NHS Community Fit

Future Fit Board Paper

November 2015

Introduction

The purpose of this paper is to provide a progress report on the first phase of the Community Fit project and to highlight the need for further work to be undertaken on the broader programme.

Phase one delivers an understanding of the underlying community activity trends and the additional impact that Future Fit may create.

The Community Fit steering group has been assembled to oversee phase one of Community Fit and the group reports into the two CCG Boards, as commissioners of the work. Programme management and analysis for Community Fit is being provided by the Strategy Unit at Midlands and Lancashire CSU. At their November meetings, the boards of both CCGs approved the Community Fit steering group terms of Reference for Phase One.

Progress to date on Community Fit

Phase one requires the gathering and merging of pseudonymised patient activity data from local hospital, community, mental health, GP and social care providers in order to provide a holistic view of out of hospital activity.

It has taken longer than planned for this data to be supplied. However, data of a sufficiently high quality has now been received from all health care providers. A technical issue has prevented some social care data from being delivered but this issue is due to be resolved on 13 November.

Initial workshops with each of the 5 constituent workstreams (Third sector, mental health, primary care, social care and community health care) are planned prior to Christmas. The first workshops will confirm the descriptive analysis of the data and provide assurance for the second round of workshops which will preview the linked data and agree high level descriptors (taxonomies) to assist with the classification of care packages by level of patient / service user need.

The voluntary sector workstream (the first of which is to be held in Shrewsbury on Friday 13th) have had strong sign up from across the sector. Delays in receiving some of the data has meant that two planned workstreams (community health and mental health) have had to be postponed but these are being rescheduled prior to Christmas.

Conditional on receipt of all data sets in line with current agreements, Community Fit is still on track to deliver the final outputs of Phase One by March 2016. Innovative work around GP data, with the potential to link these across health and social care to give a fuller understanding of a whole patient / service-user journey, is making encouraging progress.

The wider Community Fit ambition

The attached paper sets out the broader objectives and approach to Community Fit. The scope of NHS Future Fit is limited to hospital services. The clinical model, however, creates fundamental dependencies – the new hospital model will only work if community and primary care services are able to implement synchronised delivery of their part of the model.

There are challenges faced in primary and community services independently of the consequences of the NHS Future Fit clinical model; changing and rising demand; workforce sustainability issues; the need for greater service integration and structural challenges in maintaining high quality and comprehensive service offers in remote locations

Phase 1 is simply an enabler to better inform the case for investment in alternative services to hospital care.
Future phases of Community Fit will need to be agreed once the outputs from phase 1 are understood. The Steering Group will be asked to produce proposals for the CCGs to consider after March 2016

Recommendations

The Future Fit Board is asked to

- Approve the progress made by the Community Fit steering group to date
- Receive the paper regarding the broader description of the potential full scope of the Community Fit programme and agree a process for specifying and managing the Community Fit plan after March 2016.

Overarching Community Fit Briefing paper
APPROVED by CCG boards, November 2015

Further to an earlier draft of this paper being shared at the Future Fit Programme Board in August 2015, some revisions have been made to the sections regarding primary care development. The principle recommendation is that further collaborative discussions should now take place to understand the extent to which a common approach to primary care development across Shropshire, Telford and Wrekin in helpful or desirable in relation to the Community Fit programme of work, potentially involving the GP Federation.

1. Introduction

The purpose of this document is to set out the approach of Shropshire and Telford and Wrekin Clinical Commissioning Groups to developing services outside hospital. The name given to this programme of work is Community Fit.

2. Aim:

The aim of Community Fit is to deliver a sustainable, community based, health and social care system focussed on prevention and continuity of care, delivered by integrated teams of clinicians, through bespoke local solutions utilising their unique local asset base.

