Herefordshire and Worcestershire
Integrated Care System

NHS
Herefordshire and Worcestershire

Herefordshire & Worcestershire Fuller Stocktake Delivery

Worcestershire HealthWatch Board Meeting – 30 November 2023

Lynda Dando – Director, Primary Care Transformation & Delegated Commissioning
Hollie Hastings – Primary Care Networks Director of Strategy & Partnerships, Worcestershire
Esther Passingham – VCSE Strategic Lead for Worcestershire

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

How Many Strategies?

Driving the shift upstream to more prevention and best value care in the right setting

NHS Five Year Joint Forward Plan

Herefordshire & Worcestershire System Delivery Plan for Recovery of Primary Care Access 2023 – 2025

15th November 2023

ICS Urgent & Emergency Care Strategy

2028

Worcestershire Joint Local Health and Wellbeing Strategy 2022-2032

Being Well

Elective, Cancer, Diagnostics Plan 2023/24

Frailty strategy on a page … for people who are at risk of, or living with Frailty **2023 - 2028**

Our vision for local people…: **People living in Herefordshire and Worcestershire who are at risk of, or living with Frailty, will live well in a supportive community with accessible, personalised and coordinated high-quality care, delivered in the most appropriate setting whenever they need it.**

Our mission is to…: Support health and care organisations across Herefordshire and Worcestershire to collaborate and enhance integrated care services for people at risk of or living with Frailty.

Pillar	Strategic outcomes
1. Prevention	1. **Increased community intervention** measures to prevent the onset and progression of Frailty.
2. Identification	2. Increased and **early identification** of people living with or at risk of Frailty.
3. Management	3. High quality **proactive comprehensive assessment** of people living with or at risk of Frailty. 4. High quality, **accessible and co-ordinated personalised care** for people living with Frailty, their families and carers in every care setting, with a 'home first' approach. 5. Compassionate, timely and effective **advance care planning** in all health and care settings. 6. **Frailty attuned acute care** which facilitates timely discharge and smooth transitions between care settings. 7. High quality **reablement and rehabilitation after a period of illness** and at times of transition from hospital. 8. High quality **end of life care** for people living with Frailty, their families and carers.
4. Workforce	9. A **workforce with the appropriate skills** to provide specialist care to patients in all health and care settings.

…r shared …orities are …fined in 4 …e pillars …ch frame 9 strategic …comes…

…e based approach will be used to deliver the 9 strategic outcomes… → To realise the benefits for patients, their families and carers, this strategy will be used to guide the **identification of priority areas at place.** → The priority areas at each place will form the basis of **implementation plans to deliver the strategic outcomes** outlined in this strategy. → During the period of this strategy, monitoring of progress and evaluation will be conducted.

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

Delivery Plan for Recovering Access to Primary Care & Fuller Stocktake Report

What's the Link ?

Dynamic

Innovative

We need to take the pressure off

Discontent

Retain continuity

Improve experience of access

Transformation = Sustainability

Discontent

We cannot continue to work in the way we always have – the pressures & challenges are overwhelming all Providers

How PCARP supports the National and local Vision for General Practice plus other System Plans

PCARP presents a range of strategic opportunities for greater integration with wider primary care as well as other providers. It is a stepping stone towards delivery of the national vision for General Practice as set out in the Fuller Stocktake Report:

Build Integrated Neighbourhood Teams (INTs) to achieve 3 essential deliverables:

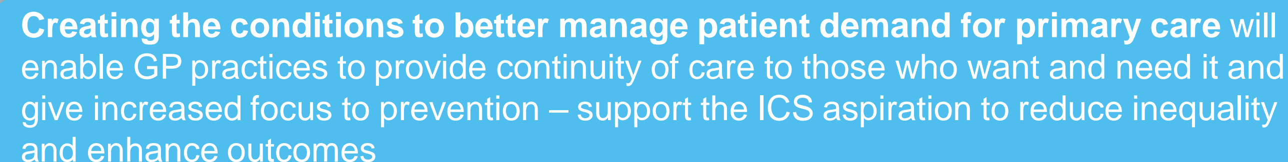
- ✓ Improved access to urgent care
- ✓ Improved continuity (and more proactive\personalised care) to people with complex needs
- ✓ Reduced health inequalities and a more ambitious approach to prevention

