

Community and Primary Care Nursing: Leading and shaping new models of care – responding to the five year forward view

Hilary Garratt

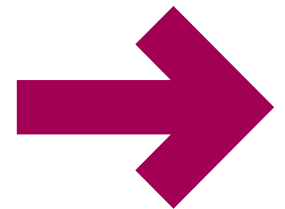
Director of Nursing:
Commissioning & Health Improvement

March 2015

Twitter: [#5YFV](#) [#shapeofcaring](#) [#FutureNHS](#)



Housekeeping



Aims of the day:



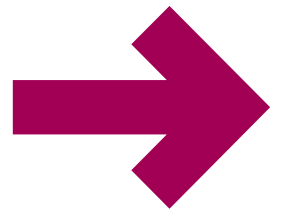
Bring people
together



Time to
think



Take
Action



Mrs Andrews Story: What went wrong

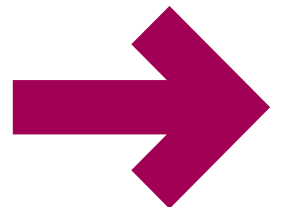
https://www.youtube.com/watch?v=Fj_9HG_TWEM



Five Year Forward View

One of the key aims is:

- To enable general practice, community pharmacy and other primary care services to play a much stronger role, at the heart of a more integrated system of community-based services.



Five Year Forward View – Opportunities for community and primary care nurses

Focus on prevention and public health

- Behaviour change to tackle lifestyle factors

Empowering patients and citizens

- Support and information for self-management and personalised care

Engaging with communities

- Partnership with the voluntary sector and public engagement

New models of care

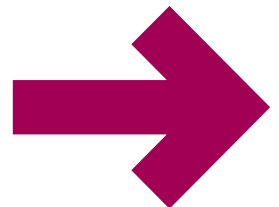
- MCPs/PACs/VsH/Care Homes

Leadership at a local level

- Influence in driving integrated care
- Supporting development of a modern workforce

Improving quality

- Patient safety
- Patient experience
- Clinical effectiveness





New Models of Care

Charlotte Williams
New Models of Care
Programme Manager
NHSE

The NHS Five Year Forward View: New Models of Care Programme

An overview

March 2015

NHS Five Year Forward View

- The NHS Five Year Forward View was published on 23 October 2014
- One of its great successes was that it is a shared vision for the future of the NHS across six national NHS bodies
- The challenge is now implementation; we know:
 - It will not be easy
 - We need to learn from the past
 - We're going to need a different approach
 - We're up for it



The core argument made in the Forward View centres around three 'gaps':

- | | | |
|---|--------------------------------------|---|
| 1
Health & wellbeing gap | Radical upgrade in prevention | <ul style="list-style-type: none">• Back national action on major health risks• Targeted prevention initiatives e.g. diabetes• Much greater patient control• Harnessing the 'renewable energy' of communities |
| 2
Care & quality gap | New models of care | <ul style="list-style-type: none">• Neither 'one size fits all', nor 'thousand flowers'• A menu of care models for local areas to consider• Investment and flexibilities to support implementation of new care models |
| 3
Funding gap | Efficiency & investment | <ul style="list-style-type: none">• Implementation of these care models and other actions could deliver significant efficiency gains• However, there remains an additional funding requirement for the next government• And the need for upfront, pump-priming investment |

New Models of Care

Initially the new models of care programme will focus on:

Multispecialty Community Providers

- Blending primary care and specialist services in one organisation
- Multidisciplinary teams providing services in the community
- Identifying the patients who will benefit most, across a population of at least 30,000

Integrated primary and acute care systems

- Integrated primary, hospital and mental health services working as a single integrated network or organisation
- Sharing the risk for the health of a defined population
- Flexible use of workforce and wider community assets

New approaches to smaller viable hospitals

- Coordinated care for patients with long-term conditions
- Targeting specific areas of interest, such as elective surgery
- Considering new organisational forms and joint ventures

Enhanced health in care homes

- Multi-agency support for people in care homes and to help people stay at home
- Using new technologies and telemedicine for specialist input
- Support for patients to die in their place of choice

Principles of New Models of Care

The vanguard sites chosen for new models of care will need to show:

Ambitious vision

Highlighting what you want to change in order to meet clear identified needs and preferences of your local population

Strong local relationships & delivery partners

Support from a diverse range of active delivery partners, local commissioners and communities

Credible plan & tangible progress

To allow the programme to move at pace and make rapid change during 2015; including progress toward new ways of working

Strong leadership

Effective managerial and clinical leadership and the capacity and capability to deliver change

What we are trying to achieve

There are three key elements to the New Models of Care programme

- 1

**Dissolving
traditional barriers**

- A need to manage systems of care not just organisations
 - Integrated services around the patient giving the patient greater control
 - Addressing pre-existing barriers to change

- 2

**Co-designing
local services**

- Harnessing the 'renewable energy' of communities
 - Targeted prevention initiatives
 - Investment and flexibilities to support implementation of new care models
 - Active patient involvement

- 3

**Applying
learnings across
the health system**

- Promote peer learning with similar areas
 - Fast learning from best practice examples
 - Applying innovations and learnings across the system

What does success look like?

A range of new care models that are locally delivered across the country and can be replicated across the system

- 1 New care models**
 - A need to manage systems of care not just organisations
 - Integrated services around the patient giving the patient greater control in their care

- 2 Locally delivered**
 - A focus on meeting local population health needs
 - Support from a diverse range of active delivery partners, local commissioners and communities
 - Active patient involvement

- 3 National replicability**
 - Fast learning from best practice examples that can be applied to other areas across the country
 - Applying innovations and learnings across the system

We are reviewing the ‘vanguard’ applications using the following principles:

- The process will be as transparent as possible
- Patients and clinicians will be engaged throughout
- Regional teams will be invited to provide local insights
- Additional insight will be sought from a wide range of partners, including the national NHS bodies, NHS IQ and Think Tanks
- The New Models of Care Board will take the final decision on who we will work with as ‘vanguards’ in the first year
- Final decisions will be a value based, taking into account all evidence received throughout the process

Summary of Vanguard identification

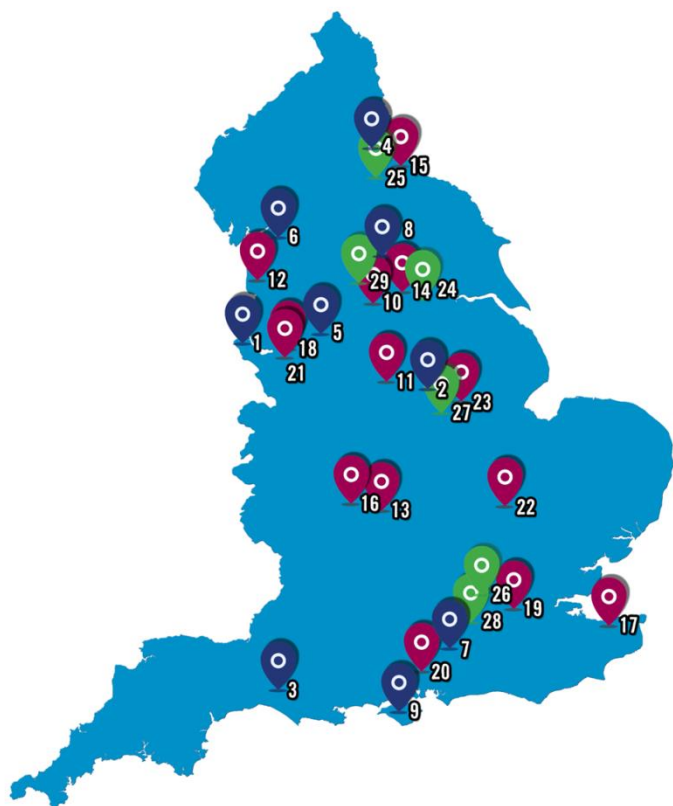
On 26 January, invitations for expressions of interest to become a vanguard site were opened.

Applicants were asked to complete a 6-question 'register of interest' form, describing the key objectives they were trying to achieve with their new care model plan, current progress, planned outcomes to be achieved April 2016, the nature of support they need

Submissions closed on 9 February, with a total of 268 received nationwide. 63 were short-listed after a national and regional review reviewers including clinicians, patients and representatives from the community, and colleagues from local government.

Care model	# submissions	# attending workshops
Multispecialty Community Providers (MCPs)	170	33
Primary and Acute Care Systems (PACS)	46	17
Viable Smaller Hospitals (VSH)	13	7
Enhanced health in care homes (CH)	36	6
Unspecified	3	
Total	268	63

First cohort Vanguard sites



Care model	Applicant
Care Homes	NHS Wakefield CCG
Care Homes	Newcastle Gateshead Alliance
Care Homes	East and North Hertfordshire CCG
Care Homes	Nottingham City CCG
Care Homes	Sutton CCG
Care Homes	Airedale NHS FT

Care model	Applicant
PACS	Wirral University Teaching Hospital NHS Foundation Trust
PACS	Mansfield and Ashfield and Newark and Sherwood CCGs
PACS	Yeovil Hospital
PACS	Northumbria Healthcare NHS Trust
PACS	Salford Royal Foundation Trust
PACS	Lancashire North
PACs	Hampshire & Farnham CCG
PACS	Harrogate & Rural District CCG
PACS	Isle of Wight
Care model	Applicant
MCP	Calderdale Health & Social Care Economy
MCP	Derbyshire Community Health Services NHS Foundation Trust
MCP	Fylde Coast Local Health Economy
MCP	Vitality
MCP	West Wakefield Health and Wellbeing Ltd (new GP Federation)
MCP	NHS Sunderland CCG and Sunderland City Council
MCP	NHS Dudley Clinical Commissioning Group
MCP	Whitstable Medical Practice
MCP	Stockport Together
MCP	Tower Hamlets Integrated Provider Partnership
MCP	Southern Hampshire
MCP	Primary Care Cheshire
MCP	Lakeside Surgeries
MCP	Principia Partners in Health



Themes of the support programme - transactional support (1/2)

Key theme	Known Barriers	How we might overcome known barriers?	What organisations could support?
Commissioning, contracting and payments	- Current mechanisms are not conducive to enabling new models across multiple organisations; multilateral gain-risk share arrangements - PbR versus block contracts; prime or alliance contracts - concerns over competition procurement law - true joint commissioning models with local government	- Establish a community of practice to share learning and expertise, offering expert and legal advice - Accelerate development of new payment systems such as capitated budgets, polled budgets and integrated personal commissioning. - Review current rules on procurement and tendering, and consider possible waiver for commissioners to deviate from those rules	- Aligned national support across ALBs - IHI - King's Fund
Information technology and information governance	- IT systems have low interoperability capability across organisations and systems; - Limited holistic data sets/means in order to track patient-level activity and costs across multiple settings; - Information governance prevents necessary sharing of secondary data across organisations	- Self assessment and diagnostic - A nationally led programme under the remit of the National Information Board	- Aligned national support across ALBs - National Information Board



Themes of the support programme - transactional support (2/2)

Key theme	Known Barriers	How we might overcome known barriers?	What organisations could support?	
Transparent measurement	Evaluations have often been towards the end of long term programmes, with real-learning not capitalised in a timely way	• Programme evaluation approach • Formative evaluation throughout NCM implementation that includes population outcomes and patient experience	• RAND • NHS IQ • Health Fdn • IHI	• Haelo • AHSNs • CLARCs • AQuA • Royal Colleges
Rigorous delivery	Ensuring appropriate individuals have local capacity to deliver effective programme management, without an industry of paperwork and numerous reporting lines	• Robust consistent programme management approach • Clear business case & gateway process	• Aligned national support across ALBs • NHS IQ • HSCIC	
Comms & engagement	Ensuring appropriate individuals have local capacity to deliver consistent comms, clinical and patient engagement and change management	• Self assessments of readiness • Mentorship and coaching • Communications development	• NHS IQ tools • NHS LA • TLAP	• Health-watch • Nesta
Workforce	There are limited holistic comprehensive workforce models that span health, social care, public health, the voluntary sector Key issues include: professional regulation, indemnity, recruitment processes, training programmes and training time lags	• A revised approach to modelling that considers the formal & informal workforce, and to include the design of new roles	• Aligned national support (led by HEE) • NHS IQ • NHS Employers • Royal Colleges • Patient representative groups • Voluntary sector groups	



