Agenda item: 7
Enclosure no: TB2018/051

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD
30 May 2018

Title	Corporate Objectives 2018/19
Responsible Director	David Williams, Director of Strategy and Business Development
Purpose of the paper	The Trust's Corporate Objectives for 2018/19 were approved by the Board in March 2018. This paper outlines the Key Performance Indicators (KPIs) Milestones and Executive Responsibilities linked to these objectives.
Action / decision required (e.g., approve, support, endorse)	The Board are asked to note the Key Performance Indicators

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

All

Please summarise the potential benefit or value arising from this paper:
Provide the Board with KPIs, Milestones and Executive Leads linked to our Corporate Objectives for 2018/19

RISK

Are there any the 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 Framework

Author of paper: David Williams, Director of Strategy and Business Development

Presenter of Paper: David Williams, Director of Strategy and Business Development

Other committees / groups where this paper / item has been considered:
Executive Management Committee

Date of Paper: 23rd May 2018

Buckinghamshire Healthcare
NHS Trust

Buckinghamshire Healthcare NHS Trust

Corporate Objectives 2018/2019

May 2018 version 11.0

Safe & compassionate care,

every time

Quality

We will offer high quality, safe and compassionate care in patients' homes, the community or one of our hospitals:

Executive Leads: Tina Kenny, Carolyn Morrice

Enhance our culture of safety Key Focus: *Implement a clinical accreditation scheme to improve quality of care, reduce variation and share best practice*	KPIs: • Ward and community areas assessed through the Clinical Accreditation scheme	Milestones: • Quality peer review established in each ward and community area June 2018 • Launch Clinical Accreditation Programme September 2018 • 75% of areas will be independently assessed by December 2018 • Minimum 3 areas will be accredited excellence in all categories March 2019
Listen to our Patient Voice Key Focus: *Work in partnership with patients to improve their experience of discharge from our care, outpatients and A&E*	KPIs: • Achieve monthly targets for patients waiting in A&E for treatment • Reduction in outpatient cancellations • Reduction in delayed discharge due to patients awaiting medication • Friends and Family patient survey	Milestones: • Reduce number of patients waiting longer than 4 hours in A&E – monthly review • 10% reduction in outpatients cancellations (11,651 appointments) by March 2019 • 95% of patients will have their discharge medication provided within our standard by March 2019 • A&E Friends and Family response rate improved by 75% and 'would recommend' rates exceed 95% by March 2019
Develop as a learning organisation Key Focus: *Learn and share best practice to improve safety of medications and recognition of sepsis and clinical deterioration*	KPIs: • Maintaining a sustainable HSMR at equal of less than 90 • Reduction in cardiac arrests by 10% • Emergency department suspicion to needle time within one hour: 90% by September 2018	Milestones: • Implement Go Engage initiative to improve staff engagement. September 2018 • Approve a Trust –wide learning organisation framework. December 2018 • Review and revitalise the processes for learning from good practice through BHT Way. December 2018 • Implement an quality improvement skills programme for all staff March 2019

People

We will be a great place to work where our people have the right skills and values to deliver excellence in care:

Executive Lead: Bridget O'Kelly

Inspirational leaders developing strong teams Key Focus: *Our leaders and teams are enabled to innovate and develop their services*	KPIs: • Staff retention rates improved by 10% for teams involved in 'Go engage' • Percentage of colleagues recommending the Trust as a place to work or receive treatment – better than national average 2018 survey	Milestones • Each leader has a transformation project as part of their annual objective June 2018 • 15 teams enrolled in Go Engage June 2018, • 15 further teams enrolled December 2018 • 50 leaders complete Trust Development Programme March 2019
Attracting and retaining high calibre and engaged people Key Focus*:* *Transform our nursing workforce for the future*	KPIs: • Reduction in Trust wide vacancy rate to 15% • Reduction in nurse turnover to 14% from 15.9% • Meet our total agency spend annual cap of £10.5m	Milestones: • Recruitment of 70% of University of Bedfordshire students in September 2018 • Recruit 25 individuals from Portugal by March 2019 • Increase internal appointments from 179 to 230 by March 2019
Pioneering new ways of working across sites, services and organisations Key Focus: *Use apprentices to provide skilled workers for the future*	KPIs: • Recruit >100 colleagues onto apprenticeship pathways	Milestones: • 60 Level 3 by March 2019 • 60 Level 5 by March 2019 • 20 Level 6 by March 2019

Money

We will be financially sustainable, will make the best use of our buildings and be at the forefront of innovation and technology:

Executive Lead: James Drury

Deliver our system control total

Key Focus:

Manage within agreed budget and agency cap

KPIs:

- Improvement on prior year underlying position and meeting control surplus of £9.9m including STF.
- Staff costs not exceeding 2018/19 budget of £250m
- Meet our total agency spend annual cap of £10.5m

Milestones:

Budget approved May 2018

Monthly reporting against agreed targets

- Income and Expenditure
- Staff costs
- Agency costs

Improve our operational productivity

Key Focus:

Use model hospital data to highlight areas for improvement and take actions

KPIs:

- Reduction in cost per Weighted Unit of Activity (“WAU”) across all specialties.
- Deliver £20m transformational programme

Milestones :

- Refresh action plan linked to 2017/18 model hospital data once released
- Monthly review of progress against transformation plan including back office, divisional efficiency, non-NHS income and procurement.

Deliver our capital plan

Key Focus:

Manage and mitigate risks in capital backlog

KPIs:

- Keep within the Trust’s Capital Resource Limit

Milestones:

- Phased disposal plan June 2018
- STP Estates bid submission June 2018
- Monthly capital risk assessment and escalation
- Maximise opportunities for external funding and replacement of medical equipment

Reducing Variation in Quality and Efficiency

Executive Lead: Natalie Fox

Ensure we are meeting NHS Constitutional standards

Key Focus*:*

Meeting A&E, Referral to Treatment and Cancer Access targets

KPIs:

A & E
Meet agreed monthly targets for achieving 95% of patients seen < 4 hours in A & E by March 2019

Referral to Treatment
National target 92%
Meet our agreed monthly targets
Waiting list which is smaller in March 2019 than March 2018

Cancer 62 day performance
To meet agreed monthly targets of >85% of patients receiving treatment within 62 days

Milestones*:*

- Implement NHS Improvement ‘moving to good’ programme across the trust by September 2018
- Medical Patients to be assessed and managed within Acute Medical Unit September 2018
- 30% of medical patients to be seen within the Ambulatory care service with at least 50% of these patients returning home after treatment June 2018
- Introduction of the Acute Frailty Model September 2018

- Optimize the use of our elective treatment centre at Wycombe – monthly review
- Improve theatre productivity to deliver our waiting list targets – monthly review
- Work with the ICS to improve patient pathways or musculo-skeletal and ophthalmology care – monthly review

- Implement redesigned prostate pathway September 2018
- Commence Vague Symptoms Pathway September 2018
- Monitor new two week lung cancer pathway monthly review

Reducing Variation in Quality and Efficiency

Executive Lead: Tina Kenny

Adopt best practice to reduce clinical variation to improve quality and efficiency of service

Key focus:

Implement top two 'Getting It Right First Time' recommendations in each specialty specialties

KPIs:

Ophthalmology
- Achieve national benchmark standard of 8 cataracts on a list
- 10% increase in co-morbidity coding capture for cataract patients

Orthopaedics
- National benchmark of 4 joints on a list
- 80% of patients over 65 receive a cemented hip joint

Urology
- For patients with a diagnosis of a urinary tract stone, reduce the number of stents, and reduce the length of stay

General Surgery
- Reduce Infection rates by 25%
- Inguinal Hernia – absolute reduction in average post surgery costs for patients by 10%

Milestones:

- All service lists to have a minimum of 8 cataracts June 2018
- Revised theatre coding process implemented September 2018

- All arthroplasty consultants to have 4 joints booked on list. June 2018
- Policy on use of uncemented hips implemented. June 2018

- Increase daycases and reduce stents in line with national benchmarks March 2019
- Review strategic provision of urology services across the network March 2019

- Introduce an antiseptic bundle across the Trust June 2018
- Reduce clinical supplies costs through procurement September 2018

Integration,
Care Pathways
and Models of Care

Executive Lead: Natalie Fox

Deliver Urgent and Emergency Care Transformation Key Focus: *Transform services to reduce demand for Urgent and Emergency care*	KPIs: • Reduce demand for A&E attendances and emergency admissions in line with contract agreements	Milestones: • Implement 24/7 Primary Care Access Service April 2018 • Engage in co-production and co-design of 24/7 Primary Care Access Service September 2018 • Implement agreed changes to model of care March 2019
Deliver Primary and Community Care Transformation Key Focus: *Implement integrated care teams and community hubs in Buckinghamshire Communities*	• Reduce demand for A&E attendances and emergency admissions in line with contract agreements • Increase in the use of the Community Assessment and Treatment Services(CATS)	• Completion of system integrated team workshops July 2018 • County wide implementation plan September 2018 • Increase the scale of delivery of the hubs and integrated teams across the county. June 2018 March 2019 • 40% increase in CATS service by September 2018

Sustainable Service Growth

Executive Lead: David Williams

Repatriate patients into the Trust from Buckinghamshire and surrounding areas

Key Focus*:*

Work with ICS to treat more Buckinghamshire patients and seek opportunities to expand services into new markets

KPIs:

- Increase number of patients choosing to be treated at the Trust in the following specialities: musculo-skeletal, cardiology, obstetrics, plastics, and general surgery
- Increase number of women choosing the Trust as a preferred place of birth

Milestones *:*

- Expand outreach clinics in community hubs September 2018
- Clinical engagement programme with local GP practices June 2018
- Maternity Open days for local women and GPs by September 2018
- 5% increase in patients choosing the Trust in key specialities by March 2019
- 10% increase in maternity bookings by March 2019

Increase non-NHS income

Key Focus*:*

Increase private patient income

- Increase private patient/ non-NHS income

- Expand provision in cardiology, dermatology, ophthalmology and orthopaedics in line with Commercial Strategy March 2019

Health and Wellbeing

Executive Leads: Bridget O'Kelly & Carolyn Morrice

Support health and wellbeing for all staff

Key Focus*:*

Programmes to combat stress and increase resilience; MSK care and targeted approaches to the flu vaccine uptake

KPIs:

- Reduction in number of sickness episodes due to stress and MSK episodes by 10%
- Improvement in flu vaccination uptake

Milestones:

- Specific programmes to be created for staff under stress or suffering from MSK issues June 2018
- Successful flu vaccination programme roll out to achieve 75% uptake by March 2019

Ensure the best start in life for Buckinghamshire Children.

Key Focus*:*

Ensure children are safeguarded from harm by working with agencies such as police, social care, education and other health providers

- Safeguarding Level 1 & 2 –over 90% of the relevant staff have received training
- Timely Health Assessments for Looked After Children

- Divisional Safeguarding Leads in place May 2018
- Buckinghamshire Children's Safeguarding Board Improvement Plan approved June 2018
- Monthly monitoring of the Plan through Trust Safeguarding committee
- Monitoring of safeguarding training – monthly review
- Monitoring of Health assessments for Looked After children

Innovate & Improve

Executive Lead: David Williams

Develop an improvement and innovation culture

Key Focus:

Implement a single improvement methodology that supports the adoption and spread of best practices.

KPIs:

- Number of staff trained in service improvement methodology
- Service improvement projects monitored through annual appraisal

Milestones :

- Launch service improvement methodology throughout the Trust by September 2018
- 200 additional staff trained in service improvement methodology by March 2019

Launch Buckinghamshire Life sciences Innovation Centre (BLIC)

Key Focus:

Establish innovation hub to support SMEs develop new products with patients and clinicians.

- Number of SMEs developing new products and services within the Trust

- Innovation centre at Stoke Mandeville Opened December 2018

Technology

Executive Lead: James Drury

Implement Digital Transformation to support our Clinical Strategy

Key Focus:
Implement interoperability across ICS and E-Observation within the Trust

KPIs:

- 100% escalation and action recorded for deteriorating patients.
- Improvement in quality indicators linked to length of stay and the deteriorating patient
- Deliver efficiencies in medical and workforce productivity
- Approval of business cases for external funding rounds

Milestones:

- E-Observation implementation December 2018
- E-Prescribing business case July 2018
- Integrated Care Record implementation starts December 2018

Estates

Executive Lead: James Drury

Deliver the Trust's Estates Strategy

Key Focus:
Delivery of theatres electrical resilience, A&E Phase 2, Research and Innovation Centre and Clinical Decision Unit

KPIs:

- Delivery of the capital projects on time and within budget
- Approval of business cases for external funding rounds

Milestones

- Submit STP Estates Bids June 2018 Quarterly review against project timetable

Organisational Development

Executive Lead: Elizabeth Hollman

Demonstrate that the Trust is a Well-Led organisation

Key Focus:
Self Review using the Well Led Framework and implement actions to improve

KPIs:

Well-led Framework

Milestones

- Self-assessment completed June 2018
- Independent assessment completed September 2018
- Prepared for CQC Well-led inspection. September 2018

Agenda item: 8
Enclosure no: TB2018/052

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
WEDNESDAY 30TH MAY 2018

Details of the Paper

Title	Community Hubs
Responsible Director	Natalie Fox, Chief Operating Officer
Purpose of the paper	To inform the board of the evaluation of the pilot of the Community hubs at Thame & Marlow and for the extension of the pilot to include roll out of the model across Buckinghamshire.
Action / decision required (e.g., approve, support, endorse)	For information

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? Patient Voice, Providing integrated Care closer to home.

Please summarise the potential benefit or value arising from this paper:

The paper outlines the evaluation of the current pilot and the value of extending the pilot and roll out of the model across the county in collaboration with the local community and stakeholders.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk: None

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Quality, Safety, Effective, Responsive and Well-led

Author of paper: Natalie Fox, Laura Isard
Presenter of Paper: Chief Nurse & Chief Operating Officer
Other committees / groups where this paper / item has been considered: Divisional Operations Committee
Date of Paper: 22/05/2018

Your community
Your care
Developing Buckinghamshire together

Developing out of hospital care:

Community hubs pilot evaluation and next steps

Report for: Health and Adult Social Care Select Committee (HASC)
11 April 2018

Executive summary

Following extensive engagement during 2016 with patients, GPs, staff, other health and social care organisations, voluntary organisations and local communities, the community hubs pilot was launched in Marlow and Thame in April 2017 to develop and test our vision of providing more care closer to home. A paper and presentation was given at the Health and Adult Social Care Select Committee in March 2017 outlining the background and context to the pilot with a further update on progress in September 2017.

The aim of this paper is to:

- Share results and learning from the pilot.
- Explain how the community hubs pilot fits in to our wider community transformation strategy.
- Communicate our intention to continue with the current model at Thame and Marlow for a further two years whilst we develop the wider out of hospital care model across Buckinghamshire.
- Outline our plans for next steps and developing the model in the future.

Top-line results

- The community assessment and treatment service at Thame and Marlow has seen **1027** people from April 2017 to March 2018 which is in line with the proposal estimate.
- **Less than 1%** of patients seen by the community assessment and treatment service were subsequently referred to A&E.
- **2,439** patients seen in the multidisciplinary day service assessment (MUDAS) at Wycombe Hospital in 2017/18 - **an increase of 25%** on the previous year.
- There have been no overnight packages of care required so far during the pilot, other than transitional beds already commissioned as part of the 'discharge to assess' project.
- There has been a **60%** increase in outpatient appointments offered at the two sites.
- We have worked with a range of stakeholders to develop and refine the pilot; they are supportive of the work achieved to date and the continued development of the hubs model as part of the wider community transformation programme.

Key learning

- Some of the elements of the hubs development were slow to mobilise and still require further work with hospital clinicians, GPs and the community to increase awareness and referrals. There have been fewer opportunities to work with the voluntary sector than had been originally anticipated, although work continues to build and develop links across communities.
- The stakeholder group has been an important part of the pilot, they have provided scrutiny and challenge to the developments, have represented views of their communities, and helped to develop links between the services and local organisations.
- Even with providing more care closer to people's homes, we have identified there is still support required for transport and access across communities.
- The feedback from those who have used the pilot sites and our broader engagement with communities have helped to inform the next steps. It is clear that a one-size-fits-all solution will not meet local needs, and therefore more specific discussion and planning will need to take place within localities.
- The full impact of community hubs will not be evident for some time, as the programme is aiming to impact prevention and early-intervention; it also requires the other complementary elements of the community transformation programme to be implemented and integrated.

Proposed next steps

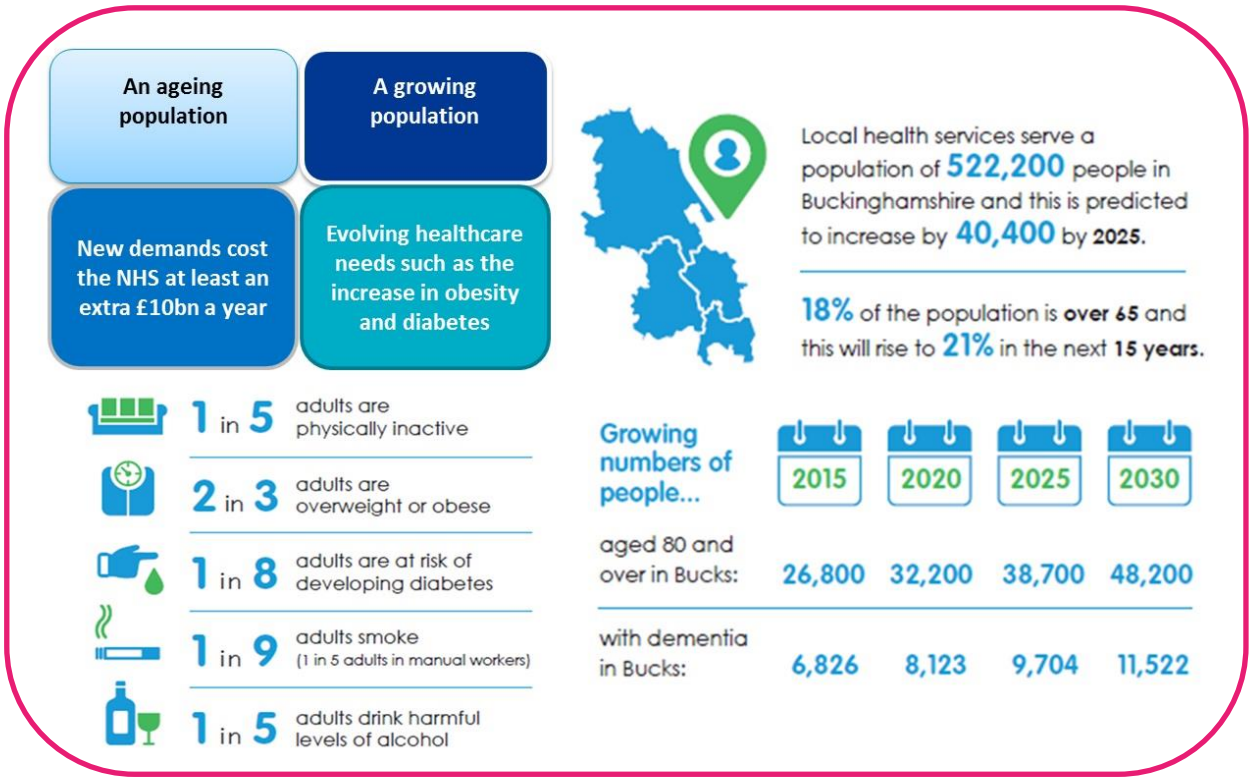
Continue with the current community hubs pilots at Thame & Marlow for another two years so that the other complementary elements of community services transformation have time to be developed, rolled out across the county and evaluated for impact. This includes developing the community hubs model across the county.

- Phase 1, April 2018: confirm the continuation of the community hubs pilot in Thame and Marlow for a further two years
- Phase 2, April - June 2018: Review out of hospital care model to understand scalability of services between the Hubs and Integrated teams.
- Phase 3, June 2018 – March 2019: Increase the scale of delivery of the hubs and integrated teams across the county.
- Phase 4, April 2019 - March 2020: Integrate the out of hospital elements into the full care model.

1. Context

The commissioners and providers of health and social care in Buckinghamshire have been working closely together to make health and care services safe, sustainable and able to meet the future needs of our local population.

Buckinghamshire population



In line with the Five Year Forward View, our patients and clinicians have told us that it is important to them that we provide more care closer to home, with care delivered out of hospital and in local communities.

Evidence from the national New Care Models programme found that by implementing a whole population care model, including hub-based care, health and care systems:

- reduced the rate of growth in non-elective admissions by approximately 4%, when compared to non-new care model systems
- emergency bed days showed a 1% reduction in comparison to a non-new care model systems which grew by 1%.

We are seeing a significant increase in the older population and increasing numbers of people with multiple long-term conditions and frailty. Long-term conditions and frailty are not an inevitable consequence of ageing, much of this is driven by unhealthy lifestyles coupled by a historic lack of investment in prevention so we must find ways to improve this too.

We also know that a frail, older person has muscle deterioration equivalent to 10 years for every 10 days in hospital. Inpatient beds are not always used effectively and can impact on a patient's ability to remain independent as their stay can be extended inappropriately. In summary, keeping people healthy and independent in their own homes is what our patients have asked for, is better for them and for the provision of services.

Our vision is to have everyone working together so that the people of Buckinghamshire have happy and healthier lives. We want to rebalance the health and social care spend to increase support for more people to live independently at home, especially older people and those with long-term conditions, by providing high quality prevention and early intervention services.

In summary, through prevention and early intervention we want to:

- Support people to keep themselves healthy and live well, age and stay well
- Enable more people to live independently for longer
- Create the right health and support in the community in order to reduce pressure on our hospitals and GPs.

The principles of the vision that have and continue to shape our transformation are:

- People are cared for at home wherever possible and that services are focussed on this
- People will be encouraged to manage their own mental and physical health and wellbeing (and those they are care for) so they stay healthy, make informed choices about care and treatment to manage their long-term conditions and avoid complications
- We combine resources and expertise across the health and care system so that people receive joined-up care
- People can access good quality advice and care in the most suitable and convenient way possible, as early as possible, to prevent problems becoming more serious
- People have access to specialist support in their community, working with a named responsible clinician
- We will work together on prevention, not just as professionals but as communities and individuals.

2. What we've done

The care model we have been co-designing with a wide range of stakeholders, including staff, GPs, patients, general public and other health and social care providers, will deliver care closer to home in the least intensive setting and has four elements:

1. **Prevention and self-care**
   – supporting people to live healthier lives and manage their own health

2. **Integrated urgent care services**
   – including rapid community response to reduce the number of people attending A&E and admitted to hospital

3. **Enhanced primary care**
   – where access to general practice is extended and where the range of professions which can be accessed in a local hub setting including for example; community services, therapies, mental health and social care

4. **Integrated care for those with complex needs**
   – where patients are systematically identified and clinicians and patients work together to develop proactive care plans

Community hubs

A key part of the model has been the development and pilot of community hubs in Marlow and Thame community hospitals. Over the past year they have offered:

- Community assessment and treatment service (CATS) including a frailty assessment service where geriatricians, nurses, therapists and GPs provide expert assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission
- Additional diagnostic facilities such as one-stop blood tests and x-rays
- An extended range of outpatient clinics, including chemotherapy clinics at Marlow, community occupational therapy clinics at Marlow (and in Thame in the near future), tissue viability clinics, Parkinson's disease and falls clinics
- Support from voluntary organisations, such as Carers Bucks and Prevention Matters, ranging from clinics, drop-in sessions and information stands. There are monthly stands from Age UK in Thame and Carers Bucks are running a 'clinic' in Marlow on a fortnightly basis. Victim Support has also begun a weekly session in Thame
- Links with other public services have also been made – for example library services are now available in Marlow, providing books to support self-care and the management of mental health and long term conditions.

This is in line with what patients and clinicians told us they wanted - rapid access to testing and diagnostics and a place where they could access a full range of therapy services. Having these services based in the local community makes it easier for GPs to become full members of the multidisciplinary team that delivers the care. We have put in place a single point of access to make it easier for clinicians to refer to the multi professional, multiagency frailty assessment clinics.

To support we have invested £1m into the community services. A total of nearly 36 new posts were created in the community. We have also redeployed staff from the Community Hospitals in both Thame and Marlow to work within the community assessment and treatment service (CATS) team.

	Community care coordination team (Single point of Access recruitment (wte)	Rapid response (wte)
Band 7	1	
Band 6	4.8	7.7
Band 3	3.25	19.13
Total	9.05	26.83

Community assessment and treatment service (CATS)
The community assessment and treatment service operates from 9am to 5pm at Marlow on Mondays, Wednesdays and Fridays and Thame on Tuesdays and Thursdays. There is a geriatrician on site in the mornings and a GP in the afternoon.

The community assessment and treatment service was made possible by re-utilising the space that had previously been the inpatient ward at both Marlow and Thame. By developing the CATS service, along with the rapid response team, it was felt that more people could be supported in their own homes and therefore not require an overnight community bed. During the pilot, we ensured that overnight packages of care were still available if required – this included the other community hospital sites across the county and the ability to spot purchase local care home beds. We separately commissioned a range of services as part of the discharge to assess scheme, which had options for domiciliary care, some 24/7 care and transition beds in local care homes across the county.

