NHS
Oxfordshire
Clinical Commissioning Group

Overall strategy for health and social care

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Oxfordshire Clinical Commissioning Group

Board Workshop

10 February 2015

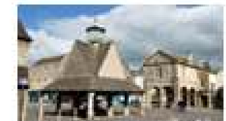
North

North East

Oxford City

South East

South West

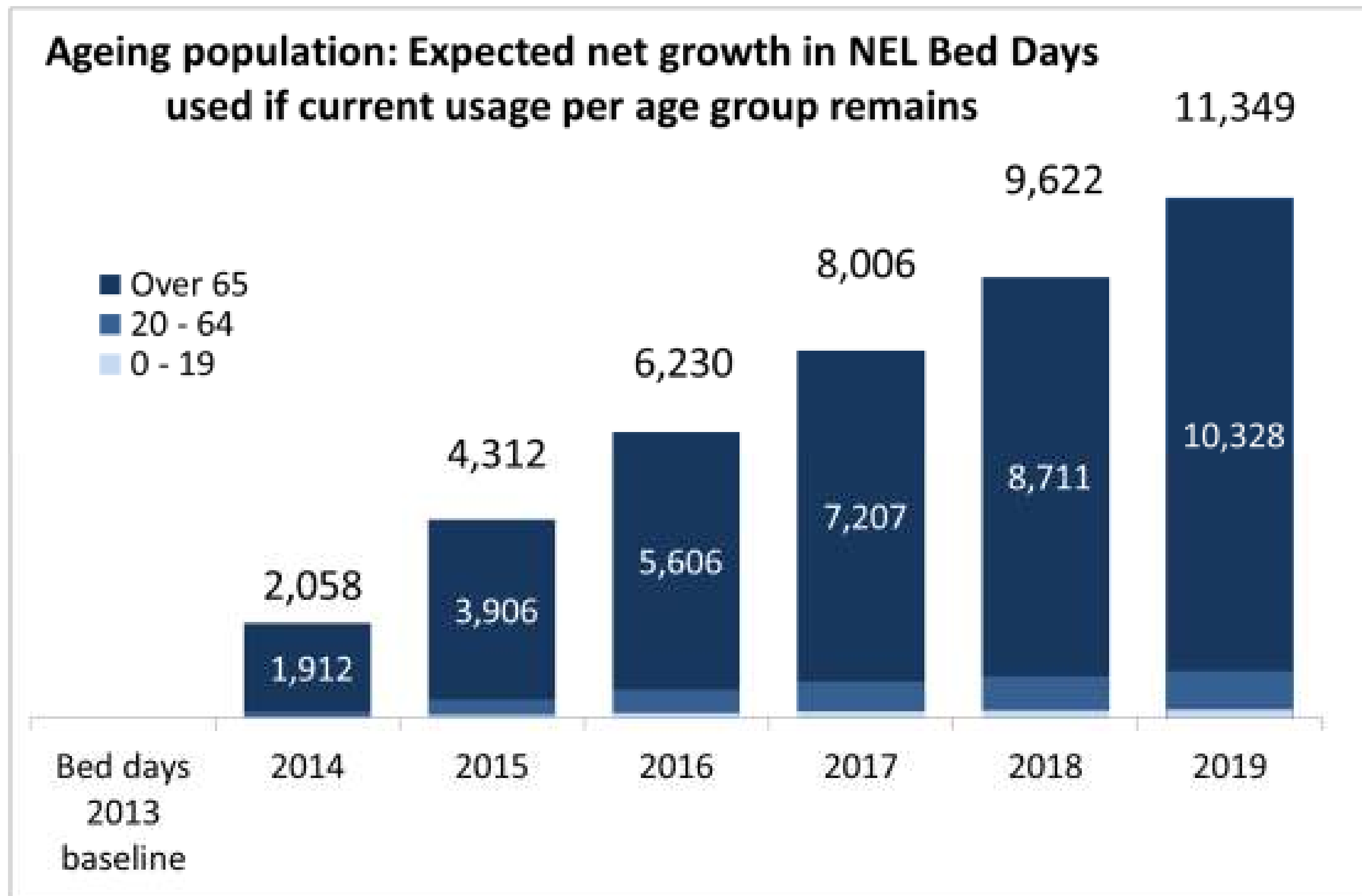


West

