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Herts Valleys
Clinical Commissioning Group

Shaping the future of Primary Care in Herts Valleys

The journey to date: June 2015

Transforming Community Services

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Developing Our Vision for Primary Care Plus

"We want people to experience services that are truly seamless, with effective signposting, co-ordination of care and exchange of information supporting every patient's journey"

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Progress made since last meeting (February 2015)

- **Community Gynaecology**: work progressing with our current service providers to deliver a fully integrated Hospital and Community Service to be operational by the 1st December 2015.
- **Community Cardiology**: work progressing to deliver an full integrated Hospital and Community Service for implementation in 2016/17
- **Community Ear, Nose & Throat**: work progressing to deliver an Enhanced Community ENT and Audiology Service across Herts Valleys in 2016/17.
- **Community Dermatology**: work has started
- **Community Ophthalmology**: work has started

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Progress made since last meeting (February 2015)

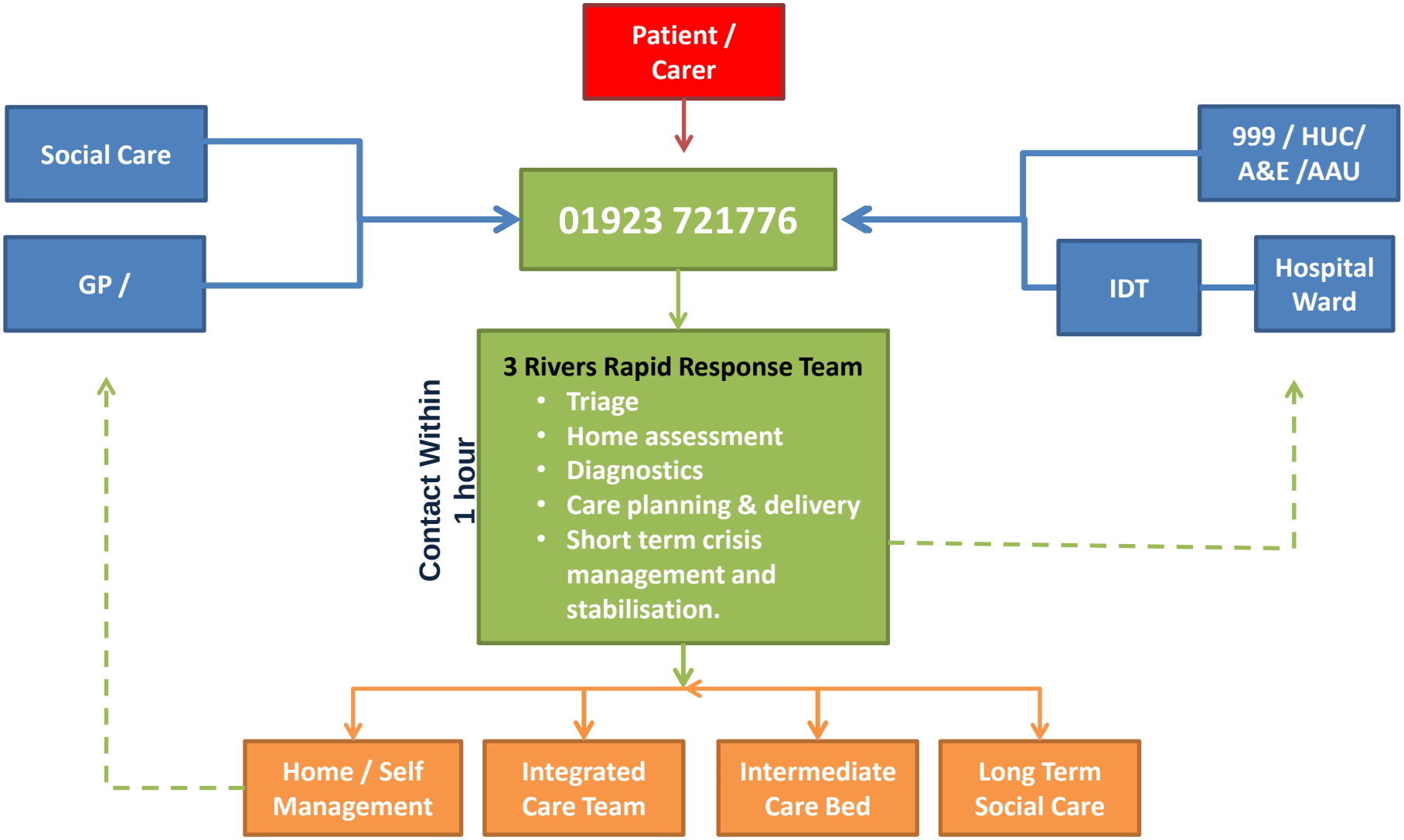
- Adult Community Rapid Response Service to be rolled out in St Albans and Harpenden Locality and expansion in Watford & Three Rivers to cover all 28 Practices. The new services will be operational by October 2015

- Living Well – 53 patients in Feb & March – a group of patients who might benefit from more integrated & coordinated care. Weekly multidisciplinary team meetings