Rapid response and intermediate care (RRIC)
The rapid response and intermediate care service was expanded to ensure adequate and integrated support for people at home. Therapists, nurses and healthcare assistants are now working as one countywide team with staff located across the county, aligned to localities. The service provides short-term packages of support based on clinical need (up to three times a day for up to six weeks) to those who would benefit from rehabilitation to help them get back to their level of independence. The service is available 8am – 9pm, seven days a week and is accessed through the single point of access.

Community care coordination team – single point of access
To support both of these initiatives, and to provide a general single point of access to community services, a community care coordination team was developed. They provide GPs, hospital clinicians and other health and social care staff with a 'single point of access' via phone and email to organise specialist community services for their patients, including district nursing, rapid response & intermediate care and community physiotherapy. The service operates 8am – 5pm weekdays and 8am – 4pm weekends and bank holidays and will eventually operate 8am - 8pm 7 days a week once we have recruited the relevant staff. The Trust has a wide-ranging strategy to recruit and retain the staff required to run these essential services with recruitment days held at all sites and six district nurses trained locally each year. There are excellent relationships with the university to attract newly qualified registered nurses to roles in the community and in collaboration with Bucks New University; bespoke courses are offered such as Transition to Community Nursing.

This service is now aligning with the new integrated urgent care service across Thames Valley and will be able to expand the range of services it can access.

Management and governance

To ensure quality and safety was maintained whilst these developments were implemented, the pilot has been overseen by the medical director and chief nurse of Buckinghamshire Healthcare NHS Trust. Day to day monitoring of the pilot is managed by the operational group which meets on a weekly basis. Recommendations from the operational group and the stakeholder engagement group are fed into the monthly governance group which is comprised of GPs, social care and clinicians and is chaired by the medical director, Dr Tina Kenny. Combined feedback and recommendations from these three groups are presented to BHT's executive management committee.

The role of the stakeholder engagement group

Central to the development of the hubs has been the co-design with local people through the stakeholder engagement group. The stakeholder engagement group is chaired by our system wide chief nurse and director of communications. It comprises of representatives from Healthwatch, Marlow and Thame Community Hospitals' Leagues of Friends, Thame and District Day Centre, Marlow and Thame town councils and patient participation groups of local practices. The group acts as a critical friend to the pilot, helping us to review how the new services are working and performing against key indicators, as well as helping us to shape how we can engage and involve people in the on-going development. The group has been meeting every six weeks since the pilot began, reviewing the activities of the hubs, the feedback we have had from people that have used the services and they have made suggestions to refine and improve the model. All information, KPIs and minutes from the meetings are published on the Trust's website.

3. How patients are benefitting

Community assessment and treatment service

The introduction of the community assessment and treatment service (CATS) has been the most significant development to the services provided. This service has seen **1027** people from April 2017 to March 2018 which is in line with the proposal estimate.

We have carefully monitored the impact and there have been no overnight packages of care required so far during the pilot other than transitional beds as part of discharge to assess project.

Readmissions to hospital have remained the same, which would suggest that by being cared for in the community you are not more likely to have to go back to hospital.

Outcomes

Thame community hospital

2016/17:
148 inpatient spells
512 outpatient appointments

2017/18:
459 CATS appointments
756 outpatient appointments

Over **310%** more patients seen in CATS than in the inpatient service in 2016/17

Over **48%** increase in outpatient activity

84% increase in total number of people seen in the hub Vs 2016 activity

129% increase in activity delivered to local people

Marlow community hospital

2016/17:
189 inpatient spells
444 outpatient appointments

2017/18:
568 CATS appointments
604 outpatient appointments

Over **301%** more patients seen in CATS than in the inpatient service in 2016/17

Over **36%** increase in outpatient activity

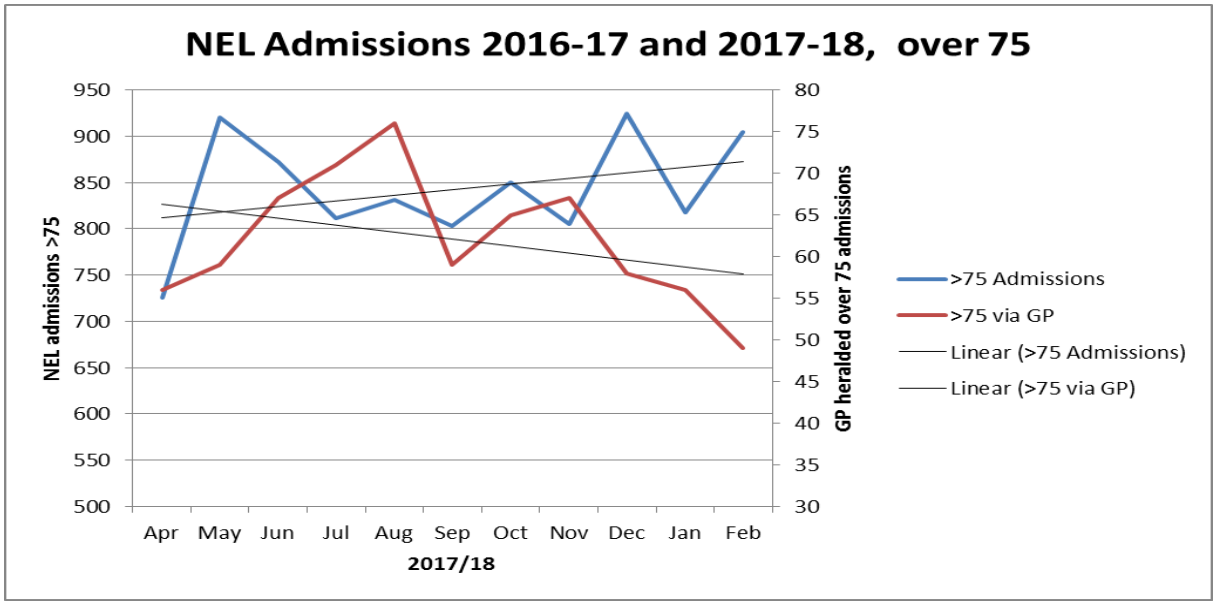
85% increase in total number of people seen in the hub Vs 2016

102% increase in activity delivered to local people

How else are patients benefitting?

- **980** patients seen in the community and **92** followed up in their own homes
- **Less than 1%** of patients seen by the community assessment and treatment service were subsequently referred to A&E.
- **2,439** patients seen in the multidisciplinary day service assessment (MUDAS) at Wycombe Hospital in 2017/18 - an increase of 25% on the previous year. This service is similar to the community assessment and treatment service at Marlow and Thame, and is referred to through the same route via the geriatricians.
- Since April 2017 **128,006** patient visits have been undertaken by the rapid response and intermediate care service.
- Since April 2017, the community care coordinator team has received **6,063** referrals.

We have seen a reduction in non-elective admissions via GP referral for people over 75 years of age when we compare 2016/17 with 2017/18. In addition, although the numbers of people over 75 attending A&E have risen throughout 2017, the trend in referrals from GPs to A&E has reduced over the last 4 months. This may be indicative of GPs referring more patients to MUDAS and CATs services. We believe that the increase in referrals to the MUDAS service is due to an increased awareness of and commitment to a more community-based model of care by general practice.



Who is being seen in the hubs?

The vast majority of patients using the community assessment and treatment service are referred from home by their GP. Only three patients were referred as part of their discharge from hospital care. **77%** of patients were seen only once, the majority of whom were discharged with no further care required or back into the care of their GP.

There were **60%** more outpatient appointments available in Thame and Marlow than in the previous year. A range of additional clinics have been offered at these sites, although we believe there is opportunity for this to be expanded further. The addition of systemic anti-cancer therapies (including chemotherapy and psychological assessments) at Marlow has been a particular benefit for those who would have previously travelled to Aylesbury and Wycombe. Following the success of these therapies we are working in partnership with Macmillan to look at how we can roll this model out across the county and Macmillan are providing funding for additional staff to support the project.

4. What our stakeholders have said

Please see Appendix 3 for the full stakeholder engagement report.

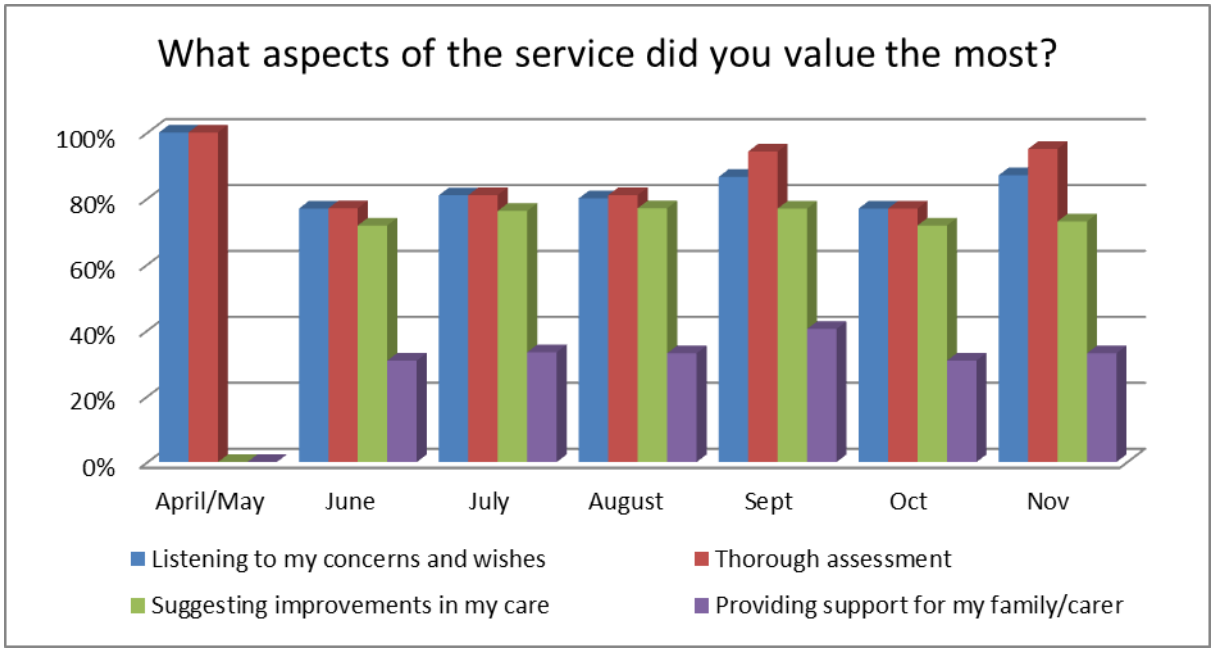
The involvement and engagement team gathered the views of 352 stakeholders, using a mixed methodology tailored to different groups:

- Focus groups with 28 hub patients
- Appreciative enquiry workshops with 7 hub staff
- 3 telephone interviews with staff from Healthy Minds, Alzheimer's Society and Age UK
- Public engagement workshops in Buckingham, Chalfont, Marlow, Wycombe, Thame, Aylesbury, and Iver, attended by 191 members of the public
- Sessions with 123 members of voluntary sector service user groups, and a patient participation group

This was in addition to the public and community group meetings the Trust was invited to present at and the open days at both hubs. The Trust engaged with over 1000 members of the public through its community hub open days, and meetings of organisations including parish councils, University of the Third Age, PPG's and stalls at community markets in which there was more general discussion and information giving.

Patients

Every patient attending the community assessment and treatment service have been asked to complete a feedback form at the end of their appointment. In this feedback people have been consistent in feeling listened to and having a thorough assessment and there are a growing number of people who report that they received improvements to their care and support for their family or carer was given as part of the package. Care has been almost unanimously rated as excellent.



**please note that, following feedback from the stakeholder engagement group, the questionnaire was revised following the November survey*

We have received feedback from some patients that parking and transport can be an issue. We are working to provide parking which can accommodate up to 10 patients attending CATS as well as patients attending other services in the community hub. We will improve turnover of parking spaces by staggering patient's arrival time and will better accommodate the parking needs of our patients by adding an extra disabled parking space at both locations with easier access to the entrance.

Patients attending a CATS appointment are encouraged to provide their own transport where possible. Flexible appointment times are offered in order to accommodate rush hour traffic.

Patients can be offered patient transport from the ambulance service with same day or next day availability. Recently the contract has confirmed a patient can be accompanied by a carer if the need arises. Patients have to be ready 2 hours in advance of the appointment time. Pick up and drop off times can vary and be unpredictable. On occasions this has led to delays in patients being picked up from the hub. This has led to reluctance in booking later afternoon appointment times.

As an alternative, a number of community voluntary transport options have been sourced. Many of these require notice to book and therefore are unable to respond to the rapid response appointment system of the CATS service. However for those appointments that can be planned in advance these transport options have been of benefit and offer a cheaper and reliable alternative to taxis. Community Impact Bucks offers signposting to transport services across the county and their number is offered to patients at the time of appointment booking.

Patients who took part in the focus groups reported that:

- The hub model, of having a range of services organised around the patient, is working well for those who have experienced it. Patients feel cared for, and the services received have had a clear positive impact on health and wellbeing, including avoiding hospital stays
- Patients benefit from being able to access outpatient appointments closer to home
- Having staff based in the hub visit patients at home to give advice and practical help was working well with a number of patients feeling their quality of life had improved as a result
- Patients feel more could be done to raise community awareness of the hub
- The key challenge for patients in accessing the hub is having transport ,most were reliant on friends or relatives, as public or community transport options were limited or unavailable
- There is still much scope for developing the hub to achieve the ambitions set out by patients and the public for a community hub

Staff

There is strong evidence to show that happy, well-motivated staff provide better quality care[1]. As a system we are committed to improving our staff's health and wellbeing.

Both clinical and support staff have been integral to the development of the model. Staff who attended our consultation events felt positive about the changes. They felt that having the time and support to offer a truly holistic and thorough assessment and work out how best to help the patients was fantastic and had really added value. They want to see the service develop further, opening for more days of the week, broadening the range of services on offer and working hard with key partners, particularly GPs to enable the service to see a larger number of patients and be more proactive.

GPs

GPs are integral to the new model of care, which was co designed with some local GPs. As part of the CATS service two GPs work as members of the multidisciplinary team undertaking assessments, developing care plans and arranging on-going care. The wider community of GPs, who refer into the service, also participate as part of the stakeholder group. To ensure a wide range of views are taken into account as the service develops, meetings with locality leaders have taken place, and some sessions with GPs in the localities.

Referrals to the new CATS service have been made by almost every practice in the county although the majority have come from those closest to the hubs themselves. There has also been an increase

[1] *The quadruple aim: care, health, cost and meaning in work Sika et al (2015) BMJ Quality and Safety*

in referrals to MuDAS (multidisciplinary day assessment service) at Wycombe Hospital as awareness of this new model of care has increased generally.

The GPs have been relatively consistent in describing how they would like to see the service develop. They want it to become more proactive and hold responsibility for the patients for longer. In addition, care co-ordination has been identified by GPs as one of the areas on which we could improve as well as access to a single IT system to increase ease of communication. To this end EMIS, the preferred GP computer system, has gone live in both Thame and Marlow allowing CATS staff to both see and enter information directly into the GP record. We are working with clinicians to understand what other benefits we could get from the system e.g. taking away the need for the GP to make a separate referral.

Voluntary sector partners

Voluntary sector organisations have been engaged in the process of community hub development both in the stakeholder group and by providing services in the hubs themselves. These services have not yet been as well used as everyone had hoped. Their views were sought as part of this review to inform the development of the hubs programme.

Key findings:

- All interviewees found the Hubs staff friendly and helpful
- All had expected to receive referrals to their service through CATS, but this has not happened to the extent they had hoped.
- Interviewees felt that the different organisations operating in hub could work together in a more co-ordinated way.
- The VCS organisations felt that the environment within the hub was too clinical and could be redesigned to be more patient friendly.

Senior health professionals

In November 2017 Professor Don Berwick (one of the founders of the Institute of Health Improvement and adviser on health to President Barack Obama) and Chris Ham, (Chief Executive of The King's Fund) visited Buckinghamshire as part of the support package for ICSs. We shared with them our vision for transforming care in Buckinghamshire by creating an integrated hub based model of care. Their reflections were that this model of care matched the Whole Population Health model developed by the New Care Models programme and the wider international direction of travel for health and social care.

General public

314 service users and members of the public took part in engagement sessions across Buckinghamshire. Participants were shown an assessment of how the hubs had progressed in relation to the model developed in 2016 following public engagement:

They were then asked to discuss this vision and its relevance now, taking into account the learning from the pilots. They continue to support the vision of community hubs developed through the public engagement in 2016, though a café was no longer viewed as essential to the model. They wish to see the current hubs continue and for the model to be rolled out across Buckinghamshire, taking into account local need. They raise concerns about the lack of awareness amongst the public and GPs of the current hubs. Lack of access to public and community transport was also raised as an issue. They wish to see a wider range of referral routes including self-referral, higher levels of awareness of the hubs, and an increase in the range of clinics available at the current hubs.

Conclusions from the stakeholder engagement

The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review. Patients and the public wish to see the current hubs continue and the model rolled out across Buckinghamshire, with provision tailored to different needs in different areas

All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential. Levels of awareness of the hubs was low amongst both patients and GPs. Transport was highlighted as an issue, with concern expressed that the lack of community transport to the hubs could potentially be a barrier to access for many patients.

Key recommendations

Current hubs

- Raise awareness of the current hubs with public and GPs, in part through clearer branding.
- Increase the service to at least five days per week at both sites.
- Review the current referral process with GPs, and consider expanding the process to self-referral.
- Ensure better co-ordination of the different services operating within the hubs.
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic-like, to provide better facilities for partner organisations to provide their services, and to be dementia, mental health and learning disability friendly.
- Mobilise a wider range of outpatient clinics.

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units and other public sector estate.
- Ensure effective joint working across health and social care and with voluntary sector.
- Consider how pubic and community transport to hubs could be improved.
- Provide signposting to other public and voluntary sector support services.

5. What we have learnt

- The pilot has tested the model for 12 months and found that it is supported by both users of the services and clinicians.
- Outcomes demonstrate that we are moving in the right direction in terms of reducing the need, particularly for people over 75 years of age, to make unplanned visits to A&E.
- Engagement with local people in communities across the county show that there is support for replication of the model across the county.
- Key Performance Indicators which have been developed with the stakeholder engagement group and used to monitor and challenge performance during the pilot is outlined in Appendix 1; it shows that the services have grown over the year and they continue to grow.
- Unfortunately the uptake of the voluntary sector was not as large as we had hoped. Having listened to the local voluntary organisations we realise that for many it would require new investment and this made it difficult for some 3rd sector organisations to work within the Hub, as they had already established bases elsewhere or had restricted funding.
- Feedback from service users is that someone based in the hub to signpost people to the service they need and to encourage those reluctant to accept help, for example the lonely, to contact services would be more helpful than co-location.
- Work more closely with acute clinicians to facilitate earlier patient discharge with support provided by the community hubs.
- Work closely with GPs to proactively identify patients who may benefit from being referred to the community assessment and treatment service.
- Explore the option of greater direct access for patients.

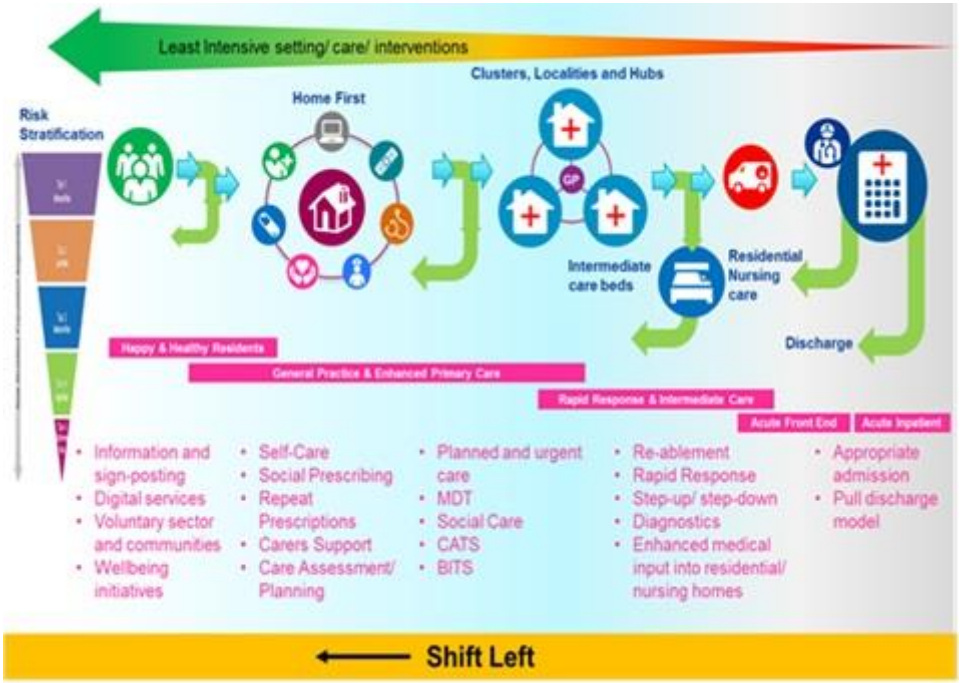
6. How community hubs fit with our wider transformation strategy

In July 2017 Buckinghamshire was announced as one of the 8 shadow Integrated Care System (ICS) nationally, in recognition of the strength of the relationships between commissioners and providers across the system and the innovative new care models it was piloting.

NHS England, through the Integrated Care System programme, has committed to support Buckinghamshire with both capital and transformation funding in 2018/19. This will help us develop general practice at scale to increase resilience, extend access by driving collaboration between practices and develop the estate which would allow this to happen.

The development of community hubs is only one part of our wider transformation strategy to deliver more care closer to home and out of hospital across Buckinghamshire.

Whilst the evidence shows that community hubs are already making a significant contribution to achieving our vision, they can't be viewed in isolation. The real impact will only be seen once the other elements are fully operational.



GPs and provider organisations across Buckinghamshire have been working to develop a blueprint that will bring together community and practice nurses, social workers, mental health staff, GPs, other health professionals and relevant voluntary organisations as multidisciplinary teams serving clusters of 1-3 GP practices, and their associated care homes, covering populations of 30-50,000 patients. They will provide a personalised plan of joined-up care and support to meet the patient's holistic needs (physical health, social care and mental health) to enable them to remain independent for as long as possible. This is building on the CCG's work on the over 75s project and the Wycombe locality integrated team that has been running for almost two years.

The new locality teams will have attached members working across clusters such as specialist nurses, rapid response and intermediate care and paramedics. As a result patients will receive better, more coordinated care in their homes. The 'blueprint' for these teams is in development. These, together with the community hubs and locality-based community services will be the building blocks for the integrated teams.

This model of care is in line with the findings of the NHS England New Care Model programme. The evidence points to each individual element having a small impact; but the aggregation of the impacts of each intervention being greater than that of the sum. As a consequence community hubs will not reach maximum effect until all elements of the model reach maturity.

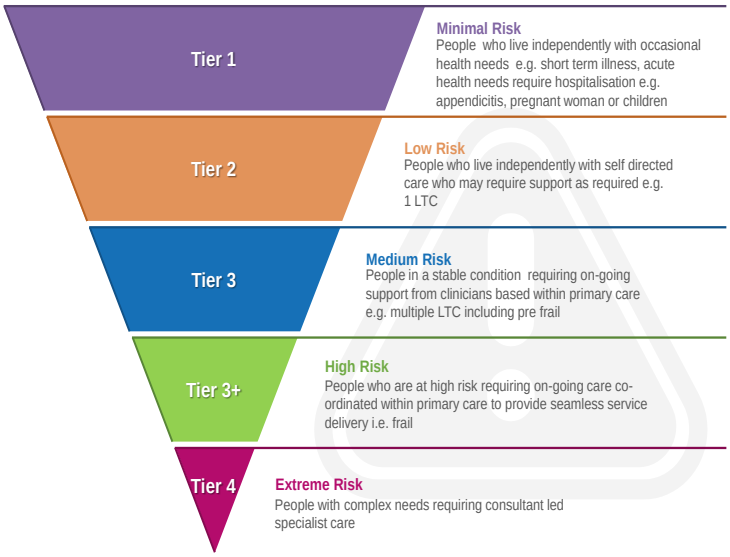
Success of the programme will be measured by the delivery of high quality and sustainable care. It aims to slow the growth in non-elective (NEL) activity by between 1% and 3% (A&E attendances, NEL admissions) and reduce variation in elective care. It also aims to improve the experiences of patients, their families and carers as well as the health and social care workforce.

Key work streams

Population Health Management

The Public Health Department of Buckinghamshire County Council is leading population health management work. It aims to improve the health of the entire population and to reduce health inequalities among population groups and reflects a shift in thinking about how health and care is defined. Care, in particular healthcare, is traditionally organised into relatively siloed specialties or services.