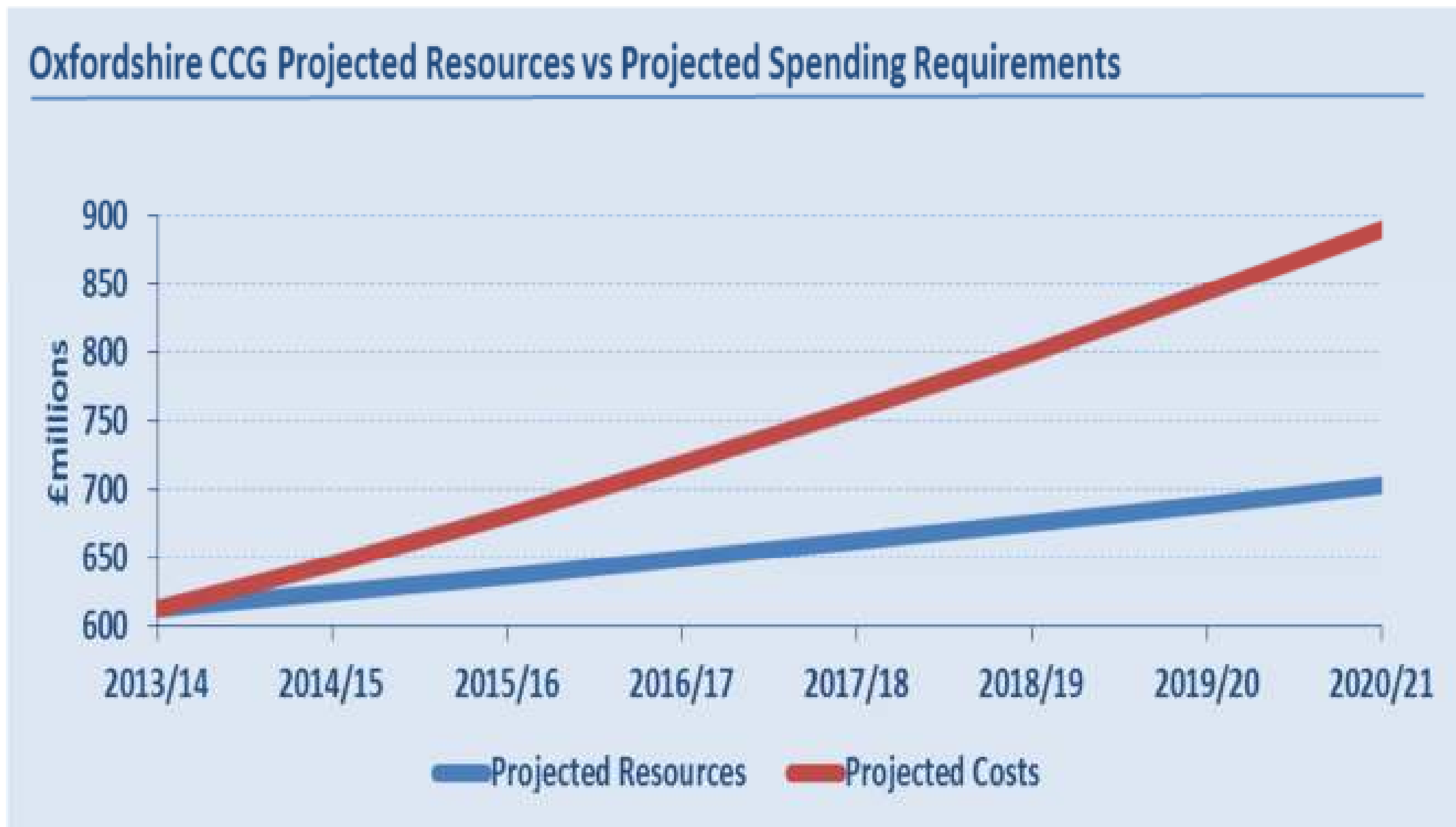
Content

- Context: demand; money; existing strategy of the CCG; existing plans and priorities
- Alternative visions?: CCG and Health and Wellbeing Board
- Principles from Single plan – views?
- Local focus: Abingdon: what exists; how it works; how should it work?
- Roles of different parts of the system; models of care. What do we want?

