Your community Your care
Developing Buckinghamshire together

Buckinghamshire Integrated Care Partnership

Health & Wellbeing Board Update

5 September 2019

NHS Buckinghamshire Clinical Commissioning Group
NHS Buckinghamshire Healthcare NHS Trust
FedBucks
Buckinghamshire County Council
NHS Oxford Health NHS Foundation Trust
NHS South Central Ambulance Service NHS Foundation Trust

ICP Update Outline

- **Section 1: NHS Long Term Plan Update**
- **Section 2: Summary of Multi-Morbidity Analysis**
- **Section 3: Primary Care Network Development Update**
- **Section 4: Preparations for Winter Planning**

Section 1: ICS Long Term Plan Update

ICS Long Term Plan Update

We are working together as the **BOB Integrated Care System** to develop a five year plan. It will describe how all partners within the ICS will work together locally and, when appropriate, together across the Buckinghamshire, Oxfordshire and Berkshire West area, to ensure current and future health and care needs are met.

The **BOB ICS Five Year Plan** will be published by the end of November 2019 and will describe how we are tackling our health and care priorities and will deliver our ambitions so that together we can:

- Deliver care that is fit for the 21st century – offering more services closer to where people live, tailoring care so that it better suits individuals' needs and making the most of technology
- Recruit people into health and care jobs, offer new and exciting roles at all levels to help deliver our ambitions and keep our staff through more flexible and supportive employment opportunities
- Help people earlier rather than later, keeping them well and reducing health inequalities
- Improve care quality and outcomes for stroke, cancer, mental health services
- Ensure health and care keeps up the pace with advances in innovation and research
- Making best use of taxpayers money, including getting value for money by doing some things such as procurement once and on a larger scale

Our plan is being developed by a range of staff and clinicians who are experienced in planning for and delivering a wide range of services, such as mental health, children's services, primary and hospital care. Engagement will initially focus on incorporation of feedback to date from engagement events undertaken by systems, supplemented by national engagement work requested from health watch.

H&WB chairs and clinical chairs will be invited to an event with Fiona Wise and David Clayton Smith.

Commitment to openness and transparency – signal areas where conversations will take place about future opportunities.

ICS Long Term Plan Priorities

Priorities to be tackled together as an Integrated Care System

- Strategic planning and preparing for the increase in demand of services. Addressing the pressure on planned hospital care, particularly in gynaecology, urology and ophthalmology
- Improving outpatient care
- Addressing the needs of our buildings and estate
- Developing our people strategy
- Maximising the opportunities for digital technology to improve care

Shared ambitions to be set by us as an Integrated Care System but delivered by Integrated Care Partnerships, Primary Care Networks and Organisations

- Urgent & Emergency Care
- Primary Care
- Cancer
- Mental Health
- Learning disabilities and autism
- Maternity
- Financial balance and efficiency

Working together to address particular health inequalities, support particular priorities or encourage innovation

- Preventing ill health and addressing health inequalities
- Children and young people
- Population Health Management
- Personalised care
- Research and innovation

ICS Long Term Plan Timeline

27 August	Workstream lead to submit draft sections to STP office
2 September	BOB strategy summary (being discussed at 20 August DOG) made available on STP website (for comment until 4 October)
Mid-Sept	Draft version of system plan to be issued to Boards for engagement
27 September	Draft submission to NHSE/I
27 September	Draft plan published to BOB ICS website
11 October	Section leads submit final drafts of system plan to STP office
21 October	Final draft of system plan issued to Boards for approval (by 31 October)
1 November	Final submission to NHSE/I

The final draft will be circulated to HWB members to provide opportunity for final comment before submission to NSHE/I on 1 November.

Section 2: Summary of Multi-Morbidity Analyses for Buckinghamshire

Summary of Multi-Morbidity Analyses for Buckinghamshire

Analysed and Produced By
Public Health and Public Health Intelligence
Buckinghamshire County Council

Why focus on multi-morbidity?