Themes of the support programme - transformational support (1/2)

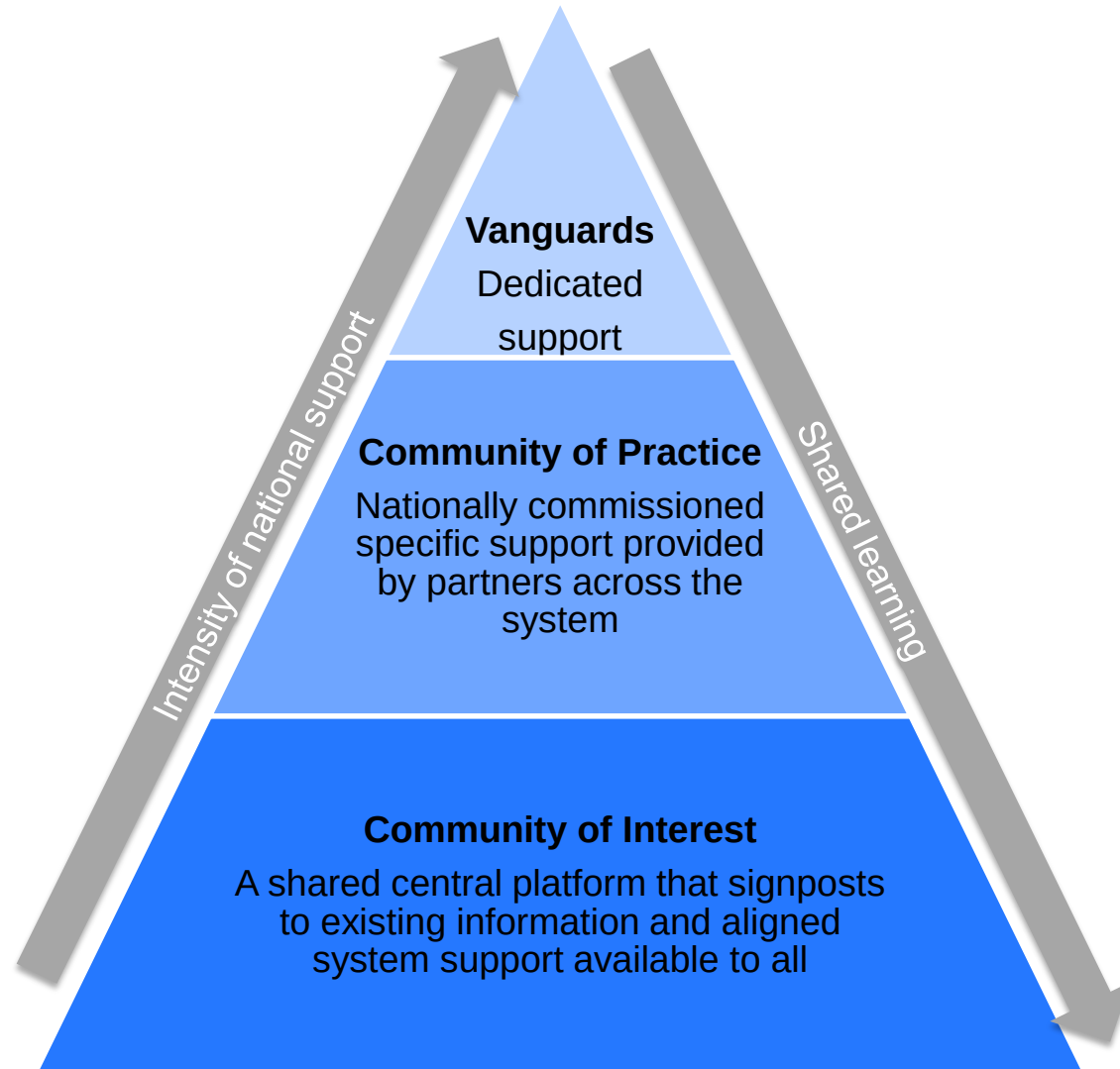
Key theme	Known Barriers	How we might overcome known barriers?	What organisations could support?	
Leadership for change	Local health and care economies need to be able to agree and move together on actions that will led to new models that very likely change current patterns of activity and funding flows Cultural issues could either be at a number of levels eg within a new clinical team, within an organisation, or across organisations	- Prioritise the development of system leadership both for the NHS as a whole and in LHEs, including learning from other sectors - New styles of provider leadership supported by national bodies to avoid the wrong kind of regulation	- Aligned national support across ALBs - NHS Leadership Academy - Clinical Leadership - Programmes led by HEE, Royal Colleges and/or AHSNs - King's Fund & Health Foundation	
Spread of innovation	Often innovative approaches are not shared or communicated in a timely way nor easily replicable to be implemented elsewhere	- Self-assessment of the readiness and likely success of spread and adoption - National learning sets - guidance for strengthening areas that need attention	- ALBs - NHS IQ - NHSLA - Health Fdn - IHI	- Haelo - Nesta - AHSNs - CLARCs - NHS Confed
Improvement methodology	There is a need to rely less on external pressures such as targets and inspection and more on support from leaders and staff	Develop a strategy for quality improvement to foster a learning institution on the basis that it will provide national support through small teams of credible experts to local delivery	- Aligned national support across ALBs - NHSIQ - Health Foundation - Whole System Intervention support	



Themes of the support programme - transformational support (2/2)

Key theme	Known Barriers	How we might overcome known barriers?	What organisations could support?	
Transparent measurement	Evaluations have often been towards the end of long term programmes, with real-learning not capitalised in a timely way	Should be a commitment of discovery not design with a commitment to real-time evaluation and learning throughout	- RAND - NHS IQ - Health Foundation - IHI	- Haelo - AHSNs - CLARCs - AQuA - Royal Colleges
Comms & engagement	Ensuring appropriate individuals have local capacity to deliver consistent comms, clinical and patient engagement and change management	- Self assessments of readiness - site diagnostics - Mentorship and coaching - Communications development	- Aligned national support across ALBs - NHS IQ - NHSLA	- TLAP - Health-watch - Patient groups - Voluntary sector
Workforce	There are current challenges both with an insufficient number of staff and not enough staff trained in multi-disciplinary and generalist care.	- Self assessments of readiness - Learning sets - Specific training programmes	- Aligned national support across ALBs - NHS IQ - NHS Employers - Royal Colleges	

New Care Models (NCM) Support programme framework



Find out more...

<http://www.england.nhs.uk/2015/03/10/new-era-of-patient-care/>

<http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/>

Transforming Nursing for Community & Primary Care

Sarah Elliott
Regional Chief Nurse
NHS England South

March 2015



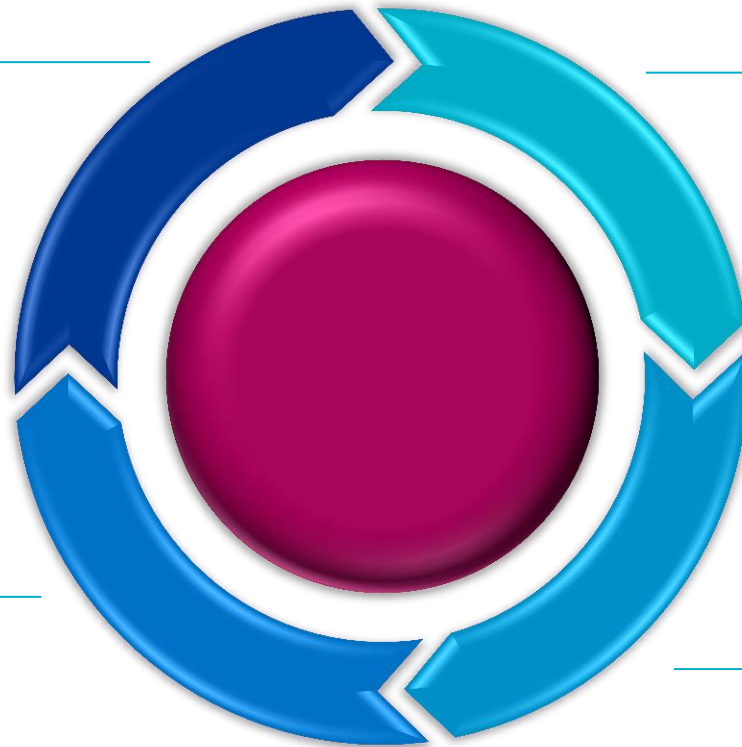
Purpose of the day

New Models of Care

Contribute to the development and implementation of the models

Good Practice

Sharing and learning in line with the 5YFV



The Shape of Caring

Consider the implications of the review for community and primary care nursing

Compassion in Practice

Embedding the Action Areas and 6Cs

What we know

- Meeting the health and care needs of people in their local communities will require a different approach
- Ageing population requires an emphasis on frailty
- Needs of communities changing – secondary prevention
- Need to engage and mobilise Community and Primary Care Nursing
- Partnership approach required

Where do we need to be?

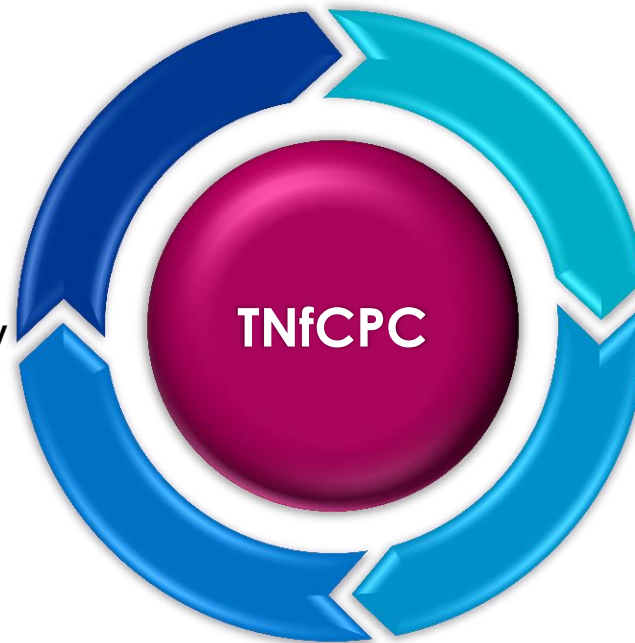
- New Models of Care - right skills, values and behaviours to deliver them
- Engagement with patients, carers and citizens
- Focus on well being and prevention
- Personalised care planning & self management
- Upskilled Workforce – across all care sectors
- Working across organisational boundaries

What have we done so far?

Commissioning

Development

- Shared good practice
- Pricing & Incentives
- Frail Older People
- Supporting Community & Primary Care Nursing



Integration

- Joint medical & nursing collaboration
- Service component handbooks

Prevention

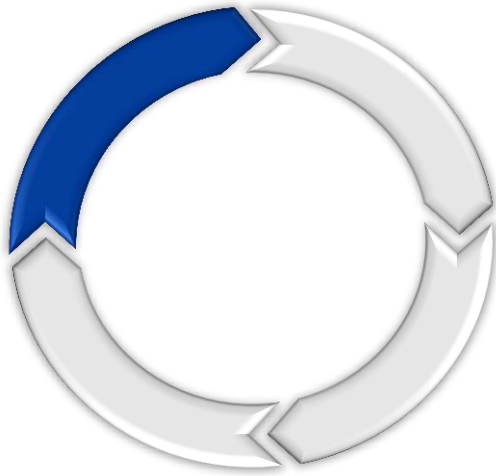
- Securing clinical leadership
- Commissioning tools & levers
- Working in partnership
- Action planning
- Supporting carers

Workforce

- Education & career pathways
- Workforce planning

Commissioning Development

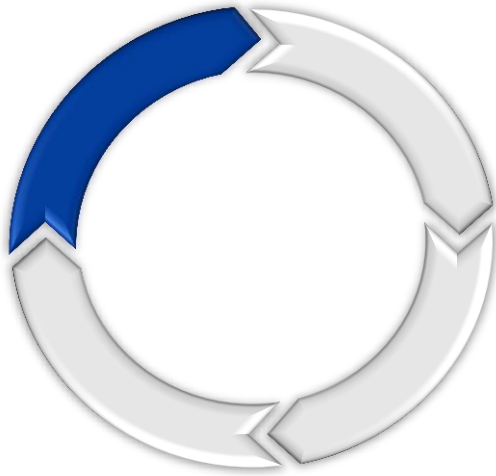
...is supporting commissioning



- QNI review of workforce planning (2014)
- Community Nursing Workforce Commissioning Specification
- Consolidated literature on out of hospital care for commissioners (2014)
- Working with the Commissioning Nurse Leaders Network (CNL Network)
- Sharing good practice
- Working with the national pricing and incentives team
- Guidance and toolkit for frail older people