3. Background:

Community Fit was borne out of the need to describe in detail how the NHS Future Fit model (reconfiguration of acute and community bed-based services) would function and enable the intended transfer of inpatient activity to be delivered within the primary care setting. However, a significant amount of work had already taken place over the preceding months where both sponsoring CCGs (Shropshire and Telford & Wrekin) had started prototyping models of care that would become central to the delivery of Community Fit. These projects ranged from supported discharge through the Rapid Response and ICS teams integrating health and social care; admission avoidance through CHAS; increasing the scope of the co-ordination centre and referral services to utilise local resources differently; piloting and embedding care pathways aimed at LTC management at home through schemes such as COPD, heart failure and Osteoarthritis. Work was also already underway with the Third Sector to strengthen community support and resilience, focussed on the most vulnerable in our society and projects such as “Team around the Practice” were starting to be explored.
Collectively these projects had started to cover the spectrum of support and care needed to enable patients to be discharged earlier, managed in the community and treated by local teams. Ranging from community support with volunteers through to formal clinical interventions and active case management we had created the basis for the Community Fit model.
However, to enable safe transition from the current care model, which is heavily inpatient based, all aspects of care will need to be covered to ensure that the reliance on inpatient beds is adequately met by community alternatives before the Future Fit model is fully implemented.

4. Principles:

Future Fit had focussed on a suite of principles co-created by local clinicians and patients. Community Fit will need to draw on the key themes.

1. **Adequate access** to services within the local community utilising the community asset base in that area through bespoke solutions
2. **Providing joined up care** through full integration of services and teams – avoiding any patient feeling "abandoned" by the system as they transition the care pathway
3. Eradicating silo working and ensuring that **no clinical decision be made in isolation**
4. Adopting a permissive approach to **local bespoke solutions** whilst upholding the expectation of equitable outcomes across the whole county and both CCGs.

Delivery of Community Fit programme will need to align with the Future Fit model focussing on identified care pathways of:

1. Urgent Care
2. Planned Care
3. Long term condition management
4. Prevention

And adding the additional area of

5. Community resilience

5. Themes

5.1 Urgent Care: Based on the model of networked delivery of urgent care through a single Emergency Care Centre (focusing on time critical cases) networked with Urgent Care Centres (focusing on urgent cases that aren't time critical) a model for local urgent care services will need to be developed.
Ensuring that UCCs meet the needs of the local population, work in an integrated way with the Emergency Centre and support admission avoidance will be the main aim of these models. To enable delivery of urgent care within both urban and rural care environments a bespoke solution option may need to be adopted on the understanding that local areas utilise their asset base to staff, and deliver care in the UCC, with the explicit understanding of equitable patient outcomes and agreed core minimum service standards.

5.2 Planned Care: Developing care pathways, skilled teams and integration with secondary care to enable earlier discharge back into the community and a shift from reliance on inpatient stays post intervention to day case procedures.

5.3 Long Term Care (LTC) pathways: Working through integrated teams a suite of LTC pathways will need to be co-designed and embedded across primary and secondary care to enable patients to be cared for in, and around, their home environment for as long as possible

5.4 Prevention: Focus on early prevention strategies through to preventing further deterioration in health and admissions.

5.5 Community resilience: Enabling local primary care clinicians, alongside patients and volunteers, to co-design solutions, and support networks, that enhance wellbeing, independence and self-care

5.6 Enablers: key enablers to deliver the Community Fit programme:

1. Shared care records and integrated information system
2. Co-ordination of care ranging from formal co-ordination centre through to care co-ordinators for individual patient cases
3. New models of care – MSCP,PACs, Integrated care team delivery, Team around the practice
4. Meeting the seven day service requirement
5. Skills based training and education programmes focussed on new working practices
6. Communication, information and education packages for patients and the public.

6. Phase 1 enabling project

Work has begun on Phase 1 of a key enabling project which is intended to model and describe the demand for primary care and community services to absorb the activity coming out of the acute trust and the other changes which will impact on the use of primary and community health and social care services such as demography, ageing population and increased demands on the primary care and community.

