Your community
Your care
Developing Buckinghamshire together

Reducing costs through integrating health and care services

NHS Aylesbury Vale Clinical Commissioning Group
NHS Chiltern 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

Similar challenges…

Local health services serve a population of **522,200** people in Buckinghamshire and this is predicted to increase by **40,400** by **2025**.

18% of the population is **over 65** and this will rise to **21%** in the next **15 years**.

Growing numbers of people...	2015	2020	2025	2030
aged 80 and over in Bucks:	26,800	32,200	38,700	48,200
with dementia in Bucks:	6,826	8,123	9,704	11,522

1 in 5 adults are physically inactive

2 in 3 adults are overweight or obese

1 in 8 adults are at risk of developing diabetes

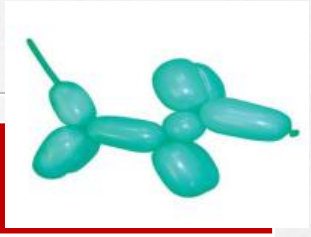
1 in 9 adults smoke (1 in 5 adults in manual workers)

1 in 5 adults drink harmful levels of alcohol

A growing, ageing population

Significant increases in obesity, dementia and diabetes

Our accountable care system



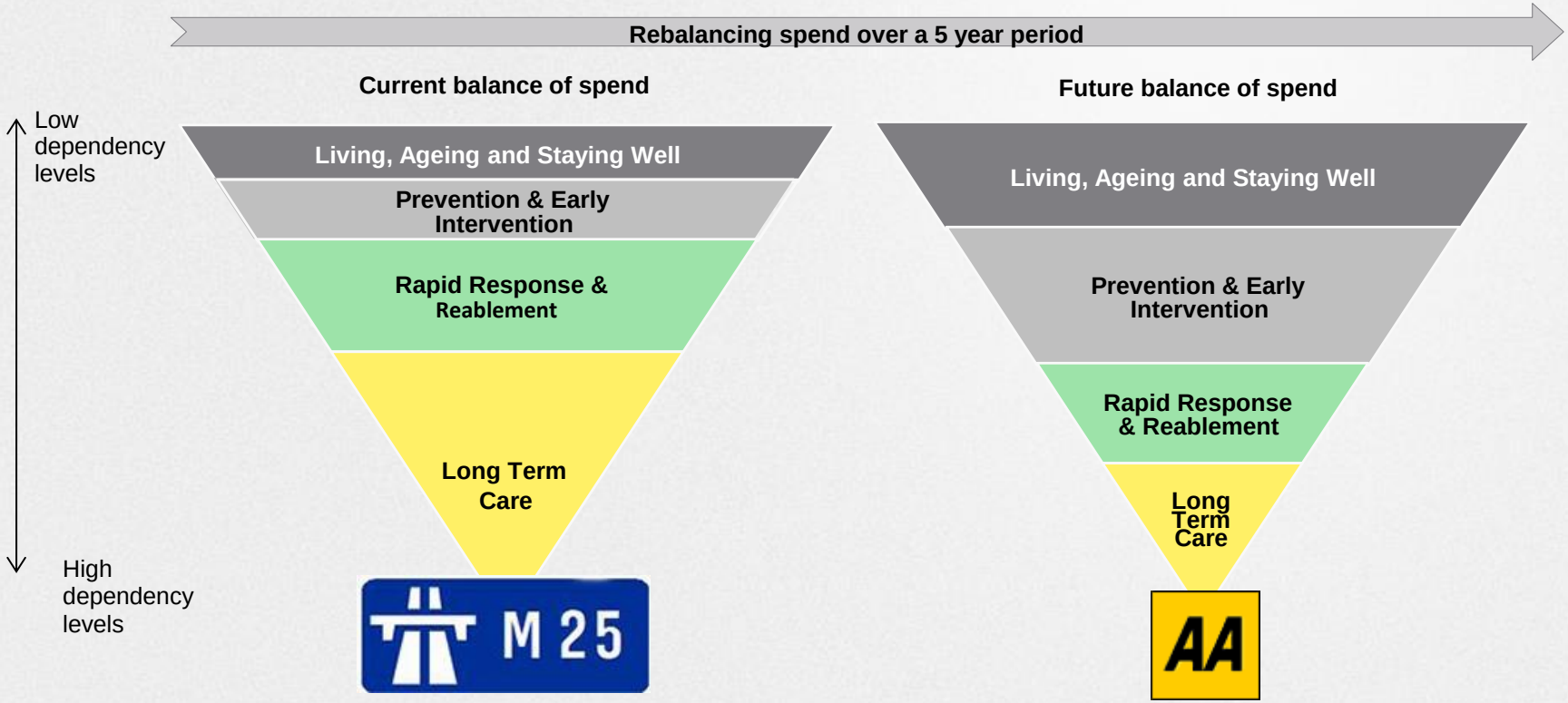
What it is:	What it is not:
Mature partnerships - a coalition committed to collective decision making	New statutory bodies or change to existing accountabilities
Partners making **a single, consistent set of decisions** about how to deploy resources	Employers, ways of managing financial or other resources
Stronger local relationships and partnership work based on **common understanding of local priorities, challenges and next steps**	Legally binding (deliverability rests on goodwill, commitment and shared priorities and objectives)
A **clear system plan** and the capacity and capability to execute it	Getting rid of the purchaser / provider split or of respective statutory duties and powers
Place-based, multi-year plans built around the needs of local populations and local health priorities	Tried and tested. There will be bumps along the way – the true test is in the relationships!
Delivering improvements	Removing the need for consensus and collaboration


