Your community
Your care
Developing Buckinghamshire together

Health and Wellbeing Board update report

Buckinghamshire integrated care partnership

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NHS Buckinghamshire Healthcare NHS Trust

FedBucks

Buckinghamshire County Council

NHS Oxford Health NHS Foundation Trust

NHS South Central Ambulance Service NHS Foundation Trust

Strategy & Transformation

Vision

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

Objectives

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

Strategic Priorities

Develop a resilient Integrated Care System that meets the on the day need of residents consistent with constitutional requirements.	Progress a whole system approach to transforming health and care to deliver resilience, better resident outcomes, experience and efficiency	Develop the ICS supporting infrastructure to deliver better value for money and reduce duplication	Deliver the ICS Financial Control Total and required System Efficiencies	Redesign care pathways to improve resident experience, clinical outcomes and make the best use of clinical and digital resources

Core Pillars

- Integrated Care Delivery Board
- A&E Delivery Board
- Access, Care & Efficiency Delivery Board
- Ox/Bucks Mental Health Delivery Board

Enablers

- Professional Support Services
- Population Health and Prevention Delivery Board
- Digital Transformation Delivery Board

QG4

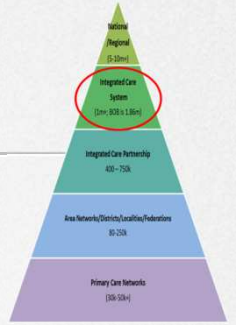
System priorities 2019/20

- Progress a whole system approach to transforming health and care to deliver resilience, better resident outcomes, experience and efficiency
    - Participate in the design, agreement and implement the system architecture of ICS at BOB level, aligning commissioning functions effectively
    - Design, agree and implement Buckinghamshire's Place Based Care and Primary Care Network development, ensuring each element adds coherently to delivering the NHS Long Term Plan and the Health and Wellbeing plan
    - Redesign care pathways to improve resident experience, clinical outcomes and make best use of clinical and digital resources
- Develop a resilient Integrated Care Partnership that meets the on the day need of people consistent with constitutional requirements

Slide 3

QG4 should the bullet points be aligned on this slide?
Quinton, Gillian, 17/06/19

BOB STP Roadmap to ICS



BOB STP has a roadmap to becoming an Integrated Care System ("ICS") by April 2020. They has provisionally determined which outcomes and actions are best driven at Place Level (Buckinghamshire) and which at STP/ICS level. This has resulted in a set of collective priority areas for STP action as set out below:

- Work is set at STP level and broader – e.g. specialised commissioning requires work with Milton Keynes, Swindon & OUH and our Local Health and Care Record Exemplar ("LHCRE") includes wider Thames Valley and Frimley.

STP role	Description	Clarification and rationale
System design & delivery	Design approach to a problem at STP level. Deliver solution at STP level	Population and economic growth; Acute collaboration on planned care; Strategic planning, resource allocation & system design
System design & place/org delivery	Design approach to a problem at STP level but leave places/ organisations to deliver	Workforce; Capital & estates
Set or confirm ambition and hold to account	Agree STP ambition (or confirm STP signs up to nationally set ambition) and hold places to account for/support delivery	Primary care, inc. PCNs; Financial balance & efficiency; Mental health; UEC; Cancer; Devolved oversight from NHSE/I
Coordinate, share good practice, encourage collaboration	Bring places/ organisations together to share approaches and solutions	Research and Innovation; Children and young people, inc. maternity; Personalised care; Digital; Prevention & reducing inequalities; Population health

STP/ICS oversight running through all strategic priorities
Partnerships & Engagement, including patient and public involvement

Developing our Integrated Care Partnerships

Buckinghamshire system is now working to develop into an Integrated Care Partnerships (ICP) Providers will work with commissioners using a population based approach, targeting resources to the most appropriate need, aligned with our Health & Wellbeing Strategy. The ICP will be responsible for:

- the county level 'Place' based alliance of providers, commissioners, local authorities and third sector providers that will work by collaboration not competition;
- management of delegated commissioning budget
- Co- terminous with Local Authorities and having a shared responsibility for statutory duties (e.g. safeguarding);
- System Clinical and Care Forum to ensure we have coordinated, multidisciplinary clinical input into local decision making
- System Stakeholder Group ensuring - coordinated, multi focussed approach to public engagement

Oversight by Health & Wellbeing Board

Scrutiny by HASC

Integrated Care Partnership:

- Acute & Community Services
- Mental Health
- PCNs in wider form (GPs, Nurses, Dentists, Pharmacists, Voluntary, Federations
- Local Authority
- Commissioners
- System Stakeholder Group
- System Clinical & Care Forum

Transforming Commissioning Functions

As part of the ICP team, commissioners will make shared decisions with providers on how to use resources, design services and improve population health on a local basis. Historic commissioning functions, such as transformation & planning will be embedded into the ICP.