This work will take place between October and February 2015. Assuming the timely transfer of data, phase one will deliver the following:

- An agreed way of modelling activity in of social care, primary care, community healthcare, and mental health
- An agreed taxonomy (classification) of care packages delivered by each of these sectors
- An agreed estimate the impact of demographic change on activity levels within these sectors
- A linked health and social care dataset, identifying patients receiving care from two or more sectors and describing the care they receive
- A description of the activity that the NHS Future Fit Programme models anticipate will move out of the acute setting and therefore may have an impact on primary care, community services, mental health and social care services.

In response to feedback at the Provider Forum launch of Community Fit, an additional workstream has been added, focussing on the contribution from voluntary and 3rd sector partners. Therefore an additional deliverable has been added to the Phase One work programme:

- An assessment of the potential voluntary and third sector services contribution to the broader programme and suggestions of mechanisms and approaches that might be employed to maximise this contribution.

Alongside this focused piece of work, both Shropshire CCG and Telford & Wrekin Clinical CCG are implementing the overarching aims of Community Fit through their own existing strategies. A summary of these is set out below.

7. Engagement of Citizens

Both CCGs have put the engagement of citizens in their care, in the design of services and in commissioner decision-making at the heart of their everyday business. CCG committees are established which review the work programmes and activities of the CCGs to ensure that patients and the public are being effectively engaged in all aspects of the commissioning process. Support is provided to patient and public representatives to enable them to engage effectively in this work.

The CCGs led a major local engagement process as part of the national Call to Action programme. Almost 3,000 responses were received and the Call to Action process was brought together at a conference in November 2013 at which the Chief Executive of NHS England was the keynote speaker. Key messages from the Call to Action – from the public and from local clinicians – are particularly shaping the Future Fit programme but are also being used within other key development strands for the CCGs. There is strong representation from patient groups on the Programme Board and a substantial programme of public and patient engagement will ensure that there is meaningful and authentic citizen participation in the design of the plans and decision-making process.

There is a strong network of practice patient participation groups (PPGs) which provide a strong foundation for public engagement. CCGs have also been working closely with Healthwatch organisations and building wide networks of engagement to include PPGs, voluntary sector organisations, disease specific groups, groups based in particular localities, disease specific groups and young people.

Engagement with young people includes the development of Youth Champions. The aim is for these young people to become active and valued partners, working with service providers and commissioners, to jointly deliver better health and wellbeing outcomes. In addition to the benefits for local organisations and wider communities, the young people taking part will individually benefit through improved confidence and a sense of pride in their achievements.

Further information on the specific approaches of each CCG are set out in the CCGs' Operational Plan submissions.

8. Carers

Both Shropshire and Telford & Wrekin CCG's have dedicated work streams focusing on the role of and support for carers. Examples of current schemes are:

- Funding carer breaks – provision of non-residential respite and support services for family carers
- Shared lives for people with dementia - respite provided in people's own homes on a regular basis rather than institutionalised respite care
- Hospital carers link worker - supporting carers of people coming out of hospital in order to ensure they have information about the support and services available to them
- Dementia CQUIN including supporting carers – now included in acute contracts

The Royal College of General Practitioner's recommendations in general practice for improving support to carers will be used the basis to develop the local NHS strategy. The CCG's will also work in partnership with their local councils and voluntary sector organisations to develop a new health economy wide strategy, following the publication of the Care Bill.

Local Councils and CCGs already work together to support carers. This work will form a strand of work under the better Care and will build on existing local arrangements as well as absorbing funding for carer breaks (in line with the NHS Operating Framework 2012-13 stipulations.)

The work within the areas outlined above is linked to the delivery of the system vision via the implementation of the CCG's Operational Plans . A summary of these plans can be found in the Improvement Interventions section of this document.