Just 10 days in hospital leads to the equivalent of 10 years' ageing in the muscles for people over 80.*
NHS
We've pledged to do everything we can to keep our elderly people safer, and out of hospital, where appropriate.
What will you do?
NHS Aylesbury Vale and NHS Chiltern Clinical Commissioning Groups
*Functional impact of 10 days of bed rest in healthy older adults. J Gerontal A Biol Sci Med Sci.2008

Our strategy requires system integration

Put Care in the Best Place

I**nvest** in prevention and early intervention, with increased community services to provide **care at home**, reducing **bed-based** care through our providers, who are working together to make this happen

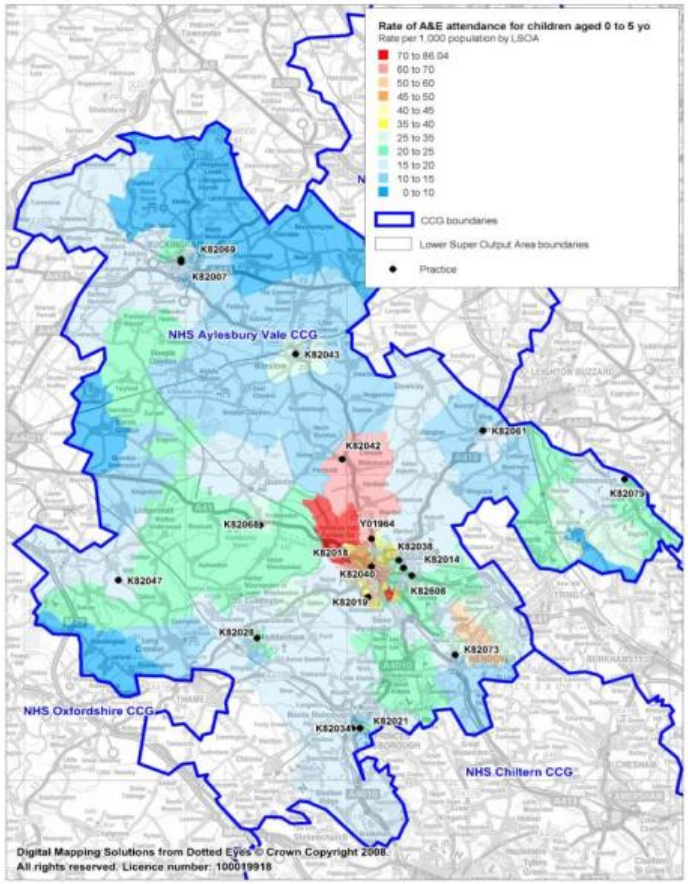


Our shared principles

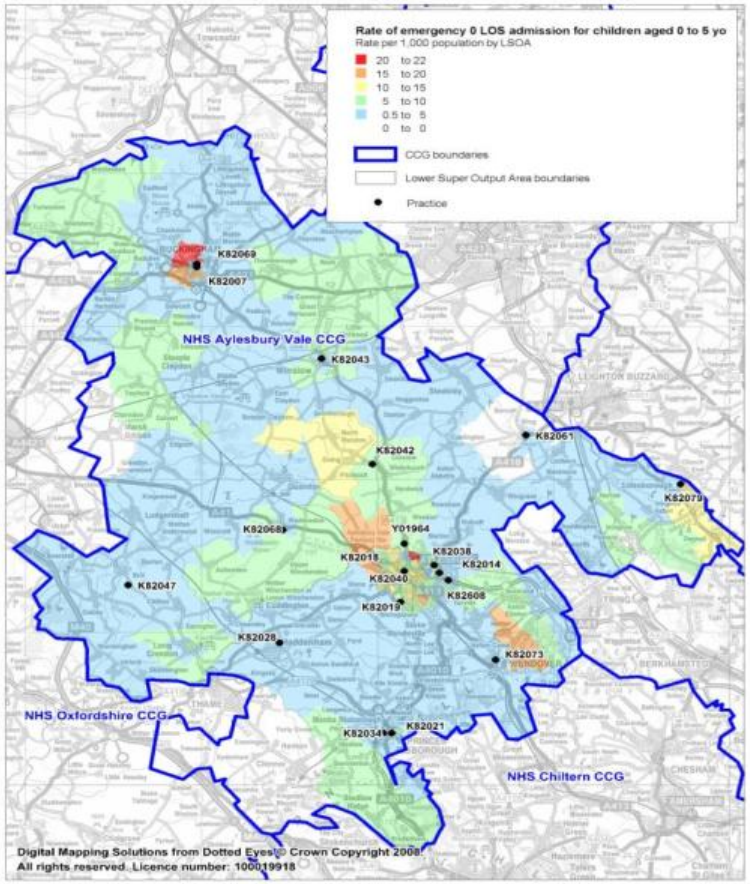
- **Co-ordinating** people's care at every stage
- A **shared focus** on the local **population's health** needs and risks
- Treating and supporting people in the **most appropriate settings**
- **Involving patients**, service users and staff in the changes
- Supporting **collaboration** (sharing information, skills and resources)