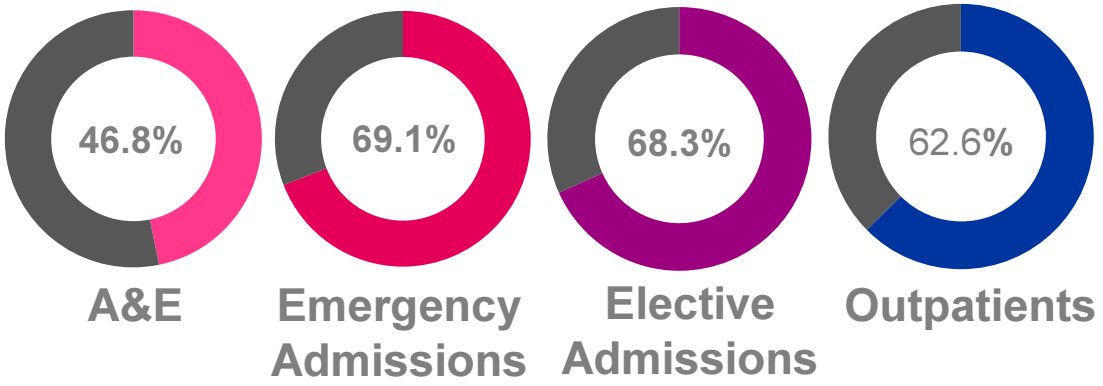
- Increased demand for health and social care services is driven by a population with a high prevalence of multiple long term conditions (LTCs).
- **Multi-morbidity, more than age and frailty, is driving the overall increase in costs.**
- Multi-morbidity is common, socially patterned, and significantly driven by common lifestyle factors (smoking, drinking alcohol and physical inactivity) and social determinants.

Multi-Morbidity Key Findings

1. 1 in 2 patients in Buckinghamshire has a long term condition (LTC). 3 in 10 have two or more long term conditions.

2. 62.6% of non-GP costs are for multi-morbid patients but they only make up 29.2% of all patients.

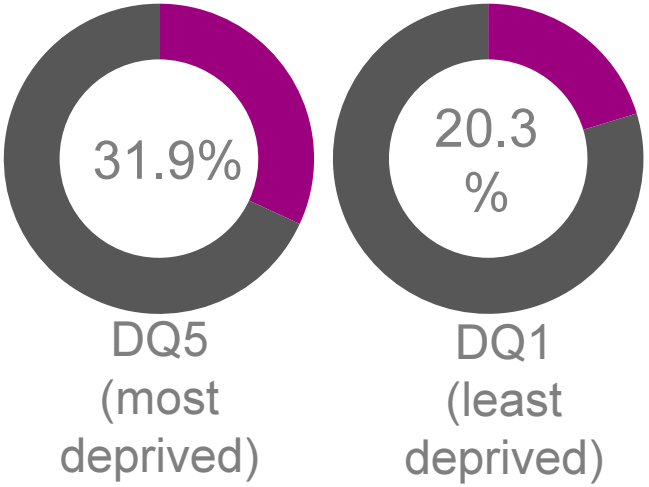
People with 2+ LTCs accounted for the following proportion of costs



Multi-Morbidity Key Findings

3. Patients who live in DQ5 (more deprived) become multi-morbid approximately 10 years earlier than in DQ1 (less deprived) areas.

Proportion of 45 to 49 year olds with Multi-Morbidity by Deprivation Quintile



4. A significant proportion of patients with LTCs have a mental health diagnosis.

- **3+ LTCS** - more than 1 in 4 patients have a mental health comorbidity.
- **8+ LTCs** - approximately 1 in 3 have a mental health comorbidity.

What to do about it?

The Health and Wellbeing Board is asked to support the following recommendations:

- Common lifestyle factors such as smoking, drinking alcohol and physical inactivity drive many long term conditions.
- **Recommendation:** ***Improve and scale up prevention initiatives across the ICP to support people to improve their health and wellbeing.***
- Traditionally high-resource-use patients have historically been managed based on the notion that they are elderly, frail and have high impact diseases (e.g., COPD and heart failure).
- However, those most at risk of high resource use are a heterogeneous group whose care requirements are different.
- **Recommendation:** ***Initiatives that aim to reduce costs should be focused on multi-morbidity and not be restricted by age. Holistic support is needed to support these patients to manage their varying conditions.***

Section 3: Primary Care Network Update

PCN Transformation

Progress to date:

- 12 Primary Care networks in place
- Agreement for Accountable clinical director to be a member of the ICP partnership board so able to inform and influence strategic plans
- The Accountable clinical directors are working with system service leaders to develop a joined up approach to meeting the needs of the local population
- Initial population health data pack has been shared with the networks informing areas for focus
- They have recruited a pharmacist and social prescriber each to add to their service offer in line with Long Term Plan goals

Next Steps:

- They will be using a self assessment tool against a national matrix- supporting them to develop into mature networks
- Using the wider population data, local knowledge and the pilots in multi disciplinary working to spread good practice across all networks – strengthening local services
- Aligning local services to work with the networks
- Use of the respiratory pathway to accelerate system change over winter – keep people at home

Section 4: Winter Plan

Key lessons from 18/19

Over 50 members of the Bucks ICP and neighbouring organisations attended the winter wash up for 18/19. Feedback from the event was shared widely across the ICP, with the key messages of:

- **Collaboration is key** – structured and regular communication is needed, as are trusted relationships to resolve challenges
- **Communications across the system** – consistent communications to staff and patients across the ICP will keep messaging simple, and avoid conflicting messages
- **Weekend flow is vital** – we need to build robust services that functions 7 days a week
- **Structured approach to escalation** – we need calm, consistent and equitable escalation via OPEL, and to review the approaches taken to increase system bed capacity
- **Engagement of the charitable sector** – we want to work with the charitable sector to enable patients to remain at home safely and leave hospital when they no longer need acute care
- **Saving patient and staff time** – designing systems that are timely, simple and reduce duplication and distress caused through over complexity

Priorities for winter 19/20

For both adults and children:

- Reduce Emergency Department (ED) attendances
- Reduce non elective admissions
- Facilitate timely discharge

The Bucks ICP plan aligns to these three objectives and the delivery of a home first approach

Clinical areas of focus

As a integrated system, these are the key areas we have committed to developing

- **Paediatrics**
  - Increased medical and nursing coverage in ED and the paediatric decision unit (PDU)
  - Rapid access to consultant support via additional hot clinics
- **Frailty**
  - Falls and frailty vehicle to support patients calling 999 and 111
  - Silver phone for immediate consultant advice for primary care, including paramedics
- **Mental health**
  - Providing bespoke mental health support away from ED, for acutely unwell patients
  - Safe havens across Buckinghamshire, in areas of high need

Admission and discharge gap

Every day it is a challenge to discharge as many patients as are admitted.

When there are not enough discharges, this causes patients to wait in ED for beds.

This is not the care anyone would want for a loved one.

Nationally there is a focus on reducing the overall length of time patients spend in Emergency Department, and avoiding patients going to ED unless clinically essential.

We need to work with our community to encourage appropriate use of our Emergency Department

To enable a smooth and timely journey through the hospital, we need to enable safe and timely discharge and care in the right setting

We need to design new pathways for patients, working across the Integrated Care Partnership, to provide the right care, in the right place for patients

Areas of focus for improving patient care and experience

How we can close the gap:

•Adopt best practice for ward teams in managing patient journey (SAFER)
•Increased consultant coverage in ED and rapid access hot clinics
•Pathway for patients who are non-weight bearing
•Community alcohol detoxification pathway
•Community based IV Antibiotic service (OPAT)
•Improved services for older people and those with frailty
•Further integration of hospital and social care discharge team and delivery of system single point of access
•Better discharge information and planning, including brokerage to support self funders

Measures of success:

•Reduction in the number of patients waiting in ED >12 hours
•Reduction in the percentage of patients with a LOS >20 days
•An additional 9 extra weekend discharges

An integrated approach to discharge

Spending time in a hospital bed when you are not acutely unwell is harmful

Existing discharge process are complicated and cause unnecessary delays in patients leaving hospital

There is clear focus in the ICP to work collaboratively in improving discharge pathways to simplify and speed up process by:

- Integrating hospital and social care discharge teams
- Delivery of single point of access for professionals to refer patients who do not require acute hospital care – avoiding admission and enabling discharge
- Bringing forward the planning of discharge to take place in parallel to the patient becoming medically ready
- Implementing national best practice for patient flow including the SAFER patient flow bundle