A practical alternative is to segment or risk stratify populations into groups with sufficiently similar characteristics and arrange supports and services to meet their expected needs. For instance we can identify groups ranging from healthy people, mothers and children, to people with multiple long-term conditions, frail people or people at the end of life for the whole county as well as at a local level (localities and groups of GP practices).



By identifying the people in each of the risk segments we can design services to meet their needs and target those services at those most likely to benefit.

Locality Integrated teams

Building on the CCG localities, GP practices are grouped together in their geographies around populations of 30,000 to 50,000 to form 13 integrated teams.

In the first phase, 4 teams are being established that consist of GPs supported by a community nurse, practice nurse, mental health practitioner, community practice worker, occupational therapist social workers, and input from acute clinicians. The workforce for integrated teams may change over the implementation phase depending on the needs of the population.

Rapid response and intermediate care (RRIC)

The two re-ablement teams of health and social care are being merged to form one countywide offer. The service is designed to increase the level of care and support provided in people's homes to avoid admissions and also to support early discharge after a stay in hospital so that people can be as independent as possible at home for as long as possible

Community hubs

Community hubs will serve a population between 100,000 – 150,000. They are intended to improve access, via a single point of contact, to a wide range of services. These include preventative, primary and specialist care from a range of providers working in multidisciplinary teams made up of representatives from the voluntary sector, social services and NHS organisations.

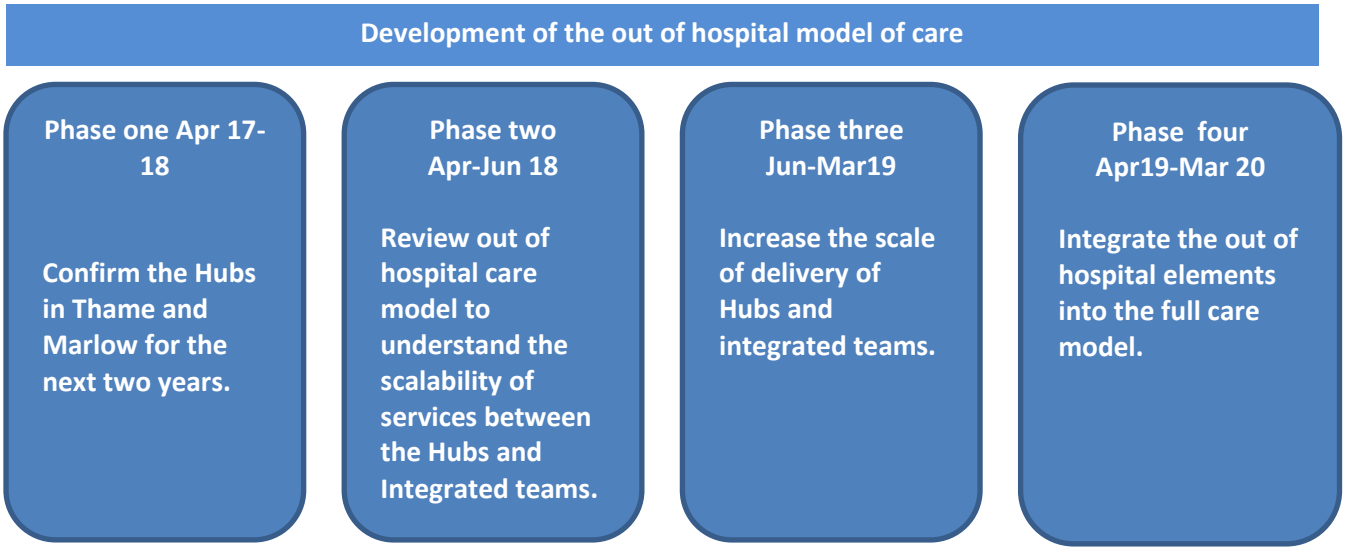
24/7 minor injuries unit and out of hours primary care services

The Buckinghamshire provider collaborative - made up of Buckinghamshire Healthcare NHS Trust, South Central Ambulance Service NHS Foundation Trust (SCAS), the local GP federation 'FedBucks' and Oxford Health NHS Foundation Trust – took over the provision of the 24/7 minor injuries and illness unit (MIIU) at Wycombe Hospital (WH) and the primary care GP out-of-hours services operating at WH, Stoke Mandeville Hospital (SMH), Buckingham Hospital and Amersham health centre from 3 April 2018. The MIIU is intended to be designated to become a first-wave urgent treatment centre (UTC) very soon after service mobilisation.

7. Next steps

- Continue with the current community hubs pilots at Thame & Marlow for another two years so that the other complementary elements of community services transformation have time to be developed, rolled out across the county and be properly evaluated. This includes developing the community hubs model across the county.
- Work with general practice localities to further integrate services and to support the proactive identification of patients who are likely to benefit from the CATS service e.g. through risk stratification.
- Work with care homes to ensure that residents in a care home, who would benefit from the CATS service, have access to it.
- Explore further development of the referral model potentially widening the range of people who can refer directly to the services within the hub including self-referral.
- Review the discharge from A&E and acute inpatient care pathway to ensure that CATS is recognised as a viable alternative to a 'bedded 'option, developing a local concept of the virtual ward.
- Work with local GPs to increase the capacity of the CATS by increasing the number of days of operation in line with demand.
- The Integrated Care System will set up local stakeholder engagement groups aligned to the integrated team localities – building on those in place for Marlow and Thame - to co-design the local detail of the out-of-hospital care model, including the hubs, ensuring that they meet the needs of the local community.
- Identify the target population cohorts and care professionals that the new model of care will apply to
- Define the service combinations that will comprise the future model and the level at which services will be delivered across Buckinghamshire.
- Drawing on the base lining of all existing projects, identify the financial contribution of the services and change projects in scope to meet the system's 2018/19 financial requirements.
- Provide suggested timeline for implementation and outline workforce projections.
- Review the care model to strengthen prevention and self-care and ensure that it maximises the care delivered locally and focusses on health and wellbeing in line with the design principles in Appendix 5.
- Development of a robust communication plan with the public and professionals to raise the awareness of the hubs and increase the productivity and value of the services for the local community.
- Review outpatient services to ensure that the shift to local provision is transformational, meets the local health population needs and not just utilising space.
- Local services for local people to minimise travel and have a home first approach where possible.
- Put in place signposting, education and care navigation in hubs.

Timeline



Appendix 1: Performance KPIs

Key performance indicators measures and indicators dashboard

The adjusted baseline has been calculated using an average of the first 6 months data. RAG rating is against expected baseline.

Measure	Baseline at start of pilot	Adjusted baseline	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients accessing outpatients at community sites (across both sites)	**83**	**143**	83	140	169	152	148	157	103	155	95	125	182	240
Marlow			31	79	68	58	69	83	53	71	30	38	81	123
Thame			52	61	101	94	79	74	50	84	65	87	101	117
Number patients seen in Community assessment and Treatment service across both sites (1st appointments, follow up and dom visits)	**No baseline**	**58**	16	52	75	52	57	85	113	121	72	119	87	131
Marlow			4	31	37	30	23	51	65	70	44	71	62	62
Thame			12	21	38	22	34	34	48	57	28	48	25	69
Number people seen in Community Assessment and Treatment Team **as admission** avoidance across both sites (1st appointments)	**No baseline**	**41**	16	52	48	30	40	65	78	88	47	80	67	83
Marlow			4	31	24	19	18	38	45	50	25	48	45	41

Thame			12	21	24	11	22	27	32	38	22	32	22	42
Number people seen in Community Assessment and Treatment Team as **supported discharge** across both sites (1st appointments)	**No baseline**	**>1**	1	1	0	0	0	0	0	1	0	0	0	
Number of people Discharged Home – no follow up required (across both sites)	Outcomes from Community Assessment and Treatment Team		16	32	20	18	19	34	68	63	38	67	38	47
Number of people Discharged Home – Follow up required from community teams (across both sites)	Outcomes from Community Assessment and Treatment Team		0	7	6	4	3	5	11	6	2	5	7	43
Number of people Discharge Home - Follow up required from Community Assessment and Treatment Service (across both sites)	Outcomes from Community Assessment and Treatment Team		0	7	13	16	6	26	18	22	19	28	18	13
Number of people sent to A&E (across both sites)	Outcomes from Community Assessment and Treatment Team		0	0	1	0	0	0	0	0	1	2	1	1
Number of people referred onto other services (across both sites)	Outcomes from Community Assessment and Treatment Team		0	2	4	5	2	13	8	17	12	7	6	2

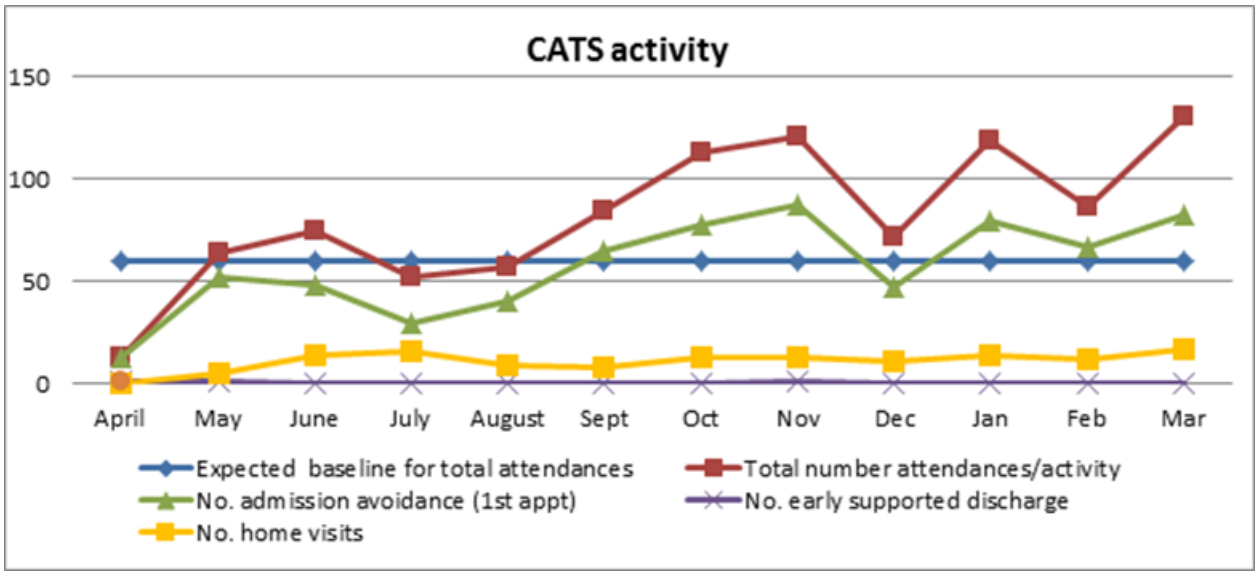
Number of patients over 75s seen within Community Assessment and Treatment Team after 28 days discharge from Stoke Mandeville Hospital (across both sites)	**No baseline**	**Monitor**	1	2	2	3	3	0	2	10	7	4	3	8
Community Assessment and Treatment Team Patient related experience measures (across both sites)	**No baseline**	**80% Rating community services as good or excellent**		100% 30/52 1st appts only	100% 48/48 1st appts only	100% 18/30 1st appts only	100% 32/40 1st appts only	100% 58/65 1st appts only	100% 67/78 1st appts only	100% 79/79 1st appts only	97% 34/35 1st appts only	100% 65/65 1st appts only	100% 61/61 1st appts only	Data not available yet
Community Assessment and Treatment Team friends and family measures (across both sites)	**No baseline**	**95% extremely likely or likely to recommend service**		100% 30/52 1st appts only	96% 48/48 1st appts only	100% (18/30) 1st appts only	93% 32/40 1st appts only	100% 58/65 1st appts only	100% 71/78 1st appts only	99% 74/75 1st appts only	100% 43/43 1st appts only	96.7% 60/60 1st appts only	94.3% 70/83 1st appts only	
Number of patients on waiting list for Community Hospital all sites (as of last day of the month)	**No baseline**	**Monitor**		30	12	17	17	28	3	20	29	33	16	38

Community county wide services indicators

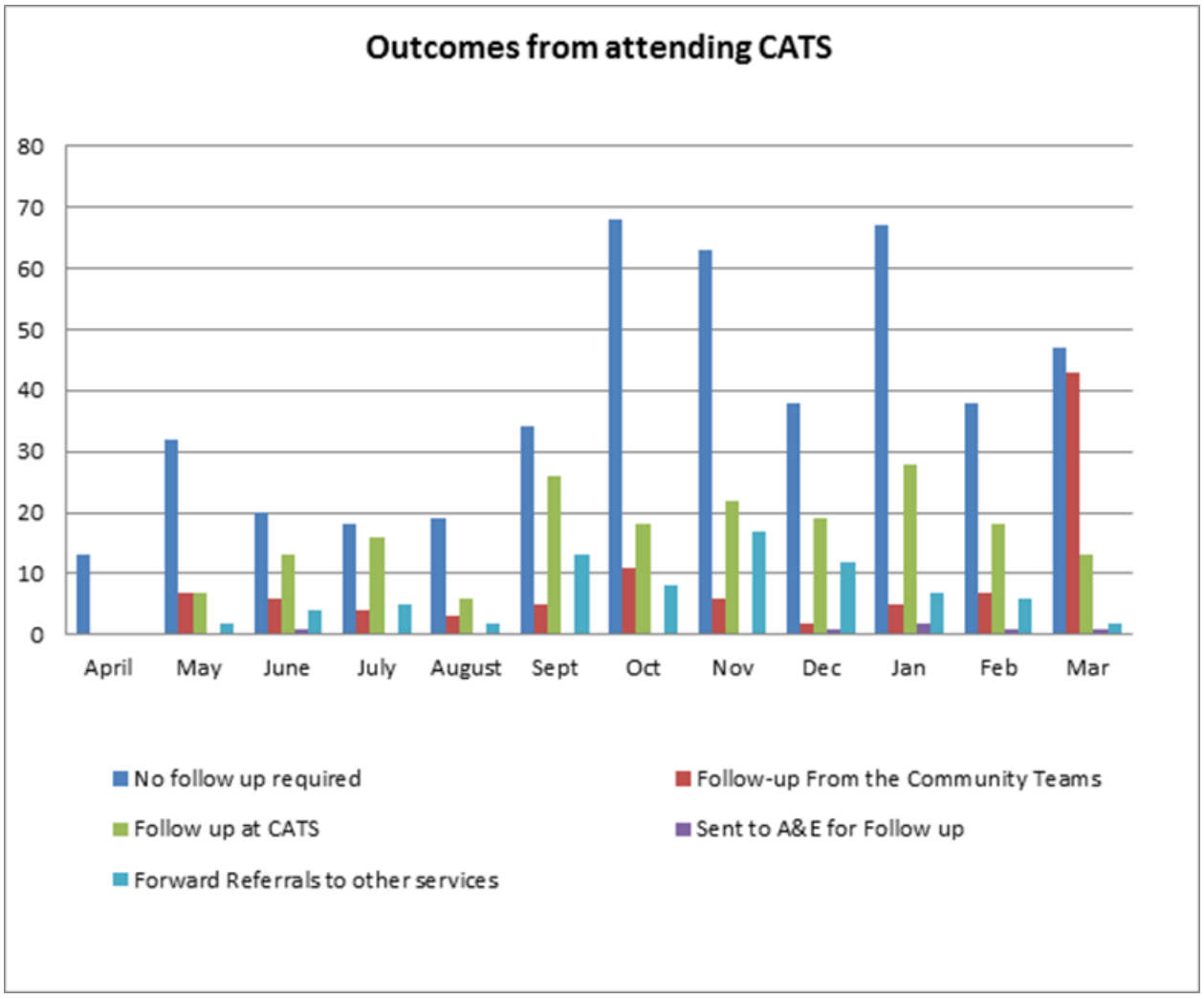
Measure	Baseline at start of pilot	Expected baseline	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of admissions avoided (Adult Community Healthcare Team & Rapid Response and Intermediate Care Team)	**800**	**850**	805	935	1020	971	897	838	888	1095	970	996	897	825
Number referrals managed through community care coordinator	**500 (not including GP referrals)**	**Expect to achieve baseline as services uptake referral pathway**	154	331	398	499	575	533	599	592	604	673	540	565
Rapid response intermediate care & therapy contacts	**7900 contacts**	**16600 contacts when fully recruited**	9750	10758	11559	11556	12439	11601	10729	11592	9991	11486	9886	9602
Rapid response intermediate care & therapy contacts	**Expected total contacts in relation to % staffing recruited - contacts are RAG rated against these**			3984	6806	8300	8300	10126	12719	10790	11288	11288	11288	11288
Rapid response intermediate care & therapy contacts	**% staff recruited**		10%	24%	41%	50%	50%	61%	68%	65%	68%	68%	68%	68%

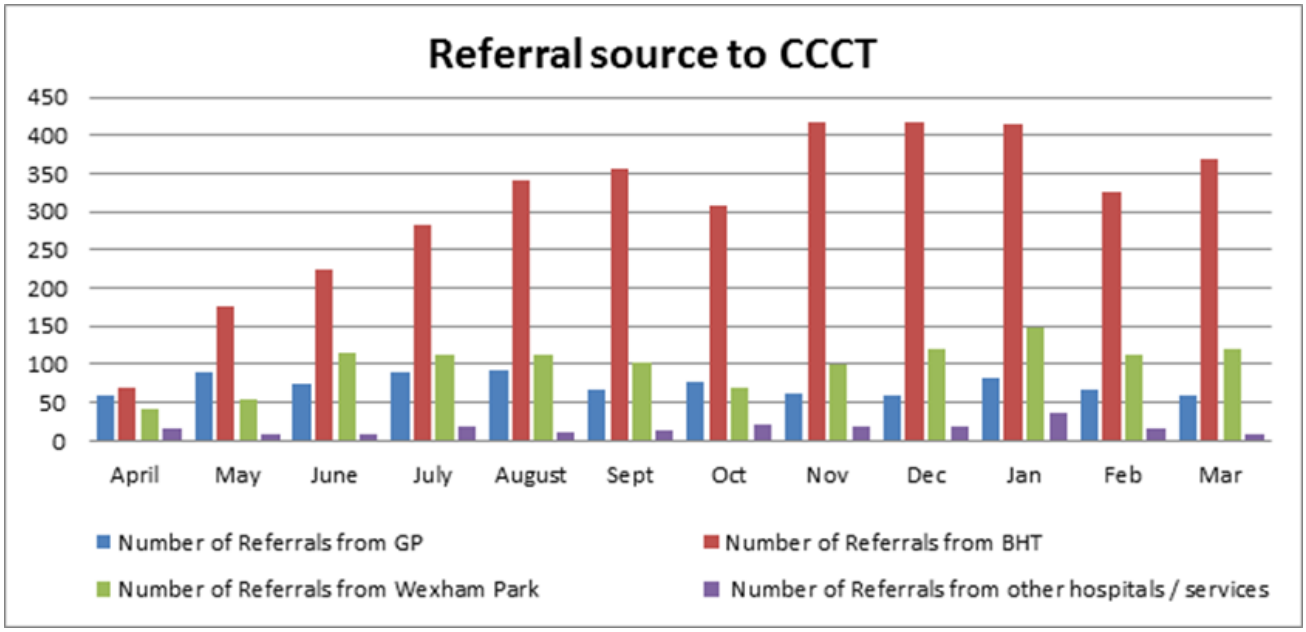
Adult Community Healthcare Team & Rapid Response and Intermediate Care Team Patient related experience measures	**80% rating good or excellent**	**Demonstrate improvement**	97% 62/62	93% 82/82	100% 74/74	97% 109/109	95% 40/40	100% 120/120	98% 93/93	99% 110/111	100% 77/77	100% 55/55	98% 57/57	Data not available yet
Adult Community Healthcare Team & Rapid Response and Intermediate Care Team friends and family test measures	**95% extremely likely or likely to recommend service**	**Demonstrate improvement**	95% 62/62	97% 82/82	97% 74/74	100% 109/109	98% 71 /71	99% 69/69	93% 112/112	98% 50/51	97% 60/62	96.7% 29/29	100% 28/28	Data not available yet
% of people discharged from acute care to normal place of residence	**92%**	**94%**	90%	91%	91%	92.7%	90.6%	91.1%	89.7%	89.5%	90.1%	95.1%	96.2%	90.1%
% of patient Readmissions of over 75s within 28 days	**21%**	**Reduction in overall admissions**	Reported in May	21%	22%	19.7%	18.9%	24.4%	18.1%	19.58%	18.1%	17.8%	Data not available yet	17.35%

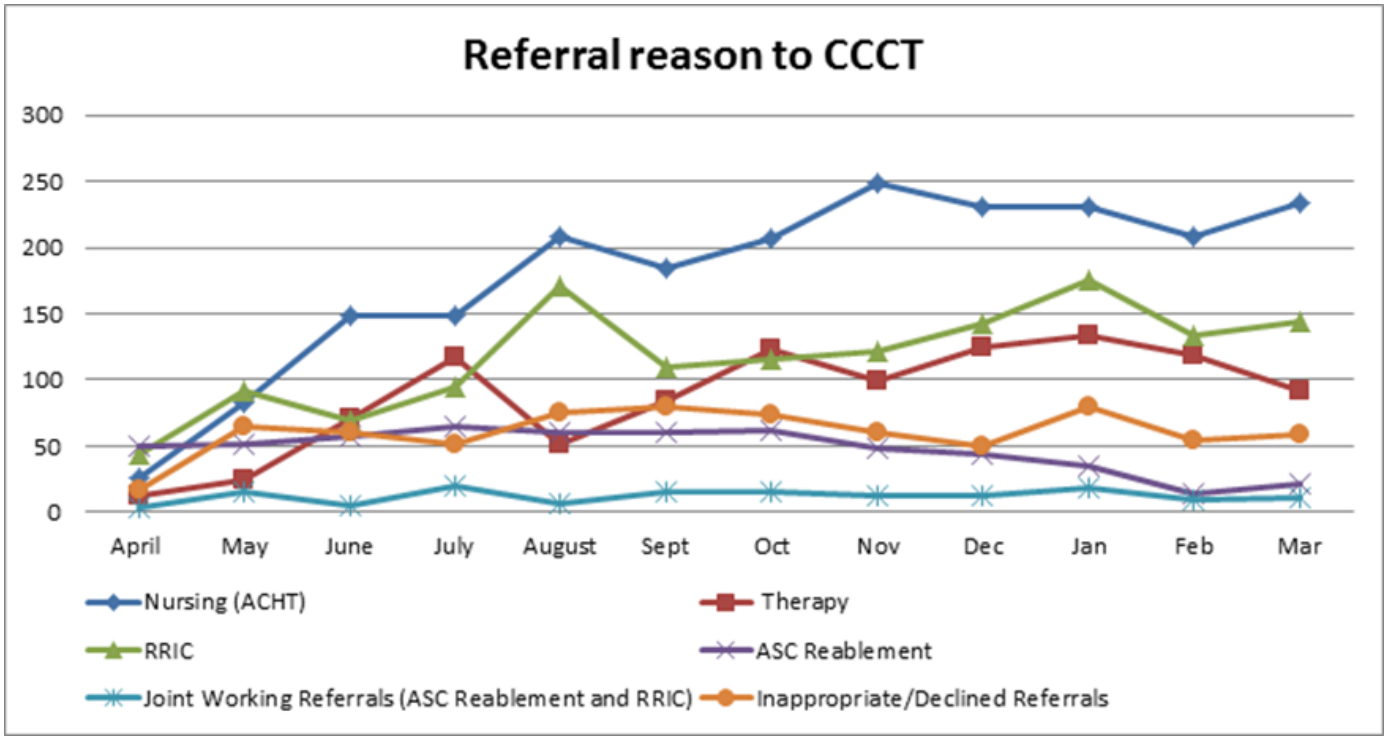
Community Assessment and Treatment Service (CATS)



Outcomes from attending CATS show that most patients do not need a follow up appointment.







A selection of answers from the questionnaire asking what patients didn't like about their visit or care that day:

- We liked everything and the arrangements which have been made.
- Waiting around
- It would have been nice to know that this I was a long appointment we had only reckoned on 30 minutes and we were here for 3 hours.
- The long wait
- Had to wait two hours for patient transport to collect me from home and then from 12 noon to 1.30pm to take me back another 1 and a half hours wait.

- The length of time not expected
- Too cold
- My visit was very satisfactory. Seen on time and looked after for every stage of my stay
- No complaints everything was very impressive.
- Nothing. It was spotlessly clean and no one else about! A few people crept in later in the morning.

Appendix 3

Your community Your care
Developing Buckinghamshire together

Bringing care closer to home.

Stakeholder views on community hubs

'They turned me from being a patient back into being a person'

Executive summary

Introduction

Buckinghamshire Healthcare NHS Trust, working with its health and social care partners, launched the community hubs programme in April 2017, at two pilot sites in Marlow and Thame. This followed an extensive public and patient engagement exercise in 2016 to find out what people wanted from a community hub. The findings informed the development of the pilot hubs.