Commissioning Development

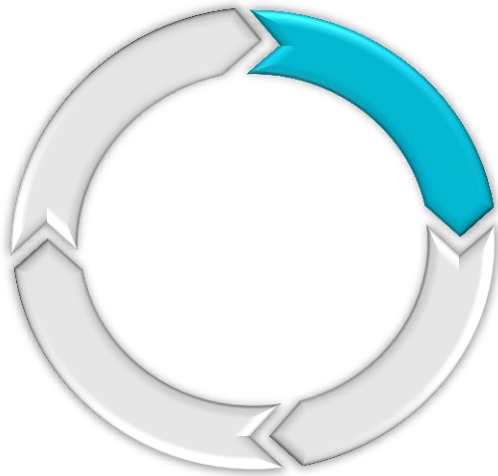
...is working to support general practice nursing



- Raising awareness of and supporting the use of the Primary Medical Services Assurance Framework for nursing in primary care
- Established a National Forum for Community and Primary Care Nursing
- Providing leadership for general practice nursing
- Contributing to delivering the Ten Point Plan for primary care

Integration

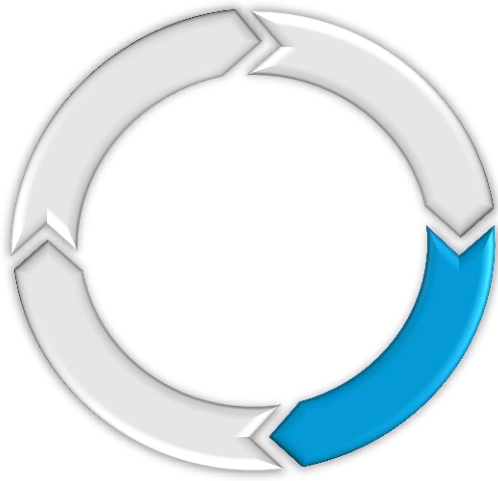
...is working to support care-planning, risk stratification and multi-disciplinary team working



- Collaboratively developed handbooks on:
 - Case finding & risk stratification
 - Multidisciplinary team working
 - Personalised care & support planning
- Accountable clinician for out of hospital care

Workforce

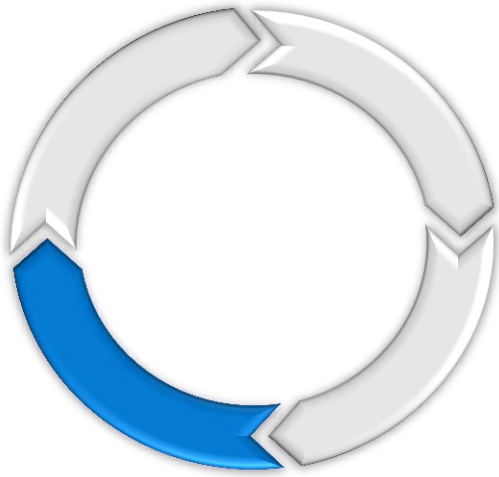
...is ensuring the right skills in the right place



- Education and career pathway for district and general practice nursing
 - Education commissioning service specification
 - Career framework
- Future workforce planning

Prevention

... is focusing on those at risk and those with long term conditions



- Secure clinical leadership for secondary prevention
- Using commissioning levers for successful outcomes
- Behaviour change – partnership working
- Supporting carers
- Framework for Personalised Care (DH/PHE)



Prevention

Empowering
Patients

Local
Leadership

Engaging
Communities

Aligned
National
Leadership

Modern
Workforce

Use of
Innovation

New
Models of
Care

Exploit
Info.
Revolution

Drive
Efficiency

What does it mean for us?

Focusing on prevention

- Incentivise healthier individual behaviours
- Strengthen powers for Local Authorities
- Targeted prevention programmes – starting with diabetes
- Additional support people to get and stay in employment
- Create healthier workplaces – starting with the NHS
- Staff as role models
- Staff as expert in behaviour change

Empowering patients

- Improve information: personal access to integrated records
- Invest in self-management
- Support patient choice
- Increase patient control including through Integrated Personal Commissioning (IPC)
- New relationships
- Sharing the leadership space with patients

Engaging communities

- Support England's 5.5m carers – particularly the vulnerable
- Supporting the development of new volunteering programmes
- Finding new ways to engage and commission the voluntary sector
- NHS reflecting local diversity as an employer

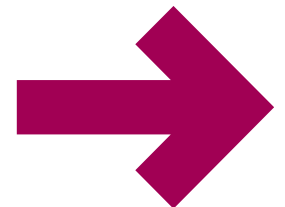


For today

- Communication and engagement
- The next steps we should take for the Transforming Nursing for Community and Primary Care programme
- Engage with the National Forum for Community and Primary Care Nursing
- How we mobilise together to have maximum input into the Five Year Forward View and New Models of Care

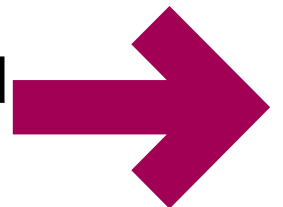
What next for the South

- A number of local examples of how new service delivery models are benefiting patients in the South will be described throughout the morning
- Our Vanguard sites will be accelerators
- Purpose of workshops this afternoon is to refine our thinking on the challenges and opportunities that the forward view and new models of care offer nursing
- 3 priorities each for commissioners, education and providers
- Establish a partnership steering group to oversee delivery of a 9 point concordat/manifesto



Developing the Detail

- Accelerate a programme of support and development across the South
- Commissioners, educationalists and providers to work together to exploit every opportunity to develop and integrate services
- Skills in delivering supported self management programmes, behavioural change and personalised care and support
- Frailty screening
- Continence
- Integrated nursing
- Core foundation programmes for Community and Practice nurses



The Shape of Caring Review: What will this mean for primary and community nursing in the next 5 years?

Lisa Bayliss-Pratt
Director of Nursing
Health Education
England



Forward View into Action: Examples from the South



General Practice and Community Nursing Transformational Change programme – Devon, Cornwall and Isles of Scilly

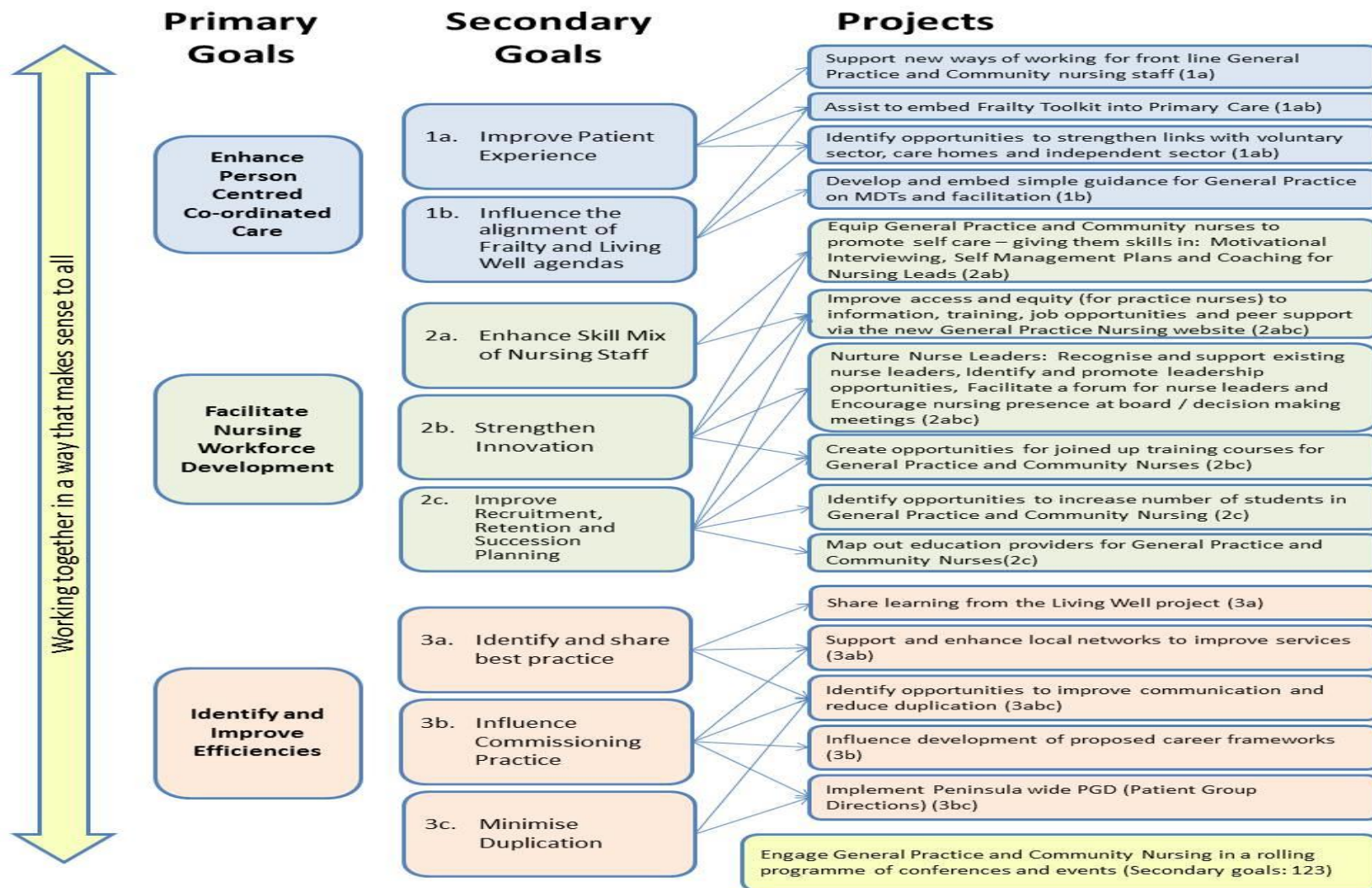
Magdalena Wood
Programme Lead

12th March 2015, Community and
Primary Care Engagement Event

General Practice and Community Nursing Transformational Change programme across the SW Peninsula

NHS England Devon, Cornwall and Isles of Scilly Area Team
General Practice and Community Nursing Development Programme
 To Advance the Implementation of the 5 Year Forward View

Aim: Progressing High Quality, Innovative and Safe General Practice and Community Nursing Across the South West Peninsula - December 2014 - November 2015



General Practice and Community Nursing Transformational Change programme across the SW Peninsula

Primary Goal 1

Secondary Goals

Projects

**Enhance
Person
Centred
Co-
ordinated
Care**

1a. Improve
Patient
Experience

1b. Influence
the
alignment
of Frailty
and Living
Well
agendas

Support new ways of working
for the General Practice and
Community nursing staff (1a)

Assist to embed Frailty Toolkit
into Primary Care (1ab)

Identify opportunities to
strengthen links with voluntary
sector, care homes and
independent sector (1ab)

Develop and embed simple
guidance on Multidisciplinary
Team Meetings and facilitation
for primary care (1b)

General Practice and Community Nursing Transformational Change programme across the SW Peninsula

Primary Goal 2

Secondary Goals

Projects

**Mobilise and
Activate
Nursing
Workforce**

2a. Enhance Skill
Mix of
Nursing Staff

2b. Strengthen
Innovation

2c. Improve
Recruitment,
Retention
and
Succession
Planning

Equip General Practice and Community nurses to promote self care – giving them skills in: Motivational Interviewing, Self Management Plans and Coaching for Nursing Leads (2ab)

Improve access and equity for practice nurses to information, training, job opportunities and peer support via the new Practice Nursing website (2abc)

Nurture Nurse Leaders: Recognise and support existing nurse leaders, Identify and promote leadership opportunities, Facilitate a forum for nurse leaders. Encourage nursing presence at board / decision making meetings (2abc)

Create opportunities for joined up training courses for General Practice and Community Nurses (2bc)

Identify opportunities to increase number of students in General Practice and Community Nursing (2c)

Map out education providers for General Practice and Community Nurses(2c)

General Practice and Community Nursing Transformational Change programme across the SW Peninsula