There will be a limited number of decisions that commissioners will need to continue to make locally but independently, for example in relation to procurement and contract awards. We plan to utilise the integrated health and care commissioning functions of our Local Authority and CCGs to do this.

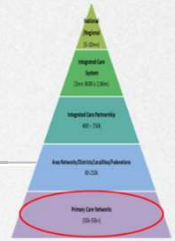
It will be the collective responsibility of the ICP and the STP ICS to ensure where possible we standardise our work across BOB, on a ‘do once and share’ ethos that reduces overlap and enhances productivity. For example, we have a successful BOB wide work stream for Primary Care that coordinates clearly scoped areas of primary care commissioning.

Realignment of CCG functions

In order to support the systems effectively, CCGs are developing a clear view of what current commissioning functions will look like in the future. Some commissioning functions make sense to do at greater scale than the local ICP,. Where appropriate, CCGs can delegate their commissioning functions to a lead CCG, coordinated by the STP, as we already do for areas such as NHS 111 and Ambulance services.

- Improving quality
- Improving planned care
- Primary and community services
- Finance planning and contracting
- Improved unplanned care
- Effective corporate functions
- Effective oversight and enablers
- Place based commissioning functions
- Transforming clinical and professional leadership

Developing our Primary Care Networks



A key priority for the Buckinghamshire and Oxfordshire ICPs is to develop our emerging PCNs, as these are key to the sustainability and delivery of out of hospital service delivery.

- There are significant numbers of PCNs and it will be important to establish a coordinated approach that ensures all PCN voices are heard within the ICP.
- PCNs already have different levels of maturity and we need to support all PCNs to achieve the baseline service requirements for their patients.
- Note that the PCN is the patient population, not necessarily the GP Practice – if a Practice opts out, their patients are looked after by a local PCN
- A geographical focus will be required as the PCNs begin to widen their local 'place' development in terms of District Councils or Community Unitary Boards.

Each PCN will have:
GPs & GP Practice staff from all PCN component practices
New PCN roles, e.g. social prescribing, paramedics, pharmacists
Community Services & Community MH Teams
Wider primary care members; Dentists, Pharmacists, Optometrists
Local Authority professionals, links to clinical staff in Care Homes
Champions in patient and public involvement
Commissioner & provider support for PHM information and analysis

What has the programme delivered in quarter one?

Population health and prevention

- Developing locality and PCN profiles to inform priorities for action
- Developing understanding of most effective interventions – respiratory, cardiac pathways
- Prevention strategy developed including a system Cquin /quality improvement target smoking and alcohol

Examples:

Living well staying well - enabling independence

Diabetes prevention

Primary care development scheme- early identification of long term conditions

- Cardiac - Hypertension
- Respiratory- Chronic Obstructive Pulmonary Disease
- Co morbidities