Between September 2017 and March 2018 the Trust conducted further public and stakeholder engagement. The objectives were:

- To engage with and involve the local community to ensure their views and experience inform future decision making around the pilots both in Marlow and Thame and more widely across the county
- To review the criteria for community hubs that the public had developed in 2016 to see what progress had been made and to test their continued relevance
- To get feedback from staff and patients, and partner organisations involved in the pilots to inform on going service development

Methodology

The involvement and engagement team gathered the views of 352 stakeholders, using a mixed methodology tailored to different groups:

- Focus groups with 28 hub patients
- Appreciative enquiry workshops with 7 hub staff
- 3 telephone interviews with staff from Healthy Minds, Alzheimer's Society and Age UK
- Public engagement workshops in Buckingham, Chalfont, Marlow, Wycombe, Thame, Aylesbury, and Iver, attended by 191 members of the public
- Sessions with 123 members of voluntary sector service user groups, and a patient participation group

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Key findings:

- The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review
- Patients and the public wished to see the current hubs continue and to see the model rolled out across Buckinghamshire, with provision tailored to needs in different areas
- All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential
- Levels of awareness of the hubs was low amongst both patients and GPs
- Transport was highlighted as an issue, with the lack of community transport to the hubs potentially a barrier to access for some patients

Key recommendations from public and stakeholder engagement:

Current hubs

- Raise awareness of the current hubs with public and GPs, in part through clearer branding
- Increase the service to at least five days per week at both sites
- Review the current referral process with GPs, and consider expanding the process to self-referral
- Ensure better co-ordination of the different services operating within the hubs
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic like, to provide better facilities for partner organisations to provide their services, and to be dementia and learning disability friendly
- Mobilise a wider range of outpatient clinics

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units
- Ensure effective joint working across health and social care and with voluntary sector
- Consider how pubic and community transport to hubs could be improved
- Provide signposting to other public and voluntary sector support services

1. Introduction

In April 2017 Buckinghamshire Healthcare NHS Trust working with its health and social care partners, launched the community hubs programme, at two pilot sites in Marlow and Thame. In 2016 the Trust conducted an extensive public and patient engagement exercise to find out what people wanted from a community hub. The key findings were that patients and the public wanted:

- Rapid access to testing
- Earlier signposting to health and care services-a single point of access
- Joined up teams across the system
- A full range of therapy services
- Health and wellbeing function, enhancing self-management and providing education
- A sociable space with a café
- A base from which skilled staff can work in the community
- More outpatient clinics locally
- Virtual networks providing information for patients supported by excellent technology
- More information shared between organisations to improve patient care

The findings informed the development of the pilot hubs. Between September 2017 and March 2018 the Trust conducted further stakeholder engagement. The objectives were:

- To engage with and involve the local community to ensure their views and experience inform future decision making around the pilots both in Marlow and Thame and more widely across the county
- To review the criteria for community hubs that the public had developed in 2016 to see what progress had been made and to test their continued relevance
- To get feedback from staff and patients, and partner organisations involved in the pilots to inform on going service development

Methodology

The involvement and engagement team gathered the views of 352 stakeholders using a variety of methods:

- Focus groups with 28 current hub patients
- Appreciative enquiry workshops with 7 hub staff
- 3 telephone interviews with staff from Healthy Minds, Alzheimer's Society and Age UK
- Public engagement workshops in Buckingham, Chalfont, Marlow, Wycombe, Thame, Iver and Aylesbury, attended by 191 members of the public
- Sessions with 123 service users from the following organisations; Alzheimer's Society, Bucks Vision, Haddenham Carers, Macular Degeneration Society, Talkback, and Rectory Road patients group

This report details the views and recommendations of the above stakeholders. In addition to the engagement sessions with stakeholders detailed in this report, the Trust and the Buckinghamshire clinical commissioning groups held information and discussion sessions to keep the public informed of progress with the community hubs, reaching over 1000 members of the public.

2. Patient views of the community hubs

Introduction

Views of patients who had used the hub were sought as part of the wider stakeholder engagement exercise to inform the Trust's plans for bringing care closer to home across Buckinghamshire. The aim of the patient engagement was to get feedback from patients involved in the pilots to inform on going service development

Methodology

All patients who had used the community assessment and treatment service in Marlow and Thame community hubs in its first 6 months of operation, and a sample of patients who had attended outpatient appointments were contacted. Two focus groups were held, one in Marlow and one in Thame. The following questions were asked:

Could you briefly describe your experience of being a patient at the hub? What went well? What went less well?

- What could we do that would have improved your experience?
- Did life at home become easier after the service you received at the hub?
- From your experience of being a patient here, do you think the hub is doing what it set out to do?
- What other services would you like to see provided at the community hub?

Participant profile

There were 28 participants in total, 21 at the Marlow event and 7 at the Thame event. 23 of the 28 people who attended completed and returned their equality monitoring form. Of those:

- 7 were males and 16 females
- The ranged in age from 65 – 80 years plus groups with the larger number being in the 65-79 age groups.
- 21 of those who responded classified themselves as white British

Discussion results

Could you briefly describe your experience of being a patient at the hub? What went well? What went less well?

In Marlow the experience of being a patient at the hub had been a very positive one for all of the participants. The holistic, 'one-stop-shop' nature of the service, being given the time to see a range of clinicians, and talk their case through, was seen to have great benefit.

- *'I was extremely satisfied with everything, I thought the team were brilliant, the comprehensive review of my condition, made me understand what was going on, after months of pain and restricted mobility. I have nothing but praise. It brought it all together, in the round. Up to then it was ad hoc, you went to the doctor when you needed a doctor, you went to minor injuries, you went to A&E if you had a fall. I felt I was a person, not a patient'*

- *'A one stop shop as mum said, we came in we saw a doctor a nurse, a physio you had an x-ray while you were here you got the results while you were here'*

- *'What was really nice was to be able to talk to them, be told things I've been trying to find out for weeks'*

- *'Everybody was so good, they had brought in a doctor who specialised in my condition, and other people coming in and saying how could they help me, escorted everywhere, whereas at Wycombe you go to one department then you are sent downstairs, here it was all compact'*

- *'They turned me from a patient back into being a person'*

Patients appreciated the speed with which they were able to be referred in to the service

- *'I was asked, can you get to Marlow 2 o'clock on Monday. You'll get a letter tomorrow, this was Friday, I did get the letter and we were here on Monday'*

- *'The paramedic came to see me on Thursday and I was here on Friday'*

Patients felt the attitude and care delivered by staff was excellent, both to patients and to carers

- *'The nurse took me everywhere to the x-rays and everything, as we sat there different people came in, physio came in, I found it absolutely incredible'*

- *'The service I received from the receptionist through the doctor and all the nurses were first class. I was so impressed. I went away very boosted up'*

- *'Usually they don't care about you,(the carer) but here it was lovely they kept asking how I was'*

For some participants in Marlow there was a clear sense that the service had helped to avoid hospital admission, for example:

- '*There is always the fear of being admitted to hospital, to come here and essentially get everything in one hit is much better, even if you went into hospital you wouldn't get things sorted out as quickly and efficiently as we have here, you spend so much time waiting in A&E and go to ward and nothing actually happens, here in just a few hours we got a lot sorted out, we got referred to the speech and language lady who came to see dad at home, for us it probably saved a hospital admission'*

In Thame patients who had attended outpatient appointments appreciated being treated closer to home, in terms of convenience, speed, and for one participant to avoid a hospital stay:

'I came to outpatients to see the chest doctor. I'm obviously in Thame, I don't have to travel. I've also used district nurses that come in, because normally I have to go into hospital, I stayed in 5 days the last time. They came to my home twice a day. But yes the outpatients bit is brilliant'

'I was here for all of 10 minutes I came to see my surgeon following surgery in March found it easy to park , I wasn't kept waiting at all I was in and out in 10 minutes'

Patients appreciated the full assessment they received:

'Very good came to improve to not fall down there was a physio they were all excellent especially the physio, it was all very good. Very good all of it'

'I thought it was super. At least they assessed me'

In Thame a number of patients spoke about not knowing why they had been referred to the hub. It had not been explained by the GP. They simply received an appointment in the post and only understood what the appointment was for once they attended.

'I didn't know what I was coming to when I came here; I have an on-going muscle condition for last 20 odd years. I'd seen my doctor because I had a lot more problems then I got a call about coming here so I thought there was somebody here a specialist, to look at some other forms of the muscle problem. I didn't know what it was until I got here. I didn't know it was a collective assessment so to speak, going around lots of people. Nobody was a specialist but they were all interested and took notes. I didn't get much advantage from it.'

'Thame rang me and said aren't you coming? I said where and they said I was booked for Thame, no communication. I didn't realise what I was coming for. Halfway through the assessment I realised what it was for, although I had severe falls it was to assess what I could do , with my brain especially. I thought it was to see what was wrong with my bones, I have osteoporosis you know'

'Were the doctors made aware of all of these things going on here, it just seems odd that several of us didn't know why we were coming here? It wasn't like someone at the surgery said do you want to see somebody about falls or anything like that, I just had a letter'

What could we do that would have improved your experience?

In Marlow having access to transport to the community hub was the main thing that would improve some patients' experience of the community hub. Most were reliant on friends or relatives as public and community transport options were very limited or unavailable.

- *'In time transport may become an issue for most of us'*
- *'My neighbour was able to drive me, but transport is an issue'*
- *'Transport is the biggest problem, it is a nightmare'*

One patient had to be transferred to Wycombe as she needed an IV. Her experience would have been improved if the hub was open all week and had the correct equipment to allow her to be treated closer to home.

In Thame participants felt that more could be done to make the community in Thame aware of the hub:

'I didn't know this was here, I mean I live on the doorstep'

'How would people get to know that it was here? There's no information anywhere, not even in the doctor's surgery, to tell you this kind of thing is available. If you are seriously ill the doctor will put himself out to tell you what is available, but people on the sort of borders of things, this sort of thing would help them not get any worse than they are if they knew it was available'

Did life at home become easier after the service you received at the hub?

Many of the patients had seen a significant improvement to their quality of life in the time since they had been seen at the hub. One of the things that had an impact was the opportunity to have someone review all of their medication, in several instances leading to a reduction or change in medication, that the patient felt had been very beneficial.

- *'Within a month Dr Johnson had changed all my medication and I felt on top of the world'*

- *'The change of medication made such a difference'*

- *'Medication, having a second opinion, they said, you might not need this anymore. They took me off two lots of drugs'*

Several patients had someone visit them at home to assess their need for aids and to provide practical advice following their visit to the hub. This had improved their quality of life.

'A lady came to my house she asked how I got off the loo I said I just hang onto the door, she said you don't want to do that, she got me a handle'

'The aids around the bathroom, they have been so helpful, my wife knows I can be left safely'

'Sometimes I can't walk at all and problems getting up and out of chairs so she gave me a loo seat with a handle that was helpful, which they delivered the next day actually'

'The two nurses came down and they brought me a wheel about trolley so I could wheel my meals around. I don't know what made me fall, I fell in the garden, they told me to do away with my rugs you know, because you can trip over them of course, that and the handle for my loo, it was very useful'

'The advice I received from the nurses, they were concentrating on my arm which I broke, they gave me quite a few exercises I hadn't done before. I had my plaster off at Wycombe and they said I could go there for physio, but of course I can't get there every day, you can't get to' Wycombe unless you have transport and of course I don't have transport. The nurses told me extra bits which they hadn't told me at Wycombe which was a great help'

From your experience of being a patient here, do you think the hub is doing what it set out to do?
Patients were asked how they felt the hub was performing in relation to the 10 criteria that patients and public had identified as what they wanted from a community hub in the original 2016 public engagement events.

Marlow:

Criteria	**Patient experience**
Rapid access to testing	Patients felt this was working well. Participants had had blood tests and x-rays and received results on the day
Earlier signposting to health and care – single point of access	Participants had not experienced this
Joined up teams across the system	It was felt the teams within the hub worked well together.
A full range of therapy services	Patients had felt they received a range of interventions. One patient felt she would have benefitted from seeing a podiatrist experienced in dealing with complications from diabetes
Health and wellbeing function enhancing self-management and providing education	Patients had not seen evidence of this, one participant who had diabetes felt control of her condition had been taken out of her control since she used the hub, with nurses visiting her at home to test her and provide insulin
A sociable space with a café	This was not seen as a priority by those present. It was felt

	that Marlow had enough cafés and that a number of organisations also provided this kind of service for older people.
A base from which skilled staff can work in the community	Participants had experience of this working well, with staff coming to their homes to assess their need for aids and providing advice
More outpatient clinics locally	As CATS patients, participants had not experienced this but could see from the list that it was happening. Questions were asked about whether people could be referred by their doctor to the clinics
Virtual networks providing info – supported by excellent technology	Participants did not see this as a priority
More info shared between organisations to improve patient care	It was felt this could be done better. It was felt that more could be done to publicise the hub.

Thame:

Criteria	**Patient experience**
Rapid access to testing	Participants had not experienced this
Earlier signposting to health and care – single point of access	Not experienced this
Joined up teams across the system	Not experienced this
A full range of therapy services	Those who had a CATs assessment had experienced this
Health and wellbeing function enhancing self-management and providing education	Not experienced this
A sociable space with a café	Participants did not see this as a priority as there were a number of cafes in the town
A base from which skilled staff can work in the community	Participants had experienced this, with community staff visiting them at home
More outpatient clinics locally	Participants had seen the benefits of having outpatient appointments closer to home
Virtual networks providing info – supported by excellent technology	This was not viewed as a priority for this patient group
More info shared between organisations to improve patient care	Participants felt this was not happening effectively

What other services would you like to see provided at the community hub?

- Access to public or community transport for those living outside Marlow in South Buckinghamshire
- Equipment and extended opening days to allow for IV treatment

- Pain clinic
- Podiatrist
- One patient suggested having a range of consultants with different specialities
  '*Specialist for a particular thing so if people who needed a particular specialist could make appointment, something like neurologist, or rheumatologist'*

Conclusions

- The hub model, of having a range of services organised around the patient, is working well for those who have experienced it. Patients feel cared for, and the services received have had a clear positive impact on health and wellbeing, including avoiding hospital stays
- Patients had benefitted from being able to access outpatient appointments closer to home
- Having staff based in the hub visit patients at home to give advice and practical help was working well with a number of patients feeling their quality of life had improved as a result
- In Thame a number of patients referred by their GPs were unaware of why they were being referred
- Patients felt more could be done to raise community awareness of the hub
- The key challenge for patients in accessing the hub is having transport ,most were reliant on friends or relatives, as public or community transport options were limited or unavailable
- There is still much scope for developing the hub to achieve the ambitions set out by patients and the public for a community hub, though having a café was not viewed as a priority**.**

3. Staff views of the community hubs

Introduction

The aims of the staff engagement were:

- To find out staff views on service delivery to patients since the hub was set up
- To explore how the community hub could develop to continually improve the patient experience

Methodology

All staff from the community hubs were invited to take part in workshops. Workshops were held in Marlow and Thame each attended by three members of staff. The following questions based on the principles of appreciative enquiry were explored:

- What has been your best experience of the community hub, a time when you felt that it worked well for everyone involved?
- What made that possible?
- Imagine we are a year into the future and the hub is working perfectly based on these ideas and principles. What would that look like?
- What would need to happen to get us there?
- Staff were asked to rate out of 5 how far they felt each of the 10 criteria for community hubs set out by patients in the engagement events in 2016 had been met.

Participant profile

Six participants took part in the workshops. This was made up of five nurses and one healthcare assistant

Discussion results

What has been your best experience of the community hub, a time when you felt that it worked well for everyone involved?

Staff in Marlow had a very positive view of the service to patients; one mentioned that if it was her mum she would want her to have this kind of service. The hub provides a 'one stop shop' for patients, having access to doctors, nurses, OT and physio at one site. Patients receive a comprehensive service without having to attend lots of different appointments potentially at different sites. Patients have thorough frailty assessments and longer appointment times. Their GPs are only able to see them for ten minutes so referring them onto the hub means that the patient can be checked thoroughly and leave knowing what their next steps need to be. They have access to consultants therefore diagnosis for some patients is quicker. Having a range of professionals together meant they could spend time discussing the patient's case and take a joint approach to best way forward. It makes life much easier for carers. The CATs team can refer patients to other services like Prevention Matters and social services. In one case social services had seen a patient at the hub.

Staff in Thame were also very positive about the benefits of the service to patients. Patients themselves were very happy with the service; one patient had spoken about 'feeling loved'. The benefits to patients included, being able to see a number of clinicians in one day instead of a series of different appointments, they can be seen by an OT at the clinic who will then visit them in their home, so more continuity in service, it was a more personal service with more time for patients and patients did not have to wait to be seen.

What made that possible?

- Having a range of services in one place
- More joint working
- Thorough assessment of clients situation and needs

Imagine we are a year into the future and the hub is working perfectly based on these ideas and principles. What would that look like?

Marlow:

- Hub would be open 5 days a week
- It would have a clearer mission statement that potential referrers such as GPs would be more aware of. Clarity about where hub fits with community and acute services
- Referral pathways working effectively. GPs educated in how to refer and to what.
- Hub would have its own doctor available whole time it was open
- There would be cover for staff when people on annual leave/sick
- There would be an administrator so nursing staff can focus on more nursing
- There would be a dedicated transport service for patients and better signage at the hub
- More varied menu available to patients, currently only able to offer soup
- More services available for patients

Thame

- The hub would be open 5-7 days a week to provide a truly preventative service and allow for consistency, for example being able to provide IV antibiotics in one place on consecutive days.
- The hub would have a clearer remit or brand, providing unique service not just taking bits from others
- It would be much busier, with potential referrers such as GPs more aware and knowledgeable about the service
- There would be additional services available such as podiatry, and ultrasound
- Administrative and reporting systems would be more streamlined and there would be an administrator, potentially working across both pilot sites
- Services would be more joined up
- BHT doctors and consultants would have access to GP patient records on EMIS
- There would be more consistency in doctors attending hub, ideally one doctor for the hub
- The environment would be more clinic like
- The hub would have the right equipment available for the work being done there
- The staff skill mix and level would be more appropriate to the service being provided, staff would feel their skills are being utilised and developed rather than feeling deskilled

- There would be cover for staff if they are sick or on annual leave

What would need to happen to get us there?

<u>Recommendations applicable to both sites</u>

Brand and marketing

- There is a need to create a clearer USP for the community hubs. This can then be used to market the hubs more effectively to potential referrers particularly GPs and increase referrals

Services

- Linked to the above is the recommendation that services are mobilised as quickly as possible into the hub, so there is clarity about what is on offer. Staff recommendations included, podiatry, ultrasound, dietician, and more third sector organisations like Age Concern
- Consideration should be given to increasing the service to 5 days per week at both sites

Staffing and administration

- The skills mix and level of staff should be reviewed taking into account what patient needs have been during the pilot to date.
- An administrator role should be created, potentially shared across both sites
- There should be cover for holidays and sickness
- Have more consistency of doctors
- Access to records: Look into how BHT doctors can have access to GP records

Governance and reporting

- Review the reporting needs with view to streamline processes and avoid duplication. Have clearer project management approach to programme development, potentially involving service improvement team

Recommendations specific to Thame

- Environment: Invest in changing to a more clinic like environment so is more functional and feels less like hospital ward that is not being fully utilised. Better use of space downstairs , including more office space and power points
- Equipment: Review and provide appropriate equipment, taking into account use over the pilot so far. For example hub has two underutilised blood testing machines, physio requires mats and parallel walking bars

Recommendations specific to Marlow

- Environment: Provide better signage. Provide wider range of food options, patients often waiting a while and current options not substantial enough
- Transport: Explore options for dedicated transport for patients
- Signposting: Develop list of available services and contact details

How far have criteria developed in the public and patient engagement sessions been achieved? 0 being not achieved and 5 being completely achieved:

Staff agreed a rating between them for each criterion.

Marlow

Criteria	Rating	Comments
Rapid access to testing	4	Need basic blood testing, echo and CT scans to complete the service
Earlier signposting to health and care – single point of access	3/4	
Joined up teams across the system	3	
A full range of therapy services	4	
Health and wellbeing function enhancing self-management and providing education	1	Would like to see cancer care and diabetes here. Already used by Parkinson's group

A sociable space with a café	0	
A base from which skilled staff can work in the community	5	
More outpatient clinics locally	3	
Virtual networks providing info – supported by excellent technology	0	We do provide this service by using our own PCs to get information for our patients
More info shared between organisations to improve patient care	2/3	

Thame

Criteria	**Rating**	**Comments**
Rapid access to testing	3	
Earlier signposting to health and care – single point of access	4	
Joined up teams across the system	2	
A full range of therapy services	4	If no annual leave
Health and wellbeing function enhancing self-management and providing education	5	
A sociable space with a café	0	
A base from which skilled staff can work in the community	5	
More outpatient clinics locally	3	
Virtual networks providing info – supported by excellent technology	1	We do go online for some of our patients and print them information off for them to take away
More info shared between organisations to improve patient care	1	

4: Partner organisations' views of the community hubs

Introduction

A number of VCS and health organisations provide services within the hubs. Their views were sought as part of this review to inform the development of the hubs programme.

Methodology

Telephone interviews were conducted with representatives from the following organisations:

- Healthy Minds
- Alzheimer's Society
- Age UK

They were asked what had gone well, what had gone less well and their recommendations for the development of the hubs.

Discussion results:

- All interviewees had found the CATS staff friendly and helpful
- All had expected to receive referrals to their service through CATS, but this has not happened to the extent they had hoped. Healthy Minds were seeing their own clients who were able to get to the hubs
- Interviewees felt that the different organisations operating in hub were working quite separately, and not in a co-ordinated way
- The VCS organisations felt that the environment within the hub was not designed in a way that supported the services they wished to deliver. The presence of day beds, lack of adequate chairs and tables, lack of space to display materials, and limited access to tea and coffee making facilities were mentioned.

Recommendations made by interviewees:

- A regular meeting of all organisations operating in the hub to facilitate better co-ordination of the services
- Ensure environment is dementia friendly and develop facilities to support group sessions, and for display of leaflets
- Both Healthy Minds and Alzheimer's offered to provide training for hub staff.
- Healthy Minds recommended the following:
    - Consultation sessions with CATS team to look at their caseload and see who might benefit from Healthy Minds service
    - Healthy Minds to provide training to CATS staff. Two courses available one on detection of common mental health problems, second '10 minute CBT' giving intro to CBT framework
    - Falls prevention classes, Healthy Minds could attend to talk about role of anxiety in falls and way to address it
    - Healthy Minds are able do home visits

5: Service user groups views of community hubs

Introduction

The Involvement and Engagement team met with a number of service user groups to ensure the views of those less likely to attend the Trust's public events were sought as part of the review.

Methodology

The Involvement and Engagement team attended group meetings and presented on progress with the hubs in Thame and Marlow, and were then asked the following questions:

- What do you like about what you have heard?
- What concerns you?
- What does the Trust need to consider in order to ensure that the hub model meets the needs of your community/group?

Participant profile

- Alzheimer's Society - 25 participants made up of people with Alzheimer's and their carers
- Bucks vision - 36 participants made up of people with visual impairments and their carers
- Haddenham Carers - 8 carers
- Macular Degeneration Society - 16 participants made up of people with macular degeneration and their carers
- Rectory Road patients group - 34 participants
- Talkback - 4 members of Talkback's management committee all of whom had learning difficulties

Discussion results

What participants liked:

- The hub model of holistic care in one place was supported by all groups
- For carers the idea of care closer to home was important as they often delayed or did not deal with their own health problems because of their caring responsibilities. If they did attend appointments at the main hospitals they either had to take the person they cared for or arrange emergency cover. One participant talked of the difficulties of having chemotherapy and having to bring his wife who had Alzheimer's. Having a hub close by would make it easier for carer's to maintain their own health
- The large hospitals could be very disorientating for people with Alzheimer's, visual impairments and learning difficulties, so small hubs closer to home would be preferable

What concerned them:

- Local transport was an issue for all groups. Many had to pay for taxis to get to appointments
- Many participants had not been aware of the hubs existence and some did not think their GPs knew about them
- People with learning disabilities were concerned about any change in the services they were used to, and particularly concerned about the risk of GPs not passing on relevant information to specialists.

Service user group recommendations for how the hub programme could take their needs into account:

- Provide a wide range of clinics
- Effective signposting to other organisations who provide support
- Assessment in the home
- Focus on supporting health and well-being including mental health services
- Being able to self-refer to the hub
- Ensure information is shared effectively with GPs
- Dementia friendly and taking into account needs of people with earning difficulties for example with signage
- Somewhere quiet to relax
- More partnership working with the voluntary sector

6. Public views of community hubs

Introduction

Buckinghamshire Healthcare NHS Trust held a series of public workshops across the county between January and March 2018 to engage with members of the public to report back on what had been achieved in the pilot hubs in Thame and Marlow and gather their views on what care closer to home could look like across Buckinghamshire.

They followed on from the public events held in 2016 the findings from which informed the pilot hubs. One of the aims of the events was to revisit and update the ideas the public had developed in 2016 for what a hub could look like in their area.

