Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Date: Tuesday 25th June 2019
Time: 9.00am – 11.05am
Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda number: 7

Report title: Locality Transformation Scheme 2019/20 – Delivering Frailty & Community Based Same Day Emergency Care (SDEC)

Report Author: David Jarrett
Report Sponsor: David Jarrett/ Justine Rawlings / Colin Bradbury

1. Purpose

This paper provides Primary Care Commissioning Committee a summary of progress made through the Locality Transformation Scheme in 2018/19 and makes recommendations for priority areas of focus for 2019/20.

2. Recommendations

The PCCC is asked to note the progress made through the Locality Transformation scheme in 18/19 and approve the following areas of focus for 19/20:

a) Delivery of LTS Phase 2 Programmes – Frailty and Mental Health
b) Development of Locality Based Urgent Care Services

3. Executive Summary

The paper provides an update on the progress made with regard to Locality Transformation in 18/19 and sets out the background and proposals for priority areas of focus for 19/20.

4. Financial resource implications

Delivering integrated models of care requires a fundamental shift in resources into primary and community services. Mechanisms for this shift of resources are outlined in both “Payment System for Reform 19/20” and the new GP Contract – “Investment and Evolution”. The reforms introduced the concept of providing shared incentives for commissioners and providers to reduce avoidable A&E attendances and non-elective admissions. Details of the Community SDEC shared incentive scheme are currently in development and will be presented to PCCC in July 2019.

5. Legal implications

There are no legal implications arising from this proposal.

6. Risk implications

A schedule of risks and mitigations are provided in the main paper.

7. Implications for health inequalities

Development of locality models and plans will be subject to equalities impact assessments and the needs of specific groups. Focus on inequalities between and within locality populations will also be a key part of this work.

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Development of locality models and plans will be subject to equalities impact assessments.

9. Implications for Public Involvement

The development of locality models and implementation plans will ensure appropriate and proportionate involvement and engagement of patients and the public.

Agenda item: 7

Report title: Locality Transformation Scheme 2019/20 – Delivering Frailty & Community Based Same Day Emergency Care (SDEC)

1. Background

This paper provides Primary Care Commissioning Committee a summary of progress made through the Locality Transformation Scheme in 2018/19 and makes recommendations for priority areas of focus for 2019/20.

2. Locality Transformation Scheme Overview

The Locality Transformation Scheme was established in 2017/18 to facilitate the development of integrated community localities, the vision and principles of which are set out below:

Vision

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

Principles

- Integrated Community Localities will be the default option for people's care
- We will expand the boundaries of "out of hospital care" so the hospital becomes "out of the community"
- We will make a significant shift to a proactive model of care
- We will deliver a reliable and consistently available 24/7 service that is co-ordinated and effective
- All partners will be focussed on the needs of the population, sharing collective resources and with a common purpose
- We will take an asset approach: valuing the capacity, skills, knowledge, connections and potential in individuals and communities
- Integrated Community Localities will be the default option for people's care

Delivery of this vision and these principles is intended to address the current fragmentation between the multiple services that exist in the community and to address key challenges for our system, including:

- An ageing population, people living longer and with more long term conditions
- Cost and demand pressures
- An over-reliance on hospital and residential care and traditionally commissioned domiciliary services and the need to focus on people's strengths

- A limited focus on prevention and early intervention
- A disconnect between social and medicalised care, and a lack of attention to the whole person
- Fragmented delivery of services leading to duplication, a lack of co-ordination, and gaps in care

The CCG has prioritised the development of integrated localities within its commissioning priorities and drives this programme through the Commissioning Executive, and through the Primary Care Commissioning Committee in respect of General Practice services. At system level this work is overseen by the STP Integrated Care Steering Group.

