Integrated Care Systems and One Herefordshire

Integrated Primary and Community Services

Herefordshire Health and Wellbeing Board

October 2019

The NHS Long Term Plan

Main themes -

1. ‘Local NHS organisations will increasingly focus on population health and reduction of inequalities, moving to Integrated Care Systems everywhere’

2. ‘People will get more control over their own health and personalised care when they need it’

3. ‘Digitally-enabled primary and outpatient care will go mainstream across the NHS’ – avoiding a third of face to face outpatient appts within 5 years

4. ‘A new service model for the 21st Century’ – breaking down the divide between primary and community services and reducing pressure on emergency hospital services’

5. Changes for General Practice - Primary Care Networks (PCNs) for 30-50k population – working with other providers at locality level

NHS Action on Prevention

- ‘the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+’
- New targeted NHS funded smoking cessation offer
- ‘hospitals with the highest rate of alcohol dependence-related admissions will be supported to establish Alcohol Care Teams’
- Reduce the NHS carbon footprint by 20% with less travelling
- Mental health ambulance transport vehicles that reduce inappropriate conveyance

Integrated Care Systems (ICSs)

- Evolution of STPs - ICSs to cover the whole country by April 2021

  'Commissioners will make shared decisions with providers on how to use resources, design services and improve population health'

- Streamlined commissioning arrangements:

  - typically involving a single CCG for each ICS/STP area
  - CCGs will become leaner, more strategic organisation
  - CCGs will support providers to partner with local government and other organisations on population health, inequalities and service redesign.

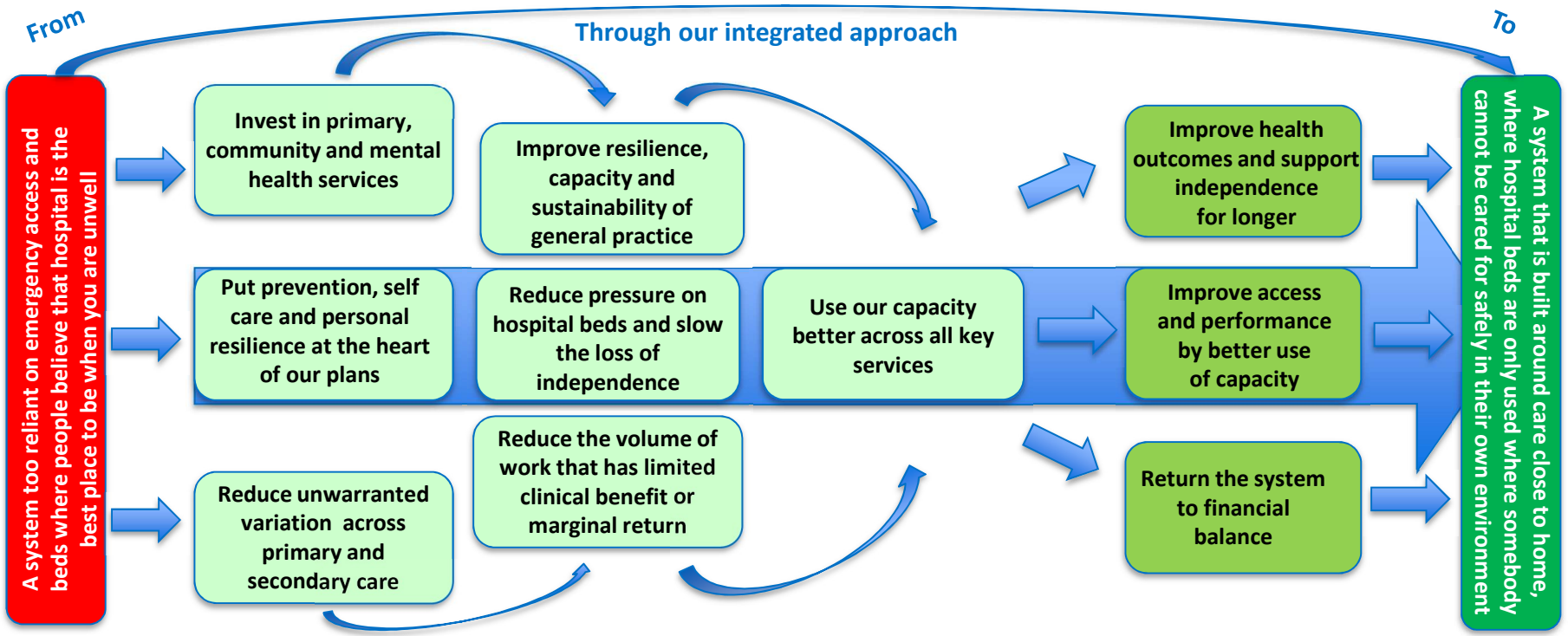
- Funding flows and contract reform will support the move to ICSs