Primary Goal 3

Secondary Goals

Projects

3a. Identify and share best practice to inform new models of care

3b. Influence Commissioning Practice

3c. Minimise Duplication

Share learning from the Living Well project across the Peninsula (3a)

Support and enhance local nursing networks to improve services (3ab)

Identify opportunities to improve communication and reduce duplication (3abc)

Influence development of proposed career frameworks (3b)

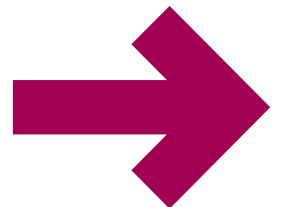
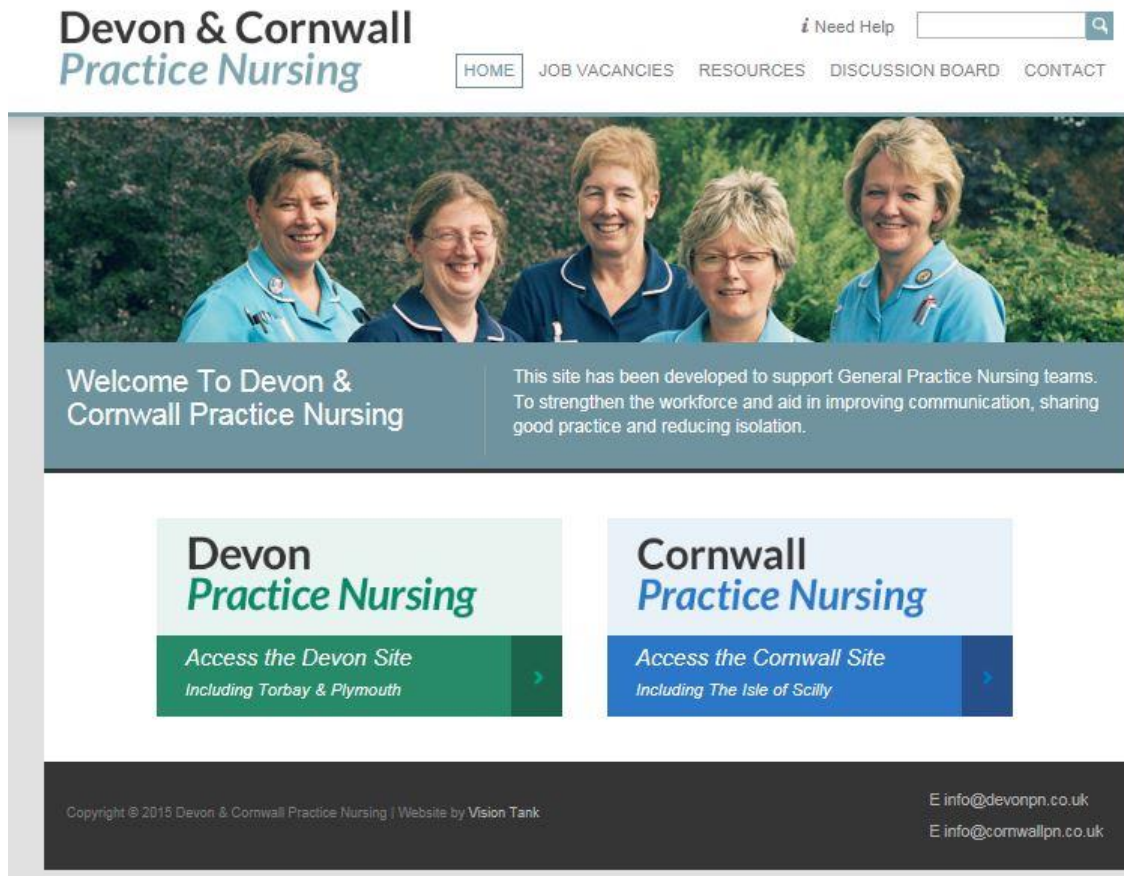
Implement Peninsula wide PGD (Patient Group Directions) (3bc)

Engage General Practice and Community Nursing in a rolling programme of conferences and events (Secondary goals: 123)

Identify and Improve Efficiencies

A brand new Practice Nursing website for Devon and Cornwall

www.devoncornwallpn.co.uk



Thank you for listening

Magdalena Wood

Practice Nursing Development Programme Lead

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- Mobile: 0776 997 2652

Symphony Integrated Care for People with Long Term Conditions in Somerset

Lucy Watson
Director of Quality, Safety and Governance

12 March 2015

Vision

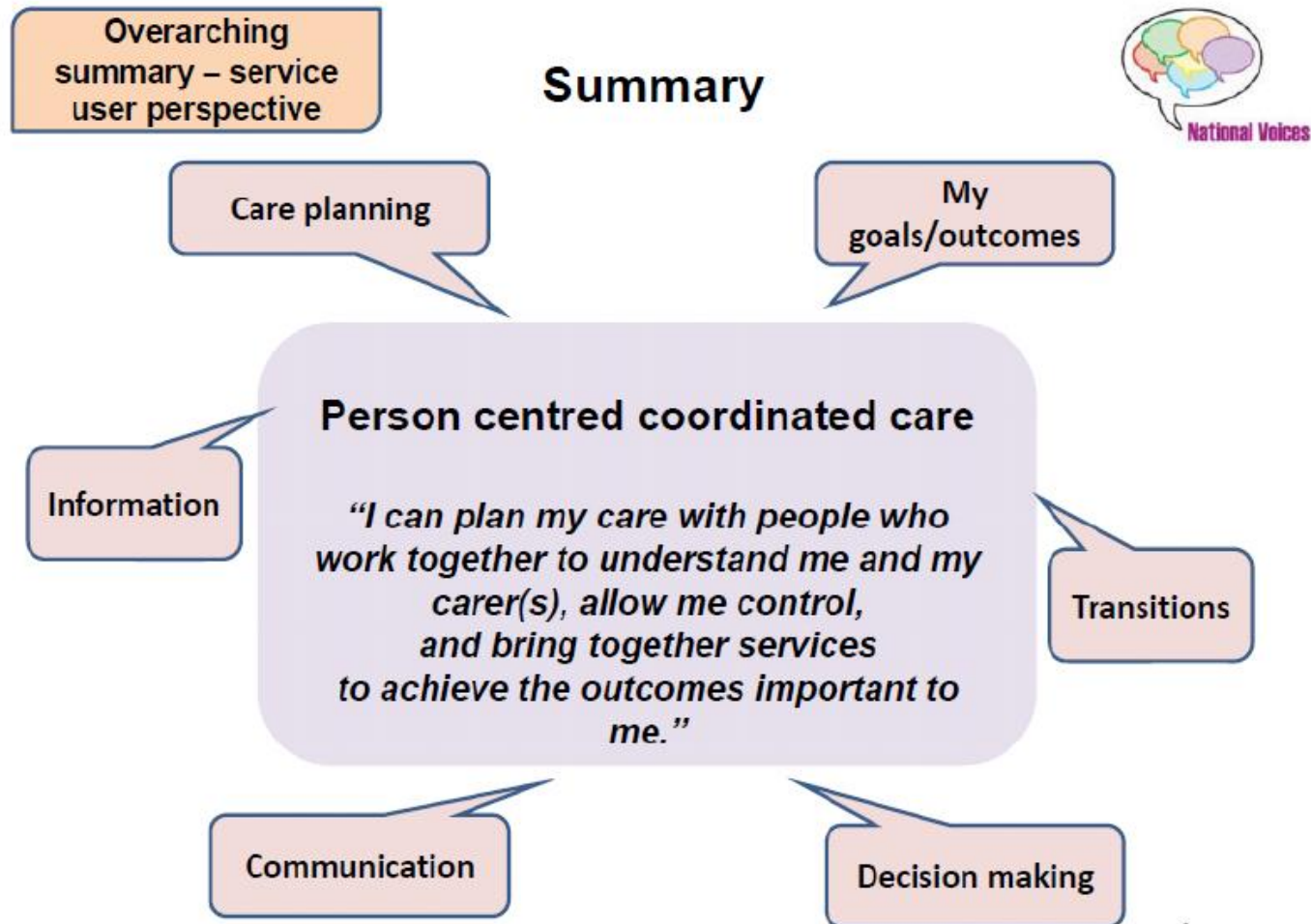
“People in Somerset will be encouraged to stay healthy and well through a focus on healthy lifestyle choices and self-care. When people need to access care or support this will be through joined up health, social care and wellbeing services. The result will be a healthier population with access to high quality care that is affordable and sustainable.”

CCG Strategy 2014-2019

- We will commission co-ordinated and person-centred care, which will be delivered through new partnerships
- We will drive changes that focus on improved patient experience through developments in the way that organisations and services work together, and the way that patients and professionals work together, to get the best health outcomes for Somerset
- We will develop collaborative approaches to commissioning and provision

Symphony

- Project focus on the population of South Somerset
- Symphony created a combined dataset across health and social care— now extended to the whole Somerset population
- Identified drivers for use of services and cost were the number of long term conditions people have not age
- Outcome Set agreed collaboratively between patients and clinicians, this is mapped to the CCG Outcome Indicator set
- Developed a complex care model to serve multiple long-term condition patients, based on care co-ordination hubs



Outcomes

A group of representatives from all parties worked through options for a hierarchy or framework

They chose a modification of Michael Porter's hierarchy of health outcomes

It combines a strong focus on what people say matters about their care with other outcomes that represent value to commissioners and providers

They link back to the aims of the project

Tier 1: Wellbeing status

Independence

Wellbeing

Health outcomes

Tier 2: Process of care

Right care

Right time, right place

Tier 3: Sustainability of services

Cost

Staff

Learning organisation

Tier 1: Wellbeing Status

Independence	People are activated to manage their own health People are actively involved in and have choices about their care People participate in work or other meaningful activities People live in a place of their choosing
Quality of life	Quality of life for people is maximised Quality of life for carers is maximised
Health outcomes	There are reductions in: – Mortality from conditions amenable to healthcare – Admissions for ambulatory care sensitive conditions – Unplanned readmissions – Emergency/unplanned admissions for cancer

Summary

- Significant transformation agenda to deliver improved outcomes for people with long term conditions
- Commissioning for outcomes
- Test and learn to engage and reflect local need
- Governance arrangements to monitor/ drive delivery and ensure shared learning
- Clinical leadership and workforce development

Tier 2: Process of Care

Right care

Positive relationships: People have one key person who takes ownership for co-ordinating their care and is trusted

Seamless co-ordination: People report that their care feels seamless and well-coordinated

Right time,
right place

People and carers find access to services easy

Staff are able to arrange care when needed

There is 7 day access to appropriate services

Care is provided with minimal disruption and travel to people and carers

Tier 3: Sustainability of Services

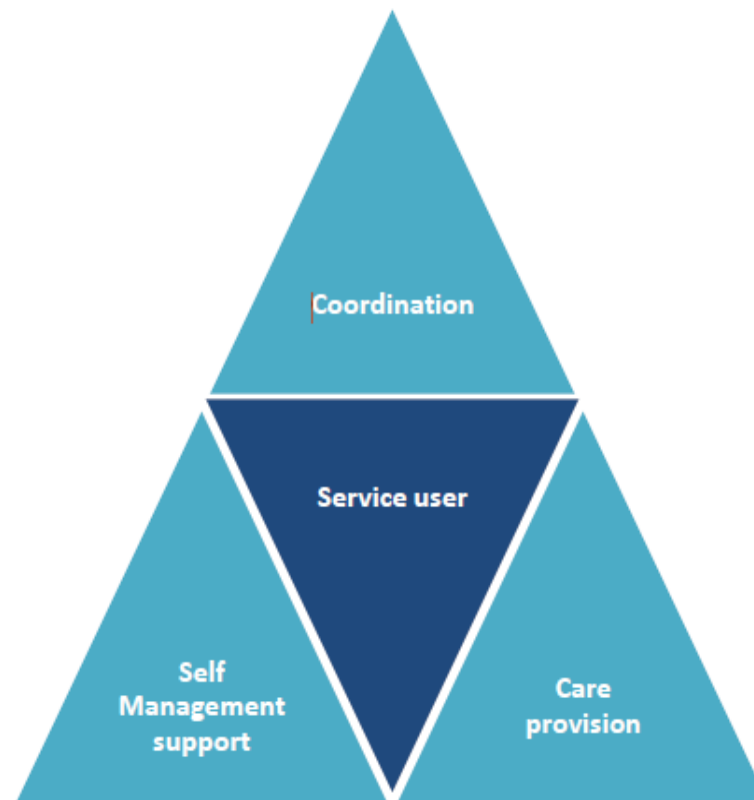
Cost	Actual costs of the service are equal to or less than target costs Total commissioning cost of person to whole system is maintained or reduced Fixed costs in the health and care economy are maintained or reduced
Staff satisfaction	Staff report increasing levels of satisfaction
Learning organisation	Improvements are made resulting from feedback from people and carers Improvements are made resulting from staff feedback or made by staff