Context: demand



Context: money



Context: Existing CCG strategy

In five years' time, the Oxfordshire health and social care system will:

1. Be financially sustainable
2. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multimorbidities.
3. Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
4. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
5. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities
6. Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services.

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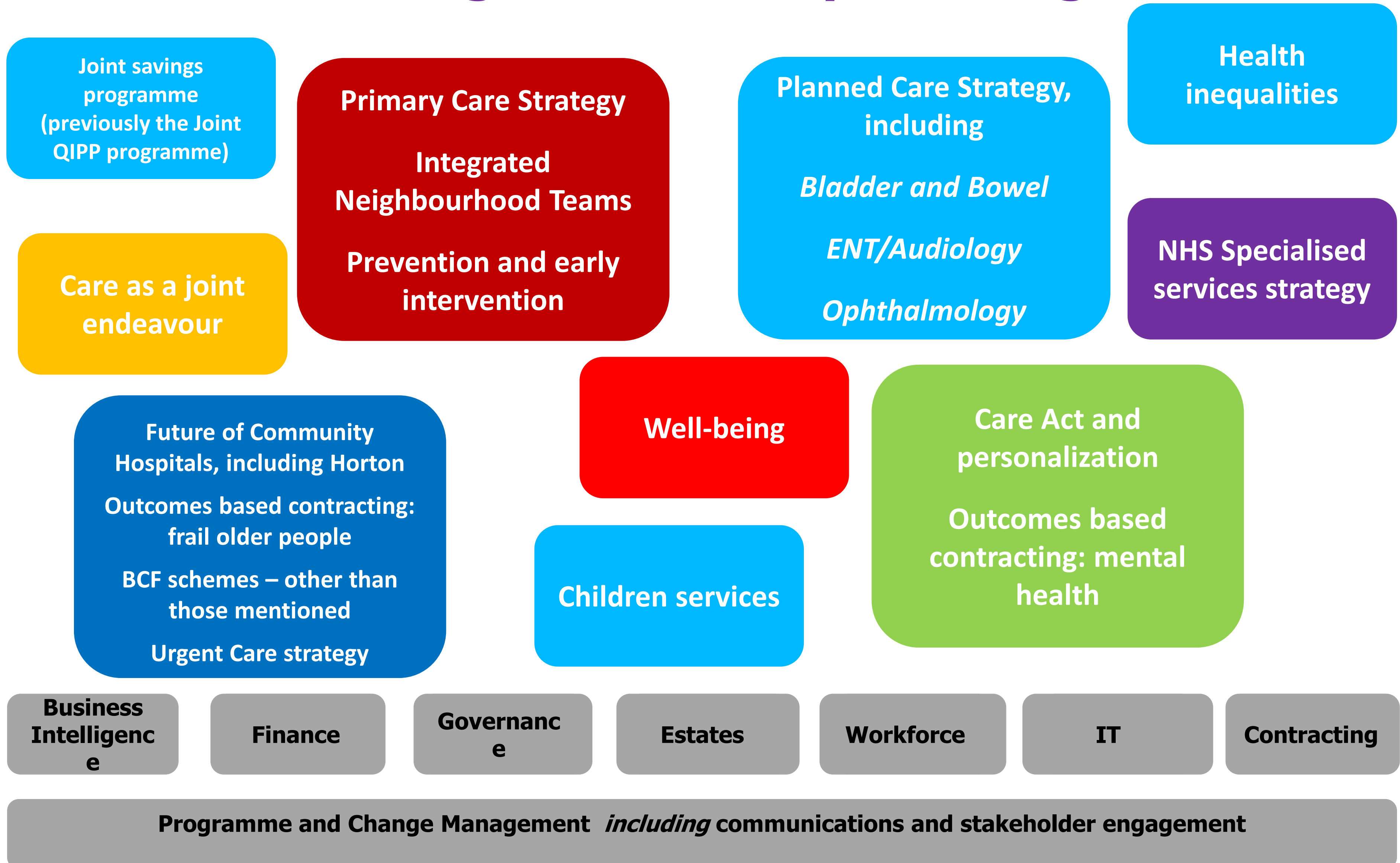
Context: lots of big issues already on our agenda



Possible Visions: existing CCG vision

By working together we will have a healthier population with fewer inequalities, and health services that are high quality, cost effective and sustainable.