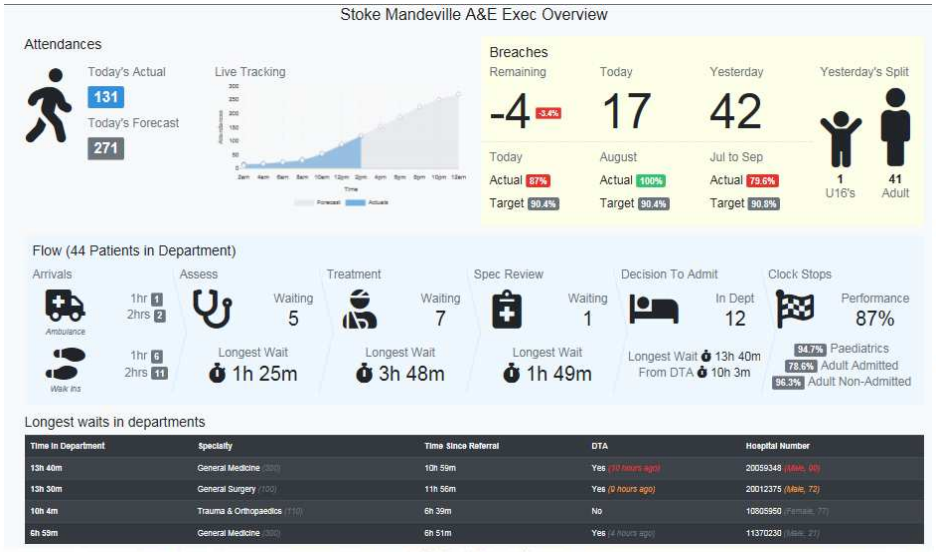
Winter Funding

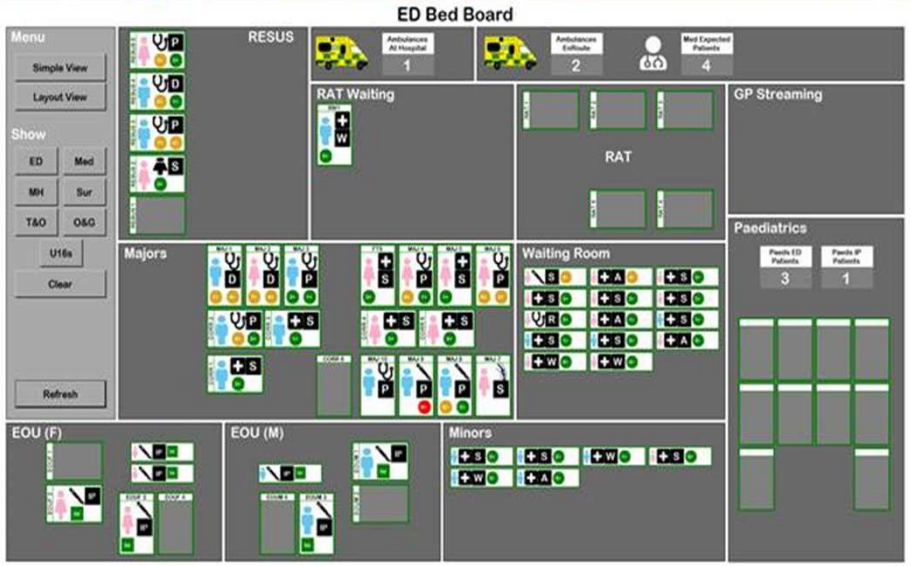
We are working across the Buckinghamshire system to agree bespoke schemes to support caring for people in the most appropriate setting. For winter 19/20 these include:

- Brokerage support to self funding patients in hospital
- Flu vaccinations for care home and preferred home care provider staff
- Additional nursing home and residential placements
- Additional home care, domiciliary care and live in care
- Falls and frailty vehicle

Real time patient flow

Live dashboards now give visibility of flow across BHT. Delivery of a ICP reporting system to replace Alamac goes live in September, and a ward dashboard in October.





Flu

We are working as members of a Thames Valley-wide seasonal flu resilience and oversight group

We have one plan across the ICP for communicating to members of the public about flu

The usual at risk groups will be offered the vaccine, including all school age children up to year 6

We are working to deliver a co-ordinated approach to staff vaccinations

Any support to promote flu vaccination this winter to the public is welcome

We ask the Health and Wellbeing Board to support our commitment to:

:

- Ensuring the safety of our patients
- Supporting our staff
- Working together across health, social care, and the third sector to provide the best care in the right setting
- Engaging our population