Social prescribing

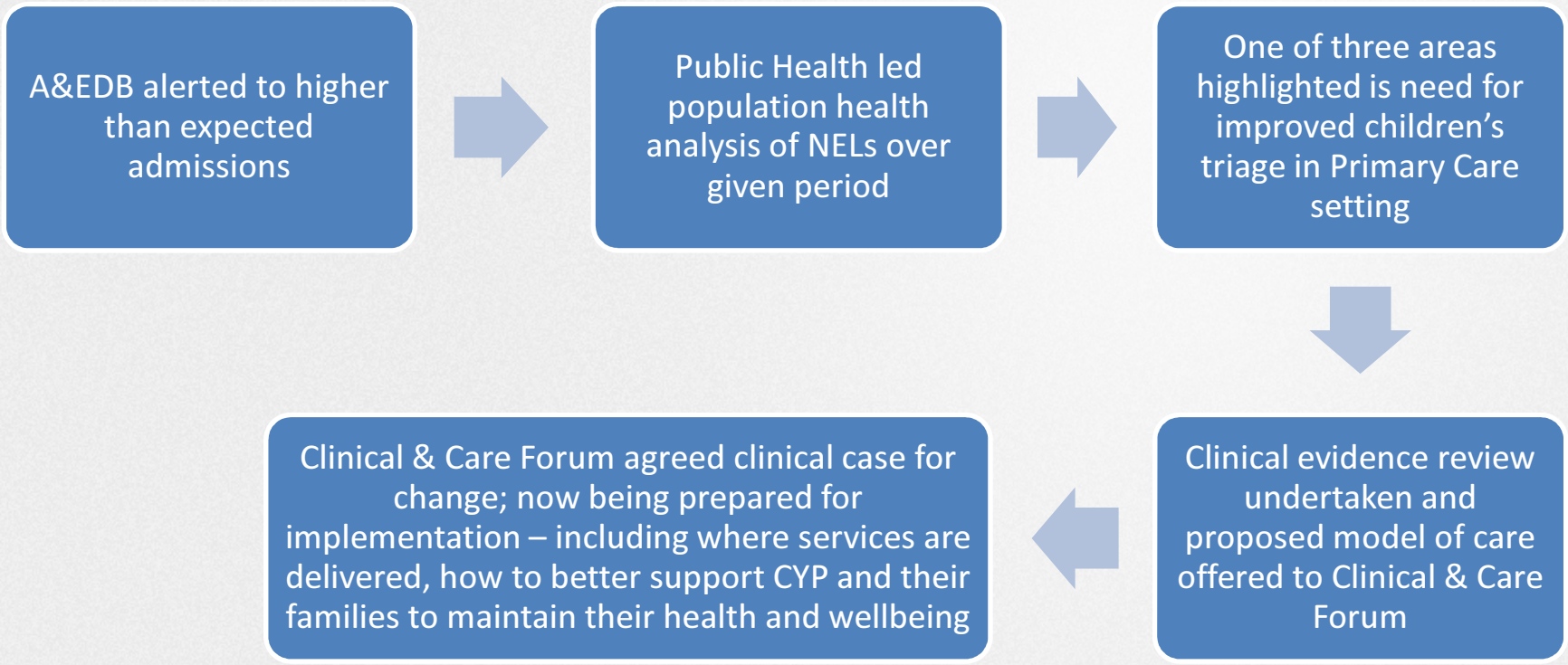
Care and support planning

Motivational interviewing

Keeping people at home
- avoiding unnecessary hospital admission

- Building on the good performance over winter
- Consultant connect – access to consultant advice
- Clinical assessment and treatment service CATS
- Multi disciplinary day assessment unit (MuDAS)
- Winter review- ensuring we learn from last year and plan early for 2019/20
- Understanding what is behind the increased attendance of children and young people to A&E
- Tier 4 CAMHS model has gone live- more coordinated approach to finding bed based care for children and young people
- Mobilisation of the three tier model of social care
- NHS self triage tool to 30% Buckinghamshire practices
- EMIS record system to EMIS referrals for approved clinical services
- 111 Direct booking pilot – Swan practice fully live

A Public health management approach - child non elective admissions



Keeping people well

- Built on the priorities identified through the population health data analysis development of pathways
  - Cardiovascular
  - Respiratory
- Successful in gaining national support NHSE/I for the ICS - planned care redesign to optimise pathways of care, patient experience and outcomes
- Commencing wave 3 – neonatal/ maternity safety collaborative
- Implementing continuity carer model for 20% of women- focusing on diabetic women and those socially/ psychologically vulnerable
- Mental health support teams in schools
- Perinatal mental health service increasing access to this service
- Progress on development of the social care digital front door

Integrated care

- Progressing the pilots of locality teams –realigned to Primary care networks
- Working towards integrating local authority occupational therapy and re - ablement service, then joining up with the rapid response and intermediate care service
- Developing a single integrated discharge team – helping get people home as quickly as possible
- Scoping further development of the Single Point of Access - streamline referral and speed up access to the right service
- Piloting a joined up approach to shared information – assist development and delivery of personalised care
- Development of colocation of health and social care teams enhancing integrated team working to better meet the needs of people with a learning disability
- Engaged a partner to scope the range of opportunities for integrating health and social care services to enhance delivery, experience, value for money and outcomes
- Whole system baseline assessment and development of a system digital strategy

Engagement

Buckinghamshire ICS website

www.yourcommunityyourcare.org.uk

The website was developed for staff to keep informed about the ICS after carrying out a survey across all six partner organisations.

ICS Newsletter

The newsletter goes out monthly to keep staff and stakeholders updated on the developments of the ICS. Going forward, we plan a redevelopment of the newsletter to focus on the work of each Board.