- **Working closer together** to look after the health and wellbeing of the people of Buckinghamshire

Integration: know your population

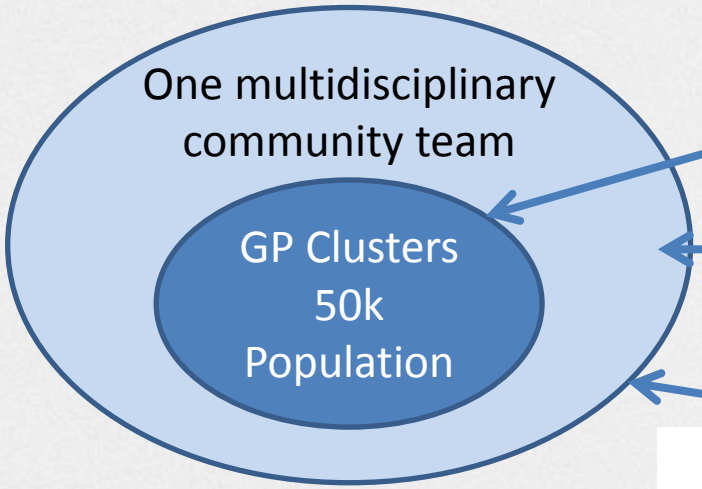
Rate of A&E attendance for patients aged 0 to 5 years old in NHS Aylesbury Vale CCG by LSOA (Feb 2012 - Jan 2013)



Rate of emergency zero length of stay admission for patients aged 0 to 5 years old in NHS Aylesbury Vale CCG by LSOA (Feb 2012- Jan 2013)



Integrating services



Clusters - 50k population, several GP practices

Core integrated team – includes social workers

Specialist practitioner team; accessible to more than one cluster, working across primary and secondary care – includes social care commissioners

Integrating Health and Care Professionals

Working together, we can:

- Empower citizens to have their independence & manage their own risk
- Prescribe assistive technology, social programmes
- Consistent messages about self management
- Develop a virtual learning community to share best practice

Managing risk: Professionals/clinicians can either enhance or inhibit the individual's perception of risk