Care Model

What were we trying to achieve

- Better health and quality for life for patients
- Patients able to take more control
- Better job satisfaction for staff
- Enable people to stay at or near home
- Reduce cost to the system
- Deliver the Symphony outcomes

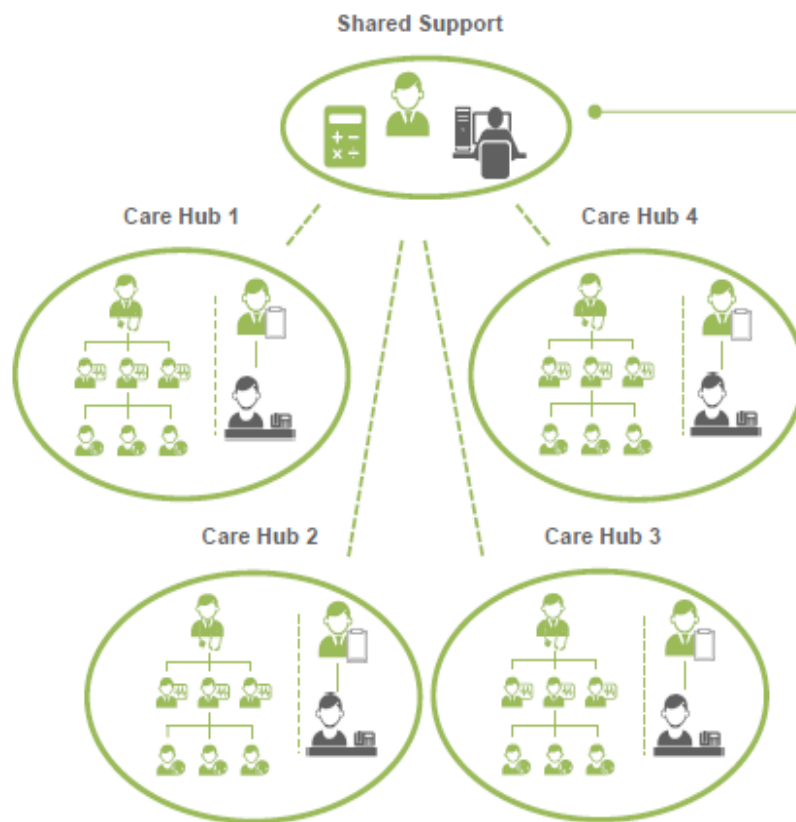
Symphony – Core Functions



Key features of the model

- Cohort of patients – intensively supported with focus on self-management, proactive care planning, escalation plans, proactive response at times of crisis, and co-ordinated care as close to home as possible
- Single care plan, single pathway – primary / community / acute / social care, plus self-management and community support
- Four hubs – GP clusters
- Supported by integrated community teams (health and social care and expert generalist medical input)
- One care-coordinator – manage transition from current pathways to single pathway across all elements of health and social care
- Key workers acting who build relationships and act as health coaches

The Symphony Complex Care Hub Network



Symphony shared support

- Shared infrastructure and support functions.
- Central business functions and Symphony management, e.g. Care model refinement, geographic expansion, planning for extension to new cohorts, etc.

Local Expert Care Hubs

- Location for co-located multi-skilled Care Coordinator and Key Worker teams to enable effective team working
- Initial point of contact for all patient needs, e.g. Questions, concerns, urgent enquiries, carer concerns
- Locally accessible to cohort patients, e.g.
 - Delivery of care as part of care plans
 - Meeting core team members for review

Summary of the Care Model

- Population group – people with 3 LTCs – all people with LTCs and people with frailty
- Risk Stratification to identify patients
- Assessment and personalised care planning
- Care coordination
- Care provision
- Self management

We want to expand integration programmes across the County

We wanted to roll this out at scale across the county through existing projects which are seeking to deliver:

- Person-centred care
- Early identification of need through data analysis
- Reablement

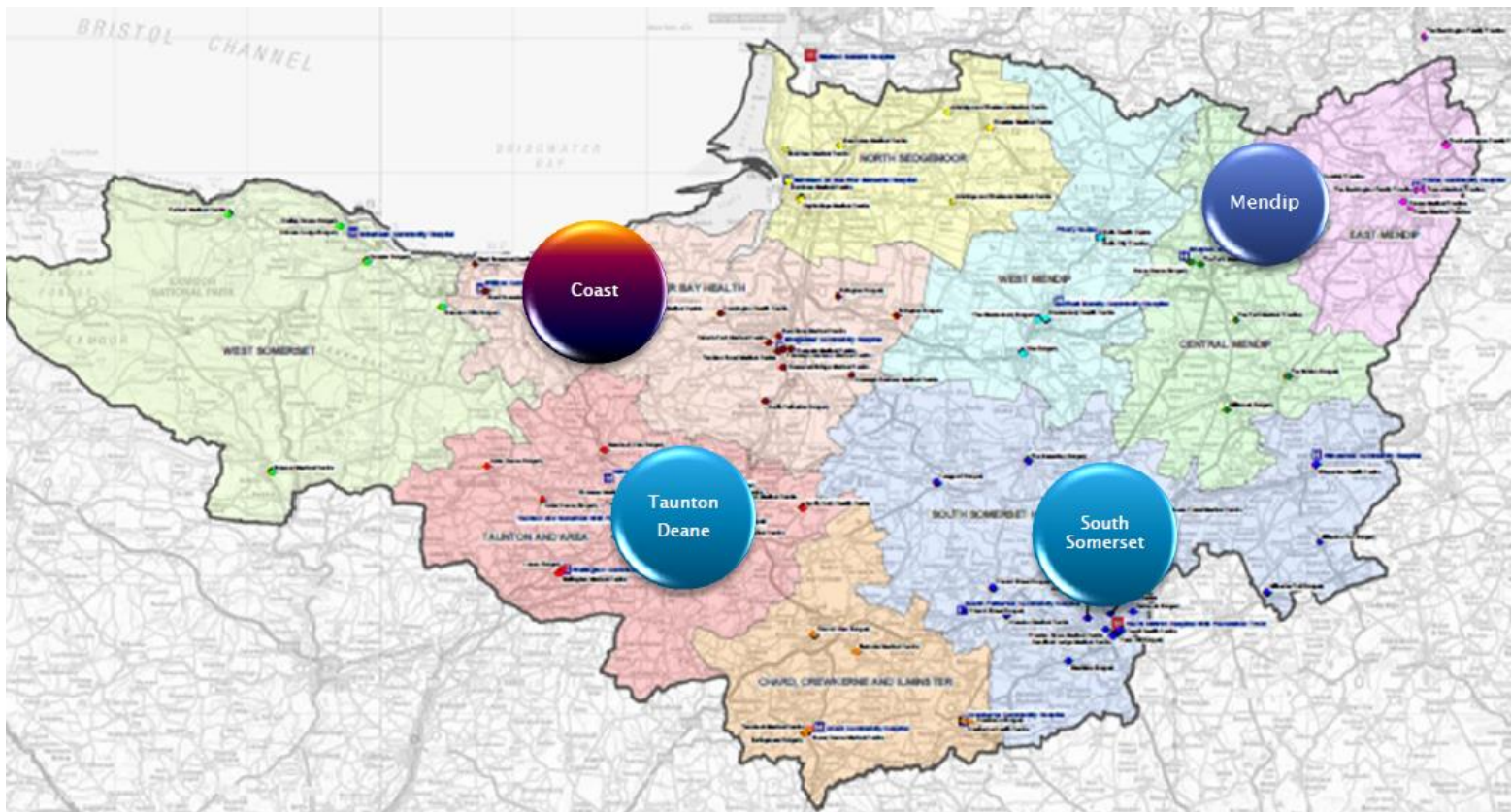
Through:

- Symphony
- Independent Living Teams
- Somerset House of Care (long term conditions)

Developed Four Local Implementation Groups (LIGs) with innovative ideas to:

- Build on the existing work and knowledge already gained
- Be aware of limitations of (e.g. social care programmes to adapt to many local models
- Have some consistency across the County

LIG areas



Multi-agency LIG membership

- Primary Care
- CCG
- Nearest acute trust (Taunton and Somerset, Yeovil, RUH Bath, Weston)
- Somerset Partnership
- Somerset County Council
- District Councils
- SWAST
- Independent domiciliary care providers (RCPA)
- The voluntary and community sector

Commissioning Strategy

- To make a step change in the provision of person centred care
- Capitated outcomes based commissioning COBIC to drive integrated working
- 3 test and learn pilots with clearly identified host provider overseen by LIGs
- Must include collaboration between providers
- Implementation plan based on the Symphony Pathway for Frail Older People
- Symphony – South Somerset have applied to be a Vanguard site for PACS - integrated primary and acute care systems

Challenges

- Two test and learn pilots led by primary care and one led by an acute trust
- All using patient cohorts identified through the primary care unplanned care enhanced service
- One test and learn looking at practice nurses to be long term conditions nurses in care hubs, others looking at nurses as care coordinators
- Development of peer supporters for self management, peer support network of support groups and portal
- Project sites understanding the need for workforce development to deliver change

Sustaining High Quality Affordable Care

- Quality impact assessment for service transformation and pathway redesign
- Clinical leadership
- Workforce development
- New roles: care coordinators, and care navigators
- Development of primary and community nursing roles to deliver person centred care

Workforce Development

- Knowledge, skills and expertise in providing person centred care, care coordination and escalation plans for people with long term conditions and for people with frailty
- Clinical leadership development to lead multi agency integrated teams and to lead cultural change across teams
- Co production and outcomes based delivery
- Competencies and development for key workers and care navigators
- Engaging UWE through the primary and community workforce development contract to shape delivery to meet the needs of the Somerset transformation project

Summary

- Significant transformation agenda to deliver improved outcomes for people with long term conditions
- Commissioning for outcomes
- Test and learn to engage and reflect local need
- Governance arrangements to monitor/ drive delivery and ensure shared learning
- Clinical leadership and workforce development

COMMUNITY AND PRACTICE NURSING: COMMISSIONER PERSPECTIVE

Contacts;

Vanessa Read, Deputy Director of Quality
Jaydee Swarbrick, Professional Practice Lead

Quality Directorate
Dorset Clinical Commissioning Group



Current workforce

- The CCG care homes quality team undertakes joint quality assurance visits with the 3 local authorities in Dorset against an agreed shared service specification.
- Aspects of workforce development are included as part of the quality monitoring e.g. standards of supervision, recruitment, staff training
- The aim is to ensure workforce development meets expected service standards and improves service user experience.
- The CCG hold annual care home manager development days to ensure current best practice is shared between care providers.
- A Care home newsletter is circulated quarterly which includes information on a variety of topics.
- A dedicated webpage which included links to useful resources and best practice guidance.
- There are excellent links for the care homes with CCG staff providing expert advice on areas such as; Safeguarding, Infection Prevention and control, medicines management, risk and safety, end of life care and dementia.



Future workforce

Careers promotion in developing community roles

- Linking with social care to promote routes to healthcare professional roles
- Local workforce and education groups
- Expanding student placement opportunities



Added value

- Joint working with education providers
- Student experience feedback on a variety of health and care provider services
- Mentor experience
- Benefits for placements
- Quality improvement



Staff engagement – whole health system

- Promotion of values based recruitment
- Valuing staff
- Effective retention in health community



**THE NHS
CONSTITUTION**

the NHS belongs to us all



Supporting people in Dorset to lead healthier lives

Professional Development

The CCG quality team provide professional support and advice to staff as required

- Professional practice lead
- Infection prevention and control specialists
- Safeguarding leads
- Medicines management
- Quality improvement and assurance managers



Professional development events are supported by the CCG including;

- Care home managers events
- End of life care workshops
- Events that support accreditation

Revalidation for Nurses and Midwives

- CCG feedback into both stages of consultation
- NMC speaker at Care homes event
- Support to providers in implementation of processes to ensure required revalidation are met
- Support and facilitation to ensure independent providers have access to appropriate third party confirmation



Practice Nursing: **New Frontiers**

Julia Barton
Chief Quality Officer/Nurse



Opportunities or threats?