Possible Visions: Health & Wellbeing Board Single Plan

To support and promote strong communities so that people live their lives as successfully, independently and safely as possible. We believe that people themselves, regardless of age or ability, are best placed to determine what help they need. The role of health and social care commissioners and providers is to ensure that everyone who needs it has access to the right care, in the right place, at the right time, first time.

Discussion

What is our vision for health and social care?

Single Plan: proposed principles

- Achieve outstanding outcomes by planning around needs
- Prevention and early detection
- Extend and integrate care outside hospital – self care, social care, primary care, community health services
- Strengthen services available locally, high quality specialist centres
- Tackle financial challenges as a partnership; make the most of our limited resources
- Deliver joined-up system easy to access and navigate
- More joint commissioning and better information sharing
- Easier to share information as appropriate – while protecting confidentiality
- Success through working together, not separate organisations alone

Discussion

Do we agree with these principles?

Local Focus: Services in Abingdon

- 33,000 people
- 1,541 known informal carers
- One Community Hospital
- Community Mental Health team
- Social care team
- 33 GPs [How many practices?]
- 12 Practice Nurses
- Six opticians
- Six NHS Dental Practices
- Eight pharmacies in Abingdon (plus one Dispenser at a GP surgery)
- At least 15 social groups and clubs for older people
- One Health and Wellbeing centre
- One Learning disability centre
- One Good Neighbour Scheme
- Two Community networkers with the Community Information Network
- Six carers' support groups
- One leisure centre; one library

Emergency and 'Out of Hours' if I live in Abingdon

- If I need a doctor there is the Urgent Care Out of Hours service which I can contact by calling 111 any time
- Minor Injuries Unit open until 10.30pm at the Abingdon Community Hospital
- Accident and Emergency department is the John Radcliffe Hospital in Oxford
- For an emergency dentist I can call 111 up until 9.30pm
- Two pharmacies in Abingdon are open after 6.30 but they are not open 24 hours
- The Emergency Duty Team for children's and adults' social care is open from 5pm-8.30am, Mondays to Thursdays, and 4pm on Fridays until 8.30am on Mondays plus bank holidays

New Models of Care

Five Year Forward View:

- Multi-speciality Community Provider
- Primary and Acute Care Systems

Plus all the big issues already on our agenda

Difficult problems

- Vanguard bid highlighted that primary care expansion/Federations Outcomes Based Contracting are not yet aligned and maybe in conflict.
- Do we see our main model as a MSCP or PACS?
- Some changes will be politically difficult and will only be delivered if all parties are engaged and lead
- How do we actually move activity and spend away from bed based care?
- How do we commission community based specialists?
- How do we build trust and understanding across the system (and beyond)?
- How do we take forward services such as community nursing?
- Implications of the General Election: bringing together health and social care?

Discussion

What do we want to see at a local level?

‘Straw man’ model of care

- 6 Localities?
- Primary care working in federations collaborates with network of community services, social care and community based specialists
- Local ‘hub’ or ‘health campus’ approach to combine teams- form ‘integrated care organisations/networks’
- Included community hospitals and EMU/MIU/urgent care centre
- Acute hospital work is accessed via these ICOs which take on capitated budgets?
- Included is population management – risk stratification, prevention, early intervention, case management

What the clinicians will see (1)

- Primary care as the 'broad foundation' of care: populations of patients managed mainly in primary care, but for greater needs access, using community 'hubs'/ intermediate care (for example EMU or a community based set of specialists)
- Multi-disciplinary primary care teams - much expanded and more ambitious (e.g. physicians assistants, generalist community nurses who break down the barrier between 'practice nurses' and 'district nurses', specialist nurses managing LTCs across a group of practices, emergency care practitioners managing home visits and urgent care, nurse practitioners managing minor illness, pharmacists managing LTC and repeat prescribing, specialist managers across practices to manage systems and reporting, administrators to manage call-recall systems and monitor capacity and high risk patients, IT experts across practices)

What the clinicians will see (2)