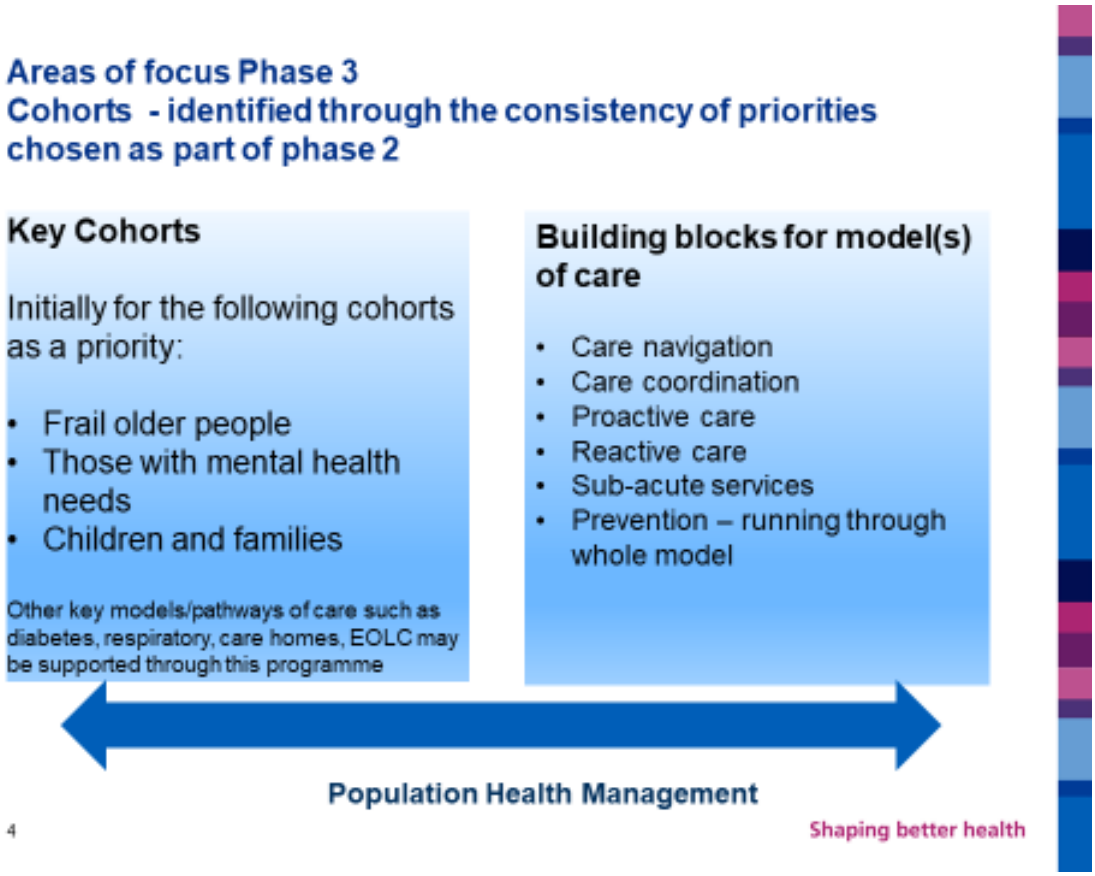
3. Progress in 2018/19

Over the course of 2018/19 there has been significant progress through our 6 locality provider groups including:

- Embedding of Provider Groups as key partners in Healthier Together through membership of the Integrated Care Steering Group
- Establishment of Locality Provider Fora and Integrated Care Working Groups: bringing together a range of partner provider organisations across localities to develop new pathways of care
- Delivery of Locality based Improved Access services (October 18)
- Identification of key cohorts for priority working
- Test bed programmes: delivering new services - e.g. mental health in primary care, clinics in practice at the weekend (CAB/Drugs and alcohol), mental health services for teenagers, new community nurse visiting service, locality wide social prescribing plan, community mobilisation

Key priority areas of focus were identified and agreed across all localities and further developed through a collaborative approach to design and delivery. This ensured that initiatives had an appropriate level of consistency across BNSSG whilst retaining local ownership and relevance. The collaborative involved front line staff, patients and the public in leading, testing and implementing change, as well as defining and measuring success.

The models are being built around key component parts as outlined below:



The outputs of this programme will see new integrated pathway delivery in frailty and mental health from September 2019.

4. Primary Care Networks and New GP Contract

A new five year framework for GP services was published in January 2019. The new contract sets out agreements between NHS England and the BMA General Practitioners Committee (GPC) in England, supported by Government to translate commitments in the NHS Long Term Plan into a five-year framework for the GP services contract.

Specifically, a new Network Contract national Direct Enhanced Service (DES), commencing July 2019, supports practices of all sizes, to work together to form Primary Care Networks (PCNs). PCNs are expected to form a fundamental building block of every integrated care system and be seen as an essential input towards achieving Integrated Care System goals. This supports and builds on the established development of integrated working in BNSSG, and emerging PCNs have agreed to continue to work within a locality infrastructure to further integration.

The new GP contract and Network DES direct significant new resources to primary care to support resilience and accelerate working together with the allocation of reimbursable funds for key new workforce roles e.g. Social Prescribers, Clinical Pharmacists.