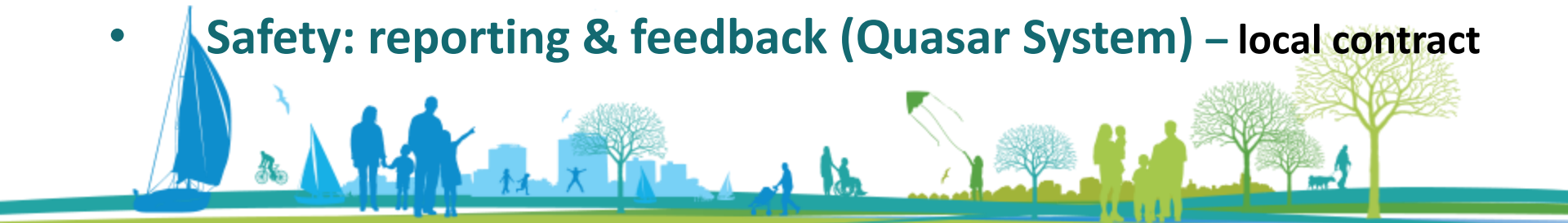
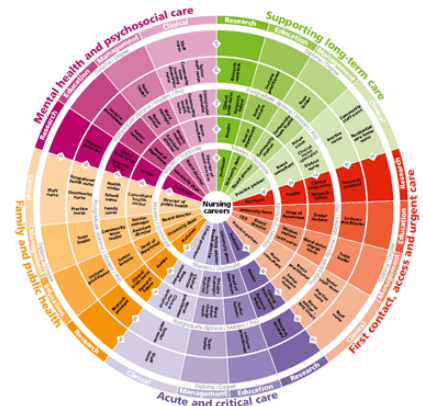
- PN role - value adding functions
- System wide out of hospital strategy
- Emerging primary care models - federations
- Workforce challenges – roles and recruitment
- NMC Code of Conduct and Revalidation
- Recruitment – situation critical
- Culture
- Morale
- Line management v professional leadership



Our local approach:

Wessex Practice Nurse Development Steering Group and CCG Practice Nurse Steering groups

- **CCG Practice Nurse Facilitator role**
 - Mock CQC inspections
- **PN role and development framework**
 - Essential and core skills
 - Leadership and management
 - Modelling e.g. non clinical time /Cassandra
- **Education**
 - Target; e-learning; Links to the Alliance
 - System to assure education quality
- **Lead Practice Nurse role and development**
- **Communication and networking - PN Fora & web resource**
- **Safety: reporting & feedback (Quasar System) – local contract**



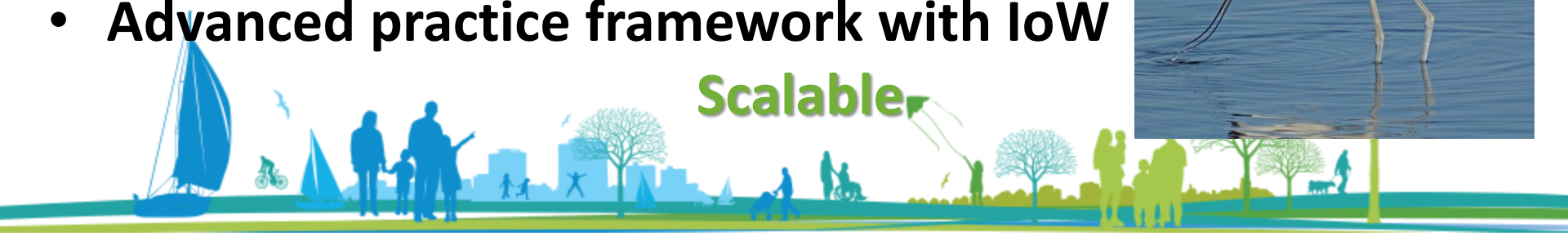
AvOCET Project

Action on Community Education and Training

NHS
Fareham and Gosport
and South Eastern Hampshire
Clinical Commissioning Groups

- **HEI refresh of community and PN modules**
- **Community based RN Post Graduate Cohort**
- **Primary care learning networks**
 - Community and primary care student placement pathways
 - Mentorship development
 - HEE PN training needs analysis
- **Integrated care teams – ICT coordinator role and FdSc**
- **Support workers and common competencies**
- **Pilot clinical apprenticeships**
- **Return to Practice cohort**
- **Advanced practice framework with IoW**

Scalable

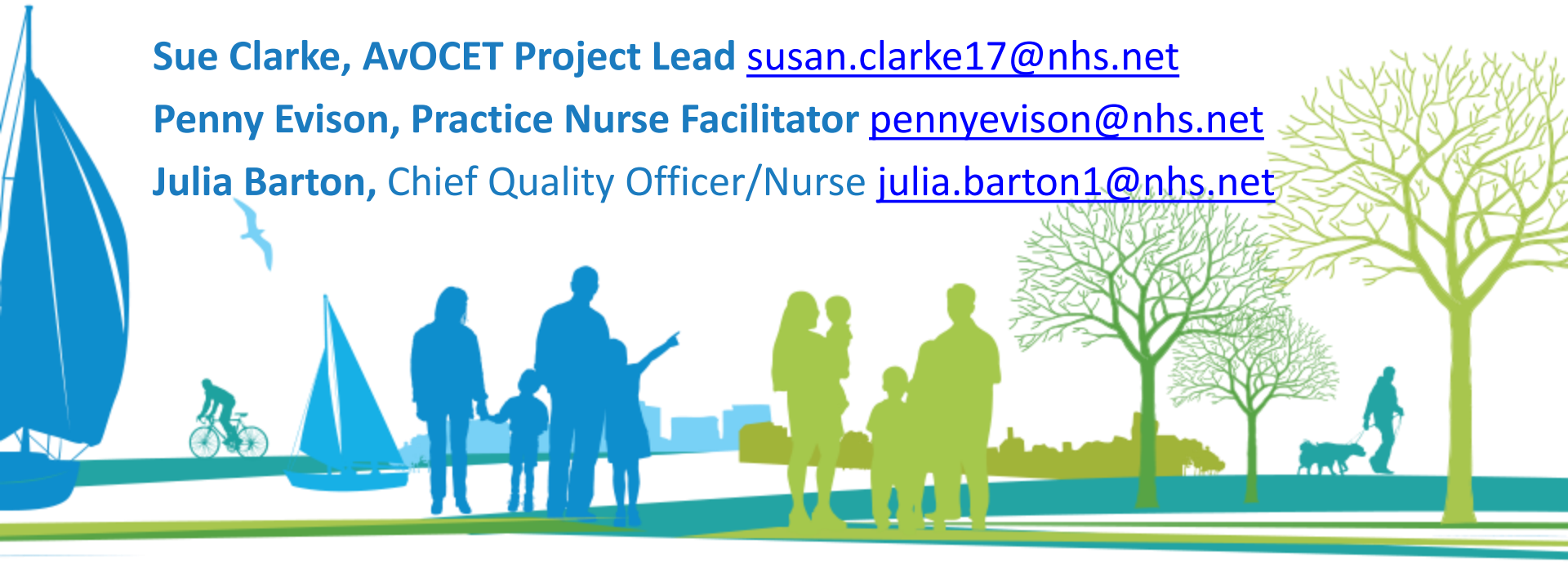


Please contact us if you want to know more or share ideas...

Sue Clarke, AvOCET Project Lead susan.clarke17@nhs.net

Penny Evison, Practice Nurse Facilitator pennyevison@nhs.net

Julia Barton, Chief Quality Officer/Nurse julia.barton1@nhs.net





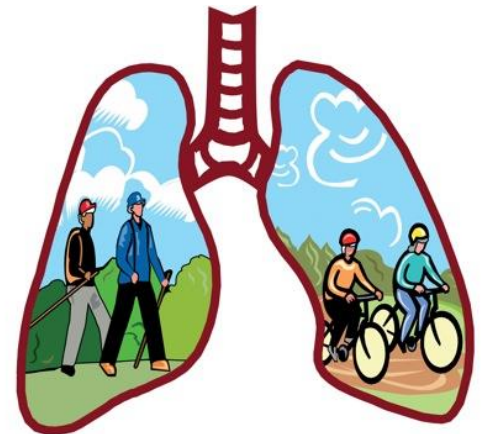
Building the House of Care for diabetes and respiratory conditions in Berkshire West CCGs

12 th March 2015

Allwin Mercer

Clinical lead nurse NWRCCG

Nurse Practitioner



We have come a long way since 2012

- Berks West identified as 3rd worst performing PCT in England for attainment of HbA1c
- This was our 'burning platform' to do better

We found our burning platform...

...we needed to do
things differently!



What happened then

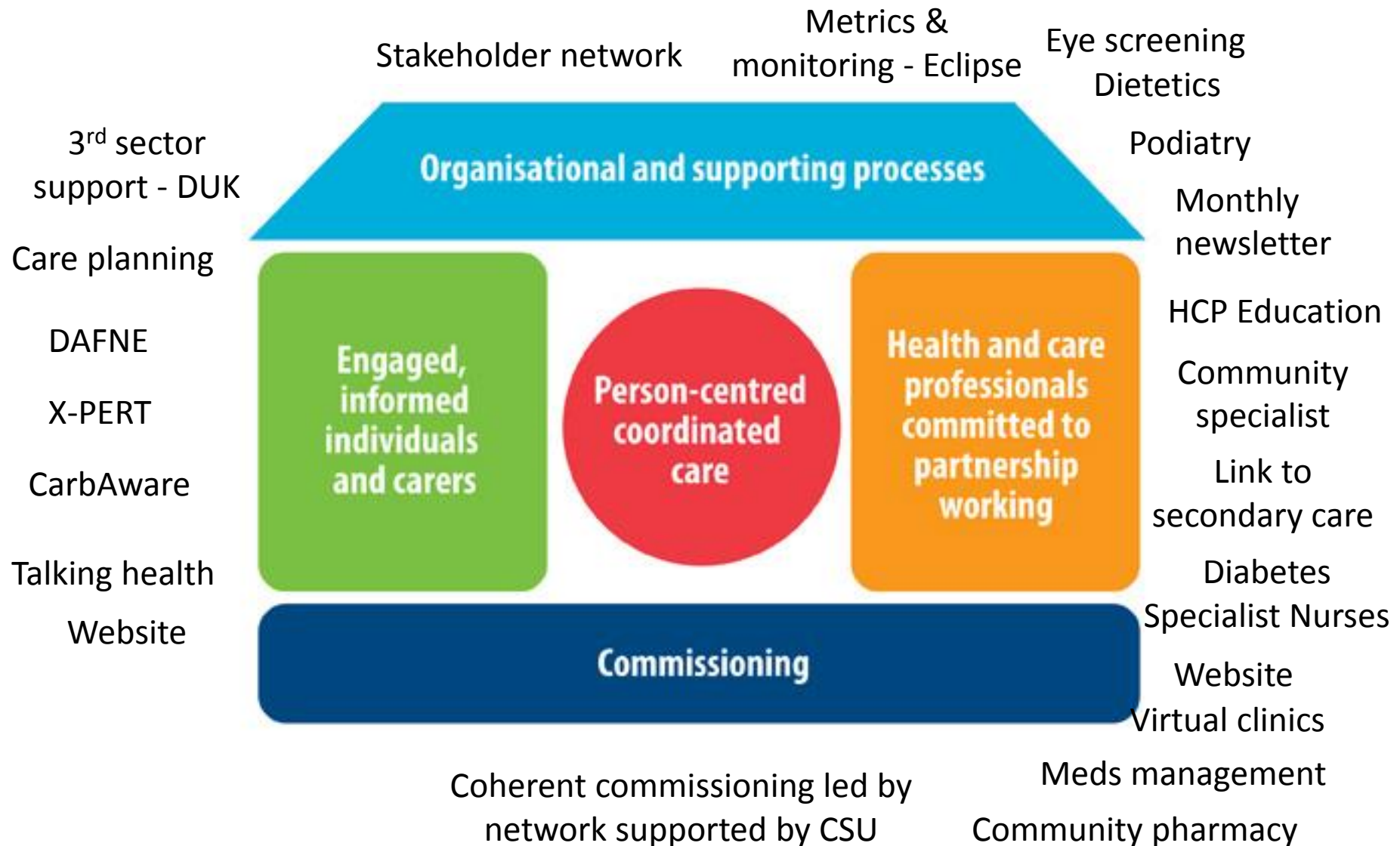
- Redesign of services began in July 2012 and launched at TIPS in May 2013 at scale and pace!!
- The current service now attracts national attention for all the right reasons!

