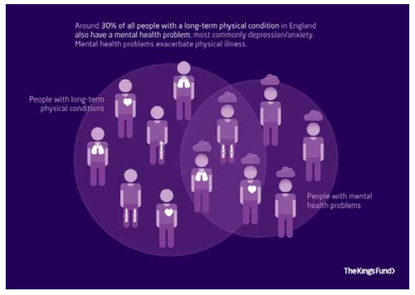
Case for change

Integrated Community Localities

Healthier Together

Mental and physical health cannot be separated but services are often delivered in silos

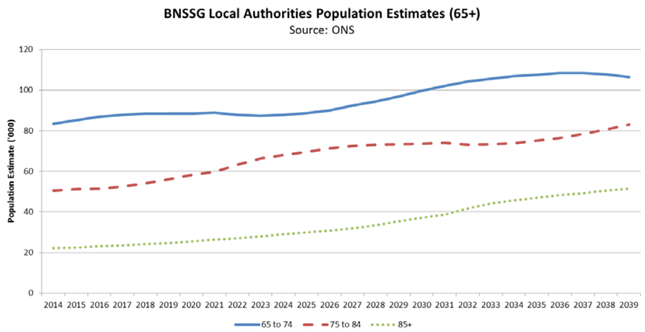
- Loneliness is thought to be as harmful for our health as smoking 15 cigarettes a day – and according to Age UK there are 1.2 million older people in England who are chronically lonely.
- People with a high degree of loneliness are twice as likely to develop Alzheimer's as people with a low degree of loneliness[1].



Our population is increasingly old, frail and people have multiple long term conditions

- Older people can lose up to 5% of muscle strength per day of treatment in a hospital bed National Audit Office (2016)
- Bedridden patients also at higher risk of developing pressure ulcers, deep vein thrombosis and Catheterisation Knight J, Nigam Y and Jones A (2009)

Rising Demand



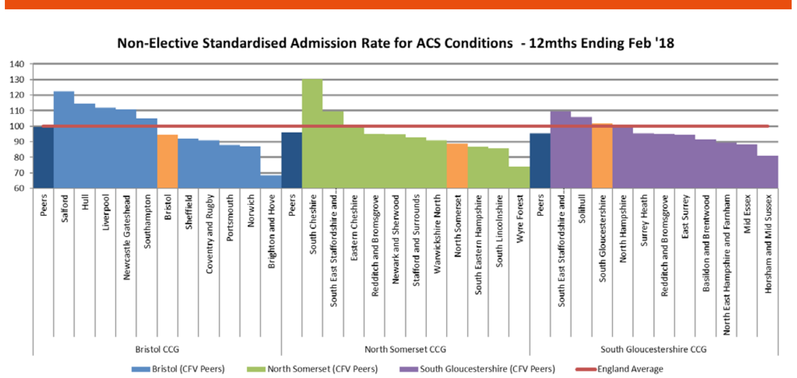
37% growth in the population over 75 will drive:

- 75% of the projected increase in admissions,
- 92% of the projected increase in demand for beds and
- 85% of the projected cost increase

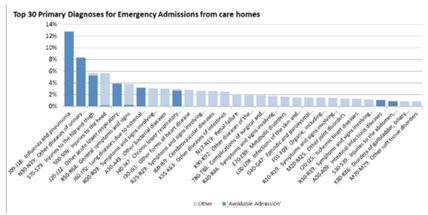
There are admissions that could have been avoided by care being provided elsewhere or by services working together in a more coordinated way

Challenges

- Ageing population, people living longer and with more long term conditions
- Cost and demand pressures
- Overreliance on hospital and residential care and traditionally commissioned domiciliary services and the need to focus on people's strengths
- Limited focus on prevention and early intervention
- Disconnect between social and medicalised care, and a lack of attention to the whole person
- Fragmented delivery of services led to duplication, a lack of co-ordination, and gaps in care



- 30 primary diagnosis blocks account for over 80% of Emergency Admissions from care homes;
- Influenza and pneumonia accounts for over 12%, and other diseases of the urinary system over 8%;



30 primary diagnoses blocks account for over 50% of all older people emergency admissions from care homes