In BNSSG we have established some key principles for the approval of PCNs in agreement with the Local Medical Committee:

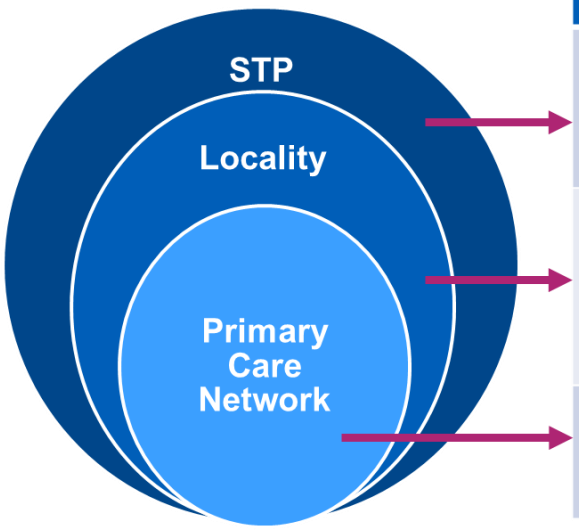
- Serving the local population in a way that makes sense for that population
- Be contiguous, with no practice being left behind
- No smaller than 30,000 but bigger than 50,000 if it makes sense locally
- Link with localities (may require some change to locality boundaries)

The PCN philosophy builds on the Locality Transformation vision of enabling ownership at a level where people know their patients/population, and supports new service delivery and joined-up care, for both physical and mental health, across a wider primary care team.

5. Developing BNSSG Integrated Community Localities

As previously outlined PCNs will be an essential building block of our Integrated Care System, facilitating resilient local delivery of primary and community care services.

As per Diagram 1 below The locality infrastructure will remain an essential element of our system, providing the co-coordinating and planning role across providers and developing and delivering services at scale that might be sub-optimal at PCN level.



Long term plan	Function
Integrated Care System (ICS)	Strategic
Integrated Care Partnerships (ICP) Provider Alliance	Planning and coordination across providers
Primary Care Networks	Resilience Local Delivery Shared Resource

- The pathway and service design and relationships that have developed through the Locality Provider Forums' collaborative working methodology now enable us to create a system of care in an identified 'place' that supports people to stay healthy, well and independent in the community and that when people do fall unwell community settings become the default service for the triage, assessment and treatment population.

Working with PCNs the localities have the opportunity to build an alliance amongst all 'providers' in the community to join up around individuals and families and establishing the community as the default setting for all of a person's care.

6. Locality Transformation – A New Urgent & Emergency Care (UEC) Model for BNSSG

Building on the locality pathway and service development work in the key areas of frailty, mental health and Improved Access, alongside the system wide developments of the Integrated Urgent Care Service, Urgent Treatment Centres and Community Services procurement, there is now the real opportunity to bring together providers and services to deliver a new and truly integrated community based urgent care service.

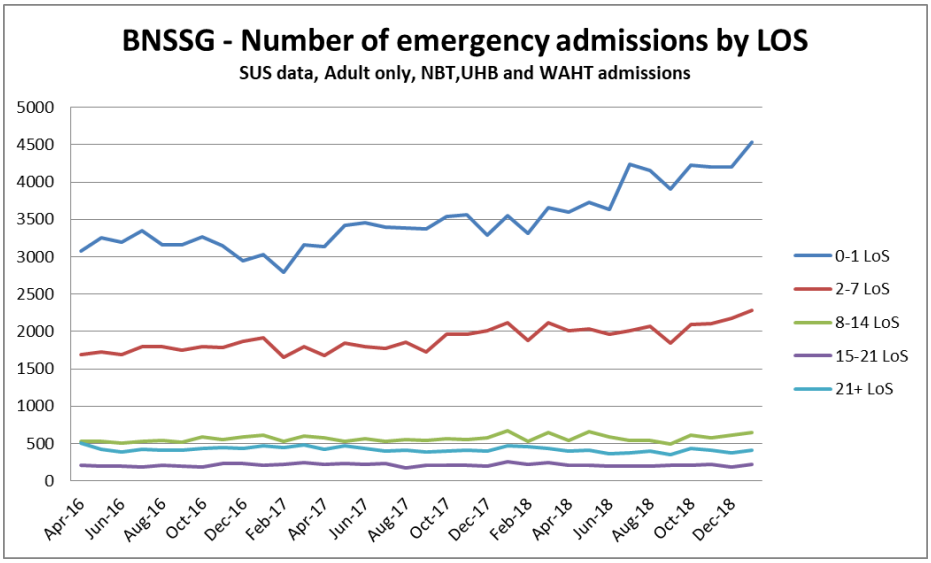
6.1 Drivers for Change

Over recent years, national trends in increasing rates of attendances and non-elective admissions to acute providers have been reflected in our local health system.
Between 17/18 and 18/19 across the 3 BNSSG acute providers there has been:

- 11% increase in 111 call demand
- 7.3% increase in ambulance conveyance to ED
- 4.5% increase in A&E attendances
- 11.8% increase in non-elective admissions
- 9.4% increase in GP referral admissions