The House of Care is central to the vision



It gives a cohesive, rational, overarching model of care centred on the patient

Building the House of Care for diabetes in Berkshire West



The biggest change in practice

For Patients, Clinical staff and admin staff

Has been the introduction of CARE PLANNING

Quick revision: what's care planning?

Here's what it's not:

- It's a verb not a noun: a process, not a list
- It's not the same as a care plan, but the process of care planning leads to a care plan
- It's nothing to do with the 2% DES

1st visit

**Information
gathering**

HCA performs annual review tests

**Between
visits**

**Information
sharing**

Sent to patient > 1 week before
consultation; with agenda setting prompts

2nd visit

**Consultation
and joint
decision making**

Prepared HCP and patient

**Agreed and
shared goals
and actions
(care plan)**

Resultant care plan shared with
patient, immediately or by post

...and this is what care planning is (in a nutshell)

Progress is being made

- Proportion achieving HbA1c ≤ 59 mmol/mol increased from 46.5% (06/12) to 59.5% (12/14)
- *HbA1c down by 18% among X-PERT attendees: 67.5 before course, 55.5 6 months after X-PERT*
- HbA1c reduction 6 months after CarbAware course of 13mmol/mol among Type 1 patients
- *HbA1c reduction 6 months after virtual clinic MDT consultation of 10 mmol/mol*
- Proportion achieving total cholesterol ≤ 5 increased from 46.3% (06/12) to 79.3% (12/14)

More...

- Care planning is now established in nearly 90% of practices in Berkshire West as the standard process of annual review in diabetes

Benefits:



- Patients taking more interest in their care
- Improvement in patients health
- Upskilling of staff and patients.
- Effective new way of working with patients
- Future alignment of care planning reviews for different LTCs into one appointment!

What's
next



The steady transformation of the management of long term conditions (LTCs) by applying the House of Care model, using care planning as the process for annual review.

Building on the experience gained in using the House of Care and care planning in diabetes, the process will begin with respiratory conditions, specifically, COPD.

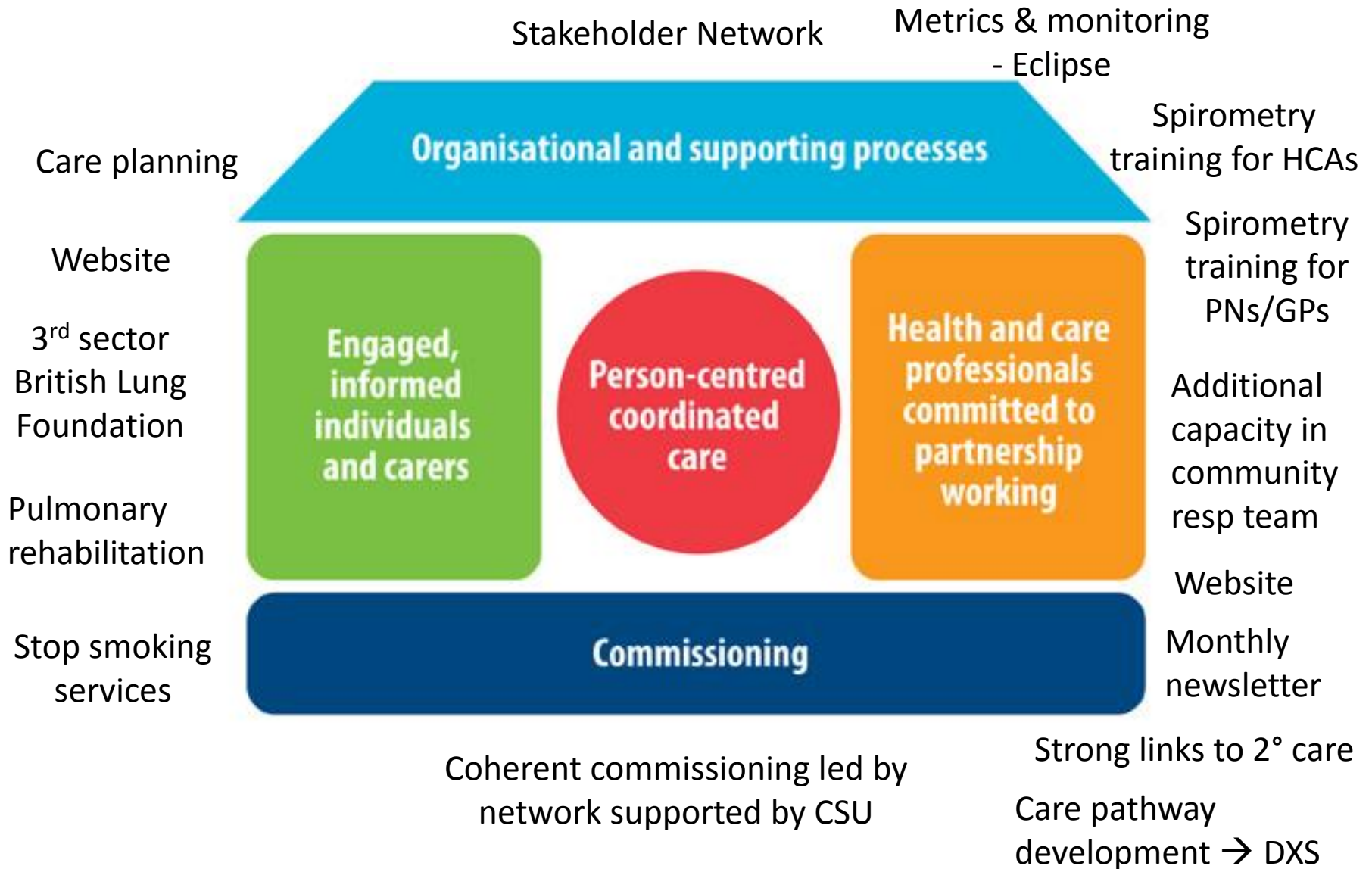
Issues in COPD

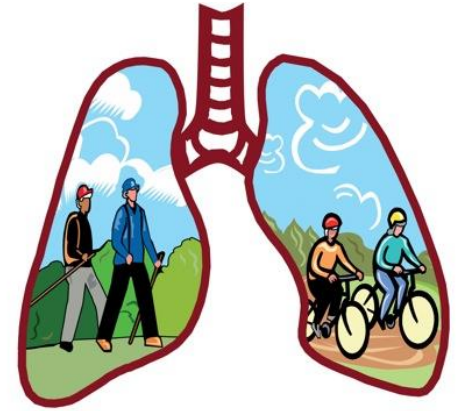
- £1.4m spent on COPD admissions – but estimated 25% are avoidable
- Need for quality spirometry diagnosis and analysis
- 95% of people do not use inhalers adequately leading to inaccurate prescribing and increased costs
- Growing demand for respiratory team input with fixed resource – they are stretched beyond planned capacity

Planned provision

- 3 additional nurses for the respiratory team
- Investment over two years for 125 HCAs and PNs to attend spirometry assessment or spirometry assessment and analysis as appropriate
- Use of Eclipse to identify patients needing extra support (with practice permission)
- Roll-out of training for practices to be able to offer care planning for COPD (and then to other LTCs in the long term)

Building the House of Care for respiratory conditions





Thank you

www.breatheberkshirewest.org.uk

www.berkshirewestdiabetes.org.uk



Developing the Primary Care Workforce across Kent, Surrey & Sussex

Eileen Clark

Head of Clinical Quality, Clinical
Governance & Patient Safety

Surrey Downs CCG

12th March 2015

Local Context - Kent, Surrey and Sussex

- **640** practices across the area of which approximately **100** are single handed
- **3,350** GPs (approx. 3,000 WTE); **22%** are aged 55 or over
- **1,800** practice nurses occupying 1,000 WTE ;**20%** are aged 55 or over
- Large vacancies of practice nursing and health care assistants
- Shift of services and long-term conditions dealt with in primary care
- Ageing demographic with associated increase in frailty requiring the need for longer consultation times

Ref: KSS Survey - 2012

A Typical Day in the life of.....

There are approximately **4.3** million people in Kent, Surrey and Sussex.

On a typical day:

- **80,000** people will visit their GP or Practice nurse
- **3500** people will be referred by their GP to a specialist
- **5,000** people will attend Accident and Emergency departments
- **800** people will be admitted acutely to hospital

One Local Solution

- A five Year Workforce Programme initiated by Health Education Kent, Surrey and Sussex to:
 - improve education and training for all of the workforce
 - increase placements in primary care and the community for the future generation of clinicians including Nurse students, GP Trainees, Paramedic Practitioners students and Health Care Assistants
 - put in place a robust plan for the future workforce planning in primary care and community that supports future models of care

The Primary Care Workforce Tutor Programme

- Primary Care Workforce Tutors have been employed within CCGs across Kent, Surrey and Sussex
- Funded by HEKSS and affiliated to partner universities
- Initially funded for 2 years with option for posts to become fully established

Main Areas of work

- Facilitation of the development of the infrastructure within GP practices through the recruitment of nurse mentors, sign off mentors and practice educators; and the creation of more student nurse placements within GP surgeries.
- Raising the profile of practice nursing by offering a flavour of the Primary Care environment to students and ultimately assisting in the recruitment of workforce in the future.
- Supporting the development of the primary care workforce through identification of current workforce skills gaps through training needs analyses; education and development programmes and the commissioning of training and development opportunities.

Main areas of work contd.

- Working closely with practices to implement and support appropriate educational activity for the whole GP Practice Team.
- Working with partner Universities to facilitate pre-registration student nurse placements within general practice and developing short and long-term courses relevant to practice nursing
- Development of a Practice Nurse Pathway as a joint project with 4 Universities that equips nurses with the necessary skills and competencies to meet the needs of their practice populations

Additional Benefits

- Support and supervision for an important and sometimes forgotten workforce
- Networking opportunities
- Sharing good practice and learning from incidents
- Raising the profile of nursing within our Clinically led organisations

Prevention in the Five Year Forward View

Sabrina Fuller

Head of health improvement

Helen Lyndon

Nurse consultant older people

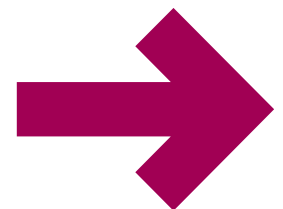
Clinical lead, frailty

12 March 2015



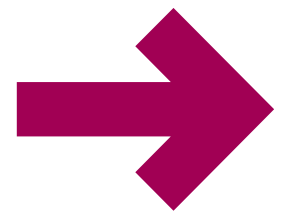
Prevention in clinical work

- Learning from clinical experience – partnership with patients, clients and communities
 - Understanding the context and circumstances
 - Explaining what could make a difference
 - Supporting arriving at solutions and strategies
 - Reinforcement and encouragement
 - Patients, clients, communities determining their own health and well-being
 - Supported by structural change
- Nurses as uniquely well placed to give help and support



Prevention in the Forward View

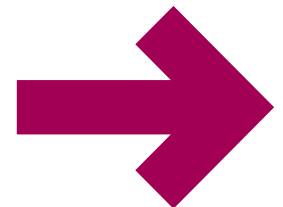
- Seventy percent of the NHS budget is now taken up by long-term health conditions rather than those susceptible to a one-off cure.
- Health behaviours
- Radical upgrade in prevention: failure would result in:
 - stalling of recent progress in healthy life expectancies;
 - health inequalities widening,
 - and an inability to fund the treatment and care that people need because we will be spending billions of pounds on wholly avoidable illness.



Reality: co-morbidity underpinned by cluster of behaviour

Increasing risk:

- Smoking: lung and other cancers, heart disease, stroke, COPD
- Alcohol: hypertension; CVD, dementia, diabetes, liver disease, cancers - breast and gastrointestinal tract; depression, anxiety, trauma
- Obesity: diabetes, CVD, hypertension, dementia, cancers, MSK
- Physically active lifestyle reduces risk including CHD, stroke, type 2 diabetes, some cancers, obesity, MH and MSK conditions.

