Community Care First

A radical upgrade in the community based offer to fundamentally change the care model and promote independence within local communities

Les Williams, Programme Director, Community Care First Programme
Tuesday 25th October 2016

Vision

Delivery of a new planned and deliberate care model which:

- Supports people to live independently and feel safe in their community
- Helps people to help themselves initially, with caring services there when needed
- Responds quickly to physical and mental health issues to enable return to normal functioning or work as soon as possible
- Places the needs of the person at the centre of a care plan developed with them
- Offers appropriate access/appointment in primary and community care, on a 24/7 basis
- Ensures children are able to reach their potential, through opportunities that health, education, well being and employment bring
- Brings together major aspects of health and social care policy objectives

Governance inclusive approach – five workstreams

Involvement of local authorities:
- Active members of CCF Programme Board and Team
- Solihull Together
- Maximising Independence in Adults
- MDT approach workshop in September
- Prevention workshop in November

System Board Executive Lead

Co Chairs
Tracy Taylor BCHC
Patrick Brooke Solihull CCG

Programme Direction

Director
Les Williams BXC
Manager
Andrew Hulcoop BCHC
Finance Lead
Angela Szabo BSC CCG

Engagement with BVSC and Solihull Sustain started

Improving health and Well being

Co-Chairs
Dr Adrian Philips Bham City Council
Dr Stephen Munday Solihull MBC
Workstream Manager
Carol Herity BXC CCG

Long Term Conditions and Maintaining Independence

Co-Chairs
Helen Kelly Solihull CCG and MBC
Karen Helliwell BXC CCG
Workstream Manager
Nilima Rahman-Lais Solihull CCG

Urgent Care – Care in a Crisis

Co-Chairs
Dr Barbara King BXC CCG
Andrew McKirgan UHB
Workstream Manager
Karen Richards BXC CCG