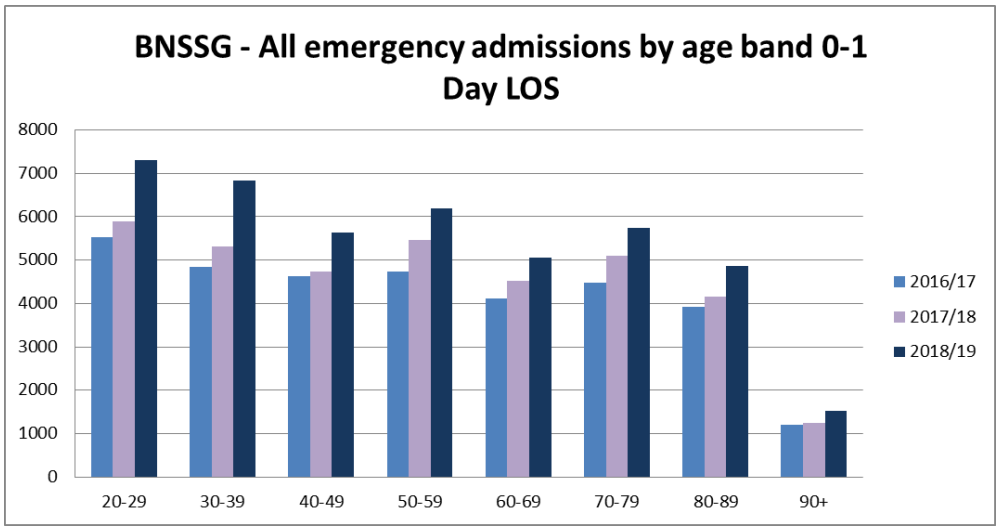
Within this general picture of increasing non-elective activity our system has seen significant and specific growth in admissions of 0-1 day LOS & continued long term trend in growth in non-short stay:

Graph 1

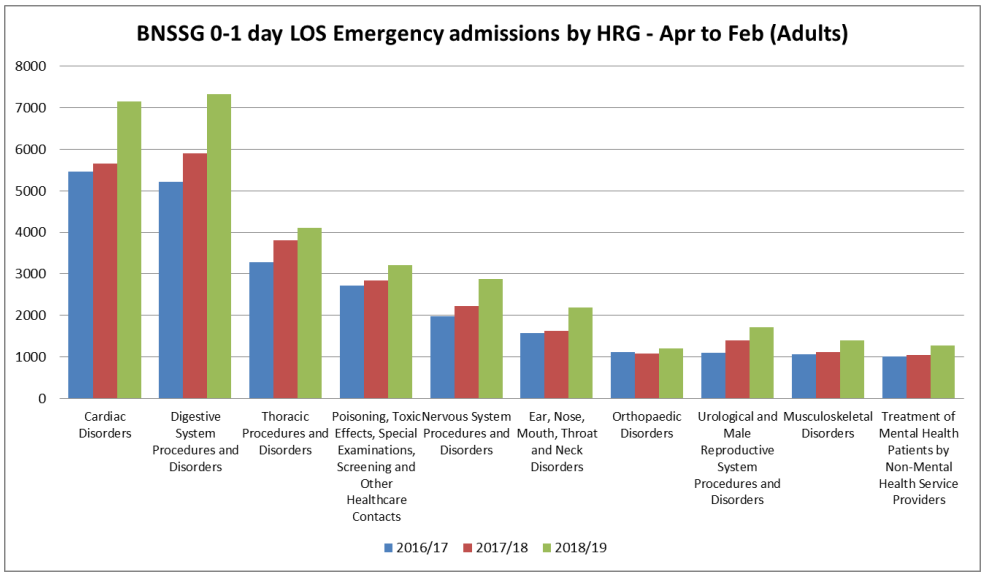


Further analysis has shown that the increase in short stay admissions is driven by the 20-59 age group and the most common admitting conditions are related to the cardiac, digestive and respiratory systems.

Graph 2



Graph 3



This growth in non-elective activity has had to be recognised through utilisation of CCGs growth allocation in the acute provider contracts for 19/20.

6.2 UEC Care Model for BNSSG

In recognition of the pressures facing the urgent care system a number of developments have worked in tandem to design a new model of UEC for BNSSG.

6.2.1 BNSSG Urgent Care Strategy

In July 2018 the CCG published "A Vision and Strategy for Bristol, North Somerset & South Gloucestershire". The Vision and Strategy identifies the key drivers for urgent care demand over the next ten years and highlights the need to tailor our urgent care services for a population with increasingly complex needs.