Methodology

Public meetings were held in Buckingham, Chalfont, Marlow, Wycombe, Thame, Iver and Aylesbury. The meetings were led by members of the Trust's executive group, Carolyn Morrice, Chief Nurse and Tina Kenny, Medical Director. Participants were shown a presentation detailing the work of the pilot community hubs including how the hubs fit into the wider community care provision. This included the assessment below, based on the discussions with hub staff and patients detailed earlier in this report, of how far the hubs had progressed against the original criteria developed from the 2016 engagement sessions:

They then worked in facilitated groups to answer the following questions and answers were recorded on flipcharts:

- What did you like about what you have heard?
- What concerned you?
- In light of what you have heard about the pilot hubs, what's working, the challenges, and local circumstances in your area in 2018, we want to know what your vision for a community hub is now

The results from the discussions were collated and themed.

Participant profile

The events were attended by 191 people in total. Of the 191, 161 completed an equality data monitoring form.

- Gender: 105 of those who completed the form were female and 54 were male
- Age:

0 - 15	
16 - 24	
25 - 34	2
35 - 44	8
45 - 54	14
55 - 64	26
65 - 79	79
80 +	27
I do not wish to declare	5

- Disability: 43 of those who completed a form considered themselves to have a disability or long term condition. 112 did not and 5 did not wish to declare
- Ethnicity

White British	136
Irish	5
Other white background	1
I do not wish to declare	5

Discussion results

What did you like about what you have heard?

There was broad support for the hub model of holistic care across all of the public events, participants particularly liked:

- Rapid access
- Access to multidisciplinary teams
- The range of services available
- Access to treatment at home
- The one stop shop nature of the service
- Access to diagnostics
- Same day results
- Reduced hospital stays/visits
- Outpatient appointments closer to home
- Work with the voluntary sector

What concerned you?

Concerns emerging across the public engagement sessions were:

- The lack of awareness of the hubs amongst the public, GPs and other organisations
- There was a need for better signposting to other public and voluntary sector support

- Voluntary sector involvement not as effective as should be
- Patient information not being shared effectively between GPs and the hub staff, and the referral system via GPs not seen as robust
- Transport was a problem, unless one had access to their own transport or support of friends and family, the lack of public or community transport options was a barrier to access to the hubs
- Following on from this limited access to parking locally was an issue
- The difficulties of accessing services across county borders
- There was concern in Buckingham about the future of the beds in their community hospital

Recommendations for how the community hub programme should be developed:

Members of the public wished to see the current hubs maintained and developed and to have the programme rolled out to where they were. In particular they wished to see:

- Self-referral, or through a wider range of services, including faith based organisations
- More effective work with voluntary sector, including social prescribing
- Effective links between health and social care
- Better public or community transport options available to access hubs
- A higher level of awareness of the hubs within the community
- Evidence based services appropriate to each community
- An increase in the range and volume of outpatient clinics
- Provision of mental health services
- An increase age range catered for
- Having a café was not a priority but having the capability to provide sociable events with a defined purpose such as a dementia café ,or death café was supported
- More focus on prevention/health and well being
- The cross border issues addressed
- A physical space, in some areas this was about making better use of community hospital facilities, but did not have to be hospital based, in Wycombe participants raised the option of a mobile unit.

7. Public information sessions

Introduction

In addition to the engagement sessions with stakeholders detailed in this report, the Trust and the Buckinghamshire clinical commissioning groups held information and discussion sessions to keep the public informed of progress with the community hubs.

Methodology

The Trust held open days at both of its community hubs. Senior staff also presented at a range of events, and answered questions on the community hubs from the public. Over 1000 members of the public were reached through the information sessions.

Event details

Event	Date	Number of attendees
Open Day Marlow	06/07/2017	87
League of Friends from Buckingham visited Marlow and Thame	11/07/2017	6
Buckingham Older People's Action Group	17/07/2017	20
Buckinghamshire County Council	20/07/2017	approximately 100
Age UK	10/08/2017	12
Meeting with Rycote Practice GPs	15/08/2017	8
Thame Community Market	22/08/2017	50
Open Day Thame	13/09/2017	92
Buckingham League of Friends	14/09/2017	12
Winslow and district local area forum	28/09/2017	15
Rectory Meadow PPG	03/10/2017	87
Thame League of Friends AGM	04/10/2017	
Older persons action group Lane End	05/10/2017	33
Marlow League of Friends AGM	09/10/2017	7
Simpson Centre PPG	12/10/2018	90
University of the Third Age AGM	02/11/2017	approximately 100
Chalfont League of Friends AGM	06/11/2017	
Stokenchurch Parish Council	18/10/2017	17
The Ivers Parish Council	06/11/2017	18
Wendover Parish Council	07/11/2017	16
Ivers Women's Institute	08/01/2018	31
Aylesbury University of the Third Age	10/01/2018	200
University of the Third Age Wendover	22/01/2018	55
Buckingham League of Friends AGM	22/03/2018	approximately 30

8. Conclusions and recommendations

Conclusions

- The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review
- Patients and the public wished to see the current hubs continue and to see the model rolled out across Buckinghamshire, with provision tailored to needs in different areas
- All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential
- Levels of awareness of the hubs was low amongst both patients and GPs
- Transport was highlighted as an issue, with the lack of community transport to the hubs potentially a barrier to access for many patients

Key recommendations from stakeholders:

Current hubs

- Raise awareness of the current hubs with public and GPs, in part through clearer branding
- Increase the service to at least five days per week at both sites
- Review the current referral process with GPs, and consider expanding the process to self-referral
- Ensure better co-ordination of the different services operating within the hubs
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic like, to provide better facilities for partner organisations to provide their services, and to be dementia and learning disability friendly
- Mobilise a wider range of outpatient clinics

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units
- Ensure effective joint working across health and social care and with voluntary sector
- Consider how community transport to hubs could be improved
- Provide signposting to other public and voluntary sector support services

Amarjit Kaur
Head of Involvement and Engagement

Appendix 4

Support statement from Patrick Land on behalf of the Marlow Hospital League of Friends

In relation to the Community Hubs Pilot, on behalf of the Marlow Hospital League of Friends I would like this statement of support to be taken into account when considering the future steps in relation to the Community Hub Pilot Scheme. In the Marlow community there has been great anxiety following the closure of the beds in the Marlow Community Hospital some while ago. This was followed by the appearance of the "closure" of the Hospital, which caused very significant local concern. I, together with fellow representatives of the Marlow Hospital League of Friends, and other representatives of the Marlow community including the Mayor have attended regularly at the Community Hubs Pilot Stakeholder Group meetings, at which we have been able to be appraised of the latest developments through the course of the Pilot Scheme, and have been able to be involved in discussions in relation to the Community Hubs Pilot. As far as we have been able we have reported back to the local community.

The view of the Marlow Hospital League of Friends is that the Community Hub Scheme is a positive step which has the potential to be developed considerably, and as such also has the potential to be welcomed widely by the healthcare professionals involved in the delivery of the services, and also by the community will be able to recognise the constructive use of the much valued Marlow Community Hospital as an integral part of the delivery of a modern healthcare service in the locality.

The Marlow Hospital League of Friends very much hope that it will soon be possible to remove the word "Pilot" from the Community Hub Scheme, and for there to be significant ongoing progress in the rolling out of the various services that can be provided from the Community Hub in Marlow, together with the co-ordination with and mobilisation of additional sectors including the voluntary sector to maximise the potential for the services that can be delivered from the Community Hub, and to support the scheme in ways which are appropriate to the Marlow Hospital League of Friends as a local charity.

We await news of the outcome of recent discussions with anticipation.

Support statement from Sarah Taylor, Chair of Thame Hospital League of Friends

The establishment of the pilot scheme for the Health Hub in Thame means that, for the first time in years, the League of Friends of Thame Community Hospital is feeling cautiously optimistic about the future of their hospital. Indeed, there is growing enthusiasm for the project in the wider Thame community.

The hospital had always been associated with beds, originally used for a mixture of respite and patients needing overnight monitoring. Over the years, the number of beds had dwindled to a level that was not financially viable and the small number of beds meant that, more often than not, they were occupied by patients from outside Thame: they couldn't be kept free on the off chance that a Thame patient might need one. Although there was a lot of activity at the hospital, we lived in constant fear of the place being closed altogether.

The growing consensus that frail elderly patients should be kept out of hospital and at home for as long as possible has in fact potentially given our hospital a new lease of life.

What we want is a hospital that is there for the people of Thame and surrounding areas and is, in modern parlance, sustainable. That is, it should have a role that is genuinely useful and affordable for the long term. The current pilot scheme offers the vision of just such a role, combining as it does: the excellent CATS (community ambulatory treatment service) which assesses vulnerable patients and provides solutions to keep them at home and prevent admission to A&E; the existing physiotherapy service; the Day Hospital providing rehabilitation and preventative treatments; an increased number of clinics provided by consultants and other healthcare professionals coming from Stoke Mandeville and the John Radcliffe Hospital; input from the voluntary sector such as Carers Buckinghamshire and Oxfordshire; support from the neighbouring GP practices; more diagnostic services in the community; facilities for the Day Centre. The Buckinghamshire Healthcare Trust that runs the Hospital is working closely with stakeholder groups to adapt to local needs and break down barriers between Hospital and the Community.

Of course, these are early days and all is by no means perfect. We must work hard to ensure that all the GPs in the locality use the services to help make them viable and that patients are aware of what is on offer and push to be referred to the hospital rather than have to go further afield for assessment and treatment. The hospital needs investment in better IT and better equipment. Recruiting staff in an area where housing is so expensive remains a perennial problem. The GPs next door are bursting at the seams and need bigger premises. The transition between healthcare and social care is desperately short of the mark. Keeping people at home only works if there is support for them and their carers. We all must work towards finding solutions to these problems.

We have been given a commitment that, should the pilot fail, the beds will be restored and the hospital returned to what it was. However, we all know that that is not viable in the long run. Therefore, as a League, we are keen for the pilot to be successful and to be confirmed as the policy for the future.

Appendix 5

ICS design principles

1. **Standardised processes** to deliver safe and high quality care - evidence-based clinical decisions informed by peer support and review.

2. **Co-ordinated across a whole system** – ensuring coordination of care for patients across services eliminating unnecessary treatment or duplication.

3. **Population orientated** - focused on the needs in a location, and/or population groups such as those with specific long term conditions or the frail.

4. **Person-centred and holistic** – supporting patients to live independently at the centre of decision making about their care.

5. **Maximising care in the community setting** when care can be more effectively delivered closer to home.

6. **Comprehensive** - access to multi-disciplinary teams to meet patient's health and social care needs; to include wellbeing and prevention, acute and chronic care.

7. **Accessible** - responsive to the patient's needs with appropriate waiting times for advice, diagnosis and care; maximising the use of technology.

8. **Sustainable** - ensuring financial and staffing resources are used effectively to deliver best value.

Agenda item: 9
Enclosure no: TB2018/053

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
30 May 2018

Title	Buckinghamshire Integrated Care System Operating Plan 2018/19
Responsible Director	Director of Strategy and Business Development
Purpose of the paper	The vision of the Buckinghamshire integrated care system is 'Everyone working together so that the people of Buckinghamshire have happy and healthier lives' The purpose of this plan is to set out how we are aiming to achieve that vision with our partners ranging from describing the delivery priorities for 2018/19 and the infrastructure and governance arrangements we intend to put in place to ensure delivery.
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note the plan

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

Integration, care pathways and models of care

Please summarise the potential benefit or value arising from this paper:
The ICS is a collaboration of strategic partners in Buckinghamshire brought together to create a place based care system in which we rise to the challenges and deliver a transformation that improves and integrates care and makes us operationally and financially sustainable over the long term.

RISK

Are there any the specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk: ICS plans to meet the financial challenge in the system is included in the Operating Plan.

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well-Led Domain

Author of paper: David Williams, Director of Strategy and Business Development

Presenter of Paper: David Williams, Director of Strategy and Business Development

Other committees / groups where this paper / item has been considered:
ICS Partnership Board

Date of Paper: 21st May 2018

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Buckinghamshire Integrated Care System

Integrated Operations Plan

2018-19

NHS Buckinghamshire Clinical Commissioning Group

NHS Buckinghamshire Healthcare NHS Trust

Buckinghamshire County Council

FedBucks

NHS Oxford Health NHS Foundation Trust

NHS South Central Ambulance Service NHS Foundation Trust

Integrated Operational System Plan 2018-19

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SECTION 1

Executive Summary

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

Section 1: Executive Summary

The vision of the Buckinghamshire integrated care system is '***Everyone working together so that the people of Buckinghamshire have happy and healthier lives'***

The purpose of this plan is to set out how we are aiming to achieve that vision. We describe our delivery priorities for 2018/19 and the infrastructure and governance arrangements we intend to put in place to ensure delivery.

The ICS is a collaboration of system partners brought together to create a place based care system in which we rise to the challenges and deliver a transformation that improves and integrates care and makes us operationally and financially sustainable over the long term.

The population, health and social care structures and the geography offer ideal opportunities for delivering outstanding integrated care. The health of people and life expectancy in Buckinghamshire is generally better than the England average. However, the overall health profile for the county masks localised variation in deprivation and poor health such as seen in Aylesbury and High Wycombe.

Our care model describes how, through segmentation of the population, we will use a whole population health approach to ensure that care is planned, taking into account the needs of local people and delivered in such a way that we focus care on those most likely to benefit.

Our ICS transformation programme is made up of four pillars:

- Population health
- Integrated care
- Five year forward view priorities
- Professional support services

The plan describes in each case the approach we will take to transformation and the outcomes we aim to achieve.

The 2017/18 ICS system underlying deficit versus control total reported is £38.6 million. The finance and activity section of the plan sets out the approach we are taking to achieve financial sustainability.

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SECTION 2

Introduction

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

Section 2: Introduction

The ICS journey began in June 2017 and we are building a strong collaborative partnership which will be able to take shared accountability and responsibility to meet the health and care needs of the Buckinghamshire population. Our aim is to have the best health and social care outcomes in the country delivered by one of the safest and most efficient systems; establishing services that link physical and mental health, social care, general practice and the voluntary sector.

Buckinghamshire ICS consists of partners across Buckinghamshire health and social care system. It includes Buckinghamshire CCG, Buckinghamshire Healthcare NHS Trust, Oxford Health NHS Foundation Trust, FedBucks, Medicas, Buckinghamshire County Council, and South Central Ambulance Service NHS Foundation Trust (SCAS).

The Buckinghamshire ICS sits within the Berkshire West, Oxfordshire, and Buckinghamshire Sustainability and Transformation Partnership (STP). The STP identified priorities align with those of the ICS and are as follows;

- Shift the focus of care from treatment to prevention;
- Access to the highest quality, primary, community, and urgent care;
- Acute trusts collaboration to deliver equality and efficiency;
- Mental health development to improve the overall value of care provided;
- Maximise value and patient outcomes from specialised commissioning;
- Establish a flexible and collaborative approach to workforce;
- Digital interoperability to improve information flow and efficiency;
- Primary care at scale.

We are working with the other phase one ICSs and in particular Berkshire West (part of the BOB STP), Frimley and Milton Keynes, Bedfordshire and Luton, with which we have common interfaces and patient referral flows.

Chief executive officers from each system partner provide collegiate and strategic leadership to system wide programmes. There is a willingness to collaborate and this will be enhanced through the shared learning from new and emerging forms of commissioning and delivering care as the ICS matures.

Section 2: Introduction to the partners in the integrated care system

The Integrated Care System partners are:

Buckinghamshire Clinical Commissioning Group (BCCG) responsible for commissioning health services;

Buckinghamshire Healthcare NHS Trust (BHT) responsible for delivering the majority of acute and community services for Buckinghamshire patients;

Oxford Health NHS Foundation Trust (OHFT) responsible for delivering all-age mental health care and continuing healthcare services in Buckinghamshire;

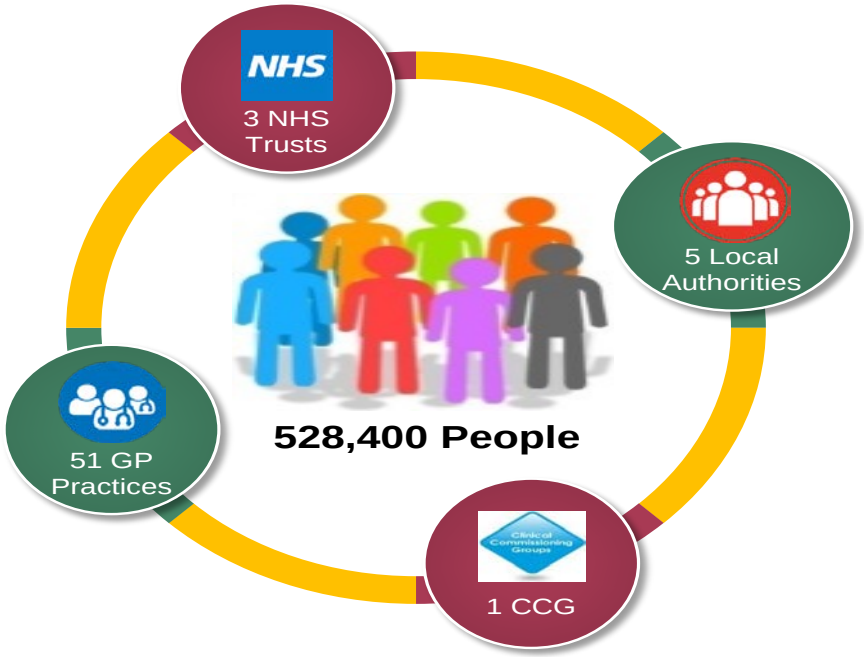
Buckinghamshire County Council (BCC), a single contiguous upper tier authority responsible for commissioning and providing social and community services as well as population and public health services;

FedBucks, a GP federation covering 85% of the 51 practices in Buckinghamshire and Medicas, a GP federation that covers all but one of the remaining practices;

South Central Ambulance Service NHS Foundation Trust (SCAS) who provide emergency and non-emergency patient transport as well as 111 services.

A Buckinghamshire provider collaborative has been formed as a delivery mechanism to build relationships between organisations to deliver integrated care in the county in areas such as urgent care and mental health.

Seven localities operate within the system with a focus on developing and delivering primary and community care.



ICS Localities

North Aylesbury Locality
- GP practices = 6
- Population 49,600

Aylesbury Central Locality
- GP practices = 7
- Population 103,200

Aylesbury South Locality
- GP practices = 5
- Population 48,400

Amersham & Chesham Locality
- GP practices = 9
- Population 75,600

Wycombe Locality
- GP practices = 9
- Population 90,800

Wooburn Green Locality
- GP practices = 8
- Population 89,600

Southern Locality
- GP practices = 8
- Population 84,200

Section 2: Introduction - Our Memorandum of Understanding with NHS England

Recognising the changing needs of the population of Buckinghamshire, the Health and Wellbeing Board has developed priorities, outcomes and performance indicators in four key areas: Healthy lives; Children, young people and families; Good health and wellbeing in adults and Healthy workplaces, environments and thriving communities. These contribute to the vision of…

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

This operating plan sets out the ICS's contribution to this strategy.

Over the next five years, the partners aim to rebalance the health and social care spend by using our funds collectively and allocating resources to support those with the greatest needs. We will develop new ways of working which will not be constrained by individual organisation's funding arrangements and/or allocation but will focus on what is best for the system as a whole. This collaborative partnership approach will ensure best value for money and spend of the Buckinghamshire '£' to improve outcomes for the people of Buckinghamshire.

As laid out in our Memorandum of Understanding with NHS England we accept a collective responsibility for resources and population health to:

- make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services;
- manage these and other improvements within a shared financial control total and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;
- integrate services and funding, operating as an integrated health system, and progressively to build the capabilities to manage the health of the ICS' defined population, keeping people healthier for longer and reducing avoidable demand for healthcare services;
- act as a leadership cohort, demonstrating what can be achieved with strong local leadership and increased freedoms and flexibilities, and to develop learning together with the national bodies that other systems can subsequently follow.

This operating plan sets out the principles and approach for the Buckinghamshire ICS implementation.

Section 2: Introduction - Case for change: Inequalities

Based on a five year average from 2011-2015, life expectancy for both men and women in Buckinghamshire is higher than the England average, however, there is wide variation. Life expectancy is 12.1 years lower for men and 13.7 years lower for women in the most deprived areas.

The infant mortality rate (IMR) in Buckinghamshire is 3.5 per 1000 live births which is similar to the England average of 3.9 (2016). However, in the most deprived fifth of the population it is significantly higher than in the least deprived fifth.

Unhealthy lifestyles present a major challenge in the population. In 2016, 26.7% of year 6 children and 62.6% of adults in 2014 (roughly 261,000 adults) were either overweight or obese.

The prevalence of smoking amongst adults in Buckinghamshire who were manual workers was reported as 28.1% in 2014 (compared to the average prevalence for all adults in Buckinghamshire of 15.1%). In Buckinghamshire, 1 in 5 adults are drinking at levels that lead to an increased risk of cancer, high blood pressure and other conditions.

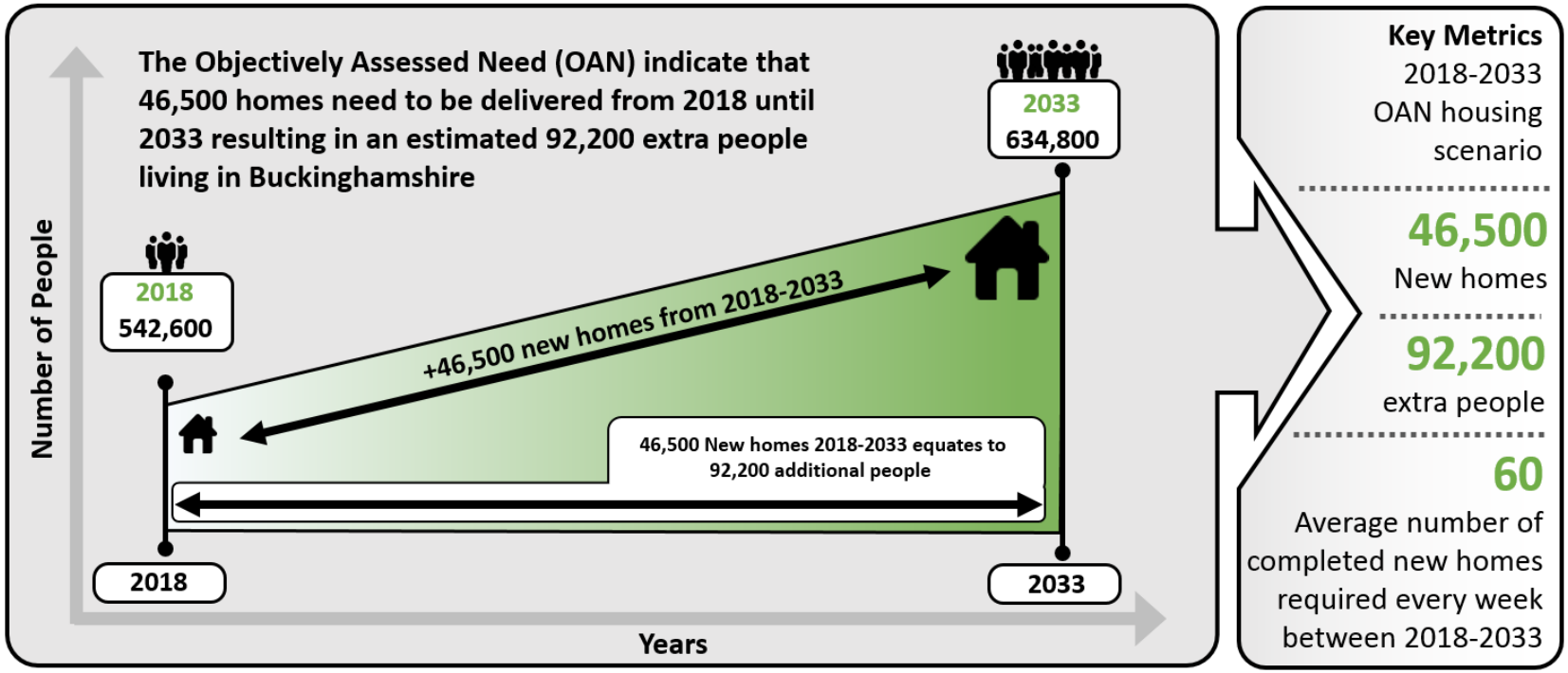
Section 2: Introduction - Demographic Change and the impact on demand for services

The Buckinghamshire predicted population growth will impact significantly on the demand for health and social care within the county and therefore it is essential that we work as a system to address the challenges which we face.

In the time period 2018 to 2033 we will see a significant increase in the older population with the 65 plus population increasing by 40% (an extra 41,000 people) and the 80 plus population by 70% to 50,000 (an extra 20,500 people).

