Public Health Dorset

Agenda Item:

Insert Item No.

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	21 November 2016
Officer	Director of Public Health
Subject of Report	**Integrated Community Services**
Executive Summary	Developing integrated community services is a core part of the Sustainability and Transformation Plan for Dorset. This report presents a briefing for board members on the current plans, progress and potential opportunities for improving prevention and population health from improving community services. Above all, it sets out how getting integration right in localities could form the foundation for a place-based approach to health and wellbeing.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: N/A
	Use of Evidence: Public Health Dorset routinely uses a range of evidence to support the development of business plans and priorities as part of its core business.
	Budget: There are no direct public health grant implications arising from this briefing. However, integration of community services is a part of the overall drive to reduce use of hospital services and improve the ability to deliver care close to home. This has budget implications

	for the organisations committed to implementing the Sustainability and Transformation Plan for Dorset, including local authorities.
	Risk Assessment: N/A
	Other Implications: N/A
Recommendations	1) Members of the Joint Public Health Board are asked to note and comment on the briefing on integrated community services development, and implications for moving to a more place-based model of care.
Reason for Recommendation	To ensure Board Members are aware of plans for community services within the Sustainability and Transformation Plan that could help deliver a place-based and more preventive approach to health and care in Dorset.
Appendices	
Background Papers	None.
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Director's name: Dr David Phillips
Director of Public Health
November 2016

1. Recommendations

1. Members of the Joint Public Health Board are asked to note and comment on the briefing on integrated community services development, and implications and opportunities for moving to a more place-based model of care.

2. Reason

2.1 To ensure Board Members are aware of plans for community services within the Sustainability and Transformation Plan that could help deliver a place-based and more preventive approach to health and care in Dorset.

3. Background

3.1 The development of integrated community services is an important part of the Sustainability and Transformation Plan for Dorset. The essential idea is that more people's health and care needs will be met outside of hospital by larger, more integrated teams of professionals working across organizations, focusing on people's needs and helping them to better manage their conditions.

3.2 However, this apparently simple concept is by no means simple to implement, because of the way that community services are currently configured, paid for, and used. The NHS has traditionally been good at developing highly specialized clinical roles, even among community nursing staff. When coupled with delivery of very specific pathways of clinical support, usually focused on a single condition e.g diabetes, this results in care processes that can appear to the individual receiving them as fragmented, inefficient and confusing.

3.3 Integration is a concept intended to overcome some of these limitations to the current, community services model. While there are many different models described in the literature, at the heart of most of the models is the idea that it is about better co-ordinated care for people living with chronic conditions, more often than not delivered in community settings and people's homes, with the aim of reducing use of secondary care services and improving health outcomes of individuals.

3.4 There are also some other important elements to integrated care programmes that could present important opportunities in Dorset, particularly the links with taking a more preventive approach to health and care, and considering the needs of populations living in a particular place. Many earlier ideas about integrated care involved ideas about measuring likelihood of hospital admission, and attempting to reduce this likelihood by focusing preventive services on the people at highest risk of admission. These ideas have been developed further by The King's Fund, which now talks about population-based approaches to health and care, looking at the needs of the whole population, not just those with the highest health and care needs[1]. This also considers the importance of wider determinants of health on the population's health and wellbeing.

3.5 So a truly population-based system of care going beyond just integration would:

- Consider the whole population's health and wellbeing needs and ensure that incentives are aligned to support improving outcomes for whole populations, including across organizations and budgets;

- Be able to offer consistent, early, evidence-based support for prevention interventions before the development of chronic diseases, including social interventions such as housing improvements; [note: this can be delivered to targeted sub-groups of populations];

- Think not just about integration of community health professionals, but integration of approaches to health that go beyond individual interventions; such as environments that promote physical activity, access to green space, higher value jobs, access to quality relevant education. This could also include consideration of the importance of integration across age groups, e.g. between adults and children's services, for example.

4. Integration in the Sustainability and Transformation Plan

[1] Population health systems: going beyond integrated care. London, Kings Fund, February 2015.

4.1 The Sustainability and Transformation Plan "Our Dorset" recognises the importance of integrated community services, and it is described within the plan as the second of three principal programmes (along with Prevention at Scale, and One Acute Network).

4.2 The stated ambition is to 'transform primary, community and care services in Dorset sot that they provide integrated care, based on the needs of different local populations'. There is an ambitious intention that this transformation will help to reduce outpatient attendances by 10 per cent, follow up appointments by 25%, and emergency medical and surgical admissions by 25 and 20 per cent respectively.

4.3 The plan envisages creating a network of community hubs across Dorset, from which teams of mixed professionals will provide care for people with physical and mental health needs. The hubs will cater for children, adults and the growing elderly population.

4.4 Each of the hubs will provide a range of health and care services, ranging from routine care (e.g. general practice and preventive services such as screening, immunisations, elements of health visiting), to diagnostics and access to secondary care specialists via outpatient clinics, consultations and some minor procedures. The hubs will also provide access to urgent care services, aiming to prevent admission to hospital for a substantial number of people who currently cannot be supported outside of hospital.

4.5 Proposals for the location of the community hubs are being developed for consultation. It is likely that in the urban areas of Bournemouth and Poole, the community hub will be located at whichever hospital becomes the major planned site. In other areas of Dorset, the existing community hospitals are likely to be reviewed for suitability to become the sites for the new hub arrangements.