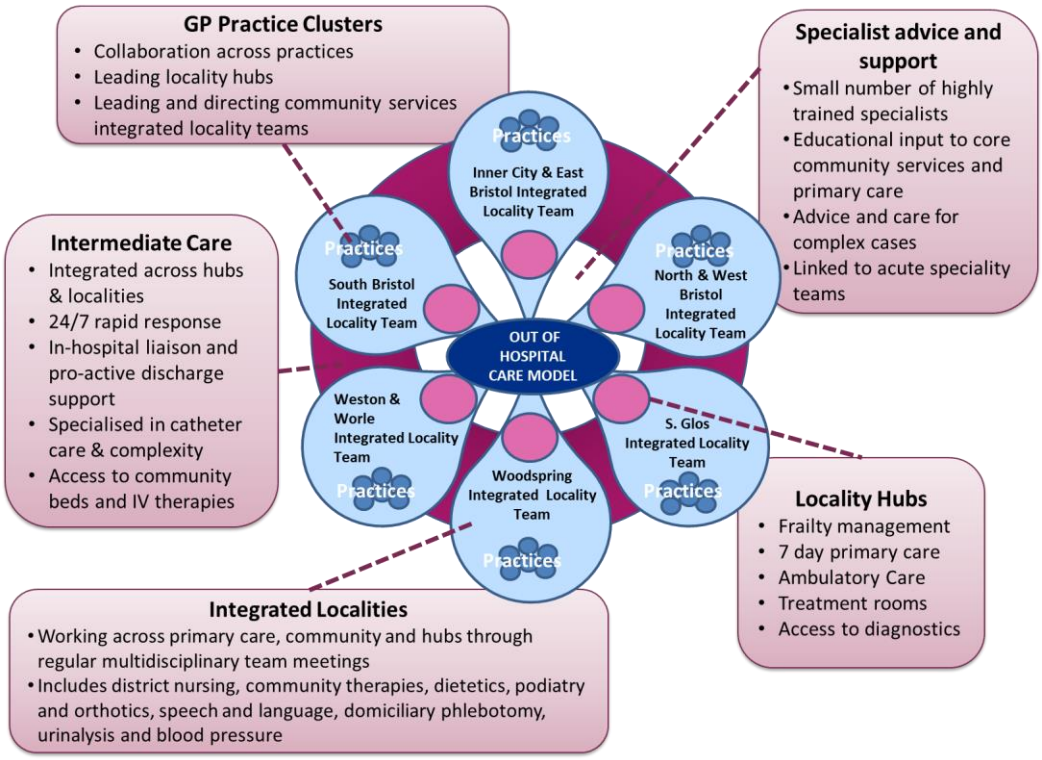
The vision established four key delivery themes of:

- Integration
- Simplification
- Consistency
- Targeted Prevention

The strategy established a vision for enhancing integrated urgent care services:
"The immediate focus is on the creation of an organised, co-ordinated and effective out-of-hospital provider environment that is seen as the main conduit for meeting a person's health and care needs. This new out-of-hospital environment sees primary care, out of hours, community services, mental health, the ambulance service, the local authority and the third sector working much more collaboratively around a single, person centred care plan. In the longer term, a more integrated model which supports an integrated, care system is envisaged but the priority now is to bring together the currently fragmented community model, including general practice."

6.2.2 Integrated Primary and Community Care Services

In September 2018 the CCG commenced a process to procure a Single Provider of adult community health services for Bristol, North Somerset and South Gloucestershire. The commissioned community services will work seamlessly with Primary Care, Secondary Care, mental health services, local authorities and Third Sector Organisations to enable people to stay healthy, well and independent in the community. The adult Community Services Provider will be a key system partner in transforming the out-of-hospital care setting, so that services provide proactive care to meet population needs and a "safety-net" to avoid acute hospital admissions. An extensive period of engagement (October-December 2018) led to the development of a detailed service specification and clinical model **(Diagram 2)**:



The service specification established that the adult Community Services Provider is expected to work closely with general practice at an individual, GP network and locality level to meet the needs of the population and to help people stay healthy, well and independent in their community.
As the service moves into the mobilisation phase it is expected that the new provider will work directly with localities to accelerate delivery in four key areas:

Integrated locality teams focus on relationships with Primary Care to support people who have relatively stable needs to manage and reduce the risk of acute worsening of their condition. This incorporates multidisciplinary team meetings between Community Services, Primary Care, social care and mental health to identify patients who need proactive support to maintain their health and wellbeing.