Back copies of the newsletter can be found on the website - www.yourcommunityyourcare.org.uk/getting-involved/newsletter/

Residents Panel

Having successfully won funding from NHS England, we are developing a resident's panel. It will have 1500 residents who are representative of our population. MES have been procured to do face to face recruitment to the panel.

Digital Engagement Tool

Another successful funding bid is allowing us to procure one digital engagement tool across the Buckinghamshire system. This will allow us to do improved online surveys and cross-analysis of results. This will link to existing databases for patient involvement as well as the resident's panel.

Engagement Framework

Across Buckinghamshire, we are working to align our approach to engagement including having one strategy for the system. This fits with the Communications work stream for Unitary where there is a focus on the approach to consultation and engagement for the new Council.

Service Planning & Engagement

- Scoping event held on 6th June with 30 attendees from across the Bucks ICS and Districts
- Reviewed the Oxford Framework and agreed to adapt the approach with the following suggestions to be acted upon by a volunteer group from the attendees:
  - A generic version for use by any partner
  - A health and social care version that builds on the generic
  - A public version
  - Guidance for HASC members
- Use of the approach to become '**the way we do our business'** rather than a framework which gets used once in a while
- Next steps are to make the adaptations required, test these back with participants and then progress through due governance
- Aim to get this supported for use in September 2019

Digital Strategy

- Set out direction of travel and deliverables to integrate technology/data to improve services so they are:
  - shaped around individual need and convenience,
  - built on a secure, value for money, responsive and accessible infrastructure
  - pushed out to provide responsive and timely information on individual care and service needs
  - Support our ambition to be a learning System

- Comprises **3 pillars**
  - **Technology** - infrastructure, hardware and software
  - **Digital** – culture change, improved patient experience, improved processes and better tools for our Workforce to deliver better and safer patient care
  - **Information** - creating information and intelligence that drive delivery and improvements in care

- Takes account of national, regional and local priorities

Our Single Digital Front Door

What will our resident see

A Buckinghamshire “**public services passport”** - details of all transactions and records - personal digital health record, all correspondence received from health and local government. Able to add information to their “passport” about not necessarily recorded **‘me as a person’** as part of standard information but relevant to how the person wishes to be viewed or treated, i.e., phobias, speech/hearing disability, or circumstances such as a recent bereavement

Supportive information “pushed” to individuals giving them easy access to relevant and appropriate information and services without having to go looking for them;

Our Single Digital Front Door

What our resident will get:

Choice of consultation types, virtual and remote, using technology of choice;
Those unable to use digital methods of service access or keep electronic records themselves, benefit from those same systems being used on their behalf by people they contact by telephone or approach face to face, or by someone they nominate to act for them.
Those using our services but living outside Buckinghamshire will receive the same level of access and ability to store their information centrally in their personal passport

Benefits

- Each person's journey from first contact will be fully visible and data available for analysis, leading to improved demand management, forecasting, skills deployment and reduced cost per contact
- Partnering with our residents will increase engagement in service design, increase take-up and generate population level data moving Buckinghamshire to "push" services ahead of demand, reduce risk of deterioration and need for more complex services.
- Real time data transmitted via remote monitoring will improve the timeliness of interventions.