General Practice has over 1,000,000 contacts every day. How patients access appointments and their experience has an impact on how people think of the NHS and can impact negatively on other services eg A&E. We know from national and local benchmarking that we have the lowest A&E attendances in the Midlands\Country and maintaining this is critical. The local System Plan will underpin delivery of our Winter Plan and the interdependency between the ICS Frailty Strategy, Fuller and our local ambition described below, provides vital alignment.

The PCARP unashamedly focuses on improved access – but as a stepping stone to maintaining relational continuity between GP and patients. The 3 aims set out in the Fuller Stocktake feature in the evolving local vision of sustainable, efficient, autonomous general practice working at scale to provide consistently high standards of care.

Our General Practice Strategy/Transformation Programme

Enhancing services in primary care by prioritising workforce, estates and technology investment at a neighbourhood level will enable our citizens to have better local access to a wider range of services they need when they need it



All designed to ensure that the people who need and want to access primary care can get it, and that GPs have more time to provide continuity of care and deliver more preventative care going forward

Herefordshire and Worcestershire Integrated Care System

Fuller Stocktake Framework for shared action – there are 15; these are our actions

NHS Herefordshire and Worcestershire

1	Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	Assist systems with integration of primary and urgent care access, specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	ICSs
5	Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place- based boards.	ICSs
6	Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England). Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England & HEE

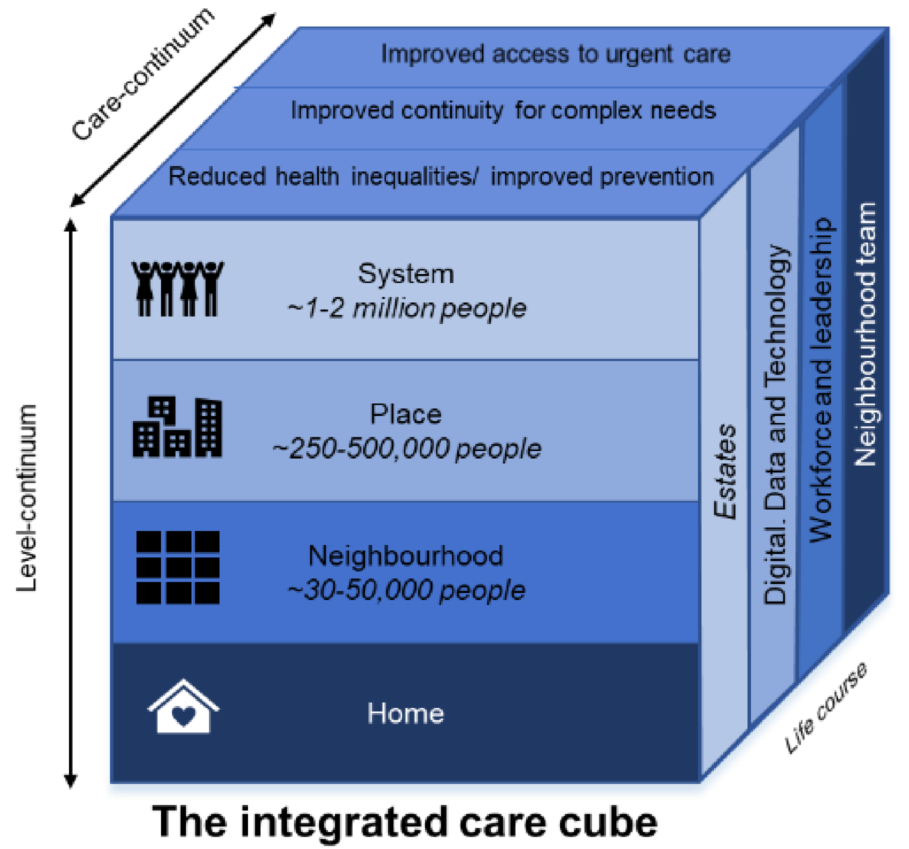
Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