Acute and reactive care teams work across localities to manage patients who have acutely worsening conditions and are at risk of a hospital admission or attendance. These teams will provide a timely response to prevent admission, including rapid response. The teams will have links to Secondary Care and community beds to help patients remain in a community setting and enable prompter discharge from hospital.

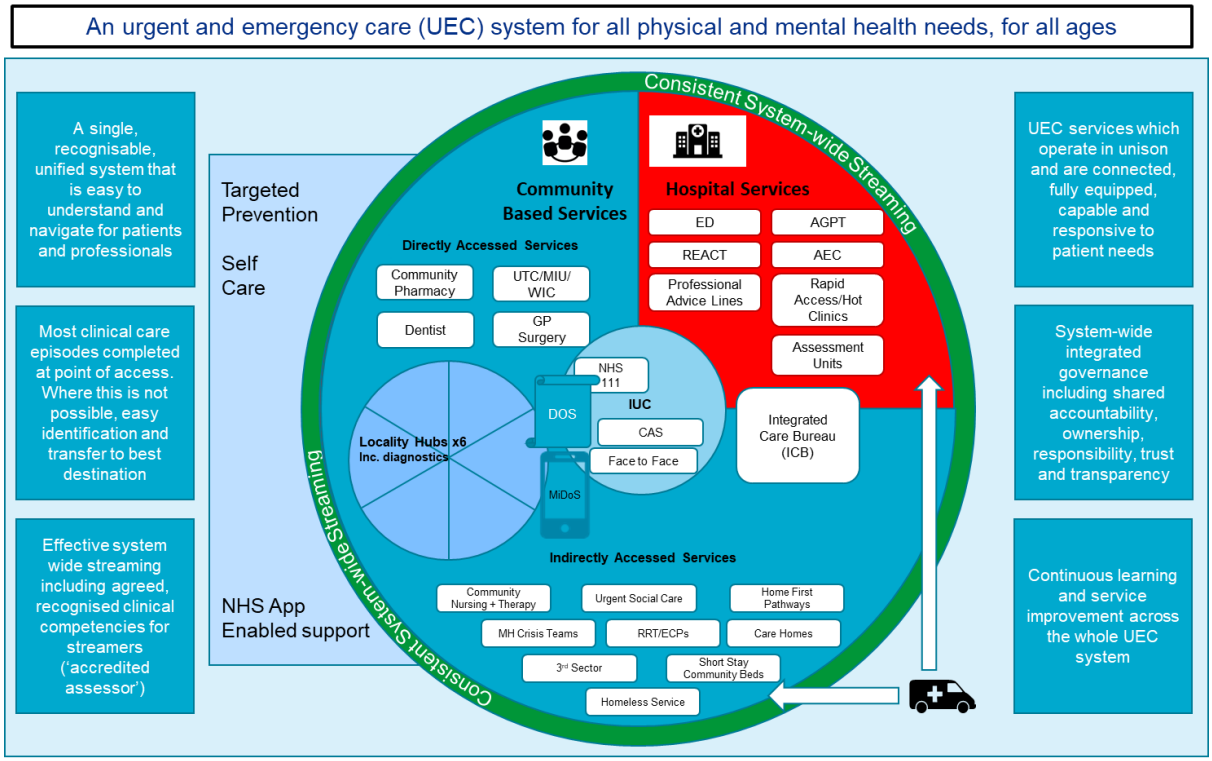
Specialist advice and support. There is an expectation that Community Services will strengthen links between Secondary Care specialist knowledge and Primary Care support and ensure patients, carers and professionals within the community are empowered and educated to better understand and manage the specialist clinical condition.

Locality hubs are settings that bring organisations together to meet population needs and focus on proactive care and a holistic approach to improve health and wellbeing. These hubs will also support patients to have the investigations and treatments they need closer to home. This specification includes frailty management and the development of future locality hubs to provide services at scale across providers, such as access to mental health services, social care support and Third Sector services.

6.2.3 A New UEC Model for BNSSG

Following a facilitated event in December 2018, clinicians and system leaders from across the BNSSG health system developed a new model of care, which brings together core elements of the UEC strategy and community procurement specification into a coherent vision for immediate change:

A New UEC Care Model for BNSSG – Winter 2019



The model offers the opportunity to utilise the Integrated Urgent Care (IUC) service to operate as a key streaming and co-ordinating function and support the bringing together of the wealth of community based services, and to enhance system wide streaming. The model also reflects the need for UEC services which operate in unison and are connected, fully equipped, capable and responsive to patient needs.

The vision and strategy for a new model of care and the continual flow and growth of resources into the secondary care sector presents a clear and present opportunity for a new GP led and co-ordinated locality based integrated urgent care offer to meet on the day demand.

The new service offers would seek to deliver a system of care in the community to truly integrate providers and services from across each locality and deliver a model of care that meets needs of the population.