- 20-30mins GP appointments to deliver proactive care for complex patients
- Better OOH Care Access 24/7 - OOH GPs access (and add to) full patient records for the 2% most complex patients. Personalised Care Plans flagged by a Special Note added to records
- Rapid community assessments and intervention to avoid acute admission
- Community multi-disciplinary team assessments to facilitate and enable timely discharge from acute admission
- Intuitive-to-use ICT systems, with accurate patient/services information, aiding clinical decision making (e.g. DXS)
- Improved 'health literacy' amongst patients resulting in better self-management of conditions

What the patients and carers will see (1)

- 20-30mins GP appointments for to discuss and plan proactive care
- Home visits by Emergency Care Practitioner/Advanced Nurse Practitioner
- Interactive online health resource – self-help chronic guides; symptom-checker; sign-posting. Access via internet, including in practice terminals. Designed to be digitally enabled for translation into other languages
- Digital consultations – with 2 hours (urgent) or 24 hours (routine) response times
- Care Navigators – tracking, implementing and supporting care for 2% of most complex patients on practice registers, liaising directly with GPs, patients, families and carers, within practices and patients' homes. *Named point of contact for all their health and care needs – accessible via phone, Skype, email, minicom?*

What the patients and carers will see (2)

- Booking GP appointments by email/on the web
- Extended access to primary care including weekend and evening appointments
- Improved communication and coordination with less repetition of assessments *(or single assessment?)*
- Consultant led ENT and Dermatology clinics in the community
- Care and timeliness of response becoming increasingly consistent over weekdays and weekends in all settings
- For urgent care patients, faster access to primary medical care, less admission to hospital and care in or near home. Fewer transfers between hospitals during an inpatient admission
- Greater patient and carer involvement. Patients will hold their own management plan and be supported to self-manage with the support of care navigators and tele-health

What the patients and carers will see (3)

- Rehabilitation and reablement will be a key focus across care pathways in all settings, with all pathways focused on being dementia-friendly
- Access to their own patient record to help them manage their own health, and check the record is correct
- *Integrated personal health and social care budgets?*
- *Self-service referrals?*
- *Amazon-style 'tracking' system showing progress of their 'case' in real-time?*
- *Bulk of 'routine' consultations, tests and minor procedures in the community?*

What will happen 'behind the scenes' (1)

- Neighbourhood Hubs – same day access and extended 8 am – 8 pm working, delivered by GP-led multi-disciplinary teams
- Early-Visiting and Home Support team – provided by Emergency Care Practitioner/Advanced Nurse Practitioner, supporting GPs to respond to some urgent visit requests early in the day, releasing GP time for more complex patients
- Tele health consultations providing enhances GP support to other healthcare professionals in care homes and Emergency Medical Units
- Increased practice capacity to meet unplanned, urgent primary care demand, freeing GPs to manage more complex patients and avoid unnecessary hospital admissions
- Enabling ICT and data sharing – e.g. EMISWEB rollout to 90% of practices; interoperability layer for practices using Vision; information sharing agreements. Relevant directories of services to link to federations' health sites
- Care navigators – acting as a key coordinator between practices and integrated community health and social care neighborhood teams; access to systems 'on the road' on hand held devices
- Physician Associates role created

What will happen 'behind the scenes' (2)

- We will be working differently with different population groups: working age families; market town communities; those with mental health needs i.e. tailoring our services to meet the needs of different segments of the population (e.g. access and/or continuity); this will include
- Two demonstrator sites at Bicester and Witney with a Primary Care Assessment Units run by GP federations. These will be based within health and social care sites, co-located with other services, including diagnostics, and will be staffed by extended primary care workforce including Physicians Assistants and Advanced Nurse Prescribers
- Mental health: coordinated treatment interventions as part of a single care plan that will be recovery focused; joint incident reporting; recovery colleges and community care assessment centres

What will happen 'behind the scenes' (3)

- Urgent care: unified care network across domiciliary, community hubs and acute hospitals. 'Local where possible, centralised only where necessary'; ambulatory care by default which is co-located, capable (24/7) with teams with plural physical, psychological and social capability; 'specialist generalist' care which is aligned with patient need and Future Hospitals Commission; universal best practice where 'Comprehensive Geriatric Assessment' and an 'Enhanced Recovery approach' are prominent

What will happen ‘behind the scenes’ (4)