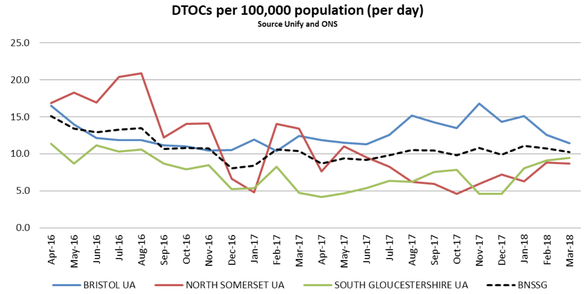
People are currently in beds who could be at home or closer to home

Recent audits at Weston General Hospital have shown

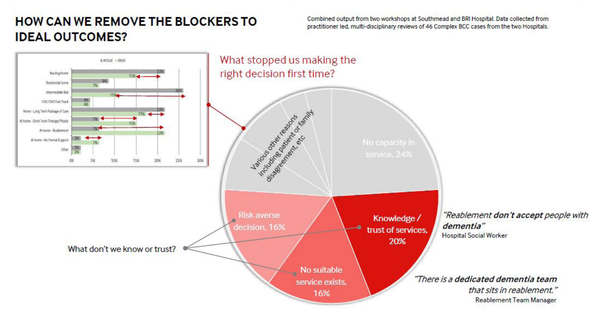
- In the initial audit of 250 patients, 98 North Somerset patients did not require care in an acute inpatient setting.
- There were 25 patients identified on a single day who were suitable for D2A pathway 1 and 2.
- In the follow up audit of Uphill ward, only 4 of the 23 patients on the ward needed acute inpatient medical care

Similar audits at other acute hospitals show the same

Delays in care and lack of services mean people wait in hospital



And they may not be given the right service when they leave



1 Social relationships and mortality risk: a meta-analytic review. Holt-Lunstad J, Smith TB, Layton JB. PLoS Med 2010;7(7) 5 Loneliness and risk of Alzheimer disease. Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. Arch Gen Psychiatry 2007 Feb; 64(2):234-240

Integrated Community Localities

But – there is evidence from elsewhere that a strong, integrated model of care in the community can make a difference

Category	Source of Evidence	Impact on activity	Reference
Comprehensive review of Integrated Care	50 reviews were included. Interventions focused on case management, chronic care model, discharge management, complex interventions, multidisciplinary teams and self-management.	Reduced NEL admissions by 15–50%; A&E use by 30–40%	Damery et al (2016)
Care coordination & Planning	Torbay, Devon. The Torbay Community Trust established 5 integrated health and social care teams organised in localities aligned with GPs. Daily occupied beds fell from 750 to 502 in 10 years.	Emergency bed day use among >65s is the lowest in the region	Case study Sonola et al (2013b).
Chronic care Model	CCM reviews reported that interventions with multiple components were significantly more effective than single component interventions at reducing admission rates with reductions of 22–32% observed in reviews that performed meta-analysis	Reduced 22–32% NEL admissions Reduced A&E use by 32-42%	Damery et al (2016)
Care coordination & care Planning	Torbay, Devon. Torbay Community Trust established 5 integrated health and social care teams organised in localities aligned with GPs. Daily occupied beds fell from 750 in 1998/99 to 502 in 2009/10; emergency bed day use among > 65s is the lowest in the region reduced DTOCs; increased home care provision	Reducing bed days for emergency admissions by 15-30% for target cohort	Case studies Sonola et al (2013) Goodwin et al. (2012)
	MDT were also associated with a 42% reduction in heart failure readmissions, a 2-day reduction in LoS	Reduced average LoS by 2 days	Systematic review Damery et al (2016).
Chronic care Model	Surrey Downs CCG: New Epsom and Ewell Community Hospital (NEECH) beds at Epsom Hospital over halved average LOS and acute stays by almost 50% – this trend was reflected in both step up and step down beds	Reduced LoS by 50%	Epsom Hospital, Trust review of NEECH initiative (2014)
	Systematic review shows that CCM interventions were associated with a significantly reduced mean LoS for COPD of 2.5146 and 3.78 days, respectively	Reduced LoS by 2.5-3.8 days	Systematic review Damery et al (2016).
Impact on social care from integrated care model	Northumberland's integrated care model has seen a 12% reduction in residential care while demand for domiciliary care has been maintained at a constant level despite demographic pressures.	Reducing residential care placements by 12%	Systematic review LGA (2014)
	Richmond's integrated reablement service has saved £2.1 million over the three years, reducing demand for council services, avoiding admissions to hospital	Reduced demand for council services	Systematic review LGA (2014)