Hertfordshire

Hertfordshire Community NHS
NHS Trust

Watford and Three Rivers Rapid Response Service



Prime Ministers Challenge Fund

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Watford Care Alliance

- 12 practices across Watford & Three Rivers federated as Watford Care Alliance
- Evening appointments at each surgery, plus weekend routine and on-the-day appointments at two sites (Bridgewater House & Colne House)
    - 6:30pm – 8pm Monday to Friday
    - 8am – 8pm Saturdays and 9am – 1pm Sundays
    - NHS 111 were able to directly book appointments from December 2014
    - Weekend blood tests available from December 2014
- GP and Palliative Nurse to integrate with the Rapid Response Multi-Disciplinary Team
- Overnight “Hospice at Home” service provided by HCAs to support patients and families to achieve their preferred place of care and death if this is at home
- Telemedicine – “virtual” GP Consultations with care homes

Prime Ministers Challenge Fund

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Watford Care Alliance

Evaluation:

- An additional **9,619** appointments were made available, including 555 phlebotomy appointments and 480 appointments directly booked by **NHS 111.** 17% of patients surveyed advised that they would have attended A&E had a GP appointment not been available.

- Palliative Care Nurse integrated with the multidisciplinary team since November 2014, however GP involvement with the team only started in May 2015;

- 24 patients were visited as part of the overnight “Hospice at Home” service; 22 of these patient have passed away - 18 of them in their preferred place of death;

- Telemedicine – unfortunately although the IT equipment and connectivity has been purchased and tested, there remains on-going firewall and accessibility issues so this has not progressed as intended. However the Rapid Response team do use this facility to liaise with a GP where necessary.

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Increasing Capacity In Primary Care

- The aim for each locality scheme was to reduce A&E Attendances and Emergency Admissions by 2% and increase access to primary care by providing extra patient appointments from November to March;
- £1.5m funding available across the 4 localities - £98,000 of Dacorum allocation used for Holistic Care business case;
- 68/70 practices signed up to this initiative;
- 102,685 appointments were available across the CCG and 97,925 (95%) of them were filled;
- A&E data shows that no conclusions can be drawn about whether the additional appointments have had an impact on A&E attendances although there was an increase in 1st outpatient appointments; however this cannot be solely attributed to the schemes.

Transforming Adult Community Services: Current Landscape

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Services currently provided: (combination of commissioned services and pilots)

- Integrated Community Nursing and Therapy Teams (comprising of Matrons, Community Nurses, Therapists and Palliative Care Nurses)
- 154 Intermediate Care Beds (including stroke rehabilitation beds)
- Integrated Point of Access (phone & fax number for accessing services)
- Community Bed Bureau (locate available beds in nursing homes)
- Integrated Discharge Team (get patients out of hospital)
- Discharge Hubs (Community)
- Rapid Response (Watford)
- Rapid Response and Virtual Ward (Hertsmere Home First)
- Community Navigators
- Non-Weight bearing pathway (additional 15 beds)
- Discharge to assess capacity (15 additional beds in 14/15)
- Agreement to recruit additional therapists to support patients at home

Transforming Adult Community Services: Why are we doing this?

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- Care is fragmented
- No single point of access into services
- Lack of continuity of care
- Ensuring services are joined up and better coordinated around the patient
- Not enough focus on prevention and early intervention
- The overarching aim of Herts Valleys Integrated Care Programme is:

"To deliver the best in class community services for adults with multiple long term conditions and complex needs in West Hertfordshire through the alignment of health and social care services including third sector provision."