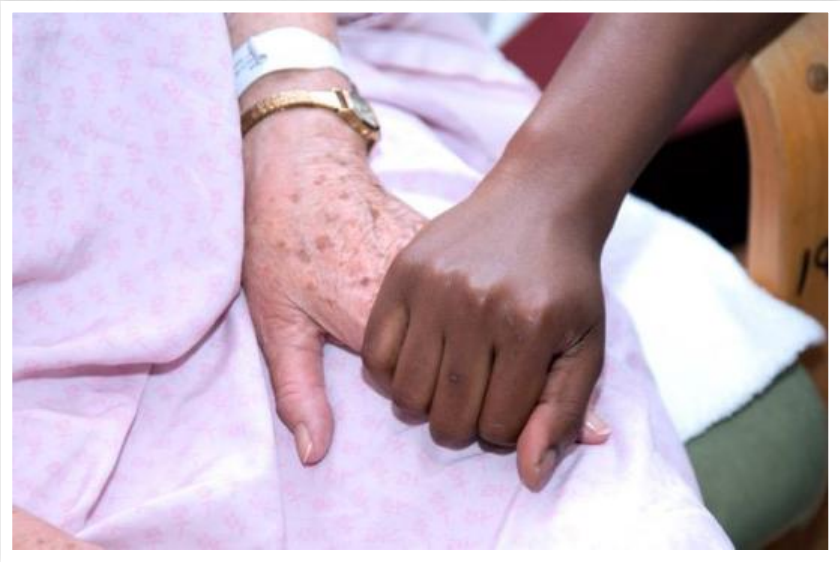
Integrating skills

System Practitioner Networks – rapid access to those with specialist experience in diet, diabetes, COPD, tissue viability, elderly care, paediatrics are accessible to the local population

We will need health and care ‘scanners’ to monitor our populations, predict demand and plan care – for next week and for the next ten years

Telemedicine project

The telemedicine service provided by Immedicare offers remote video consultation between healthcare professionals and patients in a range of settings including care homes

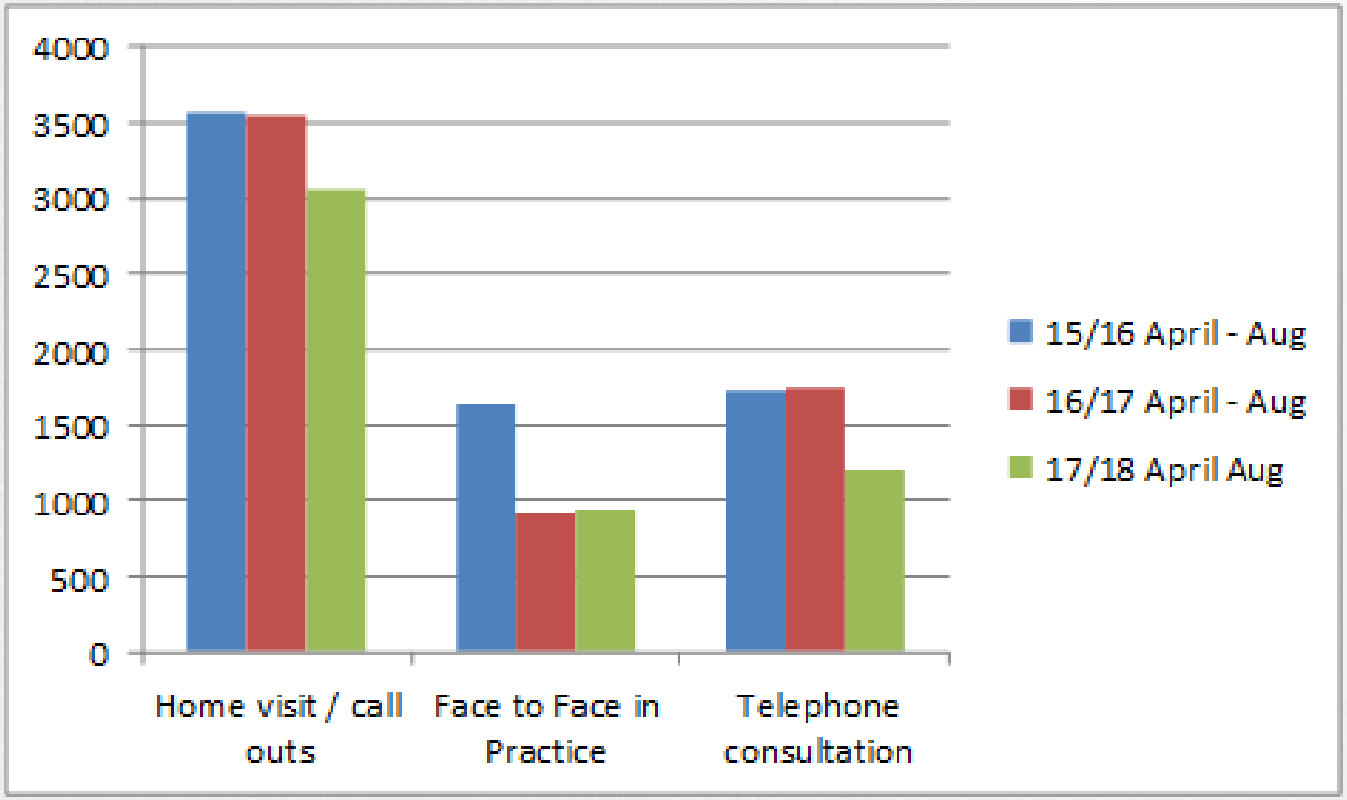


22 care home in the Aylesbury Central and Southern localities

The system is being implemented to address the issue of the rising number of emergency admissions to hospital from care homes, ease pressures on acute hospitals and demands on GP time.