Working with the voluntary sector and communities can divert people away from medicalised solutions

There is emerging evidence (Thomson et al. 2015) that social prescribing:

- Improves mental health and wellbeing
- Reduces social isolation and exclusion
- Increases patient confidence and independence
- Leads to fewer primary care consultations
- Reduces hospital utilisation

In Gloucestershire the social prescribing programme has demonstrated:

- Statistically significant improvement in patient wellbeing.
- A 23% decline in A&E admissions in the six months after referral compared to the six months before.
- That GP appointments declined by 21% in the six months after referral to a social prescribing co-ordinator, compared to six months before.

(Kimberlee, 2016)

Vision for 2023

Integrated Community Localities

Healthier Together

Individuals, families and communities keep themselves well and know how to access the care and support they need, 24/7

- I know what to do to keep myself and my family well
- I work with my care professionals to manage my health and care and make decisions about what's best for me
- I When I need care, or want to keep myself healthy I'm supported to make informed choices
- I know what support is available and where to go to for advice and I can talk to someone about the things in my life that affect my health and wellbeing
- I am helped to remain independent at home with the support I need

Our Vision: Working together in localities to enable people to stay healthy, well and independent in their communities

General Practice at the heart of an alliance of providers who all work together to support the local population

- I feel, as a GP, that I am fully able to use my skills to be a leader of integrated care and to support those who need more intensive support
- I know that General Practice in this area is resilient and well supported by our joint working with other providers so that we can do the best for our patients and population
- We have great working relationships in our locality across all sectors (physical and mental health, social care and the voluntary sector) and we can put the interests of people first
- Our resources are shared, we don't work in silos
- We don't need to admit anyone to hospital unless they really need to be there and we are able to bring people home to their community at the earliest opportunity

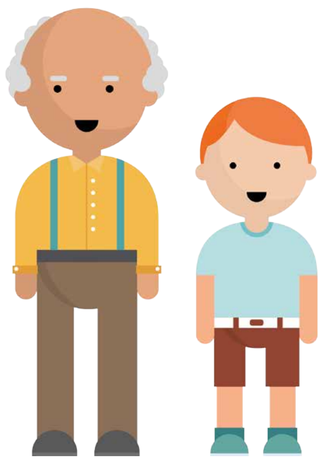
Communities and providers use technology to join up care in local areas, by sharing information more effectively and improving communications

Communities:

- I have easy access to information not just about health and care services but also voluntary and community activities in my area
- My care providers all have access to my care plan, so I don't have to tell my story every time I meet a different practitioner
- I can access care in lots of different ways using technology that I have at home

Providers

- We share access to individual care plans, which allow us to join up all the different care packages provided to individuals and give them a genuinely personalised service
- It is easy for us to communicate so that we are one team wherever we work



Every locality has a sustainable, shared workforce providing satisfying, achievable jobs and a shared sense of purpose

- I have clear goals and objectives and know that I'm making a difference for my community
- I work hand in hand with both health and care colleagues and the community to plan and deliver joined up care for local people
- I work with individuals to design the care that they need and can spend time with them to make that happen

Progress

Integrated Community Localities

Healthier **Together**

We are on a journey progressing towards a more integrated approach to care

Possible priorities might include:

Inner City & East (Bristol)	North & West (Bristol)	South (Bristol)	Weston & Worle (North Somerset)	Woodspring (North Somerset)	South Gloucestershire
Integrated locality model for mental health	Integrated mental health model	People with enduring mental health issues	Frail and older people*	Mental Health – With particular focus on adolescents	Mental Health
Children's safeguarding multidisciplinary meetings	Joint clinics run by practice nurses and District nurses, linking with voluntary sector orgs	Vulnerable families/adverse childhood experiences	Children and young people*	Care Homes	Children's Services
Complex housebound/ICE locality visiting service	Diagnostic hub in locality	Joint Frailty Clinics	Vulnerable groups*	Frailty	Weekend Care Home Provision
		Using/maximising available digital/ remote options to support locality team working	* The above are the 3 priority areas of the Healthy Weston Programme. There are multiple projects aligned to each of these priorities to deliver improvements.	IV/Ambulatory Care Pathway	

Our achievements to realise the vision:

- December 2017 – Locality provider groups established: Groups of GP practices working together in 6 localities covering the whole population across BNSSG
- July 2018: Plans being developed by these locality groups to deliver improved access and new areas of joint working with other health and care providers in the locality (community; mental health; voluntary sector; out of hours services; local authority adult and children's services)
- May 2018: Joint provider forums established in each locality (primary and community physical and mental health services, social care and voluntary sector

Progress

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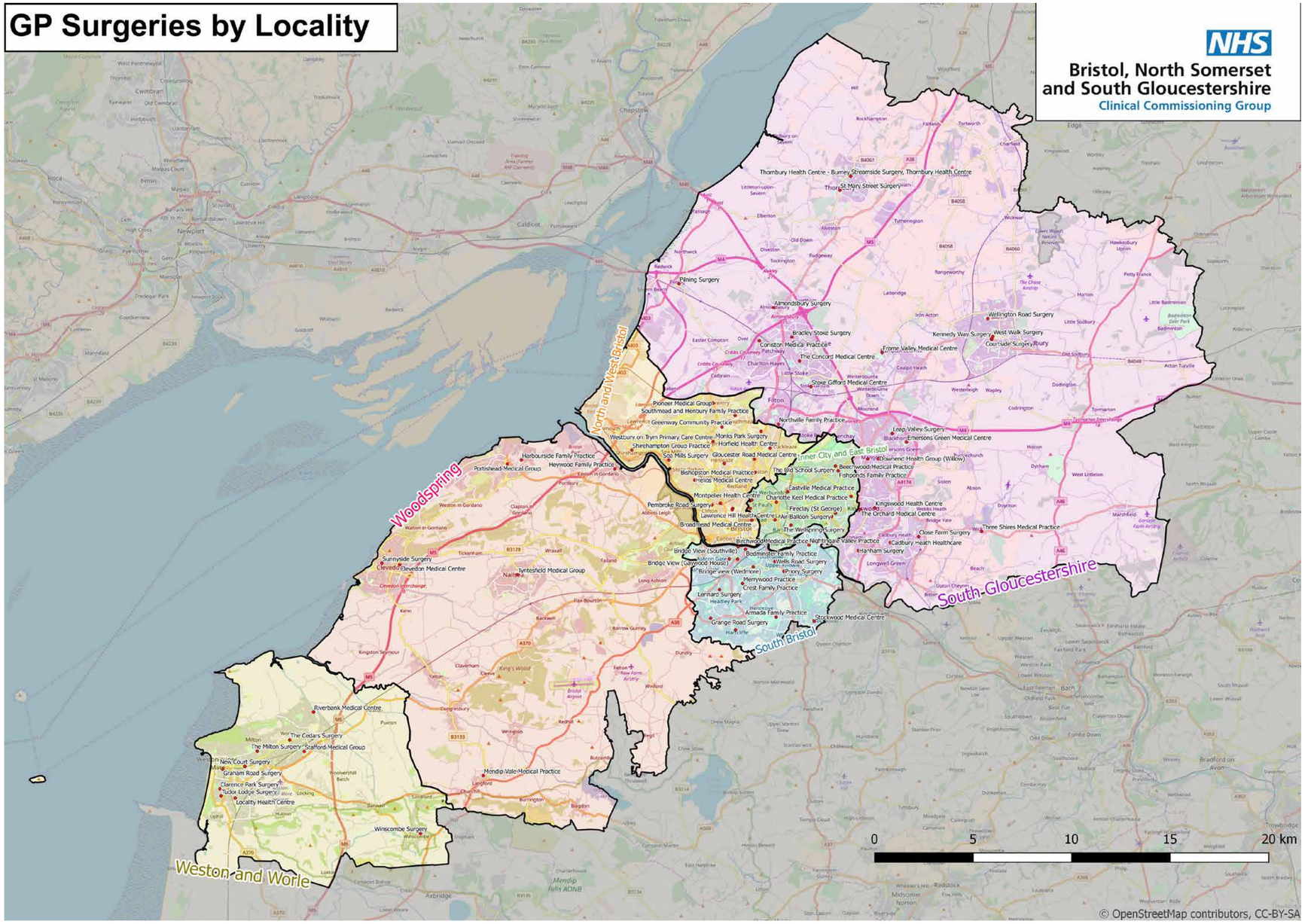
Healthier Together



