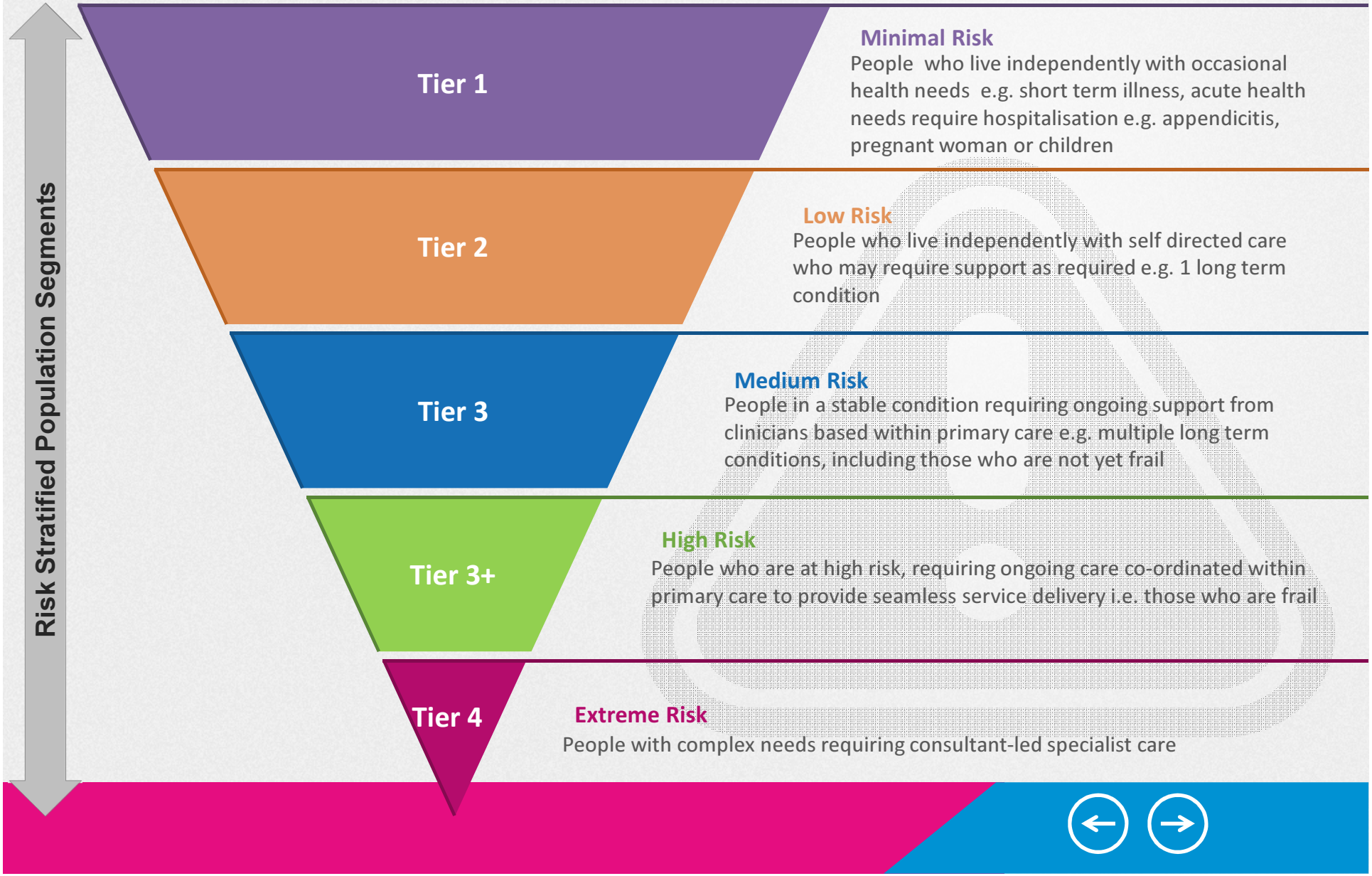
Professional Support Services

- Piloted GPs working together in networks (30,000-50,000 population) supported by integrated local teams (community nursing, mental health, social care, clinical pharmacy etc) - joining up care for older people and people with complex health needs, to help them stay healthy for longer
- Established working groups focusing on Organisational Development, Quality, Population Health Management, Workforce, Finance, Communications and Engagement

