Agenda item: 7
Enclosure no: TB2018/074

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD
25th JULY 2018

Details of the Paper

Title	Buckinghamshire Integrated Care System
Responsible Director	David Williams, Director of Strategy and Business Development
Purpose of the paper	To provide an update on progress and next steps for developing the ICS operating model of care
Action / decision required (e.g., approve, support, endorse)	Endorse

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	***Strategy***	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
Deliver primary and community care transformation.

Please summarise the potential benefit or value arising from this paper:
Working as an integrated care system is fundamental to delivering better value care for the population of Buckinghamshire. A shared understanding of the vision and plans for the system are essential for success.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well-led *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Daniel Leveson, Deputy Director of Strategy
Presenter of Paper: David Williams, Director of Strategy
Other committees / groups where this paper / item has been considered:
Date of Paper: 16th July 2018

1. Introduction

528,400 people live in Buckinghamshire with the south of the county more densely populated whilst the rural north is much sparser. The health of people in Buckinghamshire is generally better than the England average and life expectancy for men and women is higher than the England average. However, the overall health profile for the county masks localised variation in deprivation and poor health.

The population is expected to grow by 14% by 2033 with a 44% increase in people aged 60+ years and a 140% increase in people aged 90+ years. The changing demography of the older population will increase demand for primary care services and the specific areas where the increase in demand will be seen are in people affected by dementia and the prevalence of other long term conditions.

Buckinghamshire health and care system is one of eight wave 1 Integrated Care Systems (ICS) in the country and aims to work together to deliver the objectives of the Five Year Forward View Delivery Plan and improve the health and wellbeing of the population. The key changes the ICS is focussing on are:

- Integrating care locally to provide better support for people with complex needs and frailty.
- Improving urgent and emergency care services.
- Improving resilience in primary care services.
- Improving survival rates for cancer.
- Improving outcomes for people suffering mental illness.
- Reducing unwarranted variations in quality and efficiency of planned care.
- Digital transformation creating IT platforms that support integrated care.

This paper provides a brief update about progress and next steps of the Buckinghamshire ICS.

2. ICS Operating Model

The ICS Partnership Board has approved the operating model for the ICS that describes an approach to developing the integrated care system, its governance and programme/portfolio management. Importantly, it describes our emerging model of community care that will be managed, located and deployed on different footprints; with localities of approximately 80,000 – 120,000 and clusters of 30,000 – 50,000 population.

We will use population health management tools to support in the planning, identification and delivery of care. We will work closely with local authority partners to align with adult social care transformation as well as the children and young peoples strategy – integrating care where it is sensible to do so. Integrated care is central to the delivery of population health and it is proposed that integrated multidisciplinary teams of health and care professionals are based at cluster level. These teams are pivotal to our success and their development is key to our model of care.

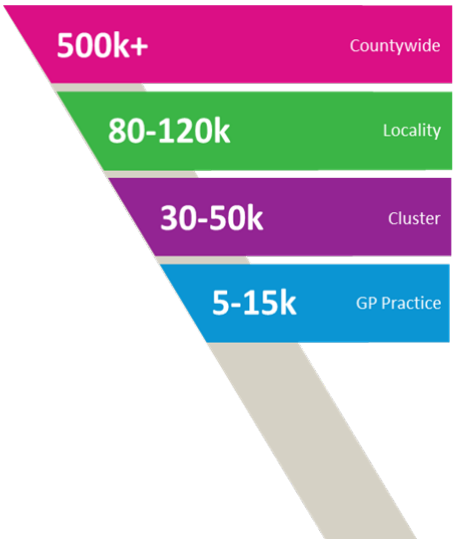
To date there is alignment on the role of GP clusters / integrated teams (population 30,000 – 50,000) and the need for some services to be provided at a larger 80,000 – 120,000 population. The ICS operating model outlines an approach to support the development of resilience in Primary Care by developing out of hospital services to support people who benefit most from more care closer to home.

It recommends identifying **early adopter localities** to focus on and once there have been successes mirror with others. The process is repeatable and scalable. Over a period of 12-24 months it could be anticipated that new models would be implemented across all localities.

It is proposed the following localities are early adopters:

Readiness and progress to date with integration.	Large health inequalities in local population	High demand for health & care & growing population
Buckingham Covering a population of approx. 58,000, 7 GP practices, 1 community hospital	**Wycombe** Covering a population of approx. 103,000, 9 GP practices, 1 community/acute hospital	**Central Aylesbury** Covering a population of approx. 90,000, 7 GP practices, 1 community/acute hospital

Definitions of Place-Based Care



Recent system workshops have endeavoured to agree definitions and scope of the different 'places' in our ICS.

The purpose of the ICS Care Model is to describe how the services accessed by the population of Buckinghamshire in the community will be organised. We are committed to developing place based care through a whole population health model.

The operating model focusses delivery on early adopter clusters/localities. Each cluster/locality will have a delivery plan which will describe how they will develop from their current state to full implementation of a new community care model. This will require a multidisciplinary locality team from across all partners to discuss integrated care strategies and make local tactical, operational and strategic decisions as to how the care model and ICS strategy is delivered.