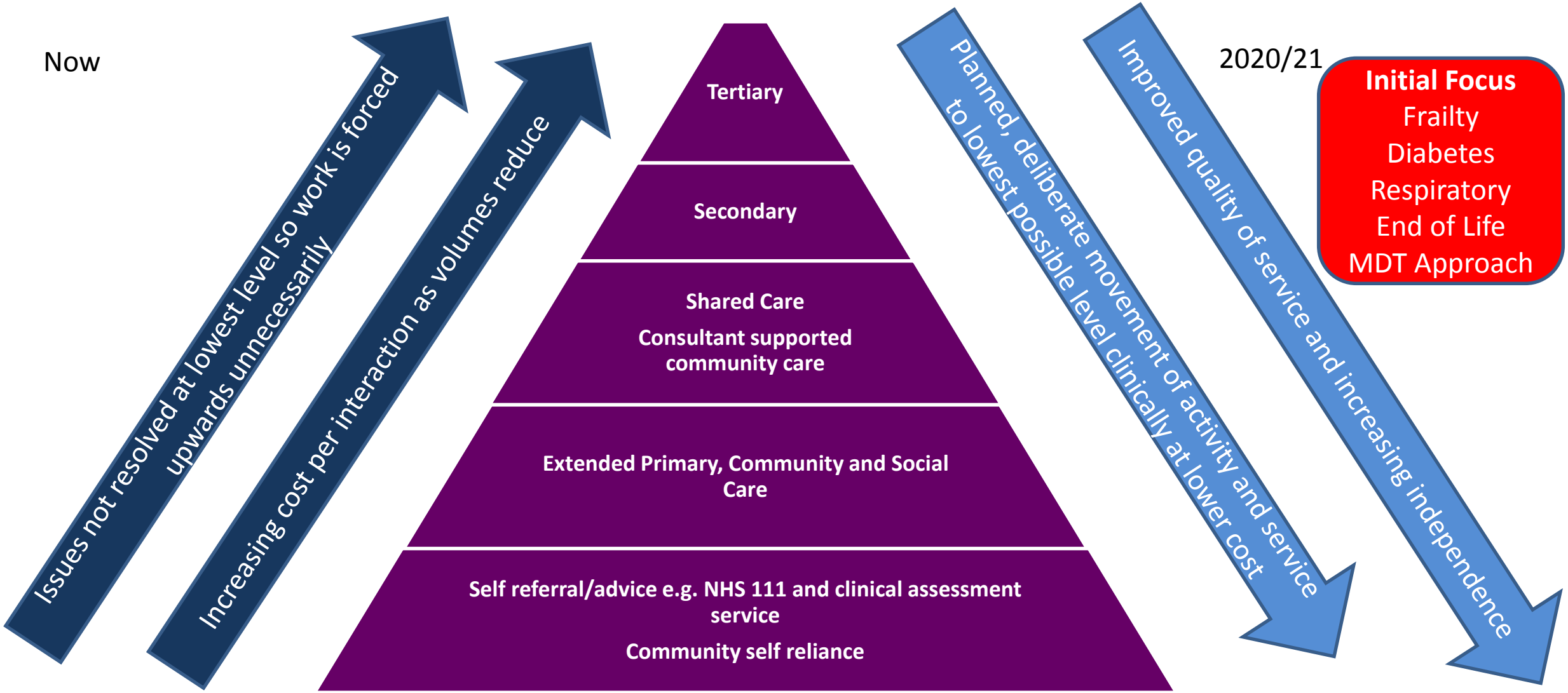
Children and Young People

Co-Chairs
Dr Doug Simkiss BCHC
Dr Mary Montgomery BCH
John Lees
Joint Commissioning Team BSC
Workstream Manager
David Coles
Joint Commissioning Team BSC