- Aligned care pathways with increased multidisciplinary working
- Collaboration with patients and their carers so that they are better enabled to make decisions about their care needs and to engage actively in co-managing their conditions
- Redesigned workforce roles with professionals working to the optimum of their skillset. This will enable enhanced staff satisfaction, better retention and recruitment, and the creation of a flexible workforce
- IT integration and use of tele-health as an enabler for effective team-working across organisational boundaries
- Enhanced relationships with the voluntary sector and other local services so that the diversity of patients’ care needs are met

What will happen 'behind the scenes' (5)

7 community hospital across Oxfordshire, Bicester, Townlands (Henley), Wallingford, Abingdon, Witney, Wantage and Chipping Norton. Between them they will continue to offer the following services:

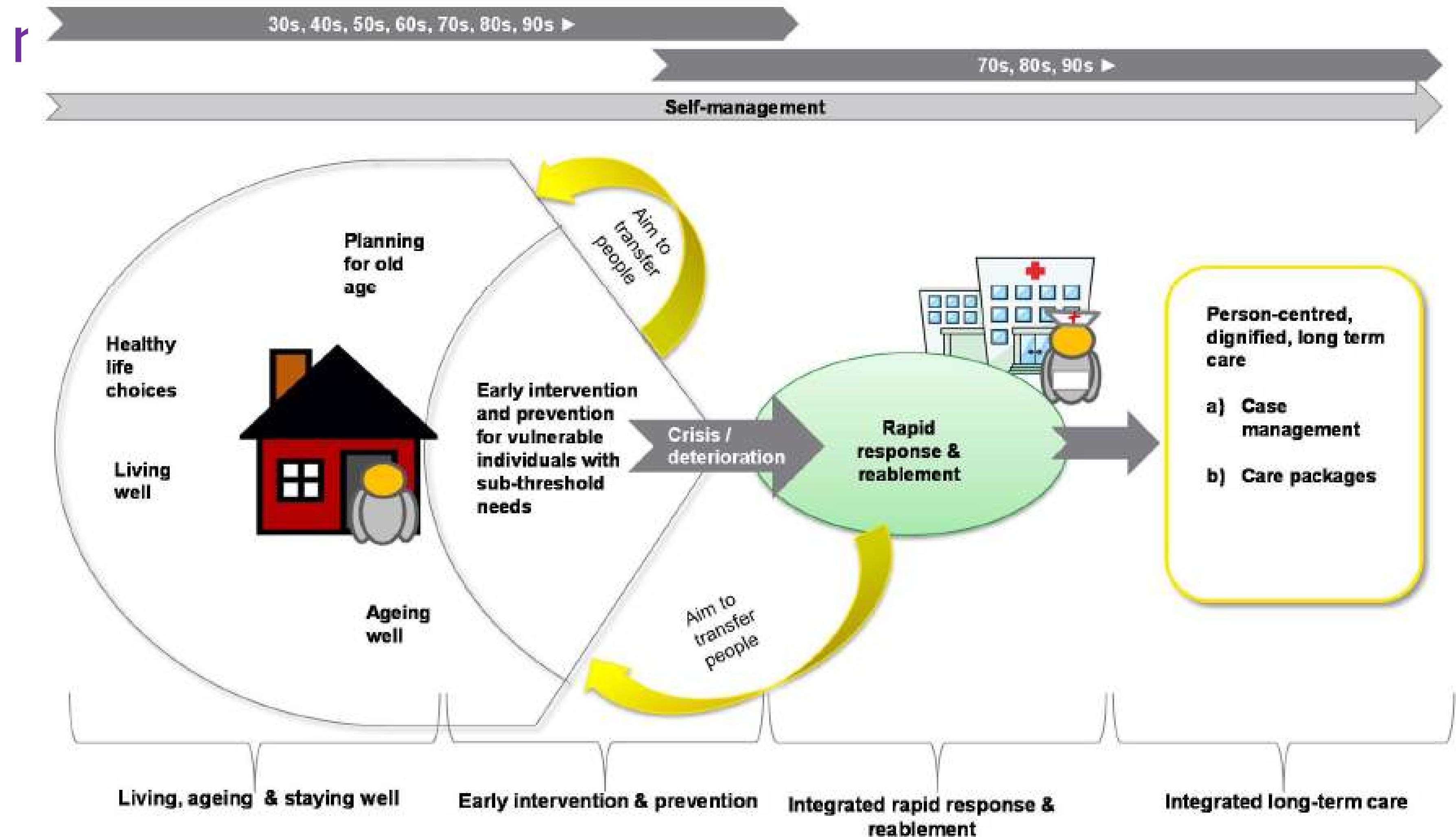
- Out of hours first aid
- Physiotherapy
- Ultrasound
- X-Ray
- Audiology
- Rheumatology