Clusters/Localities will require time to understand the ICS strategy and develop a care model, prioritise ideas, develop, implement and evaluate plans. They will also need investment in leadership, to increase data analytic capabilities and programme/project management.

3. Making it Happen

The following is a summary of the proposed approach to change being adopted (and resourced by system partners) in localities to develop community care models to meet the needs of local populations:

- Agree **Cluster / Locality Team** representing GPs, community services, acute services, mental health services, social services, voluntary services, public. ICS to provide Project / Programme Management Support.
- Cluster / Locality Team engage local population about integration and agree plan with **priority actions** to implement in the short to medium term (e.g. mental health worker, health support workers for 85+ etc.).
- Cluster / Locality team provided with Business Intelligence/Analytic capability and support from Public Health to **segment the local population***.
- Cluster / Locality team provided with Business Intelligence/Analytic capability and support from Public Health to **risk stratify*** within the agreed population segments.
- Cluster / Locality team provided with Business Intelligence/Analytic capability to analyse current (and model future) **health and social care service utilisation.**
- Cluster / Locality team participate in a **leadership development programme** which is 10% taught, 20% mentoring and learning from others and 70% design and implement change.
- Cluster / Locality team present **developed community model** informed by population data and capacity/demand and cost models to ICS Executive and Partnership Board.

4. Transformation Funding

An approach to managing ICS Transformation Funding (circa. £1.8m) has been endorsed by the ICS Partnership Board in July. Louise Watson (Managing Director of the ICS) has been granted delegated authority by the CCG to hold the transformation fund budget.

The governance requires robust business cases (including value for money/return on investment) to be reviewed and recommended by Director of Finance Group to the ICS Executive. The ICS Executive will notify ICS Partnership Board and CCG Governing Body of decision on business cases based on alignment with strategy and joint plan.

Criteria for funding will be based on at least two of the following:

- That it delivers against one of the key transformation ICS priorities as defined within the systems joint plan for 2018/19.
- That it supports the development of the ICS operating model.
- That it supports the development of the ICS community care concept.
- That it supports our achievement of ICS live status.

5. Next Steps

A weekly system-wide Task/Finish Group has been established on a temporary basis to oversee immediate actions between July and September. This group will oversee decisions and activity related to delivering the community care model as well as driving the delivery of priority actions necessary to deliver the joint plan and to meet the evaluation criteria set out in the NHS I/NHS E system governance framework.

The framework has been developed by NHS I and NHS E in partnership with Local Government Association. It is intended to provide a framework with which to examine a system's leadership and governance in a holistic way. It is anticipated that Buckinghamshire ICS will be assessed against this framework in September 2018 and 'go-live' as an ICS in the Autumn of 2018.

Daniel Leveson
Deputy Director of Strategy

On behalf of

David Williams
Director of Strategy and Business Development

July 2018

Agenda item: 8
Enclosure no: TB2018/075

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
25 JULY 2018

Details of the Paper

Title	Community Hubs Board Update
Responsible Director	Chief Operating Officer
Purpose of the paper	To update the board on the progress of the community hubs and prevention work.
Action / decision required (e.g., approve, support, endorse)	Information only.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	***Operational Performance***	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
Integration, Care Pathways and Models of Care

Please summarise the potential benefit or value arising from this paper:
This paper is for information only. It is in response to an action raised in the May board meeting, to update the board on the performance of community hubs, including preventative care.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: The paper describes a risk that the community hubs do not meet their potential for optimising out of hospital care.
	Financial Risk: There is a risk that the community hubs do not deliver optimal value for money.

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	9 – Person-centred care. *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Ben Collins, on behalf of Andrew Shakeshaft
Presenter of Paper: Natalie Fox
Other committees / groups where this paper / item has been considered: **EMC**

Agenda item: 8
Enclosure no: TB2018/075

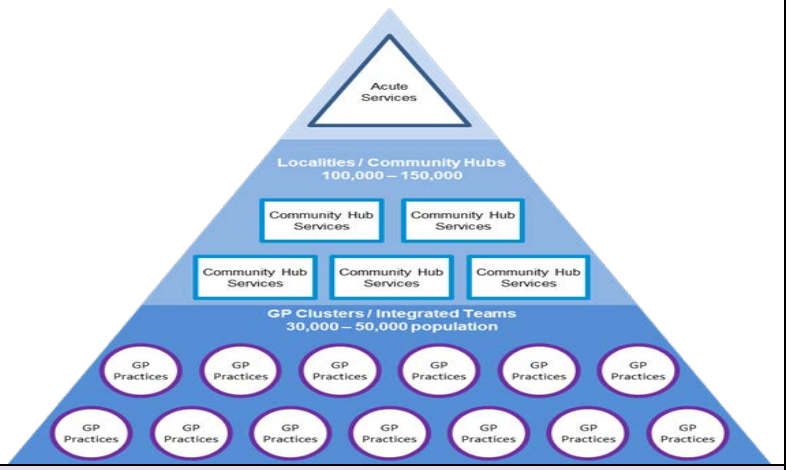
Date of Paper: 12 July 2018

Community Hubs Board Update July 2018

1.0 The aim of this paper is to give a brief update on the progress, made since the presentation in May 2018 and specifically to give information on the prevention work of the Hub.