  - Local alliance contracts or giving one provider lead responsibility

- Full review of the Better Care Fund concluding in early 2019

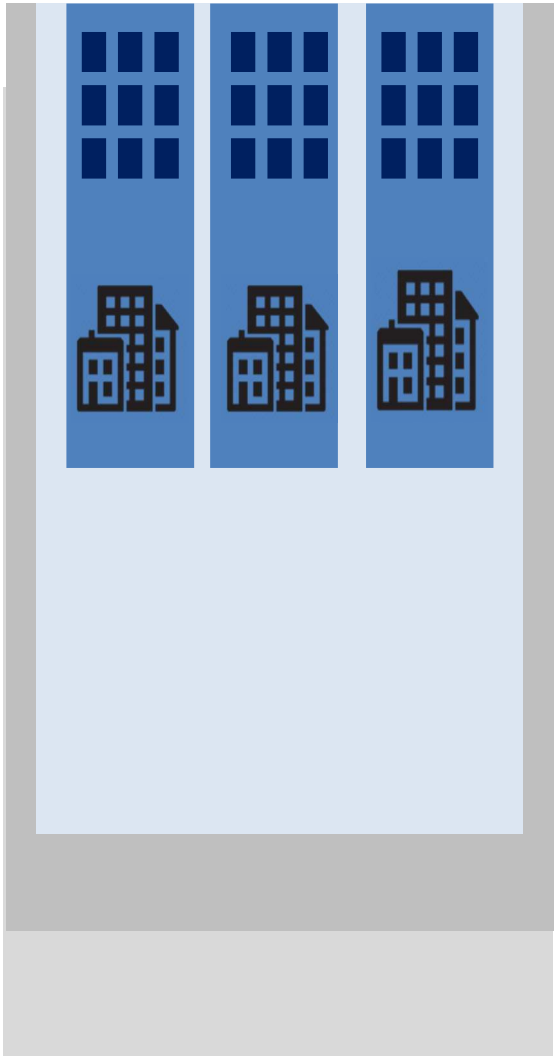
H&W STP Vision

"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people"