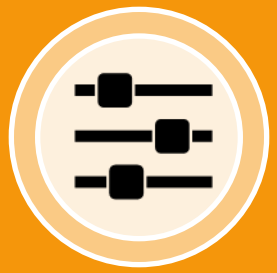
In the same time period the number of young adults 18-20's will increase by 14% (an extra 2,100 people) and the number of children will increase by 9% (an extra 10,500). The BME population is expected to increase by 43,000 over 20 year period (2011-2031) to 20% of overall population.

There is expected to be a 4 fold increase in number of Buckinghamshire residents living in most deprived areas in the county with the population increasing from 113,000 in 2015 by 21,000 over the next 15 years to a total of 134,000 people in 2031 (23% of total population)



Section 2: Introduction - key system markers

16/17 to 17/18 Demand:
Activity continues to rise and we are developing innovative ways of meeting people's needs. Annual Performance Data for BHT A&E attendance increased by 5%; emergency admissions increased by 1.6%; delayed transfers of care increased by 18.5%.



Performance Pressures
ICS is committed to delivering the NHS Constitutional Standards. February Performance Data for the CCG:
ED Performance: 84.6%
RTT Performance: 90.46%
Cancer Performance: 80.0%

Financial Squeeze
is the longest & deepest in health and social care history: The ICS had a £38.6m underlying deficit against control total in 17/18 owing to rising demand and performance pressures

New Care Models
Developing and implementing new innovative adaptable and flexible ways of providing care to the population to live independent happy and healthier lives

Structural Change
ICS Transformation Programme is underway to ensure operational and financial sustainability; requires significant investment to develop leadership and system capacity and capability

Workforce Challenges
System-wide to drive change and to attract, recruit and retain the best staff. ICS sees opportunity to develop new roles with core competencies that can be flexible to meet patient needs

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SECTION 3

Buckinghamshire's Emerging Care Model

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

Section 3: Overview of the emerging Buckinghamshire care model

The emerging care model for the ICS builds on the clinically led change that has taken place so far to deliver improved clinical outcomes and the quality of patient care.

We will develop a care model which brings together all partners to deliver seamless patient pathways with shared responsibility and accountability at any point in the patient journey.

Population health management will be used to help us target care for those most likely to benefit. It is a process which takes a defined population, analyses its needs in detail and, as a result, creates tailored health and social care services.

Prevention of ill health and maximisation of wellbeing is core to the model, building on the Buckinghamshire County Council asset based approach.

Those with minor illnesses or long term conditions will have the confidence to manage their own health or have their needs met in primary care by a pharmacist or a general practice.

Our care model will deliver a shift in emphasis from reactive to proactive care where those with long term conditions will discuss their future needs with clinicians and contribute to the development of their care plan.

Focusing on a philosophy of "Home First" we will deliver care as close to home as possible.

The development of community based services, to support resilience of primary care, will improve access. We will develop community hubs to facilitate the delivery of care traditionally delivered in hospital, closer to home.

We recognise that some people will require on-going care. For this group, continuity of service is important where all who deliver their care have access to shared information.

As the complexity of a patient's needs increases, we will work with the individual and their family to develop an integrated care plan to keep them independent in their own home as long as possible.

Where either a planned or unplanned hospital admission is necessary both the admission and the discharge will be co-ordinated to minimise the amount of time spent in hospital.

Integral to our model of care is the provision of specialist and local services, targeted to the needs of the population.

We will provide the right care, in the right place, at the right time so improving patient outcomes, the quality of care and deliver an effective and efficient care model for the population of Buckinghamshire.

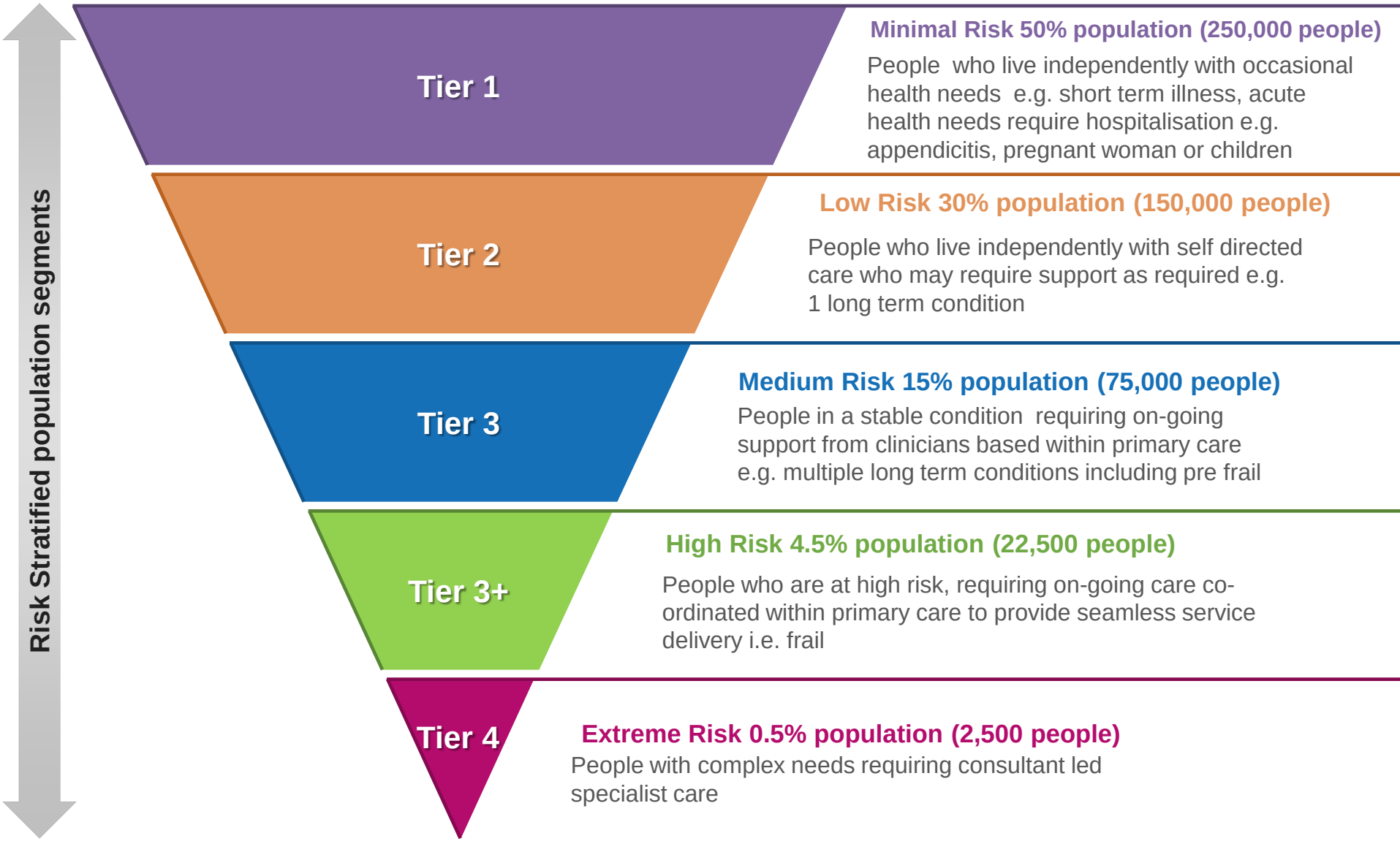
Section 3 – The Buckinghamshire care model principles

Our aspiration as a first wave integrated care system is to develop a new model of care using the following design principles:

- Standardised processes to deliver safe and high quality care; evidence-based clinical decisions informed by peer support;
- Co-ordination across a whole system; ensuring coordination of care for patients across services eliminating unnecessary treatment or duplication;
- Population orientated; focused on the needs in a location, and/or population groups such as those with specific long term conditions or the frail;
- Person-centred and holistic; supporting patients to live independently at the centre of decision making about their care;
- Maximising care in the community setting when care can be more effectively delivered closer to home;
- Comprehensive access to multi disciplinary teams to meet patient's health and social care needs; to include wellbeing and prevention, acute and chronic care;
- Accessible and responsive to the patient's needs with appropriate waiting times for advice, diagnosis and care; maximising the use of technology;
- Sustainable care, ensuring financial and staffing resources are used effectively to deliver best value.

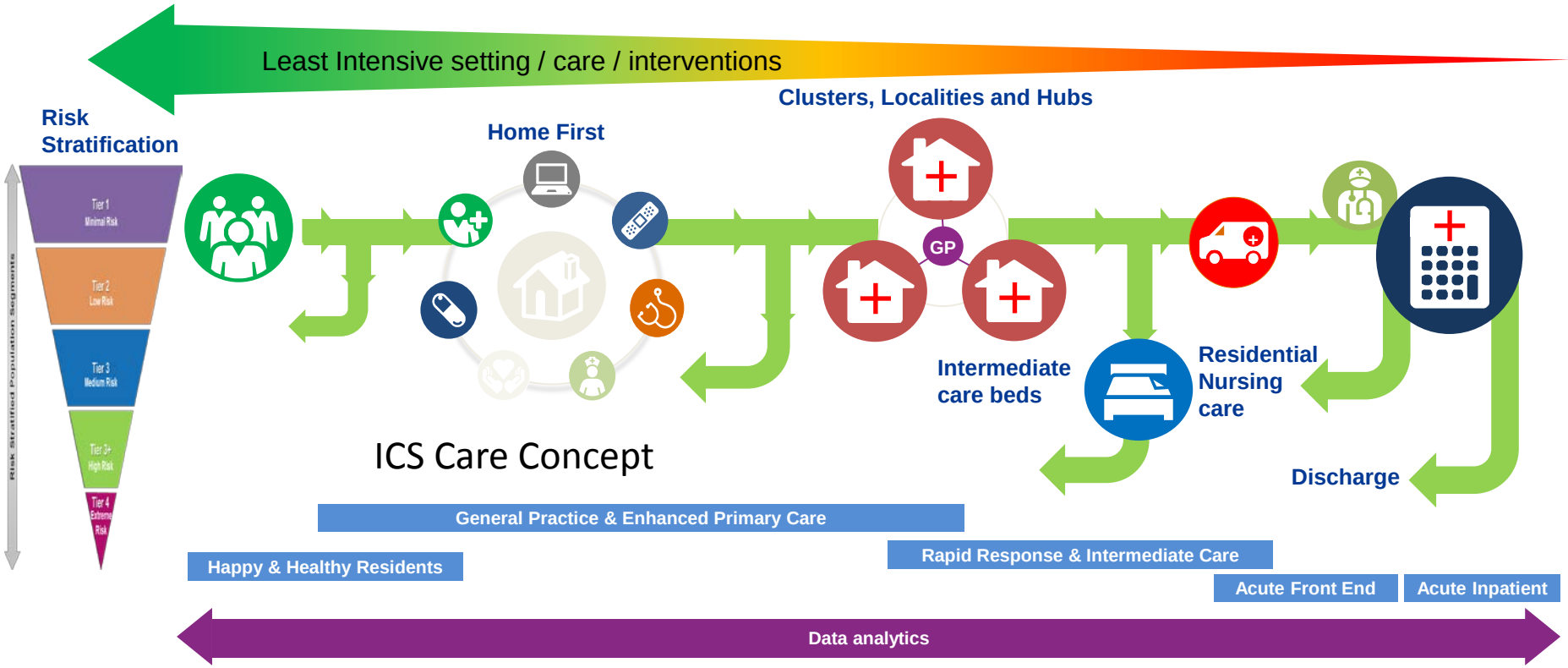
The Focus of Population Health Systems (Source: King's Fund)

Section 3: The care model focuses on population segmentation according to risk



Section 3: The Buckinghamshire Care Model Concept

The model below describes the ICS Care Concept which is being developed within Buckinghamshire



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

- Self-Care
- Social prescribing
- Repeat prescriptions
- Carers support
- Care assessment/ planning

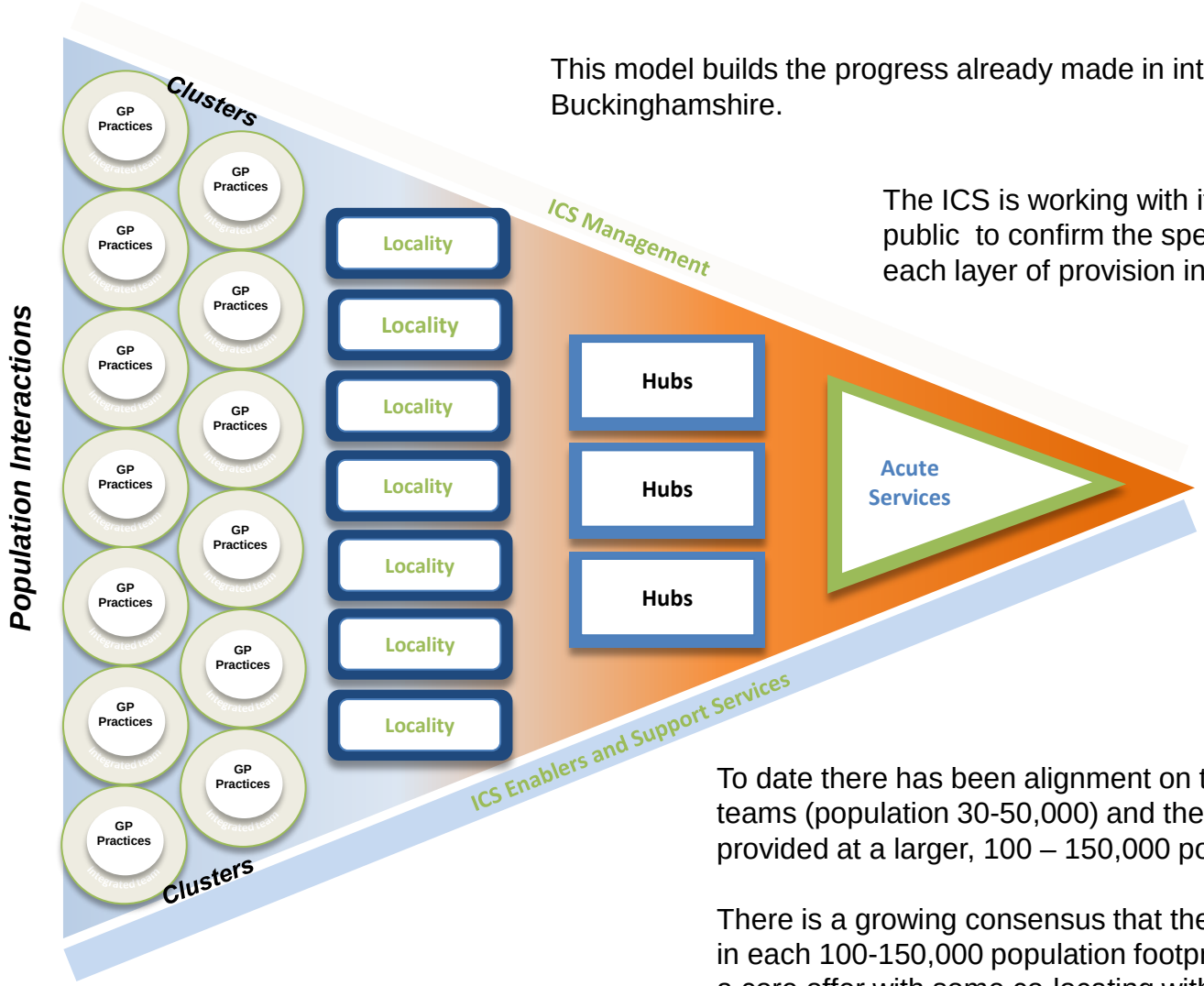
- Planned and urgent care
- MDT
- Social care
- Assessment teams
- Integrated teams

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

- Planned admissions
- Trauma/ medical emergencies
- Discharge model

Section 3: The Buckinghamshire Care Model Concept

The Community model will be operationalised across a number of different geographies and organisations



This model builds the progress already made in integrating care in Buckinghamshire.

The ICS is working with its constituent members and the public to confirm the specific definitions and features of each layer of provision in this model.

To date there has been alignment on the role of GP clusters / integrated teams (population 30-50,000) and the need for some services to be provided at a larger, 100 – 150,000 population.

There is a growing consensus that there will be a virtual or physical hub in each 100-150,000 population footprint and that all the hubs will provide a core offer with some co-locating with other services e.g. outpatients.

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SECTION 4

Our Transformation Programme

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

Section 4: Background

We are a health and care system with a strong background of clinical leadership for our key projects. This has enabled us to deliver change to improve clinical outcomes and enhance the quality of care in Buckinghamshire.

The next phase of our transformation programme will be fast paced and provide support to :

- **Accelerate a system approach to improving outcomes** for our population with a shared understanding and holistic approach to meeting peoples physical, mental health and wider social needs;
- **Co-design services** with the people that use them, continue our focus on prevention, expand self-care and promote health and wellbeing to reduce the demand on health and care services;
- **Focus on key priorities to embed our approach,** using risk stratification to segment our population to guide the need for more effective, targeted support;
- **Accelerate implementation** of our agreed integrated care roadmap - ensuring the whole Buckinghamshire system is focussed on population and health outcomes;
- **Align our work** to improve outcomes and ensuring appropriate service utilisation – right care, right setting, right time - to benefit all partners and allow a coordinated focus on key priority areas;
- **Access external support and rapid learning** with other like-minded systems, maximising efficiencies of collaboration and enabling us to move at a faster pace through our organisational development programme;
- **Develop an integrated data set** – one source of the truth, which is used to set capitated budgets, enable whole systems modelling and evaluation of services and the assessment of the relative benefit of services compared to one another;
- **Work as a system to develop a framework** which enables us to be held jointly to account for delivery of our transformation programme and achievement of key objectives.

Section 4: Transformation programme vision, objectives and core pillars

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 implementing IT platforms that support integrated care;
- Long term operational and financial sustainability.

Core & Enabling Pillars

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.

FYFV: National priorities including improving outcomes for cancer, improving resilience in primary care, improving access to urgent care and improving outcomes for people with mental health.

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

Section 4: Our Journey

Working Together

2015

- Established Healthy Buckinghamshire leaders group – aligned to Health and Wellbeing board priorities
- Established Transformation Delivery group

2016

- STP footprint agreed; joint programme boards established
- Integrated commissioning executive team established;
- GP federation established

2017

- Awarded ICS 1st wave status
- Provider collaborative established
- Clinical engagement events across the county
- Partnership Board agree ICS vision, objectives, and core pillars

Delivering Together

2015

- Launch of Primary Care strategy
- Agreed joint risk share
- Pooled budgets for £30M Better Care Fund
- Go live for interoperability Phase 1 (My Care Record) - real-time view of GP held record

2016

- Specification for integrated reablement and response service agreed
- Established GP clusters
- Community hubs launched

2017

- ICS engagement sessions take place including Big Tent events
- Launch of TV NHS111 service
- GP streaming launched
- Go live for EMIS clinical services to support integrated working

2018

- Launch of 24/7 primary care access
- Submission of ICS integrated operating plan

Looking Forward

2018

- Joint OD strategy initiated
- Implementation of ICS operating plan
- Review of BITS/community hub pilots
- Launch of primary care access hubs for extended service
- Extension of integrated teams supporting patients at risk
- Launch of IT interoperability programmes
- Deployment of interoperability solutions (CareCentric & Careflow and Person Held Record)
- System control total reporting begins
- Development of new models of care to meet needs of specific patient groups

2019

- Development and implementation of capital programme
- Community, primary care and social care providers delivering new model of care with local people that has redesigned pathways, supporting more people at home and eliminates delays in hospital discharge
- Integrated care record: all core feeds live and context launch from main partners live

Section 4: Change delivered on our transformation journey in 2017/18

The Buckinghamshire health system has already started to deliver real change:

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 re-ablement 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. 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
- 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

Five Year Forward View

- 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'
- 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 supported by EMIS Clinical services to enable record sharing
- Established working groups focusing on Organisational Development, Quality, Population Health Management, Workforce, Finance, Communications and Engagement

Section 4 : Our ICS Programmes

We are developing an integrated programme structure to support and deliver the key transformation. Key to our success is the availability of high quality informatics and decision support along with good leadership and support throughout the system.

- Our aim is to ensure the wellbeing of patient/service users, staff and partners within the system to achieve long term stability and sustainability
- The transformation programme initial priorities were agreed collaboratively to increase effectiveness and efficiency, creating system sustainability, and ensuring the success of the new model of care
- We aim to create a lean process with the appropriate level of governance, rigorous system controls, and the appropriate level of decision making and assurance

<table>
<tr><th colspan="8">ICS core pillars</th></tr>
<tr><th colspan="2">Population Health</th><th colspan="2">Integrated Care</th><th colspan="2">FYFV</th><th colspan="2">Professional Support Services (Enablers)</th></tr>
<tr><th colspan="8">Examples of delivery programmes/ projects</th></tr>
<tr><td>Preventive</td><td>Self-Care</td><td>Long Term Conditions</td><td>Frailty</td><td>Mental Health</td><td>Cancer</td><td>Estates</td><td>Finance</td></tr>
<tr><td>Adult Social care and children and young people</td><td>Population Health Data and Analysis</td><td>Community Services</td><td>Integrated Care</td><td rowspan="2">Primary Care</td><td rowspan="2">Urgent and Emergency Care</td><td>OD/Work Force</td><td>Portfolio Office</td></tr>
<tr><td>Medicines Management and Optimisation</td><td>Information Advice Guidance</td><td>Planned Care</td><td>Unplanned Care</td><td>IT</td><td>Comm and Engagement</td></tr>
</table>

Section 4: Key Transformation Drivers

	Current Delivery Programmes	Outcomes
Population health	• Preventative • Self-care • Targeted Intervention • Population Management	• Promoting wellbeing through targeted initiatives and improving health outcomes • Promoting independence and self care. • Promoting self-service through information held on digital platforms • Signposting to the right services through information open to all • Promoting use of voluntary services and communities
Five Year Forward View	• Mental Health • Primary Care(to be managed under Integrated Care Pillar) • Cancer • Urgent and Emergency (to be managed under Integrated Care Pillar)	• Manage levels of GP activity , providing other, more appropriate, support for patients • Ensure optimisation of medicines management and prescribing. • Manage the demand for ED attendances and admissions to hospital providing other more appropriate services • Manage the demand for elective hospital services providing other more appropriate services • Re-profiling / redesigning outpatients. • Redesign services to eliminate duplication and provide seamless services
Integrated Care	• Urgent and Emergency • Care Homes • Single Point of Access: • Community Hubs • Planned Care • Long Term Conditions	• Provide appropriate services to support independent living , reducing the number of people admitted into residential and nursing homes, • Provide appropriate services to support independent living reducing the length of time people stay in residential and nursing homes and hospital settings. • Ensure best value for the provision of care packages. • Provide appropriate services to support independent living reducing length of stay • Minimising delayed transfers of care. • Increase the number of people dying in their preferred setting
Professional Support	• Estates • Finance – Business Intelligence • OD/ Workforce • Portfolio Office • IT • Communication and Engagement	• Maximising the use of the public estate to deliver integrated services and the most efficient use of the public pound • Sustaining a system wide PMO; developing a flexible, cost effective and agile approach while reducing risk, complexity, duplication and ensuring best use of resources available • Improving capacity within the community workforce • Increasing the capacity of the primary care • Increasing support to professionals across the ICS by introducing tools to empower patients to manage their health and wellbeing and long term conditions, and ensuring staff have access to the right information to deliver safe, effective and efficient care

Section 4: Our transformation programme – 2018/19

- Rapid review and assessment report of current ICS related projects completed, together with high level Target Operating Model (TOM)
- Buckinghamshire ICS Integrated Operations Plan completed and submitted
- Transformation plan framework developed and aligned to operations plan.
- Projects established for priority projects assigned as Year One (2018/19) delivery
- System communications plan agreed
- Interoperability design and build, My Care Record (MCR) Phase 2. and continued rollout of EMIS Clinical Services
- Pilot BITs implementation at clusters

- PMO structure and delivery process developed and implemented
- Programme reporting, system finances and governance aligned
- Knowledge transfer to staff in terms of programme delivery and reporting requirements
- Detailed communications plan enacted
- Agreed new model of care
- Introduction of population health management analytical tools
- Performance dashboard and analysis function established
- Interoperability tools rolled out to nominated pilot locations and staff to fulfill ICS Programme requirements (CareCentric and careflow)
- Interoperability tools available to patients and public in a controlled pilot (Ask NHS)

- Interoperability tools rolled out to all locations and staff to fulfill Programme requirements (CareCentric and careflow). Tools made available to patients and public (Ask NHS)
- Implementation of GP 8-8 service
- Transformation plan for Primary Care 24/7 access developed and agreed
- First phase implementation of Hubs
- Gateway to test ICS go live

- Interoperability tools rolled out to all locations and staff to fulfill ICS Programme requirements (Care records) (6 month process)
- Person held record made available to patients and public (Ask NHS) (6 month process)
- Delivery of Five year Forward View annual targets
- Continued implementation of Primary Care Hubs
- Fully develop 2019/20 program
- Lessons learned from 18/19

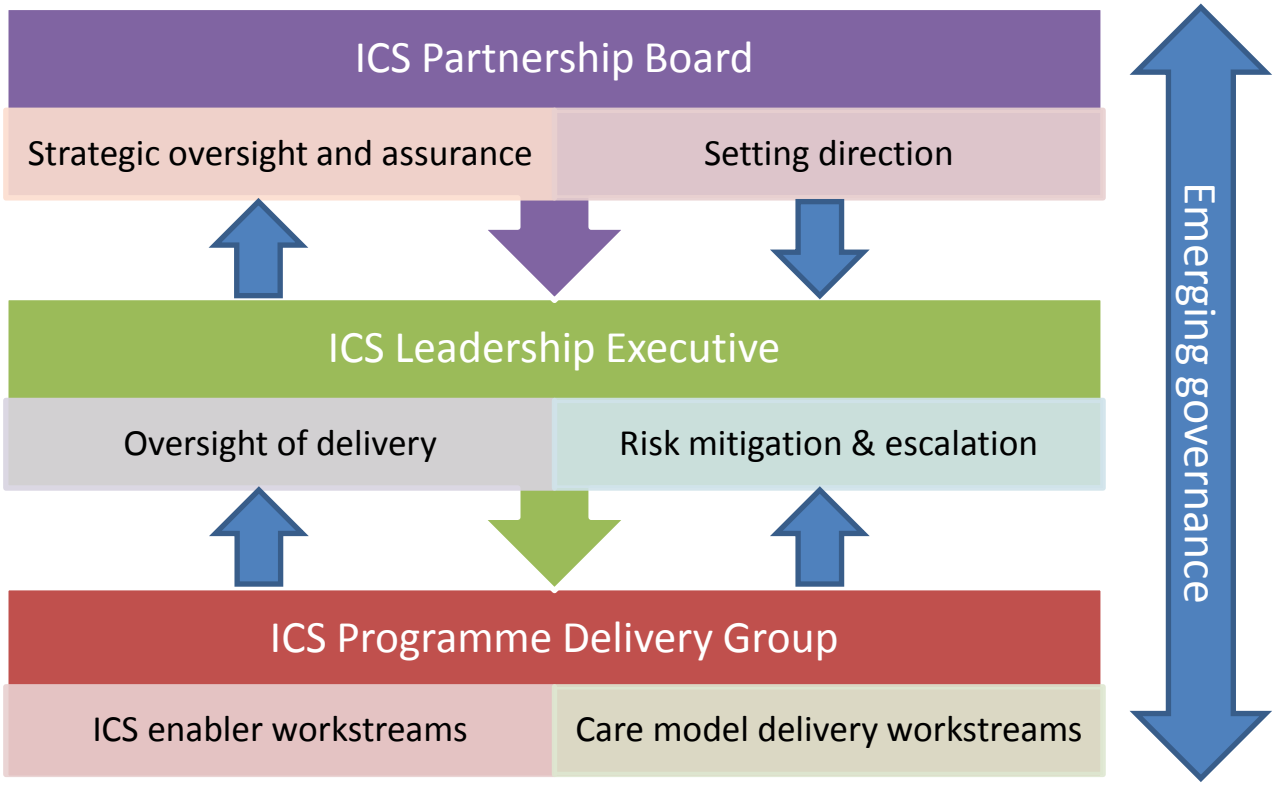
Section 4: Programmes Governance

Structured system governance will be a key element to the ICS success. The ICS partners will establish and maintain a robust accountability and governance arrangement. Building on the existing ICS governance arrangements, we will ensure clear management reporting and oversight to provide the required level of assurance across the system.