2.0 Update on Actions

Phase	**Time Period**	**Action**
Phase One	**April 2018**	**Continue community hubs in Thame and Marlow for a further two years.**
	Progress Update	
Increasing referral rate into CATs	Marketing and communication.	Working with CCG to market the service at GP protected learning time (PLT) sessions; Identifying high-referring and low-referring practices and understanding the causes of variation, particularly where low-referring practices are in close proximity to the hubs.
	Use technology to make it easier for GPs to refer into	GPs can refer to the hubs via the Silver Phone – a phone which GPs can call to speak to a consultant geriatrician. As hubs activity and awareness has increased, so has the use of the silver phone. This makes it increasingly difficult for consultants to multi-task, and risks calls being missed. A more efficient and robust solution is the 'Consultant Connect' app which directs incoming calls to a pool of consultants, rather than an individual designated consultant. It also means that the GP does not have to locate numbers. This will be trialled from Aug 2018. Additionally, Hubs staff will have access to EMIS - Bucks primary care's IT system – which will allow them to access more comprehensive patient notes and receive direct referrals.
	Developing a process for ambulances to convey appropriate patients to hubs.	There is concern from the Ambulance service that access to Thame and Marlow can be difficult and routes to Wycombe and Stoke Mandeville are much quicker. Consequently this is a two-phase approach which has been agreed: Go live in July, for ambulance crews to convey to MuDAS rather than A&E if appropriate. Once the concept is proved in Phase 1, then SCAS' concerns can be ameliorated, and the service extended to Thame and Marlow.
	Active identification of patients.	The e-Frailty Index (eFI) is a tool which supports case finding, assessment and case management of people living with frailty, and can be used to identify the most vulnerable cohort of patients. The tool is currently used in primary care. The team are working with localities to invite these patients into the service, so a care plan can then be

		developed with them.
Increasing the services offered	Outpatient Clinics	Dental, Upper GI and wound care clinics started in May 2018. We have now identified the lowest-risk out-patients activity to be relocated from Stoke Mandeville and High Wycombe to community hubs. Work is now underway with Informatics, to map demand by patient location and travel time to hubs, in order to inform the phase relocation of services. This is scheduled to be completed by October. The next phase of work will be to relocate these services, and to appraise the use of technology which can reduce demand for OP clinic attendance where necessary. The third phase of this work is to assess the relocation of services which are more complex, for example require diagnostic support, or which have specific estates requirements. This is due to be complete in March 2019.
	Diagnostics	We are working with Thame League of Friends, to appraise the installation of an ultrasound scanner in Thame hub. This requires an estates upgrade which currently being costed.
Phase Two	**April – June 2018**	**Review out of hospital care model to understand scalability of services between Hubs and Integrated teams**
Progress to date		
Scalability of Hubs and Integrated teams		This piece of work has concluded at the end of June, as outlined in the diagram 
Phase Three	**June 2018 - March 2019**	**Increase the scale of delivery of the hubs and integrated teams across the county**
Progress Update		
		As the main population centres in the county, Buckingham, Aylesbury and Wycombe have been chosen to be 'early adopters' of the integrated care model. These localities are being supported by the integrated care system to develop plans by August 2018.

		Buckingham, with a mature and established Buckinghamshire Integrated team, is now in strong position to begin to further develop a hub model. The first step of this process will be to establish the locality lead, who can assemble a team, operate under county-wide governance, and work alongside Buckingham's strong and supportive stakeholder group. There are no assumptions made about what the hub will look like, and with a community hospital and a new primary care hub, there are lots of options to develop a high-quality, efficient service for the local population. Learning from Thame, Marlow and Buckingham can then be applied to the development of the integrated care model in Aylesbury and Wycombe.

3.0 Preventative Work and the Promotion of Healthy Living

Activities within the Hub	The hubs have been working closely with Healthy Minds, Prevention Matters and Carers Oxford/Bucks, with these providers operating out of both hubs. However, it is proving more efficient for the hubs to signpost patients to these services, which can then operate out of GP surgeries where footfall is higher, or go to patients' homes. The hubs are actively signposting patients, and plan to capitalise on World Older Persons' Day on 1 Oct to further raise awareness.
Activities within CATS	Bladder health and continence advice with referrals to continence service where required; Dietary advice and referrals to community dieticians as required; Mental health assessment and onward referrals to e.g. Healthy Minds; Identification of e.g. social isolation might lead to referrals to Prevention Matters; Diabetes management advice with referral to Diabetes specialist nurses if required; Advice about bone health; Advice about increasing activity levels; information about Active Bucks or more tailored classes e.g. Better Balance classes; Discussions pertaining to Power of

	attorney/Obtaining benefits-carers allowance etc; Forward referrals for bereavement counselling.