Herefordshire and Worcestershire Safe and effective health and care services

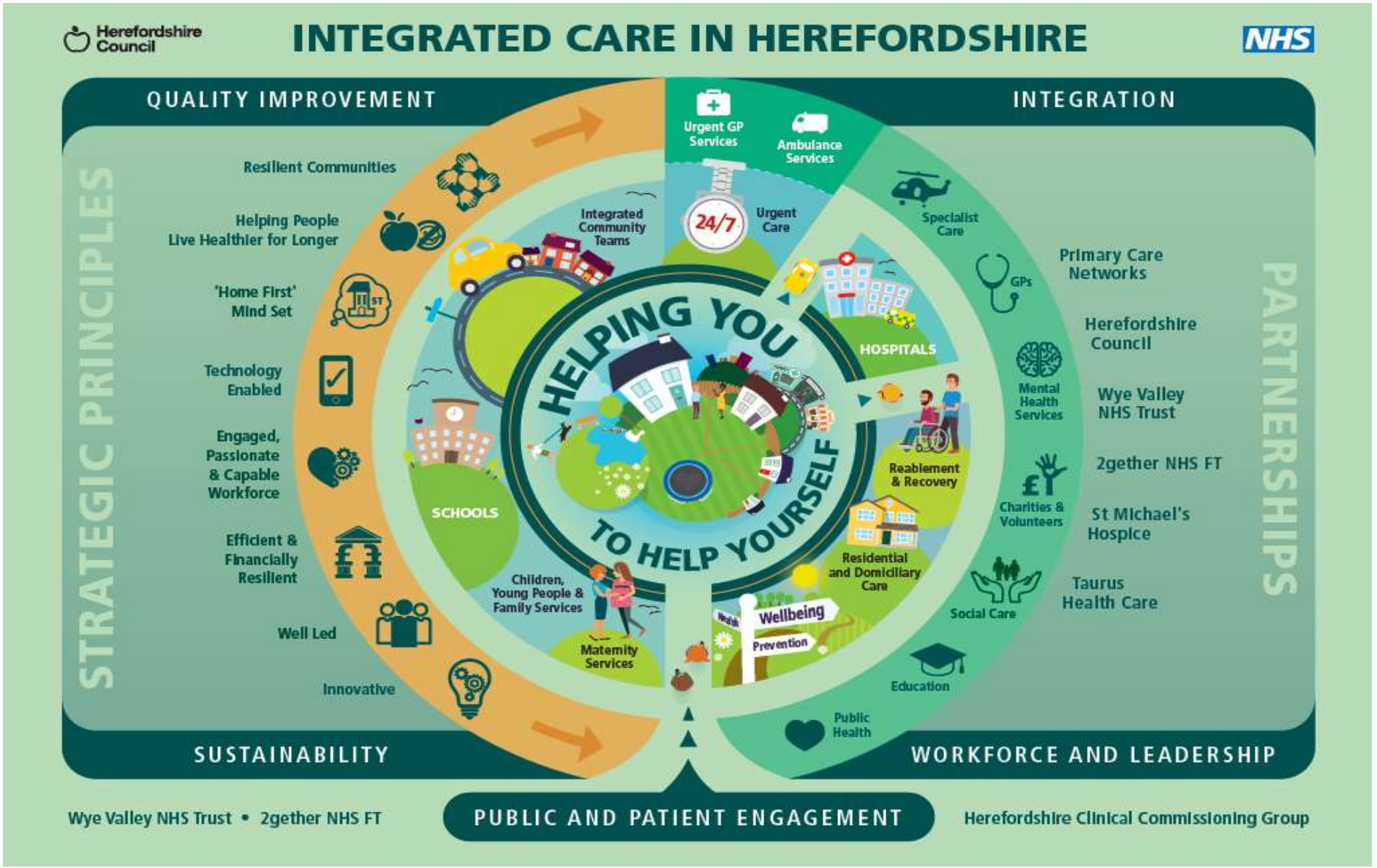
(Work In Progress)
The Tiers in an ICS



Neighbourhood (PCN) **~50k**	• Integrated multi-disciplinary teams • Strengthened primary care through PCNs – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).
Place **~250k**	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out of hospital care around specialties and for hospital discharge and admission avoidance
System-wide **~1m**	• System strategy & planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system; to reduce unwarranted variation in care / outcomes