Inpatient beds
Orthopaedics
Maternity Services
ENT
Gastrointestinal

'Physical' EMUs in Abingdon, Witney, Banbury (Horton) and Oxford City (JR) as well as a 'virtual', county-wide EMU

A different way of thinking about the future is emerging… From 'episodes of care' with different providers…

To a life-long relationship and integrated services, where both the 'carers' and the cared for take joint r



The emerging model?

Tier	Aims	Building blocks
Living, ageing and staying well	Providing co-ordinated, responsive sustainable health promotion services, and bringing partners together to tackle 'negative' lifestyle choices, to transform the overall health of Oxfordshire	- Multi-agency prevention strategies - Behaviour change programmes, including 'nudging' - Integrated 'lifestyle' service
Prevention and early intervention	Identification of and support for individuals who are vulnerable, and at risk of requiring support in the future	- Proactive identification and referrals - Integrated case management - Community-based prevention services
Rapid response and reablement	Co-ordination of services to individuals during a period of rapidly escalating health or social care need, in order to avoid attendance at hospital or the requirements for a long-term care package	- Rapid response - Reablement
Integrated long-term care	Reshaping long-term care services around a common understanding of service users' needs and establishing a single approach to management across the health and social care economy	- Integrated local teams - Joint commissioning of care packages - End of life care

***Underpinned by* Self-management**

How will we get there? (1)

Prime Minister's Challenge Fund Projects

- Same day appointment Neighbourhood Hubs
- Additional support for patients at home by ECP early visiting teams
- Additional access through Care Navigators
- The introduction of Video and E-Consultations
- Development of extended primary care workforce including community pharmacy, development of community nursing roles, including breaking down traditional barriers between Practice Nurses and District Nurses
- OH and OUH working with third sector to deliver improved outcomes for older people and patients with mental health needs

How will we get there? (2)

BCF projects

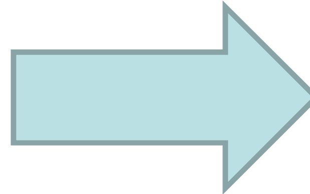
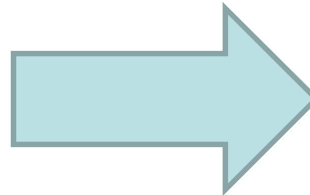
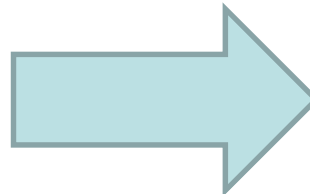
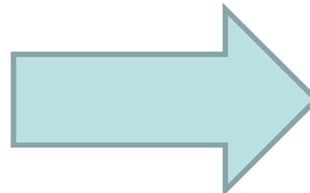
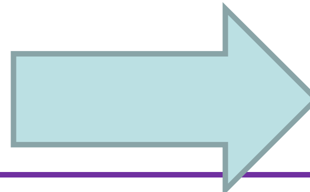
- Expanding emergency Multi-disciplinary units (EMUs)
- Enhancing reablement services
- Reducing delayed transfers of care
- Ambulatory emergency care pathways
- Integrated neighbourhood teams
- Care closer to home (advance care plans/End of Life Care and proactive medical support to care homes)
- Hospital at Home
- Oxfordshire Care Summary: proactive care planning
- Protecting Adult Social Care
- Care Act Implementation
- Carers Breaks

How will we get there? (3)

Planned care pathways redesign, including:

- MSK Including Rheumatology
- Ophthalmology
- Bladder & Bowel
- ENT
- Cardiology
- Dermatology including Plastic Surgery
- Neurology Including Chronic Pain Management
- Gynaecology
- Urology
- Oncology
- Gastroenterology
- Nephrology
- Respiratory Medicine
- Haematology
- General Surgery
- Gynaecology
- Podiatry
- Endocrinology (Diabetes – PC Development)
- Radiology/Pathology

What will (need to) change (1)

'Us 'and 'them'		'One team'
Transactional interaction		Relationships
Individual organisations' perspective		System-wide perspective
What commissioners and providers want		What patients need
What's in it for me?		What's best for the patient?