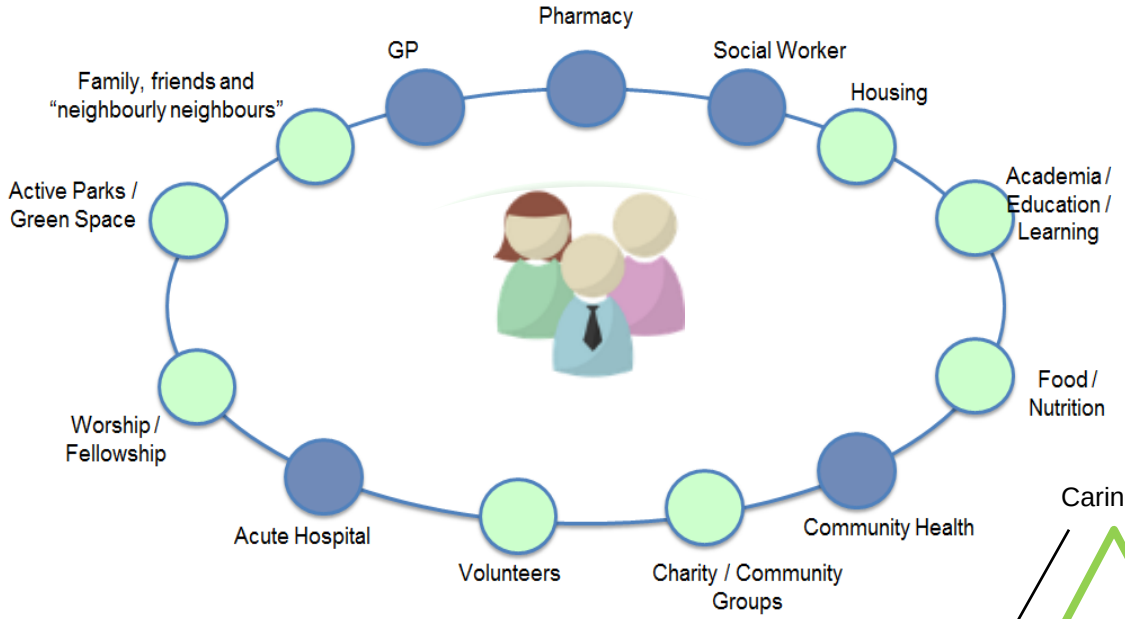
Enhanced General Medical Practice

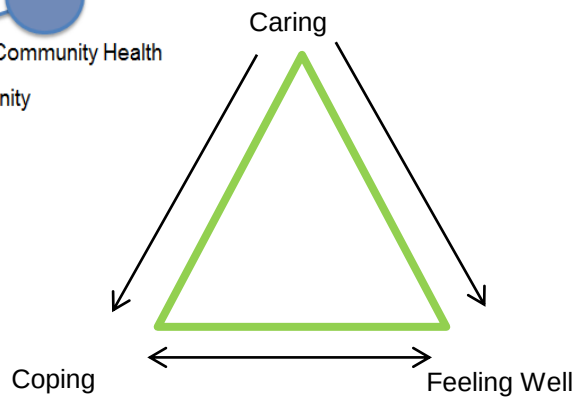
Co- Chairs
Dr Richard Mendelsohn BSC CCG
Dr Peter Thebridge BXC CCG
Dr Andy Waddell GP Alliance
Workstream Manager
Simon Doble BSC CCG

Community Care First
Overall Strategic Approach



Improving Health and Wellbeing





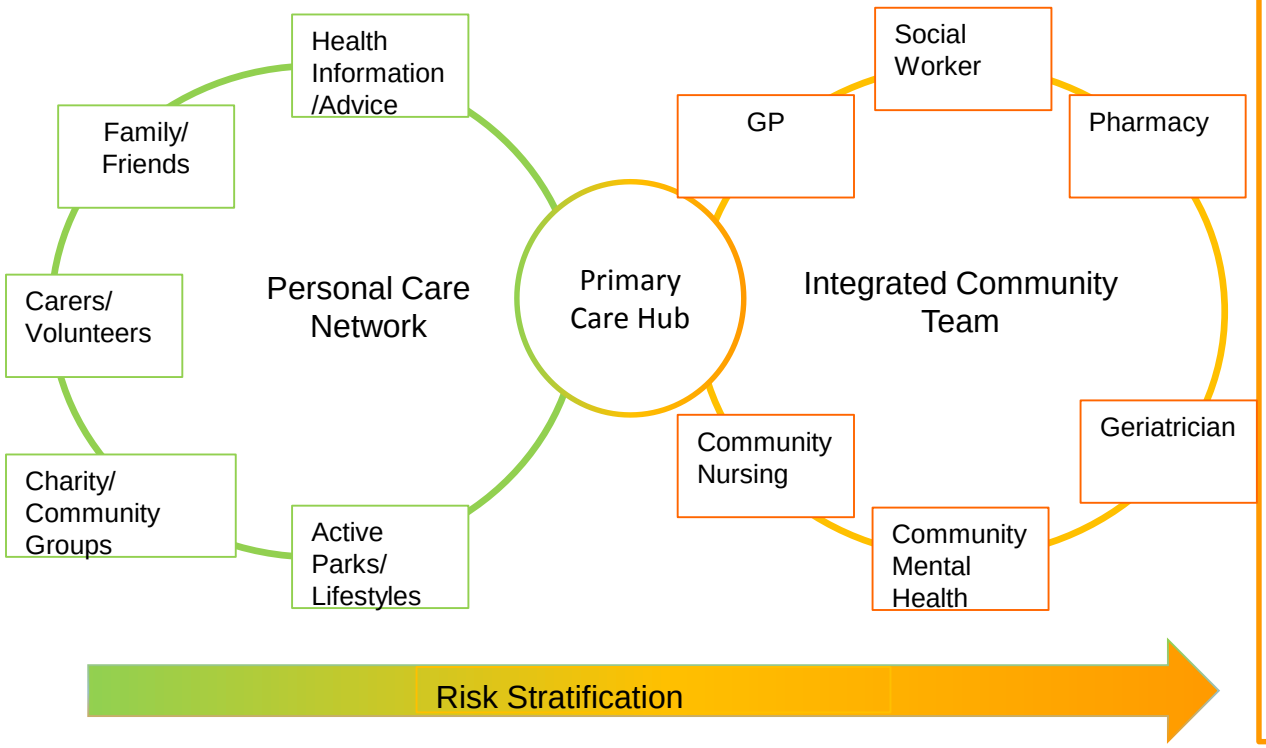
Key components:

- **Digital platforms** to support prevention, self care and well being e.g. Solihull My Life portal
- **Care Co-ordinators** based in local communities, helping to navigate and promote health and wellbeing services and develop social networks
- Opportunities **to integrate the offers of other key services** e.g. housing, neighborhood management, Ambulance Service, Police and Fire into a genuinely community based health and wellbeing offer.
- **Use of 'big data'** to identify levels of physical activity within communities and target the means through which this can be measured and improved, based on community specific drivers (e.g. Active Birmingham)

Targeted outcomes:

Reduction in outcomes gap for vulnerable communities – Improve workplace health and reduce long term unemployment – increase activity levels within local communities – reduction in prevalence of LTC (diabetes/CHD)

Integrated primary and community care



Key components:

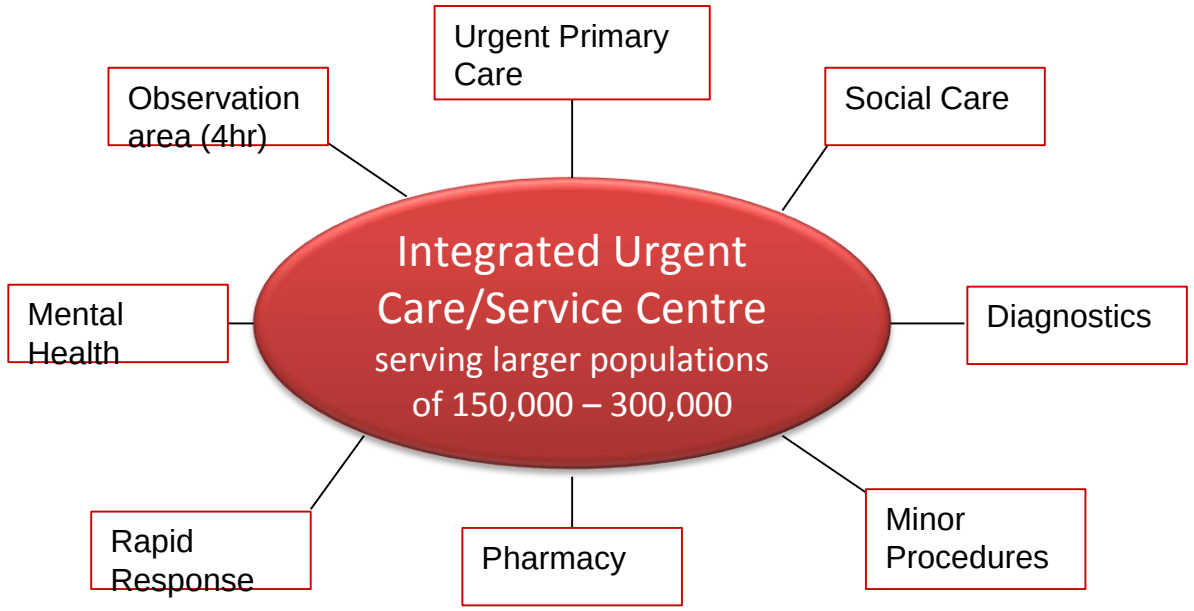
Primary care operating at scale serving 40,000 – 50,000 population

- 7 days, 8am - 8pm. Including digital options for care delivery including telephone and video consultations
- MDT care teams aligned to 'place based' primary care services
- Targeted, programmes for at-risk patient populations with a structured plan of care (e.g. extensivist model), supported by community geriatricians
- Allocation tools based on dependency and acuity
- Shared electronic patient record
- Inclusion of OP clinics
- Virtual bed models supporting earlier discharge for hospital care
- Dedicated care co-ordination to residential and care homes, supporting case management and prevention

Targeted outcomes

Reduction in admissions for ACS conditions - Reduction in Falls - Reductions in acute LOS – reduction in outcomes gap for vulnerable communities – reduce deaths in hospital – Patient experience of general practice – implementation of new models of care/vanguards prevent crisis demand for acute and social care – Dementia diagnosis

Integrated urgent care



Key components:

- NHS 111 as single entry point into the urgent care system
- At-scale clinical hubs providing local 24/7 Clinical Assessment Service
- 24/7 unscheduled walk in service
- GP and ANP on duty 24/7.
- Emergency ambulatory clinics.
- Access for WMAS conveyances.
- Observation area (up to four hours).
- Diagnostics including:
  - plain film radiology
  - ultrasound scanning
  - ECG testing
  - DVT screening.
- Pharmacy including prescriptions
- Potential to operate as integrated hub for rapid response / recovery services, mental health and social care.