The principles that will underpin the design of our governance:

- Clear, transparent and collaborative decision making
- Devolve decision making to empower teams on the ground to deliver the change required.
- Resources will follow responsibilities
- Process will be streamlined and standardised

These principles will allow us to test our governance arrangements and the degree to which they meet the needs of each individual organisation and the system as a whole. We will ensure appropriate controls and processes are in place to identify, manage and mitigate risk.



Section 4: Programme Communication and Engagement

The focus of our communications and engagement plan is to ensure that all stakeholders are well informed and have the opportunity to contribute to the development, implementation and success of the ICS; through the most appropriate channels to meet their specific needs

Public

- Involvement of Buckinghamshire residents in shaping the services we plan, commission and deliver;
- Understanding of all our audiences and how to reach all groups including those we don't hear from;
- Improved patient and service user experience for those receiving NHS and/or social care services;
- Improved understanding of the system and how to navigate ensuring single points of access and seamless service delivery.

Staff

- Greater understanding of the system and what the changes in each organisation mean for each other;
- Involvement of staff in identifying opportunities for better integration;
- Increased knowledge of each others roles and how they contribute to residents health and well-being;
- Improved understanding of health and care as one system;
- Spreading good practice across the system;
- Using real examples and demonstrating the strengths in our system will support our recruitment and retention drives showing Buckinghamshire as a "good place to work".

Deliverables in 2018/19

- Developing the ICS story including frequently asked questions to ensure a consistent message across all organisations;
- Understand knowledge of the ICS and each organisations preferred channels to help inform our plan;
- Through blogs and tweets, share our journey to greater integration;
- Continue to develop cross organisation communications networks;
- Maximise opportunities to share our messages both locally and nationally.

Section 4: Programme Communication and Engagement

We will involve people in what is changing through engagement, co-design and co-production to ensure we get it right first time whilst communication will be plain English and jargon free. We will ensure stakeholders have every opportunity to be involved.

April – June	July – September	October – December	January – March 2019
• Staff Survey – level of understanding and suitable channels (April 2018) • Communications and Engagement Plan in place (April 2018) • Share the ICS story and FAQs (April 2018) • Staff Roadshows (May 2018) • Launch Ideas Exchange – for staff to contribute and get involved (May 2018) • Launch of new Adult Social Care Strategy (May 2018) • Launch of Live Well Stay Well • Launch Co-production and engagement group	• Continue delivery of work stream communications and engagement plans including: – Buckinghamshire integrated teams – 24/7 Primary Care – Official launch of Urgent Treatment Centre – Fulfilling Lives – Prevention • Support for communications and engagement activity for Community Hubs	• Continue ongoing staff communications • Review of engagement tools and introduction of new digital tool for ICS • Continue delivery of work stream communications and engagement plans • Planning for ICS website • Launch One Recovery Buckinghamshire	• Continue delivery of work stream communications and engagement plans • Review Communications and Engagement Plan

Section 4: Our Transformation Programmes – the detailed core pillars

The following slides drill down into the delivery of our core and enabling pillars for the Buckinghamshire Integrated Care System

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.

FYFV: National priorities including improving outcomes for cancer, improving resilience in primary care, improving access to urgent care and improving outcomes for people with mental health.

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

Section 4: Population Health Management (PHM)

What is PHM?	PHM is a critical priority for Buckinghamshire ICS. It is a process which takes a defined population, analyses its needs in detail and as a result creates health and social care services tailored to that specific population. It is a journey rather than a destination and the specific service which results will be unique to each population group/locality. We aim to: • achieve parity of esteem for prevention and self-care; • improve the health and wellbeing of our residents and reduce health inequalities; • reduce clinical and financial risks to the system across health and social care.
Why is PHM a priority for the ICS?	The need for adult health and social care services is being driven by an increase in the older population and increasing numbers of people with multiple long term conditions and frailty in the ageing population. Long term conditions and frailty are not an inevitable consequence of ageing – much of this is driven by unhealthy lifestyles coupled by a historic investment issues in prevention. Multi-morbidity more than age is a key driver of cost activity and future risk and multi-morbidity occurs across the whole adult age range. Evidence also suggests that co-morbidity impacts resource use exponentially – not in a linear way. Multiple- morbidity is not distributed evenly across a population and case-mix varies quite significantly between GP practices. The Buckinghamshire ICS and wider STP identified 3 main gaps which have direct impact on the health and wellbeing of our population and on our financial sustainability across the system. These gaps are: **1.** **Lifestyle, information and motivational** – a gap in people's ability to help themselves to a healthy lifestyle and to self-manage long term conditions. There are also gaps relating to people's ability to help themselves when social problems occur; **2.** **Service** – a gap in the way we organise, focus, commission or provide services in particular in the way that prevention, self-care and asset based approaches can be integrated in to routine contacts; **3.** **Community gap** – a gap in the way we work together to build community skills and capacity in order to develop the community assets and social capital as a way to enable individuals to develop personal responsibility for their health and wellbeing.

Section 4: Population Health Management (PHM)

Our approach to PHM	1. To maximise the use of community assets, we will work with our communities to map their assets to utilise them to improve and maintain their health and well being; 2. Increase the importance of the prevention agenda, by ensuring that it is core to every intervention and contact with individuals; 3. Use data to support the targeting of interventions on those most likely to benefit, through understanding the specific needs of individuals within segments of our population; 4. Use data to inform the planning of services to meet the needs of local people, through understanding the population as a whole, how they are currently accessing health and care services and how these can be better met; 5. Devolve the delivery of services to locality and cluster level, to make sure that voluntary sector, health and care services work together to encourage people to live independently and manage their own health and well being.
Outcomes and benefits	Unlocking the potential of PHM will support Buckinghamshire residents and our system to: 1. Integrate health and social care and voluntary services to use our collective resources to provide best value for the population; 2. Enable people to live independently and increase their confidence in managing their long terms conditions, so reducing demand for unplanned services; 3. Reduce the harm caused to people by smoking, obesity and drinking excess alcohol; 4. Keeping healthy people healthy for longer; 5. Supporting chronically ill people to successfully manage their conditions; 6. Embedding population health and prevention practices in all services.

Section 4: Population Health Management (PHM)

What work is the ICS currently doing?	Overall, we have identified three programmes of work that are already underway, which we will continue to develop to enable us to realise our vision for population health management in Buckinghamshire. In addition, based on the needs identified by data analysis (population segmentation and risk stratification) we will further refine our new care and service model to ensure they reflect the identified needs of our population. The three programmes of work are: 1. **Prevention at Scale programme** and **Live Well Stay Well (**an integrated lifestyle service) will help people to stay healthy and avoid getting unwell. These two programmes will form the foundation of our PHM work stream and underpin all of the work we will do on prevention; 2. **Integrated Community Services/Integrated Teams** together with care and support planning programmes that will support individuals who are unwell by providing high quality care at home and in community settings. These programmes will transform general practice, primary and community health and care services in Buckinghamshire, so that they are truly integrated and based on the needs of our local populations; 3. **Acute and Emergency care programme** will help those who need the most specialist health and care support, through a single acute care system across the whole county.
Our priorities for 18/19:	1. Undertake a readiness assessment of our system for implementing PHM; 2. Profiling our GP Clusters to support primary care and community services transformation; 3. Ambulatory care intervention in primary care for medium risk patients; 4. Population Health Data and Analysis - Population Health Programme focusing on local variation; 5. Medicines Management and Optimisation – Embedded pharmacist in care homes and primary care; 6. Validate further our priority areas for further development and investment - Focusing on multi-morbidity and frailty; 7. Spread our Making Every Contact Count ethos across all care providers through focus on early intervention for low risk patients; 8. Information Advice Guidance – Increase access to information, advice and guidance in a variety of formats e.g. IT self-referral system and located information services within community hubs.

Section 4: Integrated Care

ICS integrated care ambition	The Buckinghamshire Integrated Care programme aims to improve 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. Supporting people to keep themselves healthy and live, age and stay well enabling more people to live independently longer, this will reduce the pressure on our hospitals, GPs and wider health and social care services. The programme will provide timely access to services by helping the public to better understand how their care needs can be most appropriately met. Our staff are our major asset, through integration we will improve their work life balance, develop their career, devolve decision making and make Buckinghamshire an attractive place to work through bringing joy back into the workplace.
	We will work with our residents to encourage and enable them to manage their own mental and physical health and wellbeing. We want to ensure people are cared for at home wherever possible and that services are focussed on a home first philosophy, which has been confirmed by feedback from the public. We are developing integrated teams across health and social care which will reduce duplication so increasing the capacity to deliver diagnosis, assessment and care in the community. This means we will provide proactive care planning, rapid response, reablement which means patients will be better informed to manage their condition and maintain their independence. We will implement enhanced access to general practice services to meet the needs for episodic care. We are developing our new care model to provide access to good quality advice and care in the most suitable and convenient way possible, as early as possible. Through combining resources and expertise across the health and care system so that people receive joined-up care and provide care navigation/care coordination to improve the quality of care for individuals in the Buckinghamshire. We will also look to reduce the variance in quality for those suffering from serious enduring mental illness or learning disabilities. We will support the development of multi agency working to allow staff to work together as one team across organisations through developing new ways of working including joint roles and empowering staff to make decisions.

Section 4: Integrated Care

Our approach to integrated care	• To simplify access to care we will implement a single point of access for all referrals into community services; • Develop hubs across Buckinghamshire to deliver expanded diagnostic, outpatient, health and wellbeing and ambulatory care services for local people; • Expand rapid response and reablement services enabling a two hour community response to those in crisis; • Care integrated locally to provide better support closer to home; • Improved urgent and emergency care; • Improved resilience in primary care services; • Reduce unwarranted variation in quality of planned and unplanned care; • Long term operational and financial sustainability.
Outcomes and benefits	• Improve health outcomes through integrated, responsive and innovative primary and community health and care services; • Encourage collaboration to ensure that family doctor services are safe and sustainable, and play a leading role in the successful delivery of new models of care; provide timely access to general practice, so reducing the need for urgent care; • Ensure patients have fewer crisis that lead to unplanned hospital and institution care; • Increase the number of people clinically assessed through NHS 111 to 30% by March 2018; • Work to achieve 95% on the 4 hour A&E standard; • Improve the working of community based multi-disciplinary teams through training and development; • Use technology to drive innovation, underpin integration of services, improve efficiency and empower patients; • Through investment we will develop flexible infrastructure and estate needed to support and promote our ambition.

Section 4: Integrated Care

What work is the ICS currently doing?	• Enhanced and improved access to primary care services from 2018 onwards; • Implementing surgery sign-posters to help patients navigate care; • Urgent and Emergency Care – Implementation of Improved Directory of Services/increased clinical triage, embed GP Streaming Service; Launch of Thames Valley NHS 111 IUC service; • Community Services – Established community hubs, piloted Buckinghamshire Integrated Teams (BITS) in 3 localities covering population of approx. 100,000; • Planned Care – iMSK transformation programme with care delivered through provider collaborative; • Telemedicine Support for Care Homes – using advanced nurse triage service which reviews patients and offers advice on continued treatment in the home setting. The service reduces the number of hospital admissions and the workload for General Practice. • Primary care: We have worked with our general practices to align them into 13 clusters . The aim of this work is to encourage collaboration between practices and so enhance their resilience. In 2018/19 our GP federations will lead the implementation of improved access to general practice. We will invest £8.8m in developing our primary care estate. Our general practices will work together to design the best solutions for their local populations. Through this collaboration and the federation support, time will be released to support general practice to transform their services and become active delivery partners with other parts of the system.
Our priorities for 18/19:	• Development and implementation of a Community Care Model; • 24/7 primary care implemented with extended GP access 8am to 8pm; • Expansion of the Directory of Services and clinical triage; • NHS 111 online; • Through collaboration between practices enhance primary care resilience; • Keep patients safe by improving safety of medications, recognition of sepsis, reducing infections and recognition of deterioration of patients.

Section 4: Five Year Forward View – Urgent Care

ICS urgent care ambition	The Five Year Forward View sets out a clear direction, showing why change is needed and the expectations of service delivery in the future. Delivering the vision contained within the report for Buckinghamshire will require a system based approach with the input of all our partners. The ambition for Buckinghamshire is set out in the ICS Memorandum of Understanding with NHS England. In 2018/19 we will make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services. The ICS is committed to working with its partners across the STP to ensure that we are delivering these services on the most effective footprint.
	Our Memorandum of Understanding with NHS England sets out the following ambition; • Urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance services; • Primary care – deliver extended access by October 2018 and use collaboration between practices to increase primary care resilience, contribute to a proactive, whole population health model of care and improve retention of GPs. We will manage these and other improvements within a shared financial control total and collaborate to maximise the system-wide efficiencies to deliver within budget, improving outcomes and patient experience. To achieve this we will integrate services and funding, operating as an integrated health system, and progressively build the capabilities to manage the health and care of the population, keeping people healthier for longer and reducing avoidable demand for healthcare services.

Section 4: Five Year Forward View - Urgent Care

Outcomes and benefits	• Reduce the number of people relying on A&E and GP OOH to access care through increasing the range of service available and streamlining access; • Increase the percentage of people who, on calling TV IUC and NHS 111, receive a clinical triage; • Improve the access to routine primary care; • Speed discharge from hospital by increasing the number of CGC assessments taking place in the community; • Reduce the number of patients who live in a care home who are transported unnecessarily to hospital.
What work is the ICS currently doing?	• To maintain current performance on DTOC ,through the BCF, partners have worked to (i) stabilise care market (II) streamline the reablement function (iii) increase support from voluntary care services for people in own home (iv) influence the self funder market; • In 2017/18 we achieved 92.3% of CGC assessments taking place out of hospital; • £1m capital funding has been invested to deliver front door primary care streaming in A&E; • Specialist mental health teams are based in A&E and work as an all age mental health liaison across the Trust; • As part of the joint TV IUC and NHS 111 mobilisation we ensure that 30% of calls receive a clinical assessment; • In April 2018 the re-commissioned primary care 24/7 service went live. This service is provided by a provider collaborative which includes all the providers across the ICS; • During the winter of 2017/18 we piloted an increase in GP appointments in the Buckingham locality. This will be rolled out across Bucks in 2018; • We have commissioned Airedale to provide nurse practitioner use technology to support care homes in reducing conveyances to A&E.

Section 4: Five Year Forward View - Urgent Care

Our priorities for 18/19:	• Buckinghamshire has many of the urgent care elements identified in the MOU in place however the challenge for 2018/19 is to integrate these elements into a single, seamless service for patients so maximising the benefits; • Deliver the 8 high impact changes to reduce DTOC; • Mobilise urgent care treatment centres; • Integrate primary care 24/7 service with wider teams; • Expand GP appointments – see Primary care slide; • Development and implementation of a Community Care Model; • 24/7 primary care implemented with extended GP access 8am to 8pm; • Expansion of the Directory of Services and clinical triage; • Through collaboration between practices enhance primary care resilience; • Keep patients safe by improving safety of medications, recognition of sepsis, reducing infections and recognition of deterioration of patients.

Section 4: Five Year Forward View – Cancer

ICS cancer ambition	The national cancer strategy is set out in " Achieving World Class Cancer Outcomes : a strategy for England. The delivery of this strategy will be through membership of the Thames Valley Cancer Alliance. The focus of the strategy is threefold • To increase early diagnosis; • Streamline treatment; • Support those living with and beyond cancer.
	The cancer programme interacts with all of the other programmes across the ICS. The Population Health programme will support us in reducing the incidence of preventable cancers through our smoking cessation, obesity and avoiding harmful drinking programmes. The primary care programme, through integration of teams and the focus on proactive care planning will support patients in managing their disease in the community and maximising their wellbeing. The urgent care pathway supports patients who need rapid access to care e.g. immuno compromised patients with sepsis to access prompt treatment so improving recovery rates.

Section 4: Five Year Forward View - Cancer

Outcomes and benefits	• Earlier diagnosis of cancer with more people diagnosed a stage 1 and 2 resulting in better outcomes for individuals; • Delivery of the 62 day pathway resulting in faster access to treatment and better co-ordination of complex care pathways; • Faster identification through screening of those with non-symptomatic disease. *Living with and beyond cancer programme* This programme is funded by Macmillan until March 2019 to develop a local model to support those living with cancer and will ensure: • Easier and more streamlined access to services e.g. pain relief and fatigue; • Supporting people to get back to being active members of the community; • Primary care resilience to deal with projected increases in incidence.
What work is the ICS currently doing?	• Funding has been invested through the Primary Care Quality Incentive Scheme to support primary care in the delivery of quality improvement initiatives to improve screening uptake; • Project to increase the use of e-Referral Service for the 2WW pathways; • Delivery of chemotherapy in community hubs reduces the need to attend hospital. *Living with and beyond cancer programme* The first phase of the programme has been engagement with the public. Consultation with the public began in Oct 2017 and ran until March 2018. This engaged over 117 patients in face to face workshops and used over 64 community venues to give access to those not on line, backed up by an anonymous online survey.

Section 4: Five Year Forward View - Cancer

Our priorities for 18/19:	• Piloting of the 'vague/atypical symptoms' clinic , supported by the TV Cancer Alliance; • Redesign of the urology pathways to improve the 62 day performance; • Speed access to CT on the lung pathway to streamline diagnosis. *Living with and beyond cancer programme* After public consultation with over 300 residents there will be a workshop on the 24 May to co-design the solutions with members of the public. This will then be translated into a delivery plan. Issues identified include integrating services into the ICS directory of services; workforce training plan to support non-cancer specialists in managing cancer and related issues.

Section 4: Five Year Forward View – Primary Care

ICS primary care ambition	Buckinghamshire ICS is committed to delivering the GPFV through local GPs working together in networks which will encourage collaboration between practices, provide a footprint suitable to enable integration with community services, including mental health and social care.
	Our Memorandum of Understanding with NHS England sets out the following ambition; • Unplanned care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance services. • Primary care – deliver improved access by October 2018 and use collaboration between practices to increase primary care resilience, contribute to a proactive, whole population health model of care and improve retention of general practice staff. To achieve this we will develop our 13 clusters of practices to improve their resilience, so enabling them to play a full role in the system. We will support practices by implementing new roles e.g. care navigators and add to our programme of support for care homes by increasing the number of pharmacists in the team. The integrated care slides demonstrate the intention to develop integrated teams, of which general practice will play an essential part.

Section 4: Five Year Forward View - Primary Care

Outcomes and benefits	• Patients will be able to access pre-bookable appointments 8-8 Monday to Friday and at times to suit population needs at the weekend; • Through a more proactive model of care delivered by the integrated teams, reduce the reliance on urgent or unplanned care services; • Make Buckinghamshire an attractive place to work in primary care so increasing GP recruitment and retention.
What work is the ICS currently doing?	• The CCG has procured an integrated 24/7 primary care service from the Provider Collaborative which brings together all the providers (FedBucks, BHT, SCAS, OHFT) under a single umbrella. This will provide the basis for transformation of the service in 2018/19; • Working with KPMG, FedBucks led a piece of work to support practices in thinking through the most effective collaborative footprint for them; • £8.8m capital funding has been allocated to develop primary care estate to support the delivery of improved access and out of hospital care; • Four footprints of 30-50,000 population have been identified to mobilise the first integrated teams.

Section 4: Five Year Forward View - Primary Care

Our priorities for 18/19:	*Health offer* • Improved access to primary care by October 2018; • Mobilise four integrated teams and use the learning to inform the mobilisation of the subsequent teams across the county; • Expansion of the Directory of Services and clinical triage; • Build on the KPMG work to foster collaboration between practices and enhance primary care resilience. • Recruit to care home pharmacists roles and establish a locality based service • Through the care model work identify and develop the services to be delivered through hubs • Facilitate collaboration between practices through the development of cluster working. *Social care offer* • 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 providing access to social care.

Section 4: Five Year Forward View – Mental Health

ICS mental health ambition	The Five Year Forward View for Mental Health sets out the ambition for the transformation of mental health services in England. Central to this is the integration of physical and mental health. We need to deliver better community support for those with severe mental illness including early intervention in psychosis, streamlined access to crisis service and support in the community to self manage before crises arise. For those with common mental health problems we need to expand access to psychological services. . Children and young people and perinatal mental health are priority groups where we need to ensure there is access to early intervention using evidence based treatments.
	Mental health is a cross cutting theme in all our work streams. Population health work stream will support people to maximise their wellbeing and live healthier lives. We need to ensure that those with sever mental illness can access the support they need both on – going and when in crisis. This means that, for instance, our primary care and urgent care work streams need to have a response for the mentally ill hard wired into their offer.

Section 4: Five Year Forward View - Mental Health

Outcomes and Benefits	• Reduced variation and health inequalities across all pathways to improve outcomes and maximise value • Better quality of life and enhanced health and well-being • Fewer crisis that lead to unplanned hospital and institution care • Enhanced experience of care through better coordination and personalisation of health, social care and other services • Improved patient experience • Improvements in staff engagement and retention
What work is the ICS currently doing?	The ICS is committed to partnership working, exploring the use of 3rd sector providers alongside the specialist mental health services. A new 'all age' MH strategy will be developed through 2018/19, based on the FYFVMH but setting the system wide vision for Mental Health services in our ICS. **Children and Young People (CYP)** Our transformation plan was published at the end of October, building on our original model established in October 2015 and more young people have been able to access the service year on year. Our plans for 2018/19 include further development of the training package, by widening access to parents and carers. We are developing a self-help resource, and reviewing the positive behaviour support offer to widen access to this support. The service has active engagement of service users and the voice of the young person continues to be of influence in service developments.