Telemedicine Results

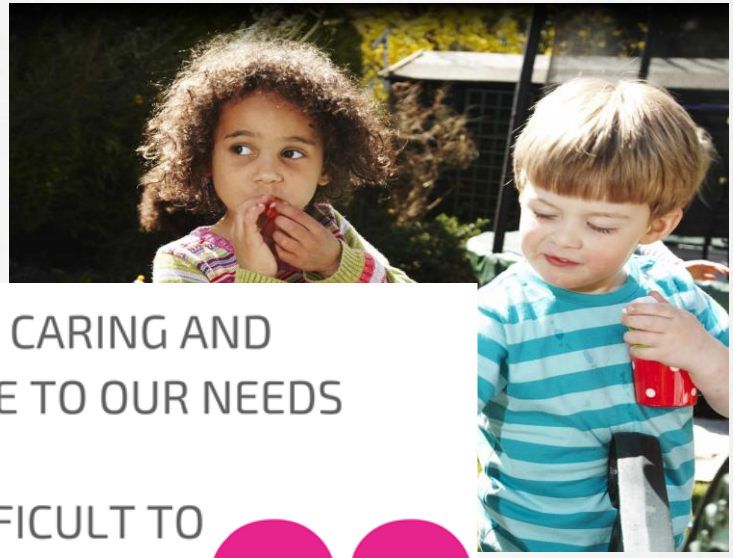
There has been a significant and sustained reduction in emergency admissions to hospital since the care homes started to significantly increase their use of the service



Community hubs

- Providing a new community assessment and treatment service (frailty assessment service)
- Rapid access to Consultants, specialist therapists and Nurses
- Skype clinics – facetime with patients
- More diagnostic testing
- Working with the voluntary sector

Fast-tracking the joined-up services everyone wants



"VERY HAPPY WITH ASSESSMENT AND ADVICE"

"ALL VERY CARING AND SENSITIVE TO OUR NEEDS"

"IT WOULD BE DIFFICULT TO FIND ANY ASPECT NEEDING IMPROVEMENT, I AM VERY IMPRESSED"

"I FELT TOTALLY CONFIDENT IN THE EXPERTISE OF THE DOCTOR AND NURSES"

Integrating our approach to quality

Our communities know Mr Smith well and can describe the level of independence that he usually enjoys.

Mr Smith admitted for full assessment
Key worker shares information so hospital staff understand what is ‘normal’

Mr Smith discharged; 4 week reablement programme to return him to his full pre stay wellness levels

Everyone working together to achieve the same quality outcomes for patients

Integrating for value

Current state….

Patient with multiple co-morbidities referred by GP for hip assessment → Consultant agrees to active treatment; booked for operation → Long period of rehabilitation for not much more mobility

Future state….

Patient talks to GP, Community Nurse, carer and family about options and risks of treatment → Patient decides not to have operation: weekly bridge and lunch club too important. → Management plan includes physio and OT for living safely, pain managed through pharmacist prescriber

Health and care services based on outcomes that are important to the service user

Integrating technology to support self help

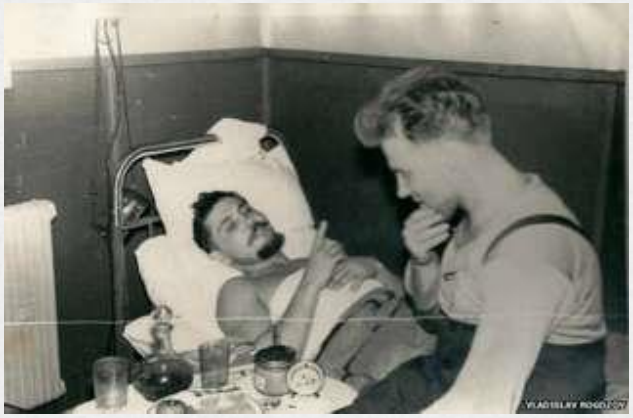
Facebook/Twitter to comment real time on health & social provision

Personalised Risk Profile

On line Health Trainer & FitBit

Baby Buddy App

Triage, then GP or Nurse appointment



And finally- the future?

Self care – but not as we know it!

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Thank You!

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