9. Management of Long Term conditions

The key overarching aims in relation to LTC are to shift resources to strengthen self-care and prevention, to ensure that the patient remains at the centre of their care, to work with a multidisciplinary focus with the GP at the centre, ensuring effective case management of patients. In addition work will also be undertaken to reduce time spent in hospital by people with LTC. Further schemes will focus on Pulmonary Rehabilitation, respiratory services, development of diabetes services and the role of telehealth.

Each of the CCGs has established strategies and plans for long term conditions which support the delivery of the aims set out in the paragraph above. These are consistent with the high level models produced by the Future Fit programme and the development and implementation of existing priorities will continue alongside the Future Fit programme. Both CCG strategies focus on developing care closer to home and the establishment of integrated care teams based on clusters of GP practices. It is anticipated that this approach will result in a reduction of admissions to acute hospital beds.

CCG Operating Plans include more detail on the actions which are being taken to improve services for people with long term conditions and ensure that people with multiple long term conditions are offered a fully integrated experience of support and care.

CCG BCF submissions also include the detail of the plans to integrate care across health and social care.

10. Primary Care

In addition, each CCG has developed plans to strengthen primary care. Further collaborative discussions should now take place to understand the extent to which a common approach to primary care development across Shropshire, Telford and Wrekin in helpful or desirable in relation to the Community Fit programme of work, potentially involving the GP Federation. There are clearly synergies in the approaches which Community Fit can capitalise on. It is recommended that these conversations take place over the next few months to agree and set out the extent and manner in which primary care development features in the Community Fit programme. It is likely that there are significant areas e.g. urgent care network where it would be helpful to develop a collaborative approach and others which would be characterised as a Community Fit programme dependency which individual CCG's take the responsibility to deliver.

Working with the GP Federation

General practices in Shropshire have established a GP Federation as a vehicle for enhanced collaboration between practices and providers. This has the potential to support primary care to operate at a greater scale to improve access and continuity of care, both in relation to core GMS

services and beyond. CCGs are in discussion with the Federation regarding the development a collective vision for Primary Care in collaboration with all practices in the County. It is therefore essential that The Federation are involved in discussions regarding the role of Primary Care in the Community Fit programme.

Appendix 1 Telford & Wrekin : The Journey towards excellence in General Practice

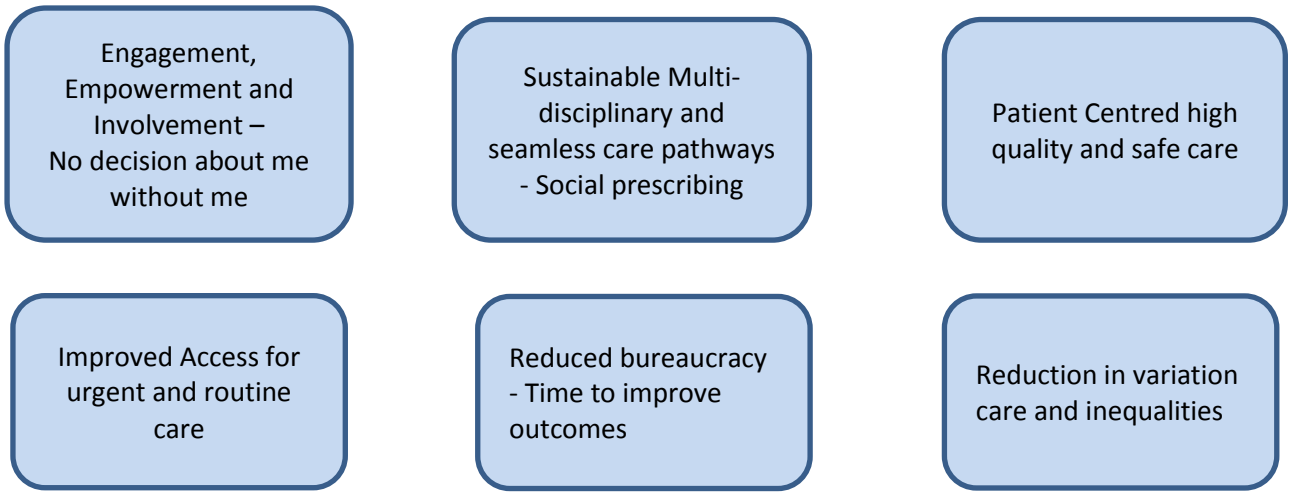
The CCG's strategy is about facilitating, shaping and exploring possibilities, in partnership with their stakeholders. They have a vision of a Primary Care Service, led by GPs who are sufficiently resourced to offer appropriate and prompt access to excellent quality care for their population that is robust against challenge.