The Baseline Assessment-February 2023

- Not Starting from Scratch:
  - How do we build on what's working well?
  - How do we go further?
  - Where will the discussions happen?
- Major Transformation & Change Management Initiative
- Baseline return, Fuller compliance:

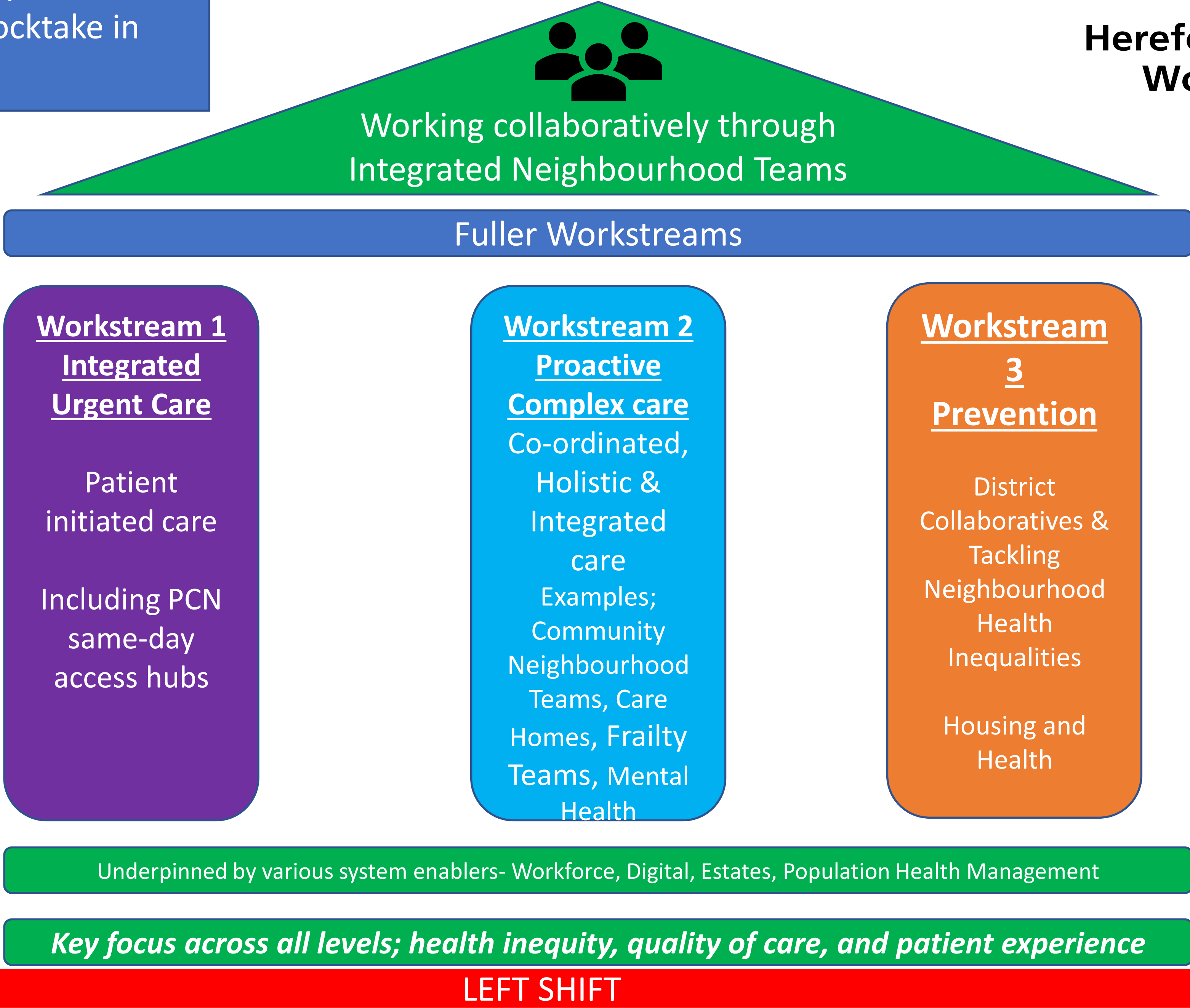
Agree	3
Neutral	5
Disagree	5



The integrated care cube

An example of our local response to implementing the Fuller stocktake in Worcestershire