Roadmap

Integrated Community Localities

Healthier Together

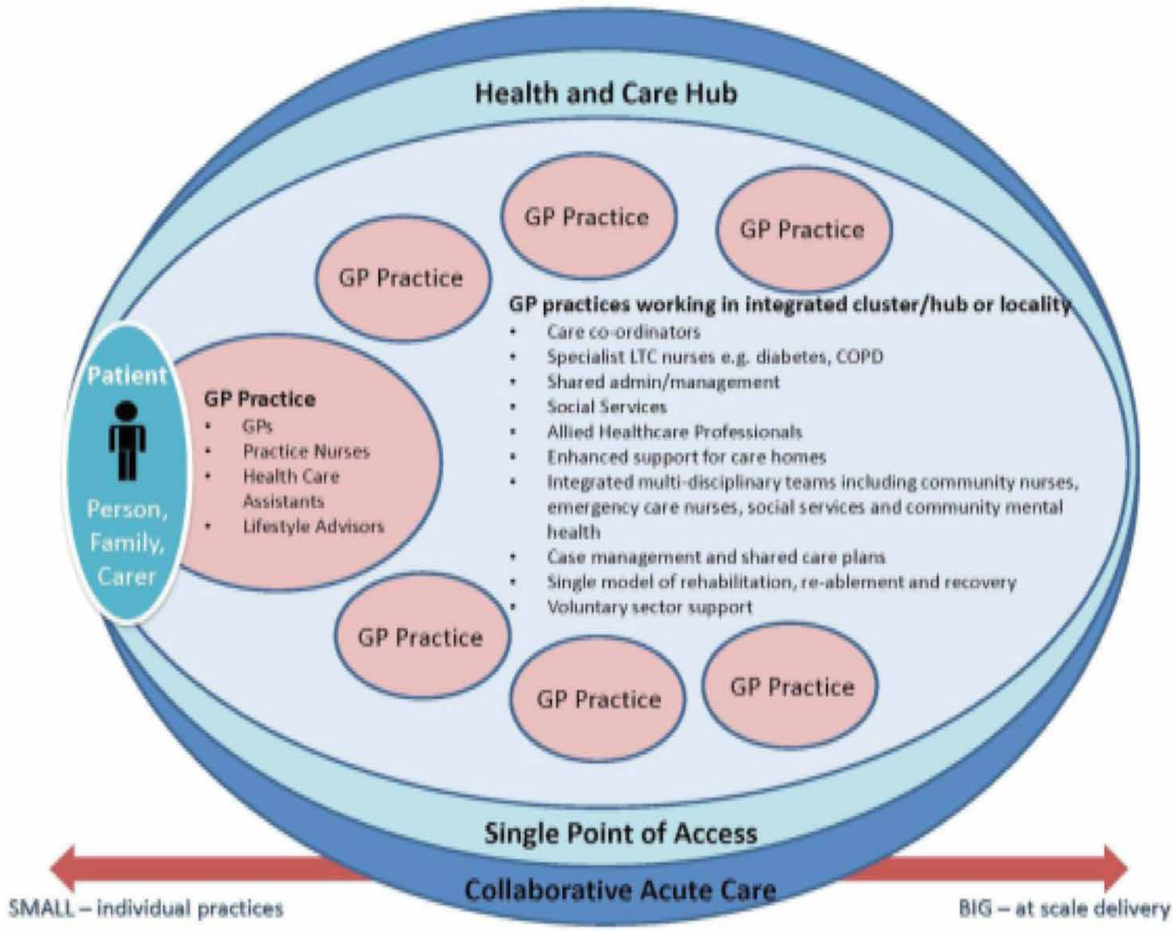
Deliverables

We will be working together in new ways, developing provider alliances in localities, starting with key priority groups of people for example frail elderly and moving towards integrated, place-based systems of care. Our ambition is to develop provider alliances in each locality. The proposal is that they will deliver care in a new way including:

GP leadership at the heart of the model of care

Integrated locality teams providing care wrapped around individuals and populations in a way that blurs traditional organisational boundaries. This will include mental and physical health, social care and the voluntary sector and a shared support plan that includes all aspects of care. These teams will focus on delivering preventative care, more effective care planning and navigation and access to voluntary sector and other preventative services.

Locality hubs. These hubs would be physical buildings from which the integrated locality team would provide services centred around key groups such as children and families; the frail elderly or vulnerable groups, their friends, family and carers. This could include support that is medical (e.g. physical or mental health assessment) and non-medical (e.g. parenting advice). The types of services and location would be determined by the population need in each locality and would need to be supported by other services such as transport



Social prescribing

Social prescribing provides a pathway to refer people to non-clinical services, linking them to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self care where appropriate and to build resilience within the community and for the individual".

Technology

Key to the model will be the very best technology (apps; texting; sharing of information and records) that can support remote communication for staff and patients and remote monitoring to support patients with known conditions

Integrated Community Localities

Healthier **Together**

We will use an asset based approach...

The asset approach is a set of values and principles and a way of thinking about the world.

What is an asset?

"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being."

Antony Morgan, associate director, National Institute for Health and Clinical Excellence (NICE), 2009)

e.g.

- the practical skills, capacity, energy and knowledge of local residents
- the networks and connections in a community, including friendships and neighbourliness
- the effectiveness of local community and voluntary associations
- the physical and economic resources of a place that enhance wellbeing

Moving from a deficit approach to an asset approach A Glass Half Full: How an asset approach can improve community health and wellbeing, Foot and Hopkins, 2010, IDeA:

Where we are now – the deficit approach	Where an asset way of thinking takes us
Start with deficiencies and needs in the community	Start with deficiencies and needs in the community
Respond to problems	Identify opportunities and strengths
Provide services to users	Invest in people as citizens
Emphasise the role of agencies	Emphasise the role of civil society
Focus on individuals	Focus on communities/ neighbourhoods and the common good
See people as client and consumers receiving services	See people as citizens and co-producers with something to offer
Treat people as passive and done-to	Help people to take control of their lives
'Fix people'	Support people to develop their potential
Implement programmes as the answer	See people as the answer

Integrated Community Localities

Healthier Together

Integrated Care

We are not standing still! Things are already changing – for the better!

Community Clinics improve care and make the most of resources

As Part of the Primary Care Home project in South Bristol the 'Healthy Together Clinic' has been established to improve healing rates for people with leg ulcers. The clinic runs in South Bristol and is staffed by Practice and Community Nurses and volunteers and sees patients from 6 Practices who would otherwise attend practice treatment rooms or be visited at home by Community Nurses. The clinic, in a relaxed community setting, provides opportunities for socialising with other patients and volunteers as well as ensuring continuity of care and optimal treatment for each person.

The clinic is overseen by a community specialist in Wound Care. It is demonstrated that this approach promotes faster healing rates and longer lasting healing. At the same time staff from different practices, community services and volunteers all work together, getting to know each other and sharing their expertise. People who would otherwise be seen at home are offered transport and a broad range of health advice and information, and signposting is also available at the clinic.

'I have found working alongside a practice nurse very helpful and feel that I have gained more confidence with wound care in general not just on legs because of having more time to work alongside and ask questions/share knowledge. Patients really do enjoy the experience too and being able to see their ulcers heal and the patients happy is extremely warranted.'
Community Nurse

There are many other examples of community clinics providing specialist support for long term conditions in local community settings convenient and accessible for the population. These include catheter clinics, a lymphedema clinic in North Somerset, and memory cafes for people with Dementia.