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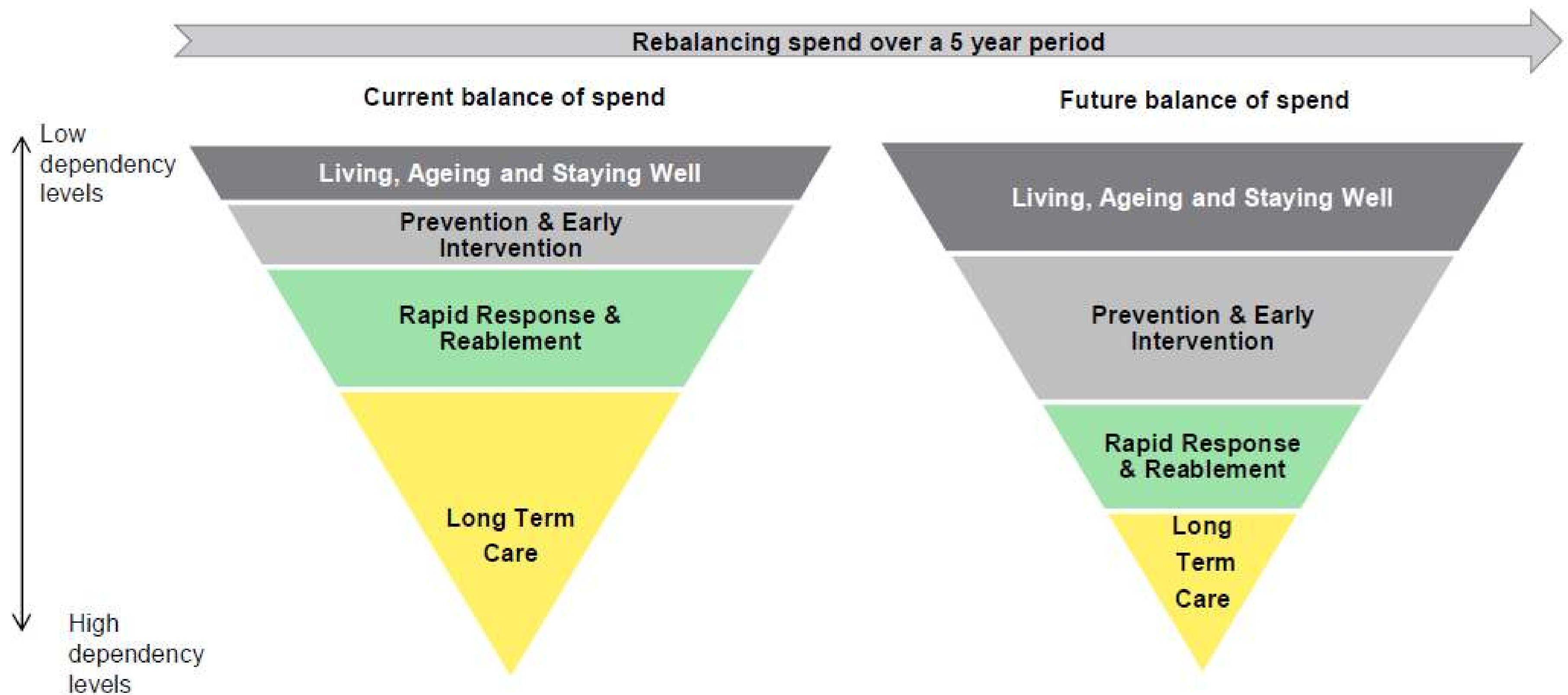
What will (need to) change (2)



Discussion

1. Do you recognise the emerging future model of health and social care in Oxfordshire? Do you agree with it?
2. Do you have any observations or comments (e.g. gaps / inconsistencies in the model)?
3. Will our initiatives (projects) deliver the model? Are there any gaps (e.g. behavioural change, prevention)?
4. What else will need to change to deliver our vision and strategy (structures, systems, processes, people, behaviours etc.?)