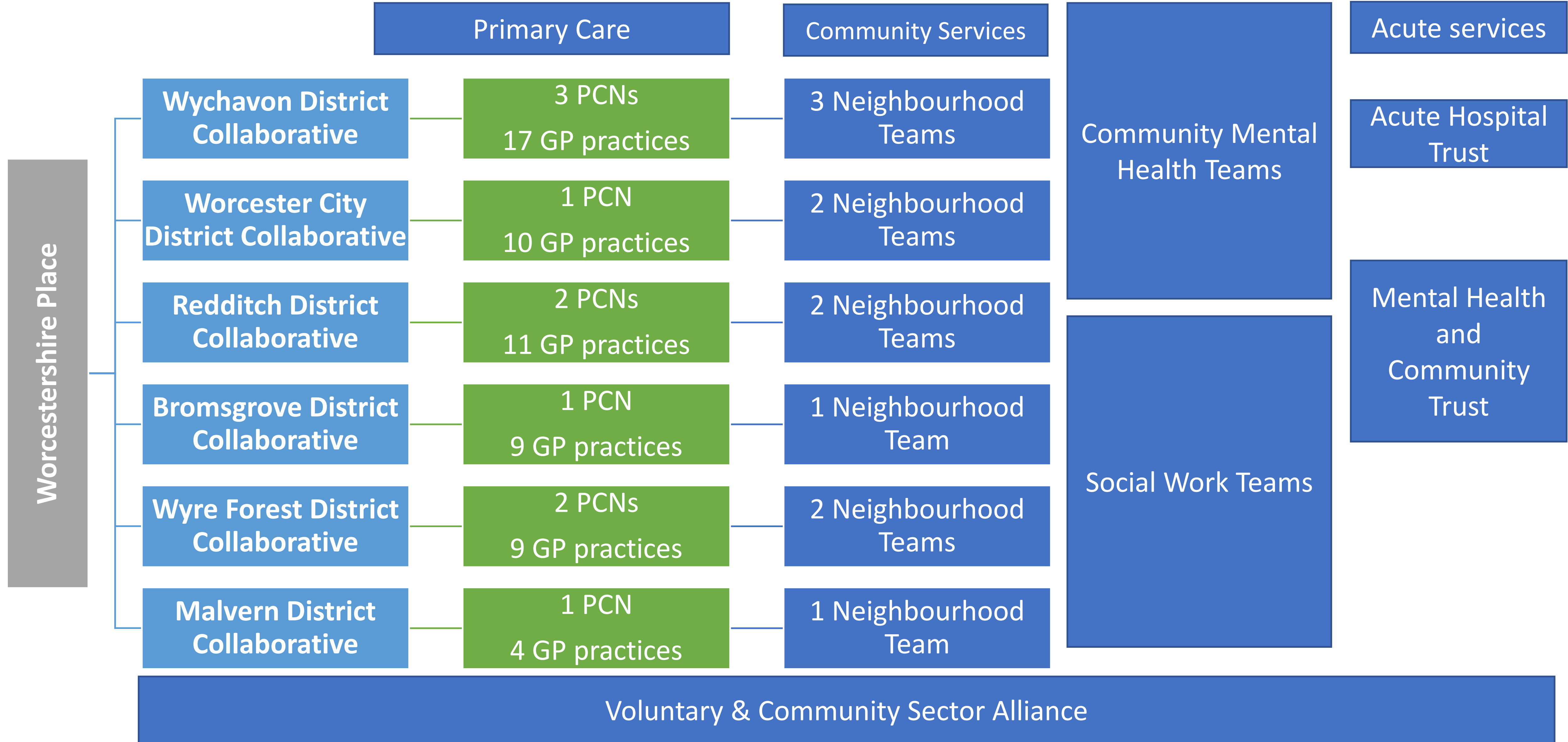
NHS
Herefordshire and Worcestershire



Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

An example of how we have started to organise ourselves at Neighbourhood Level…



Herefordshire and Worcestershire
Integrated Care System

Three NHS paradigms: state, market and community			
The NHS	**State paradigm**	**Market paradigm**	**Community paradigm**
Key organisational principle	Standardisation	Efficiency	Prevention
Key problems seeking to solve	Treating illness	Treating illness more efficiently	Preventing illness, alongside treatment when needed
Locus of power	Clinician and Whitehall bureaucrat	Clinician and manager	Clinician and community
View of service user	Deficit-led: primarily a passive patient	Transaction-led: a customer with choice determined by provider	Asset-led: a participant in their own health and wellbeing
View of communities	Not in the purview of services	A source of treatment alternatives through social prescribing	Equal partners with deep insight into effective service response
Implementation method	Top-down, uniform model of provision	Targets, performance management and productivity drives	Devolution, culture change and deep community engagement
Organisational relationships	Separate specialist organisations	Competition between organisations	Collaboration and shared community-led mission across organisations
	Centrally planned funding model	Activity-based funding model	Place-based funding allocations, joint investment in prevention
	Whitehall	Whitehall, across an increasing number of arms-length bodies	Local accountability in the context of a national outcomes framework
	Not widely pursued	Patient feedback sought through closed surveys	Community participation viewed as essential to service design
	Quantitative data informs decision-making at the top	Quantitative data informs performance management within different services	Quantitative data, combined with qualitative community insights, informs prevention shift

A focus on Prevention- working across Primary Care Networks with a range of local partners- ***District Collaboratives***

Looking to identify and solve problems, before they happen (going 'Upstream').

Supporting residents to stay well for longer- a shift to 'community power' and creation of 'good health'

Are we aiming for the community paradigm with District Collaboratives?