Targeted outcomes

Reduce Ambulance transfers to A & E - Reduce self presentations to A & E with no treatment - Reduce lower acuity A & E attendances (cat 1 & 2)- Reduce Ambulance see & treat call outs- Reduce short stay emergency admissions -

Ambitious targets

Based on achieving current national top quartile performance locally.

Some examples:

- Reduce the number of emergency admissions for adult ambulatory case sensitive conditions by **33%** and for children by **39%**
- Reduce the number of hospital admissions as a result of falls by **24%**
- Reduce the number of delayed transfers of care by **72%**
- Reduce the number of A&E attendances for adults by **17%** and for children by **22%**
- Improve accessibility to general practice – access/appropriate primary care appointment available when needed, either in local general practices or at an urgent care centre/integrated service hub
- All GP practices to be rated ‘Good’ or ‘Outstanding’
- Increase the proportion of people with LTCs feeling supported to manage their conditions to **73%**
- Reduction of deaths in hospital through palliative and end of life care in the community by **12%**
- Increase the proportion of vulnerable people in meaningful work to **12%**
- Reduce those in receipt of incapacity benefit by **10%**

Making progress

Health and wellbeing

- building community resilience through information, advice and guidance
- use of digital interventions
- 3rd sector lead interventions
- identification of preventative interventions in each workstream and other STP Programmes

Long-term conditions and maintaining independence

- development of an MDT approach, which supports the most vulnerable patients and enables them to live independently in the community, including use of care navigators
- proactive care management pathways – beginning with diabetes
- promoting self-management and community resilience

Enhanced general medical practice

- improved sustainability and resilience of general practice, able to offer enhanced services to support the care of patients where they live and improve accessibility
- based on 29 defined natural communities so that care needs are met in local areas, with clear links to four or five urgent care centres/integrated service hubs

Making progress

Children and young people:

- based on the complete care for children model
- development of paediatric integrated community teams on an MDT basis
- implementing a 24/7 rapid response team
- broadened early intervention offer to reduce crisis and avoid admissions

Urgent care

- development of four or five urgent care centres/integrated service hubs across the footprint, providing immediate access to urgent primary care, diagnostics, pharmacy, treatment of minor ailments (receiving WMAS conveyances), minor procedures, social care
- single accessible model for step up and step down urgent care services which prevent emergency admissions and enable speedy and effective discharge (recovery model)
- could be expanded to include services offered by local authorities and the voluntary sector

LDR, workforce and estates enablers - fully engaged

In combination, potential to move significant elements of care into primary and community settings away from traditional secondary care settings.

Our offer to local people

- Services which respond more **quickly and more locally** to your needs.
- Using **new technology** to allow you to access health and social care services **easily,** through your phone, tablet or computer.
- Providing information and support to **maintain** and improve your ability to live **independently.**
- Being supported by a team, who will be **focussed** on your needs.
- Giving the right appointment at a location **close to home,** no matter what the day or time, or by providing you with specialist care as **locally** as possible.
- Responding quickly to your **mental and physical** health problems**,** helping you to return to work or your normal life **as quickly as possible.**
- More likely to receive care in your **local community** in the future, with less people being admitted to **hospital.**
- Children have the chance to develop to their **full potential,** through health, education, well-being and employment **opportunities.**
- A health and social care system which is **easy to use and understand,** we will make sure you only need to tell your story **once.**
- It will be easier to **speak** to someone who can help and you will be able to see a GP who has **access** to your care records.
- You will feel in **control** of your health and well-being, with any **decisions** about you being made with you.
- You are helped to **help yourself,** with services available for you to use when you need them.
- The same **high standard** of care from services across **Birmingham and Solihull.**