Section 4: Five Year Forward View - Mental Health

What work is the ICS doing?	**Perinatal Mental Health** Perinatal mental health services in Buckinghamshire are delivered by working closely with midwifery / health visiting and psychological therapy services to provide a blended and inclusive approach to service delivery. There are strong links with services in Berkshire (as successful implementers of transformational service change) and Oxfordshire as partners in the BOB STP, with a clear pathway in place developed with people that have lived experience of the condition. **Mental Health Urgent Care** Significant work has taken place to ensure parity of delivery, Buckinghamshire has a liaison mental health service on site at Stoke Mandeville hospital which is now operational 24/7 meaning that people receive expert treatment and support from a mental health professional, this service will continue to develop and be operating at 'CORE 24' standard in line with national ambitions.
Our Priorities for 18/19:	• Development of an overarching mental health strategy across all age groups, to include; • Increase access to evidence-based CAMHS interventions for 32% of young people who met the criteria by the 31 March 2019 in line with National Trajectory . • Continue to implement new care models across the STP for specialist mental health services (forensic, CAMHS and Eating Disorders) to improve quality and reduce out of area placement by one third in this year. • Increase access to perinatal mental health services • Sustain delivery of the core 24 service • Further develop responsive mental health urgent care pathway • Extend access to IAPT services to a stretch target of 19.5% • Implement physical health checks for patients with severe mental health

Section 4: Professional Support Services - Overview

ICS ambition for professional support services	The ICS recognises the essential role that our support services have in enabling delivery of our aim of providing the best services and outcomes for our residents. Through our tailored programmes we will provide the expertise, guidance and tools to support our staff to deliver and, to the residents of Buckinghamshire, to access and manage their care needs.
	The transformation of health and social care systems is a complex programme of change which requires sophisticated methods and techniques for designing and implementing new care models which will deliver coordinated, integrated care. We will work with the market to identify a strategic partner to support us in this work, so increasing our capacity and capability at pace. Each of our support services within the system, (HR/OD, IT, Finance, estates and PMO) has a key role to play in supporting our programme of change and in developing the ICS business model which will underpin it in the future. The purpose of transformation is to support better outcomes and ensure system sustainability so improving the health and quality of life for residents. A focus on professional support services within the system will create the infrastructure, architecture, skills and capabilities which will enable the system to increase its cross organisational efficiency whilst being adaptive to meet the future needs of the population into the next five years and beyond.

Section 4: Professional Support Services - Overview

Our approach to professional support services	• Maximising the use of the public estate to deliver integrated services and the most efficient use of the Bucks pound; • Develop a system wide Programme Management office that is value based, flexible, effective and lean; • Increasing support to professionals across the ICS to enable them to communicate and collaborate more efficiently by aligning our system delivery; • IT interoperability and infrastructure fast track delivery of record sharing to support patient flows and improve outcomes; • Increased effectiveness and efficiency of enabling services provided to the system; • Improving capacity within the community and primary care workforce; • Clinical Leadership and Engagement – tailored programmes to support iidentified leadership values, skills and behaviors within the ICS.
Outcomes and benefits	• Buckinghamshire ICS is an employer of choice encouraging existing workforce to stay and develop their careers whilst attracting new workforce into the health and care system; • Strong clinical engagement and leadership, utilising our clinical expertise to develop new service models; • Improvement in our staff engagement scores; • Implemented interoperability tools and services to improve efficiency, safety and the quality of care delivered across the Bucks ICS, providing the tools required to support integrated teams; • Reduction of the risk associated with providing care without access to full patient records; • Reduced administrative burden and duplication of processes; • Increased programme/project support and oversight across the system ensuring consistent approach; • Dedicated support to develop business cases to ensure return on investment and benefits realisation; • Transform our estate to maximise integration opportunities; • Implement capital investment to improve service delivery and working environment; • Enhance our capacity to meet future demand ; • Increase percentage of estate used for clinical services; • Reduce backlog maintenance and increase opportunities for disposal of unused estate.

Section 4: Professional Support Services – OD/Workforce

What work is the ICS currently doing?	As our most valuable asset our staff and their wellbeing are at the centre of all we do. We engage with our staff and their representatives to ensure we capture their views; to help inform our plans to ensure delivery of the ICS aims and objectives. During the first quarter of 2018 we ran a clinical engagement programme attended by over 160 staff from across 40 organisations in Buckinghamshire. The feedback from the sessions was utilised to develop a clinical leadership strategy and inform the development of the clinical and care community senate. The senate will be a key enabler in the delivery of new models of care and in informing our workforce planning for the future. We have already begun to use an approach to workforce development that considers the existing skill mix and takes different approaches to managing high demand areas such as using paramedics to undertake primary care home visits and support practice based urgent care, clinical pharmacists in primary care and care homes, and GPs supporting community based geriatric day assessment. We are working with strategic partners to develop our workforce plans and in the development of our organisational development strategy to meet the changing needs of our staff and patients.
Our priorities for 18/19:	• Develop and implement a system wide clinical and care community senate to provide clinical leadership and represent the wider "clinical voice"; • Develop and launch leadership programme; supporting current leaders and developing leaders of the future; • Development and implementation of an Organisational Development /Workforce strategy; • Health Education England commissioned specific support for Bucks to model the future state workforce required for BITs. We have started with two clusters and will then apply this learning to the other eleven during 2018/19; • Implementation of new service models to include: integrating the diabetes service across primary, acute and community care; continued roll out of care and support planning for people with long term conditions; developing care co-ordinator and primary care navigator roles; integrated respiratory service across primary, acute and community care.

Section 4: Professional Support Services – Interoperability

What work is the ICS currently doing?	We have an agreed road map for the delivery of IT interoperability across the ICS and STP. There a number of key enablers within the strategy to realise our vision – delivery of population health management and risk stratification to inform our service delivery; shared care records across the system and the introduction of technology to empower patients to more effectively manage long term conditions. As an ICS we recognise the importance of being able to both understand our population health needs at a granular level to inform current service delivery and also the ability to complete predictive modelling of our future population segmentation and changing needs to inform our workforce strategy and models of care in the future. Our investment in digital solutions is supporting delivery of this requirement and will enable us to meet future population health needs. Building on previous work which delivered a real time view of the Primary Care Record across the system, we are now implementing a number of tools/systems including a shared record which will provide access for health and care professionals to the information they need from all the key IT systems used across the ICS to deliver the best possible care. In addition, we are working to deliver person held records (PHR) to support the population in the management of their health and wellbeing and long term conditions with the aim of integrating this with an app to support Patient Self Triage, self-care and direct booking into Primary Care (online consultations).
Our priorities for 18/19:	• Implementation of the Graphnet Care Centric and Care flow systems to deliver shared care record across all care settings • Connecting My Care Record in Buckinghamshire with Connected Care (Berkshire) to serve patients of GP practices in the South of the county accessing services in Berkshire • Wider implementation of the EMIS Clinical Services solution to support integrated teams in accessing the records of their caseload across a defined group of GP practices with real time view of any activity within the registered GP practice and vice versa. • Delivery of national requirements including the roll out of the Electronic Referral Service (ERS) and advice and guidance • Implementation of the MyCare Centric Person Held Record and self triage, self care and direct bookings through the Sensely Ask NHS system.

Section 4: Professional Support Services – Portfolio Management Office

What work is the ICS currently doing?	We are establishing a system-wide shared ICS PMO function to support delivery of ICS priorities and the delivery of the transformation programme. Our initial focus has been on: • Creating a baseline opportunities and benefits assessment to enable the system to advance delivery; • Working with programmes / projects to enable them to rapidly develop and enhance system delivery; • Agree options and approach to support development of the ICS operating model; • Agree the delivery mechanisms that support improved outcomes for our residents. This is an ongoing development process and will continue to improve as we move through the process and lessons learned as well as identify and drive the delivery of outcomes and benefits supporting a better patient experience and ensuring best value for Buckinghamshire pound.
Our priorities for 18/19:	• We will continue to work with our system partners to agree ICS PMO objectives and priorities; • Agree strategy on how to share PMO resource across the system; • Develop and agree ICS PMO portfolio and framework structure across the system; • Develop a streamlined governance process that supports programme delivery and decision making; • Produce programme/project documentation requirements for key programme/projects and priorities; • Review the current project tool (VERTO) and ensure fit for purpose.

Section 4: Professional Support Services – Estates

What work is the ICS currently doing?	The models of care and service delivery we are planning will need a flexible and fit for purpose estate able to efficiently and effectively deliver the new ways of working. As an ICS we actively participate in the Buckinghamshire One Public Estate programme which focuses on opportunities to maximize our public service estate to integrate services and drive efficiency. The ICS is working as part of the STP on an estates workbook to highlight opportunities, use our capital effectively and seek additional investment from NHS and other sources. We have been successful in accessing capital funding through the STP to support our vision for integrated care. £4.2m to transform A&E on the Stoke Mandeville site and £8.8m to develop primary care hubs in the community to bring care closer to home. In addition we are working with our partners in the third sector to ensure that we share resources to provide information, advice and guidance to our population across as wide an estate as possible.
Our priorities for 18/19:	• Full business case and implementation of A&E and primary care hubs schemes; • Continue developing the Bucks One Public Estates programme seeking opportunities for joint working and estates development across the ICS; • Submission of estates workbook and priorities as part of the STP Estates Strategy by July 2018; • Transfer a GP practice onto the Wycombe hospital site next to the Urgent Treatment Centre to enhance patient experience and support integrated care; • Implement in-year plans to integrate services, reduce backlog maintenance, enhance opportunities for disposal and increase the efficiency of our estate.

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SECTION 5

Finance and Activity

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

Section 5: 2017/18 Financial Outturn Position

The 2017/18 ICS system deficit versus control total ("CT") reported is £28.6 million. This is made up of:

- CCG £19.2m (community stock moved out of risk and into FOT)
- BHT £9.4m after receipt of £2.5m of STF from general distribution
- The drivers of this deficit in terms of outturn are shown on the next few slides

	Control total 17/18 £m	Actual 17/18 £m	Variance £m
BHT	6.5	(2.9)	(9.4)
BCCG	0.1	(19.1)	(19.2)
2017/18 actual control total	6.6	(22.0)	(28.6)

The ICS underlying deficit exiting 2017/18 is £38.6 million (CCG £32.6m & Trust £6.0m).

Section 5: BHT variance to control total – key drivers

	BHT £m	BHT £m
BHT 17/18 control total		6.5
STF not earned		(5.9)
CIP delivery shortfall		(4.6)
Gross over performance on Buckinghamshire CCGs of £13.0m at assumed margin of 20%	2.6	
MRET above plan / contract assumption	(1.6)	
Risk share per the contract	(1.4)	
Loss on additional activity		**(0.4)**
Under performance of £2m on other contracts at assumed margin of 20%		0.4
Non recurrent costs of £2.0m less contingency in plan of £2.0m		-
Premium costs of temporary staffing (M9 extrapolated)		(2.1)
Other mitigations delivered by the Trust		2.1
2017/18 forecast outturn reported at month 9		**(3.2)**
Elective cancellation and loss of spinal income		(1.2)
Additional MRET and contractual risk share		(0.4)
Escalation costs		(0.5)
Backlog remediation costs		(0.4)
PFI legacy costs		(0.6)
Year end adjustments		0.7
STF General distribution		2.5
2017/18 outturn		**(2.9)**

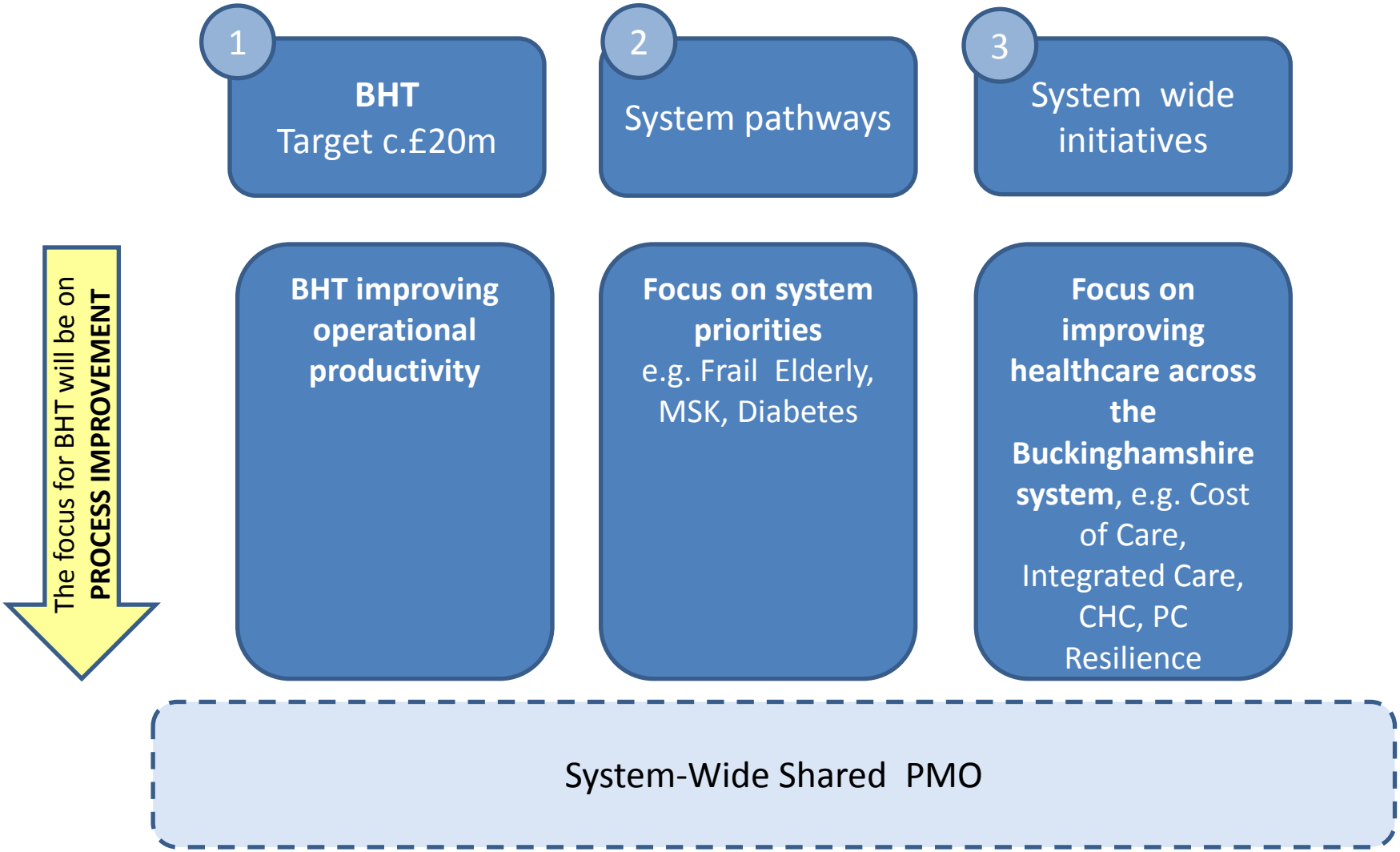
Section 5: CCG variance to control total – key drivers

CCG outturn is £19.1m deficit (which is £19.2m variance to CT).
The 5 main reasons are:

Buckinghamshire CCGs Month 11 FOT Main Variances			
Ref		**£m**	**£m**
1	Plan and Unscheduled Care-main contracts	17.4	
2	Plan and Unscheduled Care-other	4.5	
	Sub total	21.9	
3	CHC	11.5	
4	Prescribing	2.1	
5	Joint Care	2.0	
	Sub total		37.5
	Reserves/Recovery Plan/Other	18.3	
	Sub Total Mitigations		18.3
	Movement		19.2

Section 5: Finance and Activity – System approach to Financial Recovery

The focus in 2018/19 will be on improving BHT operational productivity (1), joint working to deliver system Financial Recovery Plan ("FRP") (2) and (3).



Section 5: 2018/19 Financial Sustainability

An aligned system approach is required to recover a sustainable position and the ICS will explore a:

- jointly owned demand and activity plan, based on population forecasts and recent experience;
- jointly owned transformation and service plan that can handle the activity forecast;
- jointly owned capacity plans for primary care, community care and acute services;
- joint system-wide management of activity.

In 2018/19 the system will work to the following financial governance principles:

- Review all discretionary spend and investments;
- Mandatory requirements will be subject to robust business case and outcomes based decision making;
- Review headcount and vacancies ensuring appropriate to business need;
- Review and implement NHS England's investment decisions guidance;
- Support repatriation of out of county activity to Buckinghamshire Healthcare NHS Trust whilst ensuring patient choice.

Section 5: Consolidated ICS financial position for 2018/19 plan

The ICS is planning a two year recovery trajectory to achieve its system control total.
For 2018/19 it is looking to recover the deficit to a position of £17.5 million (from an underlying deficit exiting 2017/18 of £38.6 million)

		17/18 Plan £m	17/18 Actual £m	18/19 Plan £m
CCG	Income Expenditure Deficit	680.4 (680.4) 0.0	684.1 (703.2) (19.1)	694.3 (709.8) (15.5)
Trust	Income Expenditure Deficit	398.9 (401.0) (2.1)	412.6 (399.1) (2.9)	410.0 (412.0) (2.0)
ICS	Deficit excluding Provider STF of £11.9m	(2.1)	(22.0)	(17.5)

Section 5: Savings required to deliver an £17.5m ICS deficit in 2018/19

	£m	£m
CCG allocation		694.3
BHT income per 8th March submission (to be updated for final planning submission) - NB excludes 24/7 income of £7.0m	423.6	
Less BHT income from Buckinghamshire CCG - NB excludes 24/7 income of £7.0m	(253.1)	
BHT external income		170.5
Total Buckinghamshire ICS income		**864.8**
8th March planning submission ICS savings requirements BHT CCG Total		 20.0 21.4 41.4
Savings as a percentage of total income		4.8%

Note: Demand Management savings of £41.4m across the ICS (4.8%)

Section 5: Combined savings plan for the partners within the ICS

	£m
CHC	7.2
Urgent and emergency care demand	3.4
Elective	1.5
Acute Operational Productivity Model Hospital specialties Back office Estates and Facilities Procurement Other	 11.0 1.9 2.5 0.8 1.9
ICS Prescribing (including BHT prescribing)	2.5
Contract management, budgetary control measures, holding investments	8.7
Total	£41.4

Section 5: Description of how the combined savings plan will be delivered

Work with ICS system partners to deliver integration of services to increase efficiency and reduce level of cost /activity across the system to cover:

- Integration and transformation of urgent and emergency care services to increase utilisation of existing capacity and reduce demand for hospital acute care (A&E, GP streaming, 24/7);
- Integration and transformation of primary and community care to build capacity and provide care closer to home;
- Work with GPs to reduce clinical variation in planned care through clinical pathways in areas such as diabetes, MSK and Long Term Conditions linked to Rightcare and GIRFT;
- Collaborative work between BCCG Medicines Management and BHT Pharmacy to reduce prescribing spend;
- Strengthen control over authorisation of NHS CHC expenditure in line with eligibility criteria and review historic cases and work with BCC as a system to manage CHC market;
- Identify efficiency opportunities from changes to system ways of working to reduce running costs;
- BHT to deliver efficiencies and cash savings from the transformation above.

BHT to identify and BCCG to facilitate opportunities to repatriate BCCG activity from out of county and / or increase market share from out of county CCGs.

Section 5: Finance and Activity – Improve BHT Operational Productivity

Improve BHT **Operational Productivity** as measured through the Model Hospital

- Delivery of 2018/19 cost improvement plan of £20m;
- Demonstrate clinical productivity improvements through adoption of best practice and reducing clinical variation through GIRFT;
- Deliver efficiencies across the procurement and back office functions, pharmacy and pathology services;
- Deliver benefits in the wholly owned subsidiary pharmacy business case;
- Deliver progress on hospital optimisation of medicines and transition to use of biosimilars;
- Deliver cost effective estates management, human resources and finance functions as evidenced through benchmarking;
- Deliver reduction in estates and facilities running costs;
- Delivery of cost improvements and control surplus to allow repayment of Trust borrowings.

Section 5: Finance and Activity – Capital Plan

Deliver **Capital** plan that reduces system backlog and invests in our clinical estate

- Manage risk in capital backlog (Medical equipment, IT and estates);
- Develop strategy for investment in estates backlog work;
- Secure access to NHSI/NHSE additional capital funding for digital transformation (Global Digital Exemplar, e- prescribing, GS1);
- Drive IT Interoperability with Buckinghamshire CCG ("BCCG") through Careflow implementation;
- Implement E-Observation system funded by BHT Charitable Funds across all wards by end of March 2019;
- Outline Business Case ("OBC") Primary Care hubs development to be approved by BCCG Governing Body in June 2018;
- Outline Business Case for A&E Phase 2 development of £4.2m to be approved by BHT Board in March 2018to implement prior to 2018/19 winter.

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SECTION 6

Closing Statement

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

Section 6: Closing Statement

1 We aim to deliver improvements in the quality and value for money of care we provide, working to deliver the national priorities and our three core programmes and six enablers:

National Priorities

Primary Care
Urgent and Emergency Care
Mental Health
Cancer

ICS Pillars

Population Health
Integrated Care
Five Year Forward View (FYFV)

Professional Support Services

IT Interoperability
OD/Workforce
One Estate
System wide-PMO
Communication and Engagement
Finance

2 Change needs to happen as close to people as possible, putting the person at the centre of what we do. This is why local relationships are the basis of our plans; moving from traditional cultures to embracing a transformational system approach, where we help each other to better deliver continuous improvement;

3 Community Service Hubs will bring social, physical and mental health care closer together and local health and care partnerships will come together to deliver care where council and NHS commissioners plan and pay for services together;

4 

We are committed to meaningful conversations with staff and communities and we will continue to engage people in the design, development and delivery of our plans;

5 Housing, employment and access to green spaces can have the biggest impact on health. Local government has a key role to play and health research is helping us to target those people at risk.

Section 6: Closing Statement

6

We must balance the social, physical, and mental health care against a financial deficit while meeting operational needs creating long term sustainability and maintaining investment in people.

7

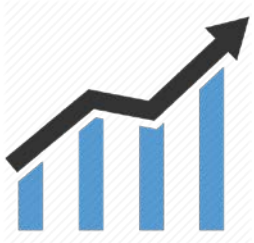
We will invest in the development and skills of our workforce to enable them to provide the best possible care. We have produced a plan to achieve this which also covers recruitment and retention.

8

The financial challenge we face is the biggest in a generation. Our response is around getting the best value from every Buckinghamshire pound. We will also be very open about the choices we have to make to live within our means.

9

Over the past twelve months our partnership has made major strides towards working together to improve social, physical and mental health care



10

What will this all mean:

Buckinghamshire people supported to live independently

Care integrated locally to provide a better support closer to home

If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs.

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

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SECTION 7

System Partners

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

Section 7 : System Partner Transformation

The ICS Integrated Operations Plan consolidates the transformation and operations plans from across the system. These plans are referenced below:

Section 7 : Glossary of Terms

Buckinghamshire Integrated Teams is a team of health and care professionals working together transforming, integrating and improving care services and support.

Business Intelligence comprises of the strategies and technologies used by industry for data analysis or business information. Business Intelligence technologies provide historical, current and predictive views of business operations.

CareCentric is a clinical portal which opens up the electronic health record to authorised users on smartphones and tablets. It gives care professionals access to patient data wherever they need it, whether at various locations within a hospital or GP practice, at other hospitals, in the community or at home.

Careflow is a communication platform available on any mobile or web device delivering faster clinical communication, better collaboration and safer care.

Clinician is someone whose prime function is to manage a sick person with the purpose of alleviating the total effect of the persons illness.

Commissioning is the process of procuring health services. It is a complex process, involving the assessment and understanding of a population's health needs, the planning of services to meet those needs and securing services on a limited budget, then monitoring the services procured.

Continuing Healthcare is the name given to a package of continuing care which is, arranged and funded solely by the NHS, for people with ongoing healthcare needs who meet the national NHS continuing healthcare eligibility criteria.

Section 7 : Glossary of Terms

Egton Medical Information Systems (EMIS) supplies patient electronic records and software**.**

Frailty is related to the ageing process, that is, simply getting older. It describes how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment. In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care.

Integrated Care also known as integrated health, coordinated care, comprehensive care, seamless care, or transmural care, is a worldwide trend in health care reforms and new organisational arrangements focusing on more coordinated and integrated forms of care provision.

Interventions is an effort that promotes behaviour that improves mental and physical health, or discourages or reframes those with health risks, as part of a public health promotion program.

Memorandum of Understanding is an agreement between two (bilateral) or more (multilateral) parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

Person Held Record is a health record where health data and information related to the care of a patient is maintained by the patient.

Planned Care are health services and treatments that are not as a consequence of a health accident or emergency. This type of care is arranged in advance and, generally, follows a referral from a GP.

Section 7 : Glossary of Terms

Population Health is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes.

Population Segmentation is based on identifying segments of the population whose needs could be better met in delivering benefit against the quadruple aim. Often this will initially be based on a presenting problem, e.g. fall, but behind the presenting problem will be a more complex set of health and well-being needs that need to be more fully understood to enable better care and support models to be developed and delivered.

Reablement is the service usually provided to people for up to six weeks to encourage them to achieve their goals and to be as independent as they can be.

Social Prescribing sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.