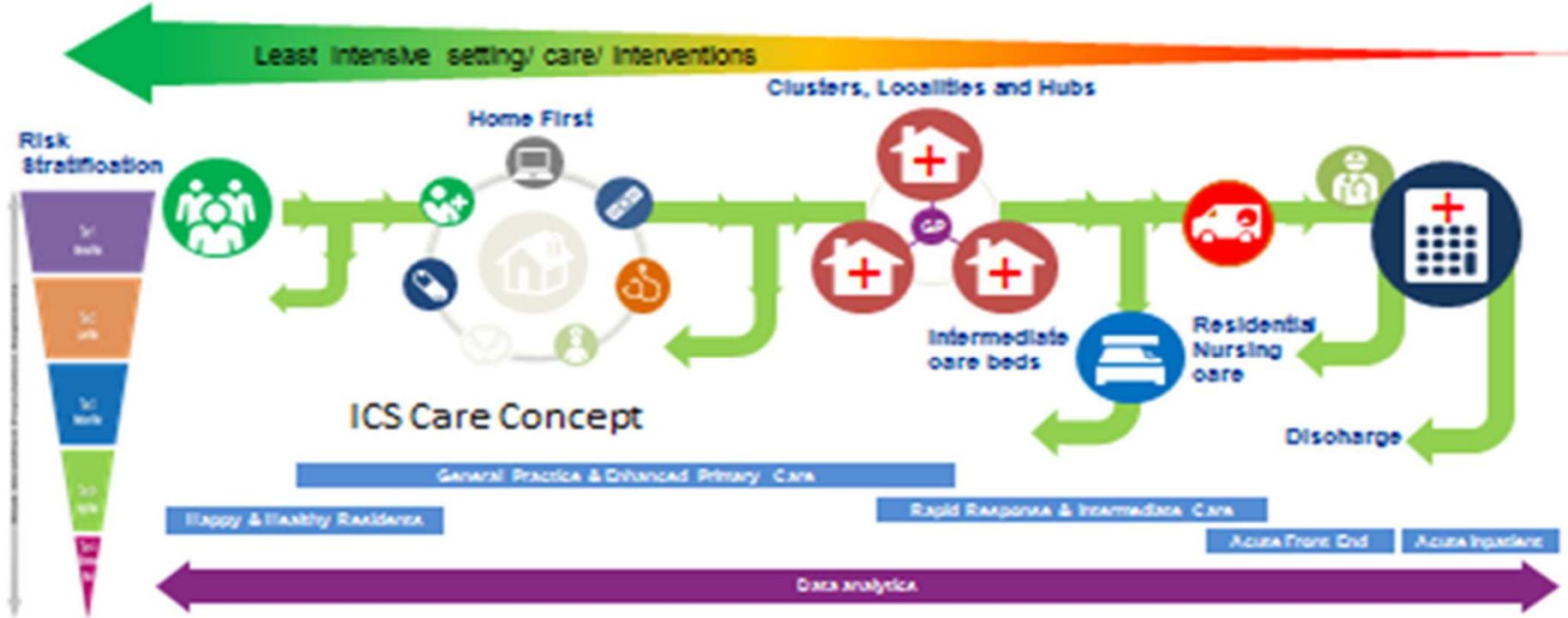
Engagement

- **Your Community, Your Care roadshows:** ongoing outreach programme to local community groups across the county, running in phases since late 2016. During the latest phase (Nov 2017-early 2018), 14 events were held, with over 600 members of the public attending.
- Supplemented by **comprehensive public/staff/stakeholder engagement for specific transformation workstreams** e.g. health community hubs engagement to ensure pilot is robust, new models of care are properly tested and ideas for improvement are implemented quickly.
- **Clinical/professional leadership:** events bringing together a wide cross-section of health and care professionals to shape the Clinical Leadership Framework, strengthening the multi-professional voice; part of a wider partnership piece on organisational development.
- Ongoing participation in **NHS/National Council for Voluntary Organisations development programme** to increase voluntary sector involvement in health and care transformation.

The emerging care model



The model below describes the ICS Care Concept Model



- Information and sign-posting
- Digital services
- Voluntary sector and communities
- Wellbeing initiatives

- Self-Care
- Social Prescribing
- Repeat Prescriptions
- Carers Support
- Care Assessment/ Planning

- Planned and urgent care
- MDT
- Social Care
- CATS
- BITS

- Re-ablement
- Rapid Response
- Step-up/ step-down
- Diagnostics
- Enhanced medical input into residential/ nursing homes

- Planned admissions
- Trauma/ medical emergencies
- Discharge model

Next steps – draft programme

Integrating care/Five Year Forward View/Population Health Management:

- Continue to develop integrated community services: out of hospital care, community hubs and integrated local teams supporting GP 'clusters'
- Continue to integrate and transform social care (later slides contain more details)
- Develop and join up primary and urgent care services, including 'primary care hubs' and urgent treatment centre models, to help people get faster and more direct access to treatment
- Enhance NHS 111 services (improved Directory of Service, increased clinical triage)
- Work with GP clusters and hospital teams to transform ophthalmology and radiology pathways
- Implement improvements in mental health crisis pathway
- Roll out successful long term conditions work from diabetes into other key areas e.g. respiratory

Professional Support Services:

- **Estates:** £4.2m investment to enhance A&E capacity and patient experience at Stoke Mandeville Hospital; £8m investment to develop 'primary care hub' sites
- **Technology:**
  - Roll out systems to support integrated team working and improve efficiency and safety
  - Introduce online consultations and direct booking of appointments for residents; enable people to hold their own records to support self-care and better management of long term conditions.
- Continued workforce and organisational development, communications and engagement activities

Plus STP-wide working as already outlined above

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Integrating & transforming social care

Gill Quinton

Integrating & transforming social care

“Better Lives” Transformation Programme - key outcomes:

- More people living independently without the need for long-term services
- Fewer people in residential or nursing care
- More people living independently after leaving hospital
- Young people moving from children’s services will be better prepared for adulthood
- More people controlling their support through Direct Payments

Underpinned by a new social work approach which focuses on what people’s strengths and what they **can** do, rather than what they can’t do.

Integrating & transforming social care

How it works now

Living with support
Many people have long-term, service-directed support.

Regaining independence
Short-term services create dependency rather than helping people to maintain or regain independence.

Living independently
People helping themselves to stay well and live independent, fulfilled lives.

Integrating & transforming social care

How it will work in the future

Living independently
The majority of people will help themselves
to stay well and live independent, fulfilled lives.

Regaining independence
Services provide short-term support
to help people maintain or regain control over their lives.

Living with support
Personalised social care support created with people
and their families.

Integrating & transforming social care

Living independently - we will:

- make sure people can access information and advice quickly
- work with others to build support and opportunities in local areas
- make it easier for people to build strong local networks
- tackle isolation by working with the voluntary and community sector to make sure people can link into or create their own networks of local support
- work with communities, local groups and organisations to find solutions to improve the health and wellbeing of people in local areas

Key transformation projects are:

- development of greater community capacity to support people at home
- a new integrated approach to prevention (universal preventative services, including Health-related services)
- Digital Front Door and the First Point of Contact

Integrating & transforming social care

Regaining independence - we will:

- support people to live well with long-term conditions, recover from illness or injury and regain their independence quickly
- provide seamless, short-term health and social care support to help people regain as much independence as possible
- work with others to build support and opportunities in local areas
- make it easier for people to build strong local networks
- support people to return home from hospital as soon as they are well enough; and help them to regain independence and live fulfilled lives

Key transformation projects are:

- improved 'front door to services' (includes mental health and learning disability) – including hospital and community pathways
- Short Term Intervention Service (reablement, rapid response and intermediate care)
- short term intervention and recovery for Mental Health
- Smart Technology and Assistive Technology

Integrating & transforming social care

Living with support - we will:

- offer people a full assessment of their needs at the right time
- fully involve people and their carers in their assessments and support
- offer all carers an assessment and support to meet their needs as appropriate
- work with partners to join up so people only have to tell their story once
- work with others to create high quality solutions which meet people's needs

Key transformation projects are:

- market shaping – the right services, now and for the future (for self funders as well as BCC clients)
- housing solutions – to support independence for longer; and to support our aging population
- a 'whole of life' approach to reduce the impact for people moving on from Children's Services (and other life stages)
- greater use of assistive technology

Better Care Fund

- Gill Quinton

Year 2 of the BCF plan 2018/19

- National refresh requirements for the BCF plan are still to be confirmed but likely to be minimal mandatory changes
- Likely to be a new focus on stranded (> 7 days) and super stranded (> 21 days) in-patients (Bucks current total 130 patients)

National performance

- Nationally social care Delayed Transfers of Care (DToCs) are 27% lower than July 2017
- Nationally health DToCs are 10% lower than July 2017

Local performance

- Significant pressures in the health and care system peaked DToCs in January, in line with national picture, and resulted in 1603 delayed days in Buckinghamshire
- February position was still over the DToC plan target but was improved to 1261
- Non elective admissions have shown a slight downward trend in February but remain 2.7% above plan
- Other BCF indicators will report for 17/18 next month