Herefordshire and Worcestershire
Integrated Care System

NHS
Herefordshire and Worcestershire

Next steps for integrating primary care : Fuller Stocktake report- opportunities for the VCSE sector

Worcestershire VCSE Alliance summary of workshop held 14th June 2023

Engagement and involvement

- VCSE representation at Place-based meetings
- Worcestershire VCSE Alliance Fuller workshop held 14th June 2023
- Place-based Fuller workshop with partners held 27th June 2023
- Involvement and representation at District Collaboratives and Being Well Strategic Group
- Ongoing discussions via representative at Worcestershire Executive Committee
- Representation and involvement in Fuller Task and Finish group 21st November 2023

Impact on the sector

- Working with primary care networks via Social Prescribing and wellbeing roles, funded from the current 5-year national primary care network contract
- Delivery of mental health projects, working collaboratively with primary care networks
- Being Well project via Public Health used to support local roles in districts
- Improved/closer working relationships with general practice, primary care networks and local partners within the districts

Herefordshire and Worcestershire Integrated Care System

NHS Herefordshire and Worcestershire

Feedback we have heard so far

- Voluntary sector is working in an integrated way
- Voluntary sector does co-production well and has freedom and flexibility to do this
- Need shared ownership for improving health and wellbeing of the local population, and we need to involve the sector and primary care networks

Feedback of what is working well

- Being Well projects- linking in with PCN makes it easier to share data, to enable closer working relationships
- District Collaborative - Introduction of the District Collaborative and bringing partners in to deliver against specific challenges in the community.
- Social prescribers are well informed and close to the grass root organisations

Source: Menti- meter feedback from VCSE event held in June 2023

Next steps

Recommendations from the recent Fuller task and finish group to Worcestershire Executive Committee in December

Continued working with primary care networks and District Collaboratives

Voluntary Sector Alliance continuing to develop

Example Frailty Model

(1292) Integrated Care Northamptonshire's Ageing Well Programme - patient stories - YouTube