4.6 A crucial part of the development of integrated community care is modernising general practice, in line with the GP Forward View[i2]. This set out ideas about new models of general practice, to address some of the current national challenges around workforce, demand, morale, efficiency and back office services, including identifying new ways of offering primary care working more closely with community health services and others in extended multi-disciplinary teams.

5. Progress to date

5.1 There has been good progress in developing new ways of integrated working in communities, with health visiting and school nursing commissioning projects that will see delivery of the services as part of the wider set of integrated services for children and young people. Already, health visitors across Dorset are working more closely than ever before with children's centres, bringing them closer to other professionals supporting children and families in the community. For adults, the Better Together Partnership (Better Care Fund) has supported the development of integrated locality teams comprising health and social care professionals in the 13 Dorset localities. These teams support early discharge from hospital, rehabilitation and recovery for patients with conditions like stroke, and better end of life care. However, to date they have not made an impact on reducing emergency admissions to hospital.

5.2 Public Health Dorset has been involved in the past year in developing new models of care to support the transformation of primary care and community services, as part of the Dorset Vanguard programme. This work is now being extended with support from the Wessex Transformation Fund to enable general practices in North Bournemouth to

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[2] NHS England April 2016. General Practice Forward View. See https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

work more closely together and implement the new model of care. Current pressures in general practice are limiting the pace at which transformation can take place, with many working flat out just to meet current demand.

5.3 Finally, the Dorset CCG has been working on a new primary care strategy to support the transformation of primary care, required as part of the development of integrated community services. There is still the need for more detail around the mechanisms through which the CCG will shape future models of primary care, for example, reducing the number of GP surgeries, and supporting new models of care as set out in the GP Forward View.

6. Potential opportunities

6.1 The integrated community services programme of the STP offers the opportunity of moving to a more place-based view of how best to organise the resources to meet the needs of populations across Dorset. This is in contrast to the current way that services are often organised, based on provider and organisation needs. This place-based view includes looking at how the total health and social care resources should be deployed around the person, not managed within organisational silos.

6.2 The transformation of primary care is a key part of ensuring an effective approach to improving outcomes for populations. For too long, there has been a push / pull on community teams like district nurses and health visitors – arguments over whether they work attached to primary care practices for example, or based in community teams.

6.3 There is an opportunity to explore new models of primary care that would see general practice as just one element of an integrated community-led model of care. Where this has worked well elsewhere, GPs are an integral part of a much more holistic model of care, often incorporating not just professionals but peer supporters and voluntary sector organisations. These people are often better placed to deal with some of the more complex social issues connected with primary care presentation.

6.4 Another aspect of ICS work is that it has the potential to address the current challenges around variation in quality of care and outcomes for people with long-term conditions like diabetes. If networks of practices established support at scale for people in whole localities living with diabetes, involving a variety of care and support planning approaches, it would improve efficiency and outcomes based on experience from elsewhere in England (Tower Hamlets and Sefton, for example).

6.5 There is also the chance within this work stream to change the culture of how community services teams work. Traditionally, resources like district nursing have been managed on a task focused basis – nurses have a case list and tend to work through the list according to tasks that need doing e.g. dressings that need changing etc. There is growing interest in different nursing care models that allow teams of nurses to determine for a particular area what the care needs and priorities should be. This model, known as Buurtzorg after the Dutch integrated nursing care organisation that first developed it[3] – has been shown to lower costs and substantially increase the satisfaction of people being cared for in evaluations so far. Public Health Dorset is working with Bournemouth University and Dorset Healthcare University Foundation Trust to see if a pilot study can be started within Dorset to test out this approach with a view to evaluating the potential for implementing at scale.

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[3] Royal College of Nursing. The Buurtzorg Nederland Home Care Nursing model. See https://www2.rcn.org.uk/__data/assets/pdf_file/0003/618231/02.15-The-Buurtzorg-Nederland-home-care-provider-model.-Observations-for-the-UK.pdf

7. Questions for the Board to consider

7.1 The following questions may be helpful for Board Members to bear in mind in future discussions and debates around how ICS is developing within the STP, including for example at Health and Wellbeing Boards.

Will integrated community services plans in the STP:

- Help to deliver the challenges identified by the Prevention at Scale programme, particularly reducing the observed variation in secondary prevention for people with established conditions like cardiovascular disease?
- Improve the use of information – both on a personal level through better shared records, and at population level, to ensure interventions consider the needs of all the population, not just those presenting most acutely?
- Enable community teams to work more upstream and prevent demand and costs in secondary care?
- Reduce overall use of secondary care – emergency admissions, outpatient attendances and follow up appointments?
- Close the health and wellbeing gap, in line with the Five Year Forward View?
- Deliver against the particular needs of communities that differ across Dorset?
- Keep community staff motivated, engaged and enable better retention of staff, particularly those working in primary care?
- Ensure that the planned reduction of secondary care use including emergency admissions does not involve cost shifting to other teams, such as adult social care?
- What are the cultural obstacles to this 'working together' given it has been spoken about for many years but there is little evidence of it happening and what can board members do in the localities to change that culture?

8. Conclusion

8.1. This briefing has been written to help raise Board Members' awareness of the current plans to deliver integrated community services within the STP. This is because there are huge potential opportunities to help resolve some of the challenges identified by the Prevention at Scale programme, not least improving peer and personalised care and support planning for people with chronic disease, and scaling up information-driven disease management through developing transformed primary care.

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4 November 2016