Wider mix of staff and new roles support sustainable general practice

Frailty can be both treated and prevented and healthy ageing can reduce the risk of becoming frail. Older people are 12 times more likely to be alive and live at their place of choice 6 months after being identified as frail, and receiving a comprehensive geriatric assessment and appropriate care and support.

In South Gloucestershire, based around clusters of 5 – 6 GP practices, practice-based multi-disciplinary team working, led by community matrons, has been developed, focusing on the most vulnerable at risk of admission and those requiring support to be discharged in a timely fashion.

Membership includes GPs, social care, community teams, active ageing and the voluntary sector. All practices also have an aligned Learning Disability Community Nurse. They offer monitoring and support of each practices register of people recognised as having a learning disability. From this data Community Nurses are able to provided support and interventions to ensure good take up of annual health checks through reasonable adjustments and clinical expertise.

In North Somerset a Community Frailty service has been established, including a Frailty MDT consisting of Community Consultant Geriatrician, Frailty lead practitioner (advanced practice physiotherapist), Mental Health nurses, Community matrons, pharmacist, to focus on frail older people who have had an unplanned hospital admission.

The service identifies unmet needs resulting in medication reviews and 'de-prescribing', mobility advice and exercise, lab and imaging requests, different or new diagnoses, onward referral to the memory clinic, optimisation of treatment plans for pre-existing long term conditions, advice and support for carer and family.

The Service has had a marked impact on hospital admissions and hospital length of stay reducing the number of times people have to go into hospital and the length of their stay of they do. This is very important for the health and wellbeing of frail older people who can lose independence rapidly if they have repeated or extended stays in hospital.

Multi-Disciplinary Working in Practices supports Frail Older People

GPs are in short supply and are sometimes overwhelmed by the volume of patients asking to see them. It can sometimes be difficult to get an appointment. To tackle this Practices are engaging a wide range of clinicians and practitioners to support them and ensure that patients are seen quickly by someone who can meet their needs.

An example of this is the use of paramedics and advanced nurse practitioners to undertake early home visits, as part of the Primary Care Home project in South Bristol, so that people who may need a hospital admission or assessment are identified early in the day. This often means they can attend and return home the same day avoiding an unnecessary and sometimes counterproductive overnight stay.

A number of pilots are taking place to extend the use of physiotherapists to see patients first, who have requested a GP appointment for a musculo-skeletal problem. Many of these people can be successfully seen and treated more quickly, without having to see the GP. Practices and Community Services are also developing new roles, training healthcare assistants in a range of nursing and therapy competencies as well as mental health awareness.

This enables them to spot and attend to a wider range of needs when visiting a patient. The voluntary sector is also an increasingly important part of the health, care and support network with volunteers supporting a range of health needs for example 'exercise buddies' helping people complete a course of pulmonary rehabilitation, as well as community navigators tackling loneliness and isolation and motivating people to manage their own health conditions.

Promoting independence and faster recovery

Proactive support for frail older people, those with long term conditions and the most vulnerable groups can help avoid unnecessary hospital admissions and get people home more quickly after a hospital stay. 'Admission avoidance' is being achieved through proactive management of those at risk through practice-based Frailty MDTs in South Gloucestershire, the Community Frailty service in North Somerset and a rapid assessment and support service based in the emergency departments of the two hospitals in Bristol.

Bristol people benefit from a community Rapid Response service which provides home-support as an alternative to hospital based care through home visits by advanced practitioners supported by GPs. Rapid Access Care of the Older Person (RACOP) delivered through a local clinic at South Bristol Hospital provides a thorough diagnosis and treatment plan to allow people who would otherwise need to stay in hospital to go home with the right support.

After a hospital stay, rehabilitation and reablement support is provided for those who need it to regain their former level of independence. Increasingly discharge is arranged prior to a full assessment of the rehabilitation, reablement and ongoing support needs of the patient, this is known as 'Discharge to assess', a full needs assessment takes place after discharge from the acute hospital.