The model of care would seek to deliver the following aims:

- Provide comprehensive primary and community care services to ensure that :
  a) No patient should attend ED who has a condition that is amenable to non-acute care
  b) No patient should be referred to the acute sector who could be managed in the community

- Over time community providers to push back the boundaries of what is done in the acute setting so that the community becomes the default setting of care for a much wider group of people
- Integrate with the emerging models of care for frailty and mental health
- Enhanced locality services for ambulatory sensitive conditions and pathways to significantly reduce the requirement for patients to attend acute settings for diagnostics and assessment

7. Locality Transformation Scheme 19/20 – Delivering the Model of Care

7.1 Locality Transformation Scheme Requirements 19/20

To facilitate the continued development of Integrated Community Localities and the delivery of the UEC model of care it is proposed to prioritise the Locality Transformation and associated funding in the following areas :

7.2 Delivery of LTS Phase 2 Programmes

£0.50 released May 2019 to support delivery.

7.2.1 Frailty

Through the collaborative model of working in Phase 2 of LTS a new draft BNSSG integrated model of care for frailty services has been developed.
Key components of the model include:

- Overarching model of care based on risk stratification linked to the relevant care model elements and including the 7 elements of care
- Risk Stratification using eFI and locality understanding of its frail population
- Assessment tools (Rockwood, CGA as indicated in detailed pathways)
- Multi-Disciplinary Team Working
- Frailty Hub in each locality
- Acute Frailty Service
- Care Planning
- Roles, including ‘Wellness Navigator’

A BNSSG Frailty Programme Board has been developed to facilitate delivery of the model of care.

Within each locality, frailty working groups have been established as part of the locality provider “alliance” to design the Integrated locality model of care for frailty and associated service delivery model. Localities have been asked to detail the impacts for which business cases may be required specifically for:

- Frailty Hubs
- MDT working – to meet locality requirements
- Pathways – where there are suggested variations in the way in which the model is delivered in a locality.

The BNSSG Frailty Programme Board is seeking the development of service delivery models/business cases over **June/July 2019.**

Mobilisation of priority elements of the model is expected from **September 2019.**

7.2.2 Mental Health

Aligned with the development of the BNSSG Mental Health Strategy work is continuing to define the integrated locality model of care for mental health.

The BNSSG Mental Health Strategy is expected to be published in September.

Localities are continuing to develop and test local models of care and will continue to work collaboratively as the strategy develops.

7.3 Locality Based Urgent Care Services

£0.50 released July 2019 for development and delivery of key elements of the UEC model of care to meet on the day urgent care demand

a) 24/7 Access to Primary Care Services:

The core elements of an enhanced model of access to primary care services will include:

- A locality and PCN approach to practice resilience ensuring consistent approach to access to primary care service across the locality
- Delivery of e-consultation systems and Digital Minor Illness systems, including working with other providers e.g. Community Pharmacy
    - NB: Following conclusion of procurement of e-consultation system– **Q4 19/20**
- Clinical decision making shifting to the earliest point of contact and enabling optimal use of the multi- disciplinary workforce (including additional PCN roles e.g. Clinical Pharmacists, Social Prescribers)
- Same Day and Improved Access capacity to be available through Locality Hubs/Virtual Hubs to IUC for same day urgent care demand, based on population need:
    - Model to include access for Primary Care Streaming services from ED

<u>Localities are requested to:</u>

i. Identify clinical and operational leads to engage in co- production of Improved Access service specification – **Q2 19/20**
ii. Delivery of Improved Access against revised specification – **Q3 19/20** onwards.

b) Community Based Same Day Emergency Care (SDEC):

Development of community based ambulatory pathways and services to replace current hospital based activity for a range of Ambulatory Sensitive Conditions (ASC) based on needs of locality population:

- Pathway Development
  - Pathways for development identified – June 2019
    - Top 10 ASC pathways identified including, Respiratory, Abdominal Pain , Low Risk Chest Pain
  - Pathways to be developed in collaboration with Primary and Secondary clinicians through established Clinical Reference Group and Clinical Oversight Group **- Q2 19/20**
  - Clinical risk thresholds identified and risk management strategy developed - **Q2 19/20**
  - Implementation of new pathways and service models - **from Q3 19/20**

- Service Delivery
  - Identification of options for provision of enhanced services PCN / Locality / hub "one-stop shop", including access to a greater range of diagnostic and assessment services in the community
  - Integration, utilisation and development of Acute General Practice Team (AGPT) within model of care
  - Alignment and integration of Urgent Treatment Centres/MIUs
  - Alignment with LTS Phase 3 delivery of Frailty Hubs
  - Provide alternative disposition for ambulance conveyance