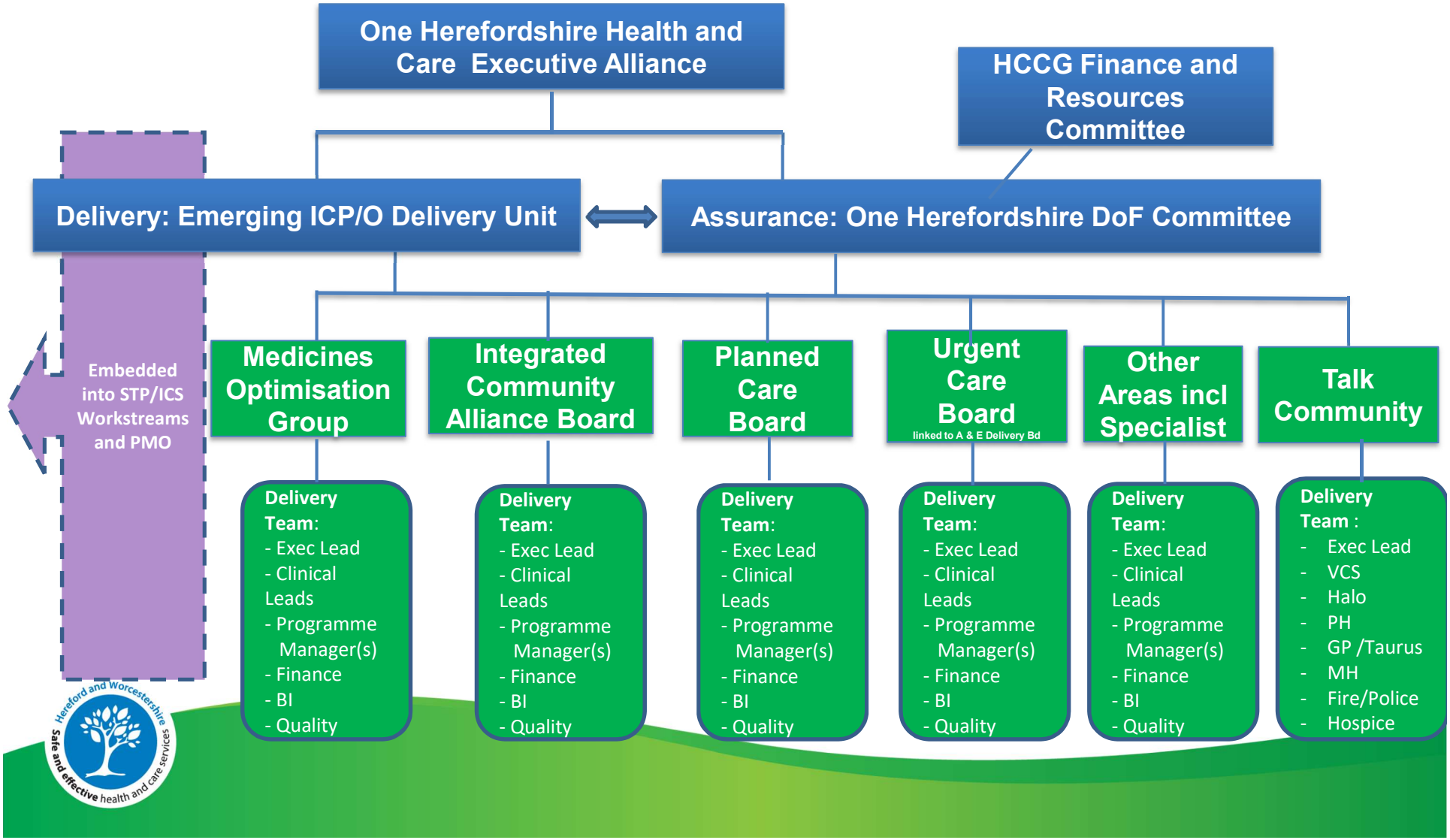
One Herefordshire

- Our ‘Place Based’ Integration Plan – within the Herefordshire and Worcestershire ICS
- Herefordshire Partners ‘Whole System Plan’
- Functional Integration:
  - Integrating at the point of delivery
  - Looking for shared efficiencies
  - Not about Shifting Risk
- This is a 5 Year Plan



Hereford and Worcestershire
Safe and effective health and care services

2019/20 Delivery and Assurance



Focus Session

A focus on the work of:

- *Talk Community*
- *Integrated primary and community services*

Talk Community Key Programmes

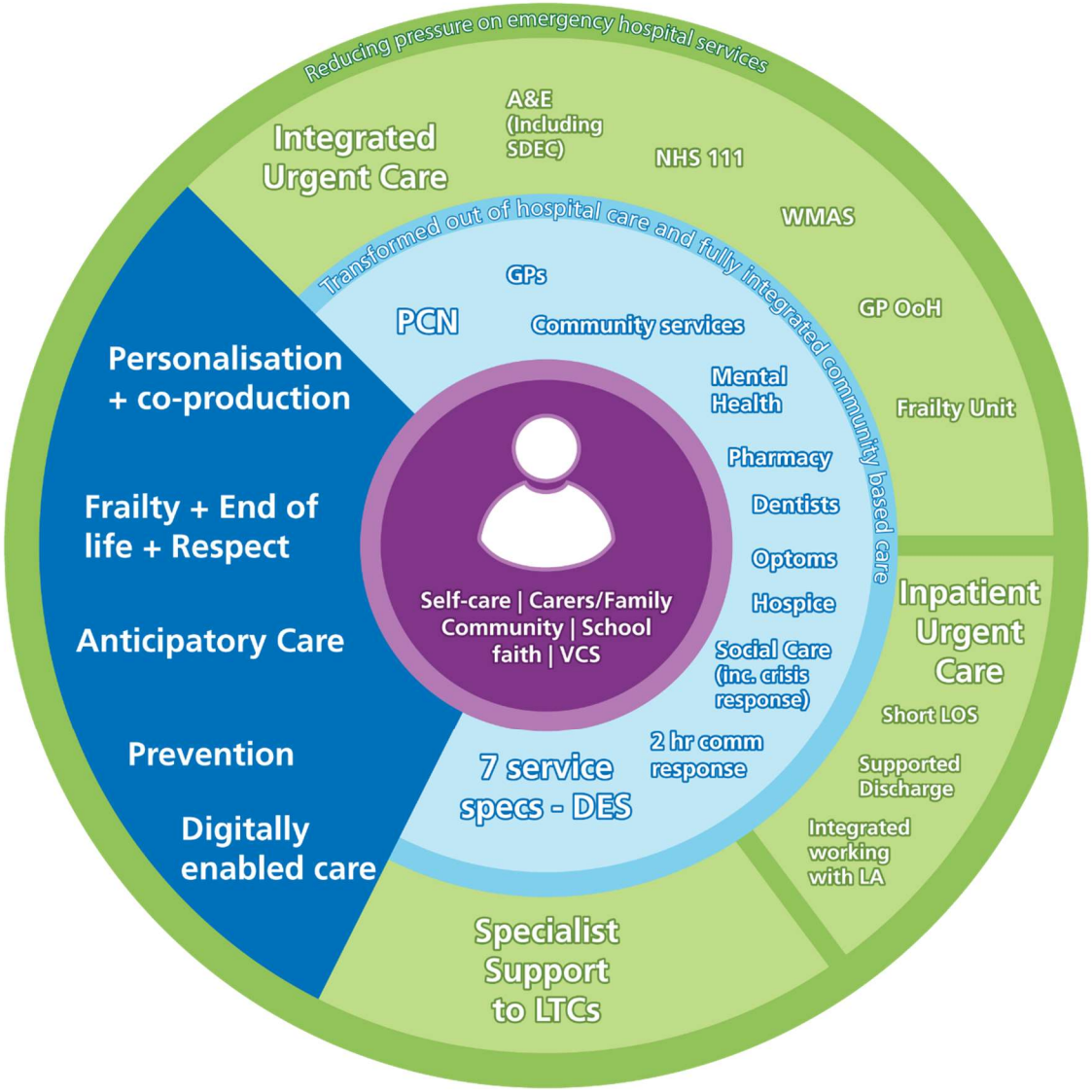
Talk Community will be implemented through detailed plans in six key areas;

- ❑ Talk Community Hubs
- ❑ The Commissioning approach
- ❑ Talk Community Business
- ❑ Talk Community Safety & Cohesion
- ❑ Talk Community public health
- ❑ Operational developments

Integrated Care Alliance Board Work Plan

Project	Lead Organisation
Development of locality Management Teams	Taurus/WVT
Development Support	Taurus
Primary Care Network Development	Taurus
Integrated HF team	Herefordshire Council
Integrated Out of Hours	WVT/Taurus
Integrated Discharge team	Herefordshire Council
High Intensity User	System approach
End of Life dementia pathway	CCG
Discharge to assess	Herefordshire Council
Integrated Psychological therapies	CCG
Community bed right sizing	CCG
BI and KPI	Taurus and system approach

To Deliver the Vision of Our STP Long Term Plan Submission



Delivering Our Commitment to Transform Out of Hospital Care and Fully Integrated Community Based Care, Reducing Pressure on Emergency Care

Our system commitment to	Outcomes we will deliver
Support people to age well by delivering integrated end to end pathways focused on anticipatory care to keep people well in their own home focusing on supporting frail and/or older people and those at the end of life	Functional integration with acute services and VCS Implementation of ReSPECT Delivery of ICOPE Strategy (Worcs) and replicate into H'fordshire
Increase the use of population health management to develop anticipatory care for targeted population cohorts	Reduce inequalities in access and reduce unwarranted variation Proactive care planning ensuring timely interventions
Deliver digitally enabled care and self care using a shared care record and information	Enhance the ability for individuals to take control of their care Facilitate rapid decision making to reduce acute admission
Delivery of a comprehensive high quality systemwide approach to frailty	Improved decision making for patients living with frailty Consistent approach in use of Rockwood Frailty Scoring tool
Delivering improved crisis response in the community within 2 hours and reablement care within 2 days	Reduction in emergency attendances and admissions Care closer to home
Delivering personalisation of care for patients with long term conditions empowering self-care by providing timely access to primary and secondary support in times of crisis	Improved access to services and delivery of right care at the right time. People feel better able to self-care and are supported to do so
Support for people living in care homes	Delivery of the 'Enhanced health in care homes'
Offering simplified access to healthcare providing alternatives to A&E	The public will have a better understanding of services available and when to access.
Focussing on rehabilitating the patients in the community and avoiding readmission supporting patients on discharge from hospital	Reduction in hospital re-admissions; patients feeling supported post discharge.
Give carers greater recognition and support	Identification of care status by primary care , Adoption of carers passports , Identification of carers and carers need in anticipatory care plans
Increase the provision of care in peoples homes	More people cared for in their place of residence
Support early discharge from hospital	Cross organisational working between system partners
Building capacity and workforce to deliver	Greater retention of staff and less reliance of agency