Their GPs will innovatively lead multi-disciplinary teams, which will include many disciplines of health and social care workers as well as those historically involved such as community nursing teams. This model will be clustered around Health hubs as proposed by the Clinical Reference Group of the Future Fit Programme and Community Fit. Primary Care Services will be designed around the needs of our population, as mandated by Patient Focus Groups. his will require careful and thoughtful management of patient expectations, and a care navigator role for many of the clinicians and other health and social care professionals.

Telford and Wrekin will continue to be an attractive place for Primary Care Clinicians of all disciplines to work as evidenced by the number of applicants for every job advertised and the excellent reputation of their Primary Care regionally and even nationally.

10.1.1 Telford and Wrekin CCG - Eight Areas of Commitment

To provide a framework for the new arrangements of delegated responsibility for Primary Care, the CCG is considering eight areas of commitment. These build on the wider objectives of the CCG and will specifically impact on the Primary Care outcomes, putting the patient and the local GP at the heart of a person-centred model of care. The CCG has re-designed their staffing structure to enable coordination of these outcomes and close working with the wider CCG team, local General Practices, Patients and stakeholders will jointly debate these areas of commitment with the aim to receive approved commitments during the first quarter of the 2015/16.



The outcomes of these commitments are shown below, with some of the key interventions that are being considered to bring them to fruition. The CCG is currently awaiting formal approval from stakeholders, once approved; measures will be set against the outcomes that will be monitored by the Primary Care Committee.

For more information about Telford & Wrekin CCG primary care commissioning please visit http://www.telfordccg.nhs.uk/download.cfm?doc=docm93jijm4n6983.pdf&ver=10919

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CCG Eight Areas of Commitment: key interventions and outcomes

Engagement and Empowerment	Patient Participation Groups in all Practices Access to information via multi-media Multi-morbidity personal care plans	All Patients will have the opportunity to contribute. All Patients with a long term condition will have agreed personal care plans and feel empowered to self-manage care
Sustainable Multi-disciplinary working	Team around the Practice Social Prescribing Seamless pathways of care Professional Development and support	Patients will receive care from appropriately qualified and caring team of clinicians. Patients will be signposted to voluntary and community organisation for support
Patient Centred high quality and safe care	New model for the management of Long Term Conditions New improved Quality Assurance Framework Review of Enhanced Services and Quality/outcomes Framework	Patient will understand the quality of care they should receive and contribute to their management plans, putting their needs at the heart of their care
Care closer to home – admission avoidance	Better Care Fund Streamlined working with health and social care Risk Stratification	Patients will receive high quality coordinated care in a safe environment close to their home whenever possible. Health and Social care will jointly support this commitment
Improved Access for urgent / routine care	Improved communication with Ambulance and Out of Hours Enable flexible appointment schedules Clear understanding of demand and capacity needs	Patients will identify a new flexible approach to accessing Primary Care, which is improve productivity and be reactive to patient needs
Reduced bureaucracy	Review of current reporting arrangement for GP practices Allowing more time to see patients Improved Contract requirements	Increased use of technology and automated data collection combined with the information requests that lead to improvements in patient care
Reduction in variation care and inequalities	TRaQs will continue to drive quality and improve referral processes Improved referral pathway for 2 week waits for Cancer Practices supported to meet their specific patient needs	Variation will be understood by practices and patients Best practice will be shared and implemented across Practices Process will be better managed and improved Quality of Referrals will be increased
Indicative Budgets	Practices will be encouraged to consider ownership of their whole budgets and recommend changes to improve the outcomes for their specific population	Practices will understand their patient expenditure and work with patient groups to identify areas for improvement. Improved use of financial incentives