Localities are asked to:

i) Engage through the Clinical Reference Group for the review and redesign of pathways relating to the Top 10 admitting Ambulatory Sensitive Conditions – **June/July 19**

ii) Work with extended Locality Provider Forums to develop high level proposals for service delivery models from Q3 2019/20 to deliver community based services for a range of Ambulatory Sensitive Conditions. – **July 19**

7.4 Locality Infrastructure and Support to Delivery

Delivery of integrated locality services must be owned and driven by locality providers in their local alliances, with robust and transparent governance. The locality will be required to lead partners in a provider alliance approach (including working with the new community provider) to deliver:

- Population health management approach in localities
- Integrated models of care for agreed population cohorts at locality level
- Ability to respond as locality with constituent PCNs to future locality commissioned services
- Maintenance of locality governance and infrastructure including engagement of PCNs within that.

Localities will be supported in delivery through:

i) Funding to recurrently support locality leadership (Funding allocation to be confirmed through alternative route). The Locality and PCNs will then be asked through the PCN Development Plan to identify from this collective resource locality clinical leadership in the following areas:

- Locality Development
- Urgent Care

- Frailty
- Mental Health

NB: Role descriptions for clinical leadership roles to be developed

ii) CCG Area Teams to provide dedicated and direct support through Locality Development Managers to enable delivery of Frailty, Mental Health and SDEC Service Delivery Proposals.

iii) A Collaborative Approach

As per the Locality Transformation Scheme in 18/19 the intention is to develop a systematic approach to transformation. This will include:

- A collaborative approach to delivery with front line staff, patients and public involved in leading, testing and implementing change as well as defining and measuring success with support from teams versed in local, national and international best practice
- A focus on implementation via system wide accelerated learning events for each cohort followed by rapid test and learn cycles in localities, flexing models to meet local population needs
- Oversight by the STP Integrated Care Steering Group with representatives from across the system

8. Financial resource implications

Delivering integrated models of care requires a fundamental shift in resources into primary and community services. Mechanisms for this shift of resources are outlined in both “Payment System for Reform 19/20” and the new GP Contract – “Investment and Evolution”.
The reforms introduced the concept of providing shared incentives for commissioners and providers to reduce avoidable A&E attendances and non-elective admissions by providing the right care in the right place at the right time – and shared financial responsibility for levels of hospital activity.
Details of the Community SDEC shared incentive scheme are currently in development and will be presented to PCCC in July 2019.

9. Risk implications

Risk/Concern	Mitigation
Speed and readiness for change • GP practices • Primary Care Networks	CCG resources need to be aligned rapidly to support but with a prioritised approach reflecting readiness of localities
The approach requires strong engagement with community providers and with GP practices.	Rapid work will need to be done to understand gaps and any key issues and develop relevant contract variations ahead of time
Willingness and capacity of all GP practices to take part	Confirmation that the CCG will continue to commission services at a locality level. Localities will be responsible for working across any gaps if practices do not take part
BI capacity and capability e.g. lack of lack of primary care data and a BNSSG population risk stratification tool	An LMC-supported data sharing agreement is being used to facilitate the sharing of primary care data. A solution to risk stratification is required and is in development.
Larger providers e.g. AWP may not have locality focus as a priority which may frustrate locality plans	Contract variations will need to be considered for providers other than community providers
Provider and commissioner savings programmes including Local Authority plans may be counter to longer term locality plans	System Savings Plan 19/20 has integrated locality schemes embedded within its core proposals. Control centre plans should be reviewed in the context of locality developments and what will bring the best value to our population.

10. Legal implications

There are no legal implications arising from this proposal.

11. Implications for health inequalities

Development of locality models and plans will be subject to equalities impact assessments and the needs of specific groups. Focus on inequalities between and within locality populations will also be a key part of this work.

12. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Development of locality models and plans will be subject to equalities impact assessments.

13. Consultation and Communication including Public Involvement

The development of locality models and implementation plans will ensure appropriate and proportionate involvement and engagement of patients and the public.

14. Recommendations

The PCCC is asked to note the progress made through the Locality Transformation scheme in 18/19 and approve the following areas of focus for 19/20:

a) **Delivery of LTS Phase 2 Programmes**
£0.50 per head of population released to support delivery of BNSSG Frailty model and continued engagement in Mental Health strategy development.

b) **Development of Locality Based Urgent Care Services**
£0.50 per head of population released July 2019 for development of proposals for Locality Based Urgent Care Services

Report Author: **David Jarrett**
Report Sponsor: **David Jarrett / Justine Rawlings / Colin Bradbury**