General Practice and PCN Development

By 2024 General Practice will:

Sustainable and comprehensive general practice through the commissioning of PCNs as the building block of integrated care will have become a proven platform for further local NHS investment. PCNs will systematically have delivered new services to implement the Long Term Plan and achieved clear, positive and quantified impacts for people, patients and the wider NHS. Our delivery model to achieve this is set out in our 5 year Primary Care Strategy .

Priorities:

- Sustainable general practice practices, working collectively within PCNs and through them with partners across health and care and the voluntary and community sector
- Implementation of the PCN DES 7 specifications by building on work already taking place
- PCNs to have formed clear and agreed multi-disciplinary teams with community provider partners and wider stakeholders
- Workforce & leadership development within and across PCNs, for clinical & non-clinical staff
- Improve quality, reduce unwarranted variation across the STP
- Ensure consistent, equitable, high quality services to patients and the public
- Remove the historic divide between Primary and Community Services
- Continued investment in general practice through local funding streams aligned to the PCN.
- Digital solutions to support the future model of care
- Consistent approach to development of Estate
- Consistent approaches to commissioning across the STP, equity of investment, supporting quality improvement as well as sustainability and efficiency

Provider and Commissioner Commitments:

There has been a collaborative approach to developing delivery plans across the STP working with the Local Medical Committee, GP federations, practices, patients and the public to ensure how we transform primary care services to meet the health needs of the population we serve. The establishment of a STP GP Provider Board will enhance these on-going conversations as the Strategy develops.

Unwarranted Variation and health inequalities:

- High numbers of older people living in poor health
- Premature mortality rates vary significantly between the two counties
- Men and women in contact with mental health services have a lower life expectancy than the rest of the population
- Addressing unwarranted variation in relation to referrals to acute care, prescribing, dementia diagnosis rate

Prevention:

- Commitment to radically scaling up prevention activities across all our health and care interactions with the population

PCNs will be key delivery mechanisms for:

- Immunisation and vaccination
- Identification, case finding and management of CVD risk factors
- Identification and case finding for National Diabetes Prevention programme
- Identification and case finding for smoking cessation and pulmonary rehabilitation
- Maintaining low-levels of antimicrobial prescribing in line with national targets

Workforce requirements:

Having access to a skilled workforce is the biggest challenge we face. To address this we will:

- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity
- Deliver STP workforce plan across 4 themes:
  - Developing a sufficient supply of highly skilled staff
  - Enabling up-skilling of the current workforce
  - Developing and promoting new roles
- Supporting pharmacy staff to take on increased patient facing roles
  - Developing and promoting new ways of working

Investment: £19.651m
Targeted Investment: £5.399m

Financial Recovery:

- Reducing pressure on secondary care through a reduction in non-elective admissions
- Reducing variation in referral rates and primary care prescribing

Personalised Care:

Shared decision making embedded within anticipatory care planning and roll out of RESPECT tool

Self management plans for people with Long Term Conditions

Digital:

- Delivery of on-line consultation offer in each practice by April 2020
- Delivery of a video consultation offer to all patients by April 2021
- Uptake of NHS App
- Offering all patients access to the Electronic Prescribing Service

General Practice and PCN Development

Timeline:

Milestone	Expected outcomes (LTP headline metrics included where available)	How we will achieve this	Delivery expected (Quarter)				
			19/20	20/21	21/22	22/23	23/24
Meeting the new funding guarantees for primary medical services and community health services;	Delivery of outcomes set out in the Primary Care Strategy	Commissioning the 7 new national service specifications		x			
Creating a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking into account of the national phasing of the new 5-year GP contract	Delivery of outcomes set out in the Primary Care Strategy	Through delivery of the service improvements set out in the Primary Care Strategy and the GP contract framework	x	x	x	x	x
Support provided for PCN development		Funding released to ICS/STPs	x				
		Funding parameters agreed. National PCN development prospectus shared	x				
		ICS/STPs support PCNs in self assessment, identifying areas of initial focus and potential support needs, focus on service improvement area i.e. new national services	x				
		ICS/STPs collate support needs and put together system plan for PCN development - General Practice Transformation Board via PCN Development Sub Group	x				
		Systems and CCGs support PCNs to review progress against PCN priorities	x				
Delivery of: i) on-line consultation offer in each practice by April 2020 ii) a video consultation offer to all patients by April 2021 iii) Electronic prescribing service (EPS) and Electronic repeat dispensing eRD)	On-line consultations available in each practice by April 2020. Video consultation to all patients by April 2021 All practices to offer EPS and eRD from April 2019	Single GP on-line consultations programme in place across H&W	x				
		Evaluation of on-line consultations pilots	x				
		Testing and trialling of NHS App	x				
		H&W Wellbeing platforms enhanced		x			
		Common framework for Technology Enabled Care Services and pilot plan			x		

Integrated Primary and Community Services

Delivering our Vision

Priorities:
Work in partnership with General Practice to develop our PCNs to deliver integrated primary and community (health and mental health) services, with functionally aligned social care. This will embed:

- Personalisation and support for self-care
- Anticipatory care – for frail and/or older people and those at the end of life
- Enhanced health in care homes
- A 2 hour crisis response and reablement within 2 days
- Cross organisational working to support early discharge
- Population health management to drive service improvements and a shift to anticipatory care for targeted population cohorts
- Digitally enabled care and self-care, including shared records and information
- Improved Long Term Condition management, including self-management
- In partnership with general practice deliver the 7 service specifications from April 2020.
- Community service redesign to ensure service delivery at or close to home.
- Develop specifications to meet integrated care needs.
- Parity of esteem

Functionally integrating with acute services and the VCS as part of end to end pathways focused on anticipatory care and domiciliary based provision to keep people well in their own home, focused on:

- Frail and/or older people
- Those at the end of life

Redesigning bed based services to support people in their own homes whenever possible

Provider and Commissioner Commitments:

- To deliver the funding guarantee
- Support to PCN development – including alignment of community resources to PCNs and delegated decision making
- Acute support/out-reach to PCNs, underpinned by education, communication and shared information

Performance & metrics:

- Percentage of NHS revenue spent on primary and community services
- PCN access measure, to include access to online/telephone GP appointments
- GP workforce measures
- Impact on UEC system – A&E attendances and NEL admissions
- Reduced elective referrals
- Awaited national health inequalities measures by PCN
- Proportion of people who report being supported to manage their own condition
- Healthy life expectancy

Unwarranted Variation:
We will utilise our PHM approach to address unwarranted variation across PCNs in:

- NEL admissions and A&E rates
- Diagnostic use
- Referrals into secondary care
- Dementia diagnoses rates
- IAPT access
- Prescribing practice Frailty Diagnosis Rates - Advance Care Planning and Anticipatory Prescribing

Prevention:
PCNs and associated services will be key delivery mechanisms for:

- Immunisation and vaccination
- Identification, case finding and management of CVD risk factors
- Identification and case finding for National Diabetes Prevention programme
- Identification and case finding for smoking cessation and pulmonary rehabilitation
- Focus on High intensity users and carer identification
- Ageing Well Agenda - to prevent reduce or delay the onset of frailty

Workforce requirements:
GP Forward View delivery
Provider input – to be confirmed through templates based on capacity modelling
Carter report recommendations:
E-rostering, mobile working, dynamic scheduling
Impact on staff re. personalised care agenda
Address the vacancy gap in primary/community providers

Ageing Well investment over the 5-year period: £8.616m

Financial Recovery:
Finance to confirm – based on:

- impact on A&E and non-elective admissions
- Community bed redesign in Herefordshire

Personalised Care:

- Shared decision making embedded within anticipatory care planning and roll out of ReSPECT tool
- Self management plans for people with Long Term Conditions
- A frailty-sensitive approach to care

Digital:

- NHS app
- GP practice telephone/online consultations
- Shared records and information
- Data sharing to enable full delivery of Population Health Management approach