Appendix 2 Shropshire CCG Primary care Development

The Potential of Primary Care to Deliver the CCG Ambition

On the 1st April 2013, Shropshire CCG became the official statutory body responsible for commissioning health care services for the resident population of Shropshire. At the same time, the CCG also assumed formal responsibility for assuring the quality of primary care services, delegated to us by the NHS Commissioning Board. The commissioning of Primary Medical Services however, remained the responsibility of NHS England.

A Shropshire CCG primary care strategy was developed and approved by the Governing Body Board in 2013 to meet the CCG's responsibility for maintaining and improving primary care quality.

Up to this time this primary care strategy has defined the priorities and work plans for the CCG in regard to primary care. The strategy concentrated on three areas;

- Maintaining and improving high quality general practice
- Providing targeted education and better communication
- Promoting service development and transformation

Delegation of responsibility for the commissioning of Primary Medical Services
In May 2014, NHS England invited clinical commissioning groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of GP services. The intention was to give CCGs more influence over the wider NHS budget and enable local health commissioning arrangements that can deliver improved, integrated care for local people, in and out of hospital.

The Chief Executive of NHS England anticipated that the potential benefits of co-commissioning for the public and patients would include:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home
- High quality out-of-hospitals care
- Improved health outcomes, equity of access, reduced inequalities
- A better patient experience through more joined up services.

Shropshire CCG now has full delegated responsibility for the commissioning of Primary Medical Services. The commissioning of pharmacy, dental and optical services have not been delegated and remain the responsibility of NHS England. For legal reasons, NHS England remains liable for Primary Medical Services and so retains an assurance role, overseeing the discharge of the CCG's delegated responsibilities.

The development of the Primary Care Work Plan
In recognition of the need to rapidly establish a focus and clarity of role for the Primary Care Commissioning Committee, to develop a functioning primary care directorate within the CCG and to ensure efficient and effective working relationships with the NHS England area team, a decision was made to concentrate on the development of a practical and prioritised work plan which, over time, can be developed into a full primary care strategy, rather than to attempt to develop a full blown strategy from the outset.

The draft work plan is derived from the Delegated Functions defined in the delegation agreement of March 2015 **and** from the primary care strategy based on primary care quality dating back to 2013.

The broad areas covered in the draft plan are Quality, Sustainability, Innovation & Transformation and Working with NHSE.

Because the terms of reference of the Primary Care Commissioning Committee relate only to the delegated functions, the draft work plan therefore contains areas of work which lie beyond the statutory remit of the Committee. The CCG however, retains the wider responsibility for primary care quality and service innovation and transformation, as well as the newly delegated functions.

The work plan will therefore provide the basis for the CCG's activity in regard to primary care, only a part of which will be the direct responsibility of the Committee. Judgements will need to be made around which areas of work require assurance and decision making by the Committee, and which areas should report to other sub-committees of the Governing Body Board.
The provisional priority areas across the full range of CCG responsibilities in regard to primary care are marked in red.

Key Priorities for the Primary Care Commissioning Committee
In light of the 'mismatch' between the wider CCG responsibilities in regard to primary care and the statutory role of the Primary Care Commissioning Committee, this paper identifies some key priorities contained within the draft work plan which do lie within the statutory responsibilities of the Committee and which require work and development over the coming months in order to enable the Committee to effectively discharge its delegated functions and to properly exercise its delegated powers.