Emerging Model for Joined Up Care

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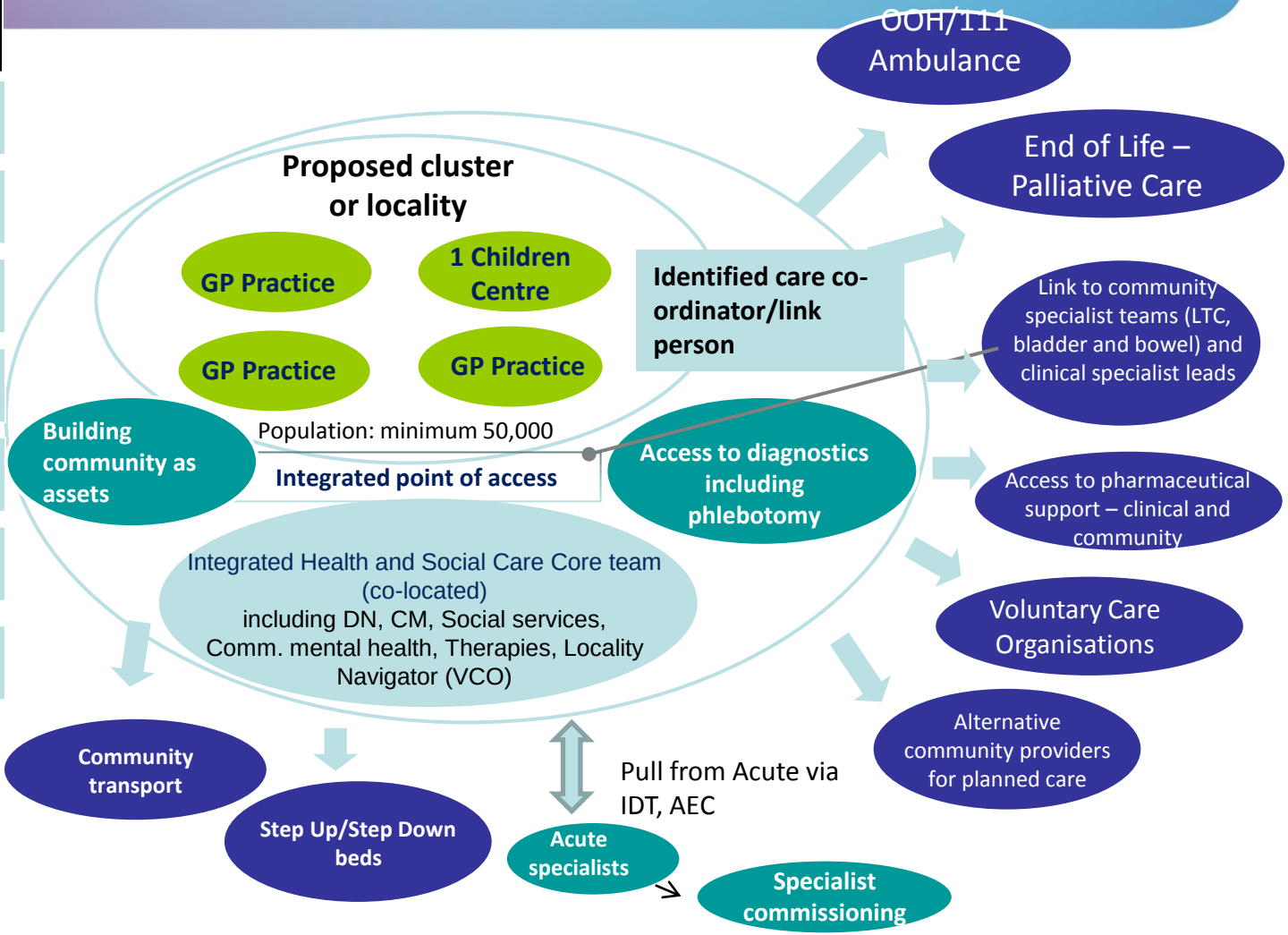
Key Enablers/Levers

- Communications feedback
- Care planning – patient centred goals
- Patient population database
- Identifying patients earlier
- Self-management – empowering patient to manage
- Information Sharing
- Education and workforce

Right care@ Right place@ Right time



Commissioning a System rather than individual projects – Transforming Adult Community Services (to include IPA, IDAT, Community Nursing and Therapy services core and rapid response and IMC beds)- Commissioning Model to be tailored to individual locality such as Hertsmere Virtual Ward, Dacorum DHHT, Watford WCA etc

Integrated Health & Social Care Community Team (IHSCT) Central point of access to:

1. Hertfordshire Community beds – including IMC, Enablement, Non Weight Bearing and Bariatric
2. Integrated Community Nursing and Therapy Teams - Core
3. Rapid Response - Enhanced
4. Social care team who provides home care and placements from Herts Community beds.
5. Neuro rehab and Early Supported Discharge Schemes
6. Community Navigator
7. CHC efficiencies
8. End of life

Social Package of Care

Residential/Nursing Home

IHSCT to pull patients via RR

GP referrals to Acute for AEC, GP Heralded admissions

Rapid Response

(Health, Social Care, Mental Health and Hybrid Health and Care workers)

1. In-reach to acute trust as per locality for example Watford Team to WHHT and Hertsmere Team to Barnet and Chase Farm
2. Daily capacity reported in Bed Bureau/IPA
3. In reach into Non Weight Bearing Beds and other schemes within locality to assist with discharge planning.
4. Integrated care to enable flow into Intermediate Care Teams

Intermediate Care Beds

(Flexi model for community beds with enablement and IMC needs)

Considerations:

1. medical cover
2. mental health support
3. 7 day therapies
4. bariatric facilities and training
5. step up
6. Enablement and therapies

Additional investment in therapists and community nursing etc.

Care provided in the patient's place of residence (including care homes)

ICT - Integrated partnership working with RR, Community Beds and Specialist Teams

Alignment of provision of Home Care and HES, EOLC - EPACCS

Patient Discharged – Patient's place of residence

Transforming Adult Community Services: Milestones

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- Complete integration of Core Community Nursing and Therapy Teams with Rapid Response Teams in Hertsmere and Watford Localities – July 2015
- Roll out of Rapid Response to St Albans and Harpenden (integrating it into the existing Core Community Nursing and Therapy Team) – October 2015
- Enhanced Therapy support in the Integrated Teams to support the service in patients own homes – (Recruitment underway) October 2015
- Implementation of a Single Point of Access – December 2015
- Agree model of care for Dacorum, to be rolled out aligning with existing services in Dacorum – April 2016

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Transforming Adult Community Services:

Any questions?