The Four Strategic Priorities for Integrated Primary and Community Services

Deliverable	Expected outcomes	Milestones (How we will achieve this)	Timeline				
			19/20	20/21	21/22	22/23	23/24
Delivery of an improved crisis response within two hours, and reablement care within two days	1. Reduced conveyance by Ambulance to Acute Care 2. Reduced A&E attendances and NEL admissions 3. Improved outcomes for patients – with reduced Hospital Acquired Functional Decline (HAFD)	**Baseline and Planning** Map existing provision across health, mental health and reablement services Specification for new service agreed – including acceptance/exclusion criteria, outcomes, KPIs Demand and capacity modelling for new service – linked to community bed redesign Operational planning including skill mix, competency and workforce development	X				
		PDSA Test and learn cycles to refine clinical model and pathway, and understand impact and risks Commences end of 2019/early 2020 linked to community bed redesign	X	X			
		Full Implementation – and Ongoing Refinement Service in place across the STP Ongoing evaluation and refinement of the model			X	X	
Delivery of the new national Anticipatory Care service in conjunction with PCNs providing 'anticipatory care' jointly with primary care (joint enterprise with GP practices as part of PCN delivery), to the following cohorts: • those living with moderate and severe frailty • those recognised as approaching the end of their lives	1. Reduced inappropriate conveyance by Ambulance to Acute Care 2. Reduced inappropriate A&E attendances and NEL admissions 3. Improved outcomes for patients – with reduced NEL admissions resulting in reduced Hospital Acquired Functional Decline (HAFD) 4. Increased achievement of death in preferred place of death	**Identification and management of frailty** using the Rockwood tool : • In 2019/20 by PCNs through local GP contracting arrangements (Primary care Excellence) • Anticipated to be in national PCN service specification in 2020 onwards • Use of CGA in proactive assessment with patient preferences guiding reactive response	X	X			
		MDT working between PCNs, community services (health and mental health) and social care, to identify and support • In 2019/20 through local GP contracting arrangements (Primary care Excellence) • Anticipated to be in national PCN service specification in 2020 onwards • Supported by regional PHM support offer • Identify other resources to support (e.g. housing)	X	X			
		Roll out of RESPECT tool: • Across PCNs and community services 2019 • Across acute providers – 2019 in Herefordshire, 2020 Worcestershire • Supported by training of General Practice, community services, care home providers, WMAS, acute providers and social care	X	X			
		Support PCNs to deliver **National Service Specification** • Understand requirements of national service specification • Engage with PCNs to agree operational delivery model • Develop implementation plan • Commence from 2020	X	X			
Supporting PCNs in the delivery of the new Enhanced Health in Care Homes	1. Reduced conveyance by Ambulance to Acute Care 2. Reduced A&E attendances and NEL admissions 3. Improved outcomes for patients – with reduced Hospital Acquired Functional Decline (HAFD)	**Baseline and Planning** • Care home engagement • Mapping of care homes to PCNs • Mapping of existing initiatives • Mapping of care home development needs against existing initiatives and national PCN service specification • Agree operational model incorporating national PCN specification– including co-ordination with local authority care home oversight	X				
		Implementation • Develop workforce plan • Develop implementation plans • Run test and learn cycles and review impacts, share best practice and grow impact		X			
		Final model in place • Implementation			X		

The Four Strategic Priorities for Integrated Primary and Community Services

Timeline:

Deliverable	Expected outcomes (LTP headline metrics included where available)	How we will achieve this	Delivery expected (Quarter)				
			19/20	20/21	21/22	22/23	23/24
(iv) building capacity and workforce to do these three things, including by implementing the Carter report and using digital innovation	1. Increased recruitment 2. Increased retention 3. Resilient and upskilled workforce – able to deliver LTP requirements 4. Improved productivity	**STP Peoples Strategy** • Draft strategy in place – to be updated following publication of national strategy with clear delivery plans by programme (cross-organisational) • Detailing new roles, competency frameworks and cross-organisation approaches to recruitment, retention and staff development	X				
		Develop New Workforce model and culture • Generate baseline of current work force – capacity and competencies against new service requirements • Consider new roles and competencies to release other time or fill hard to recruit roles • Understand linkages to PCN (GP) workforce development • Develop OD plan – including cross organisational posts and training/education requirements • Commence recruitment	X				
		Implementation • Back office approaches to employment, training, supervision, staff development, recruitment and retention. • Commence test cycles for new ways of recruiting and employing staff.		X			
		Implement Carter Report • Digitally supported mobile working in place • Shared records and information across primary are and community services – in place from November 2019 • E-rostering – to be implemented in 2020	X	X			
		Training and Education in Frailty • Development of training modules Tier 1 2 and 3 of Core Capabilities framework – WhIN and university of Worcester					

Questions?