These key priorities are:

1. **To agree the Quality and Performance reporting and Governance processes between the CCG and the NHSE team**
   This is described in the delegation agreement as requiring collaboration between the CCG and NHS England resulting in 'a co-ordinated and common approach to the commissioning of primary care services' and 'an agreed staffing model'. There are also a range of transactional activities required to achieve this objective, also listed in the delegation agreement and reflected in the work plan under the heading 'Working with NHSE'.
2. **To embed the necessary assurance processes within the Primary Care Commissioning Committee, including a full and proper assessment of risks**
   This will include, but not be confined to the development of a primary care risk register which will include risks pertaining to practices in regard to Premises, Staffing, CQC identified risks, Performance risks, Quality and Safety risks and risks relating to Access to services.
3. **To develop robust mechanisms to plan, manage and develop primary care premises**
   This work requires co-ordination between the NHS England and CCG primary care staff and encompasses the management of practices who are at risk of loss of premises as well as responding to the opportunities provided for a more strategic approach to practice premises development through the Primary Care Infrastructure Fund.
4. **To progress the NHS England area team review of PMS contracts**
   The NHS England area team have indicated that they are committed to progressing PMS contract reviews. The Committee awaits further information and guidance from them on this issue.

Whilst these key priorities are the responsibility of the Primary Care Commissioning Committee, the Primary Care Working Group will provide a forum to progress much of the work. It's membership has been refreshed and now has a representative from the NHS England Area Team. Once the CCG primary care directorate is fully formed and posts recruited to, this will also provide additional capacity to progress to rapidly progress the work.

Quality	
Performance	Planning and review of primary medical services
	Management of quality concerns and poorly performing practices
	Liaison with CQC
	Liaison with NHSE regarding complaints management
	Delivery of Constitutional Pledges
	Practice Support Functions
Education	Redefining the CCG education offer (including nurse education facilitation)
	Recruiting a new GP education lead
Communication	Fully implement Shropshare
	Enhance SI reporting and feedback through Datix (or national system - STEISS)
Medicines Management	Full implementation of Scriptswitch
	Adherence to formulary
	GP engagement with pharmaceutical industry – review of custom and practice
	Poly-pharmacy and de-prescribing (including secondary care?)
	Liaison with NHSE re pharmacy issues
IT and Data	Improve quality and relevance of practice and locality level activity data
	Support federation in enhancing inter-operability between practices
Sustainability	
Premises	Premises risks to continuity of service
	Primary Care Infrastructure Funds
	Closures, New practices and Mergers
	Premises Costs Directions Functions
Workforce	Individual practice support
	Working with HEE and other training bodies
	Enable peer group support networks – e.g. sessional doctors, Shropshire women doctors
Business continuity	Out of area patients
	Practice manager training
Service definition	Inappropriate primary care work
QIPP	Primary Care QIPP
	Other QIPPS e.g. Meds Management
Innovation & Transformation	
Community Fit	7 day services
	Team around the practice
	Multi-Specialty provider model
	Prime Ministers Challenge Fund
	'Primary Care at Scale'
	Pharmacy e.g. common ailment scheme (an enhanced service)
Contracts	
Primary Medical Services contract	National PMS review

management	
Enhanced Services	2% DES
	Local Enhanced Services Review
	Other local incentive schemes – e.g. QOF alternatives
Discretionary Payments	
Management of delegated funds	
Working with NHSE	
Collaboration	Developing a co-ordinated and common approach to commissioning of Primary Medical Services
	Staffing model
IT and Data	Personal Data Agreement
	IT inter-operability between CCG and NHSE
Monitoring and Reporting	General
	Public information and access targets
	Financial provisions and liability
	Claims and Litigation
	Contract Management
	Information sharing with NHSE
Management	Delegated Funds
	National Performers List (NHSE responsibility)
	Revalidation and Appraisal (NHSE responsibility)

Summary of Shropshire CCG Primary care development Committee workplan

To view the mandate document and the five year strategy please visit: http://www.shropshireccg.nhs.uk/strategies