Developing our workforce

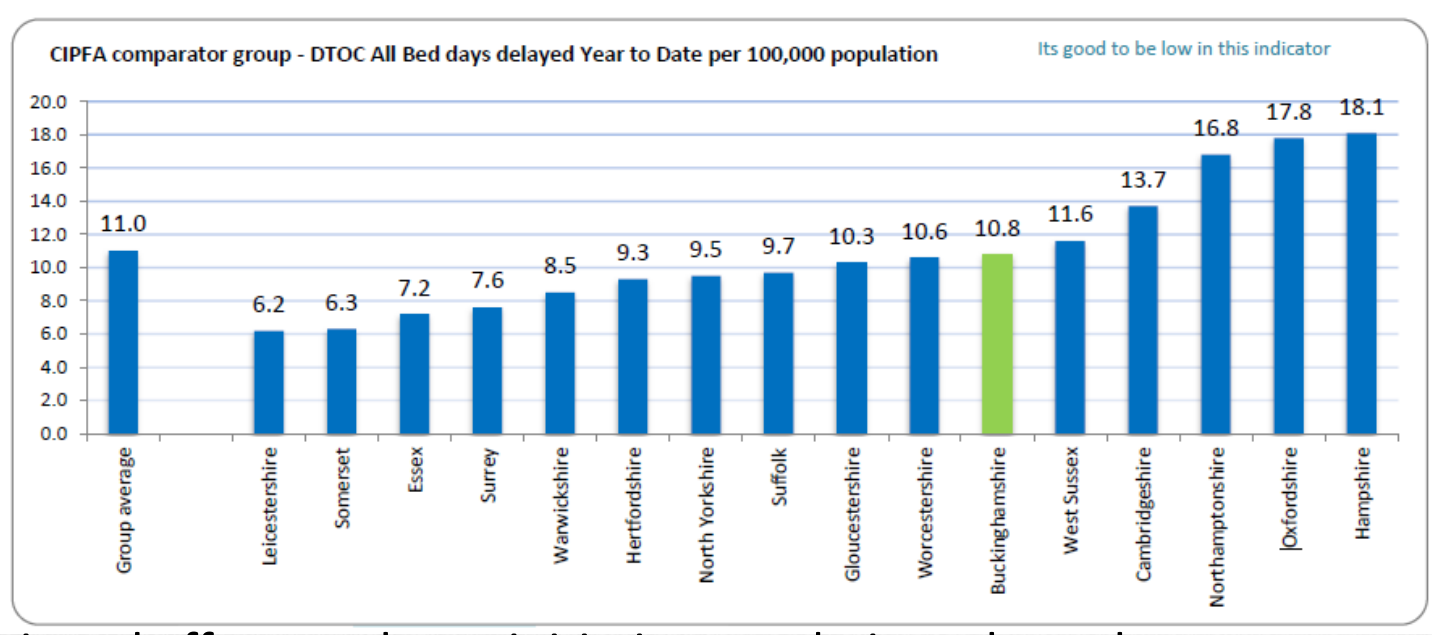
- Three tier system leadership programme
- Quality Service Improvement and Redesign (QSIR) system training
- Engagement road shows with the workforce about the transformation programme, gaining their feedback and ideas for improvement
- Established the Clinical and Care Forum – Professional system voice

Better Care Fund (BCF)

- The Integrated Care Executive Team (ICET) has evaluated all of the 18/19 BCF schemes
- The BCF Planning Requirements (including the assurance process) are expected to be published in the next few weeks - although a definitive date has not been confirmed yet
- There will be no new metrics for 19/20 and there will be light-touch monitoring
- An indicative plan for a 19/20 BCF plan for Bucks has been outlined
- There is a national review of the BCF planned for 19-20 before a substantive change for 20/21 and beyond

Delayed Transfers of Care (DTOC)

- National expectations continue for greater systems leadership and performance for DTOC through integrated working
- Buckinghamshire system continues to perform better than average compared to its statistical partners



- Continued efforts and new initiatives are being adopted to ensure we maintain and improve DTOC performance. This will benefit patients by ensuring timely discharge and reduced lengths of stay.

Better Care Fund Plan – Update

DTOC performance – April 2019

(data not validated)

Overall delays:

- The total number of bed days delayed for Buckinghamshire in April was 1,341 days compared to 1,295 in March.
- This equates to an average of 44.7 bed delays per day in April.

Month	No. of days delayed per month	Change from previous month
May 2018	1969	↑ + 402
June 2018	1593	↓ - 376
July 2018	1554	↓ - 39
August 2018	1245	↓ - 309
September 2018	1806	↑ + 561
October 2018	1464	↓ - 342
November 2018	1241	↓ - 223
December 2018	964	↓ - 277
January 2019	1204	↑ +240
February 2019	1188	↓ - 16
March 2019	1295	↑ +107
April 2019	1341	↑ +46

DTOC performance – April 2019

(data not validated)

Delays attributable to Adult Social Care (ASC):

- The number of bed days delayed attributable to Adult Social Care (ASC) fell from 198 days in March to 189 days in April.

Delays by Trust	No. of days delayed (attributable to ASC)	
	April	Change from previous month
Frimley Health NHS Foundation Trust	116	↑ +36
Buckinghamshire Healthcare NHS Trust	48	↓ -14
Oxford Health NHS Foundation Trust	19	↓ - 15

- The most frequent reason for an ASC delay in April 19 was Delay reason E – Care Package in Home, accounting for 77 days delayed
- Performance remains below the target set for the month
- The targets for Joint, Health and All delays have been exceeded.

Recommendations for the Board

- **To note**
  - the progress made by the Buckinghamshire partnership in the first quarter of 2019
  - transitional plans to align as an Integrated Care Partnership.
  - the points for the BCF 2019/20 and evaluation of 2018/19 in Buckinghamshire.