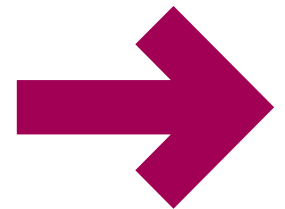


The Forward View challenges the divide between patients and professionals: better health through increased prevention and supported self-care.



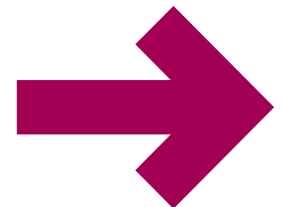
NHS role in prevention

- Local authorities and Public Health England - clear role to play in improving the health of the population
- NHS has role supporting those with risk factors, illness or LTCs maintaining or improving their own health and wellbeing.
- Mandate: *staff should use every contact they have with people as an opportunity to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more.*
- 15-16 planning guidance: CCG action plans: *behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress.*



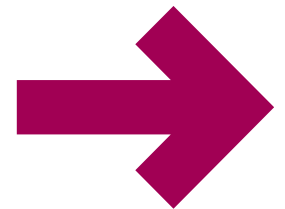
NHS England approach to behaviour change

- Systematic specific approach:
 - updated NICE guidance on individual behaviour change
 - topic specific guidance pathway on obesity, alcohol related harm and on smoking.
- Pathway approach,
 - Identification, assessment of risk, delivery of evidence-based intervention
 - behaviour change interventions of progressive intensity according to the clinician's relationship with the patient and the client's assessed level of risk.
- Supported by training and development



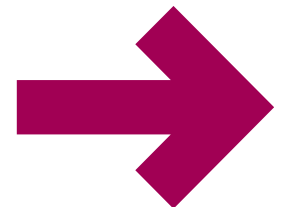
Pathway approach to behaviour change

- **Very brief interventions** (MECC) opportunistic
- **Brief intervention:** regular contact with those assessed at risk
- **Extended brief interventions:** regular and longer contacts: assessed higher risk, for example a long term condition with co-morbidities.
- **High intensity interventions**, >30 minutes, number of sessions; behaviour change service; assessed high risk of eg BMI >40; or serious medical condition that needs specialist advice and monitoring

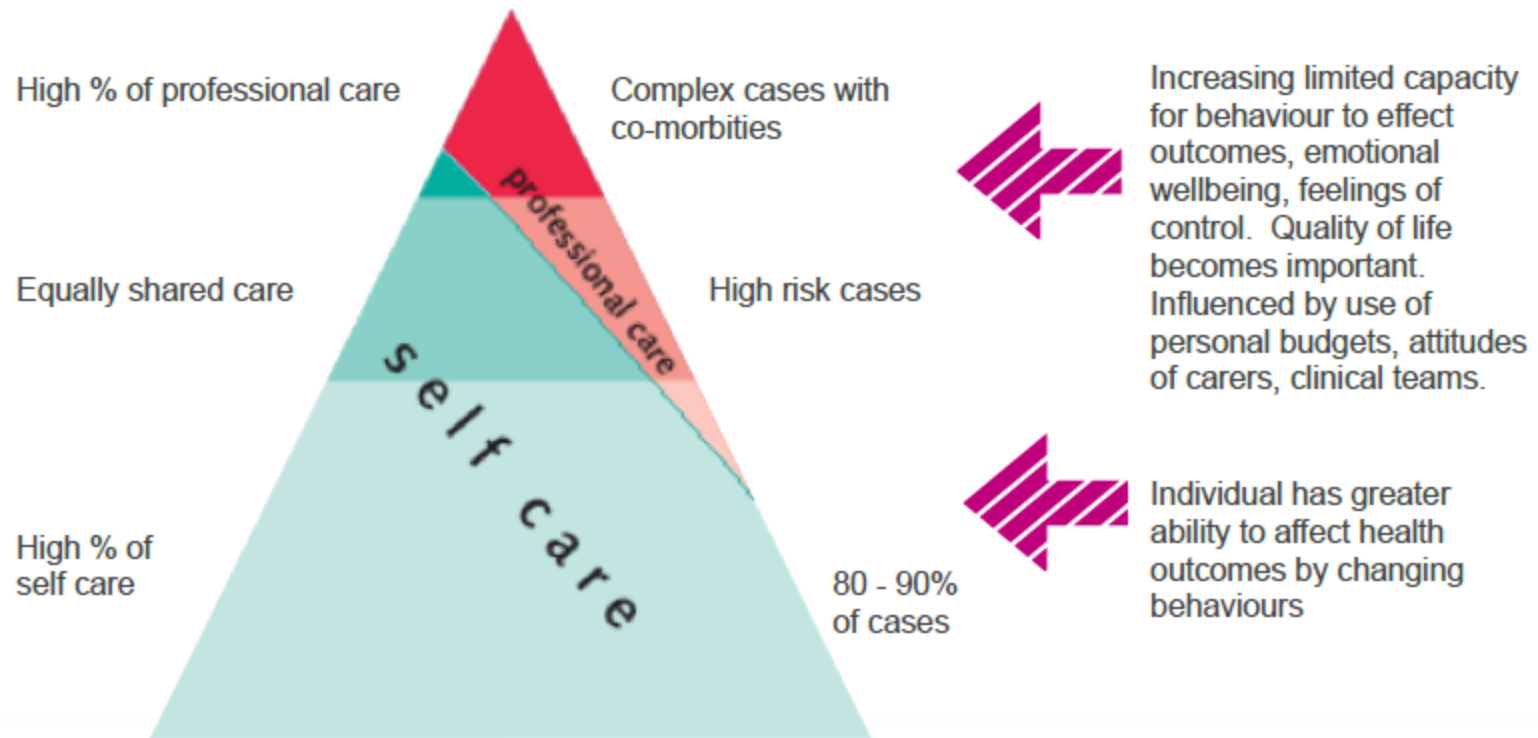


Progressive competency framework

- Listening skills
 - Understanding determinants of health
 - Motivational interviewing
 - States of change model
 - CBT
-
- Distance learning: e-learning for health; RCN; PHE etc
 - Bespoke training courses

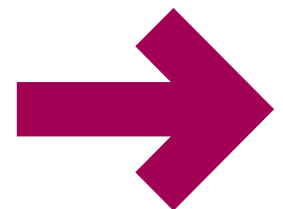


Prevention integrated in to LTC management



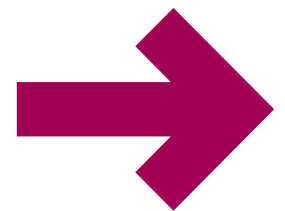
Barriers to implementation

- **Patients don't want to change?** Identify readiness to change, patient activation.
- **Patients might be offended.** Use of listening skills and motivational interviewing techniques.
- **Nurses' own lifestyles.** Organisational support.
- **Too busy.** Reorganising LTC management around people not diseases.
- **QOF drives disease centred management:** Co-commissioning for personal centred, preventive approaches.



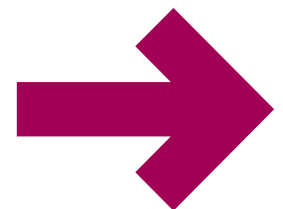
Commissioners

- Commissioning behaviour change as an integral part of care pathways.
- Using commissioning levers: revisit QOF, CQUINs, KPIs etc
- Using contracting tools: specs, LESs etc
- Commission for: delivery of behaviour change interventions by front line clinicians; competencies; staff health and wellbeing.



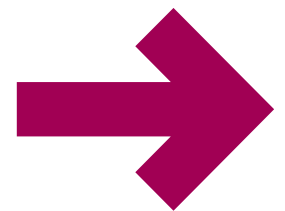
Providers

- Embed behaviour change in pathways, protocols, service design and care planning.
- Organisational support; PDRs, objective setting, PDPs.
- Accredited training and development - acquire and maintain the skills.
- Support staff as well as patients in behaviour change - opportunities for developing healthier behaviours.



NHS England are supporting you:

- Clinical leadership: making the case for change to nurse commissioners and providers
- Commissioning tools and levers: identifying and sharing good practice, providing templates.
- Partnership working: with HEE, PHE, DH and others clarifying roles and ensuring infra-structure in place especially re training and development

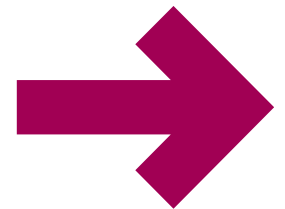
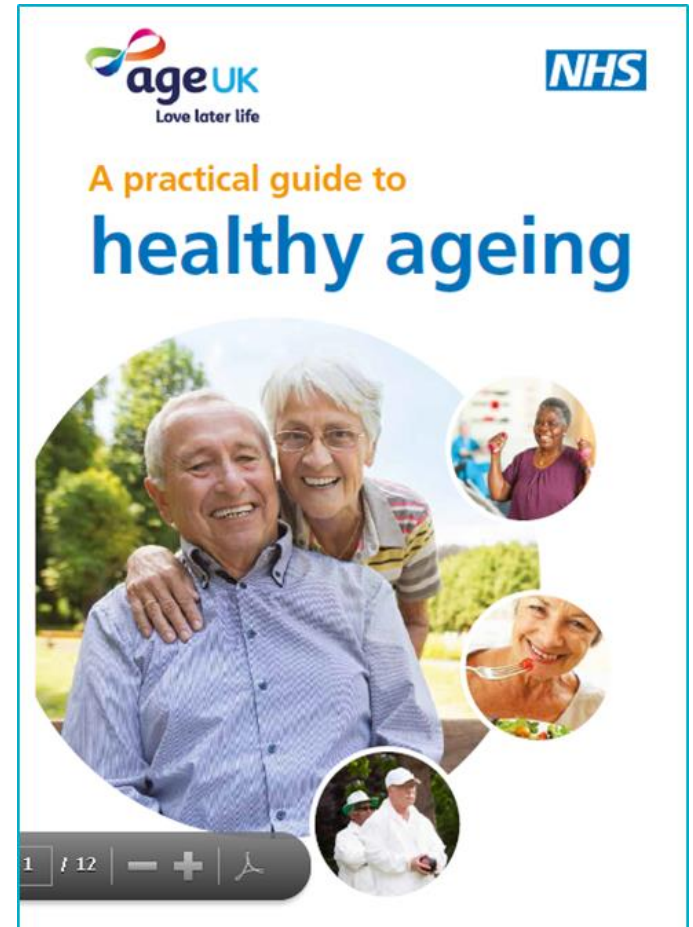


And the practice...

Over to Helen....

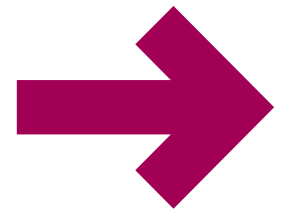
Prevention in relation to older people living with frailty

What can community and practice Nurses contribute?



Preventing and delaying onset and deterioration of frailty – the nurses role

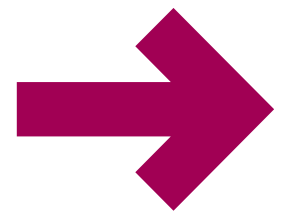
- NICE prevention guidance
- Preventable components of frailty
- What nurses can do – self management, personalised care and support planning
- Social isolation
- Examples from practice



NICE Public Health Draft Guideline: Dementia, disability and frailty in later life – mid-life approaches to prevention

‘Dementia, disability and frailty are not inevitable consequences of ageing....there is sufficient evidence to show the risk of developing them can be reduced through changing common behavioural risk factors.’

- quitting smoking,
- increasing physical activity,
- reducing alcohol consumption
- having a healthy diet
- maintaining a healthy weight.



NICE Public Health Draft Guideline: Dementia, disability and frailty in later life – mid-life approaches to prevention

- Beginnings of ill health can occur in midlife:
 - ☀ start of a decline in cognitive functions (such as memory, reasoning and verbal fluency) by age 45
 - ☀ age-related decline in walking speed has been observed after the age of 30

Mid-life is not too late for people to make meaningful changes. People often need more than one attempt to change, and mid-life can be the period in which change is finally sustained

‘However, key messages about risk reduction, particularly for dementia, are not well publicised or understood by health and other professionals or the public, unlike the link between smoking and cancer.’

Where is frailty?

“ I know it when I see it but what I see may not be the same as what everyone else sees”

Community dwelling adults aged 65+ = 7% - 12%

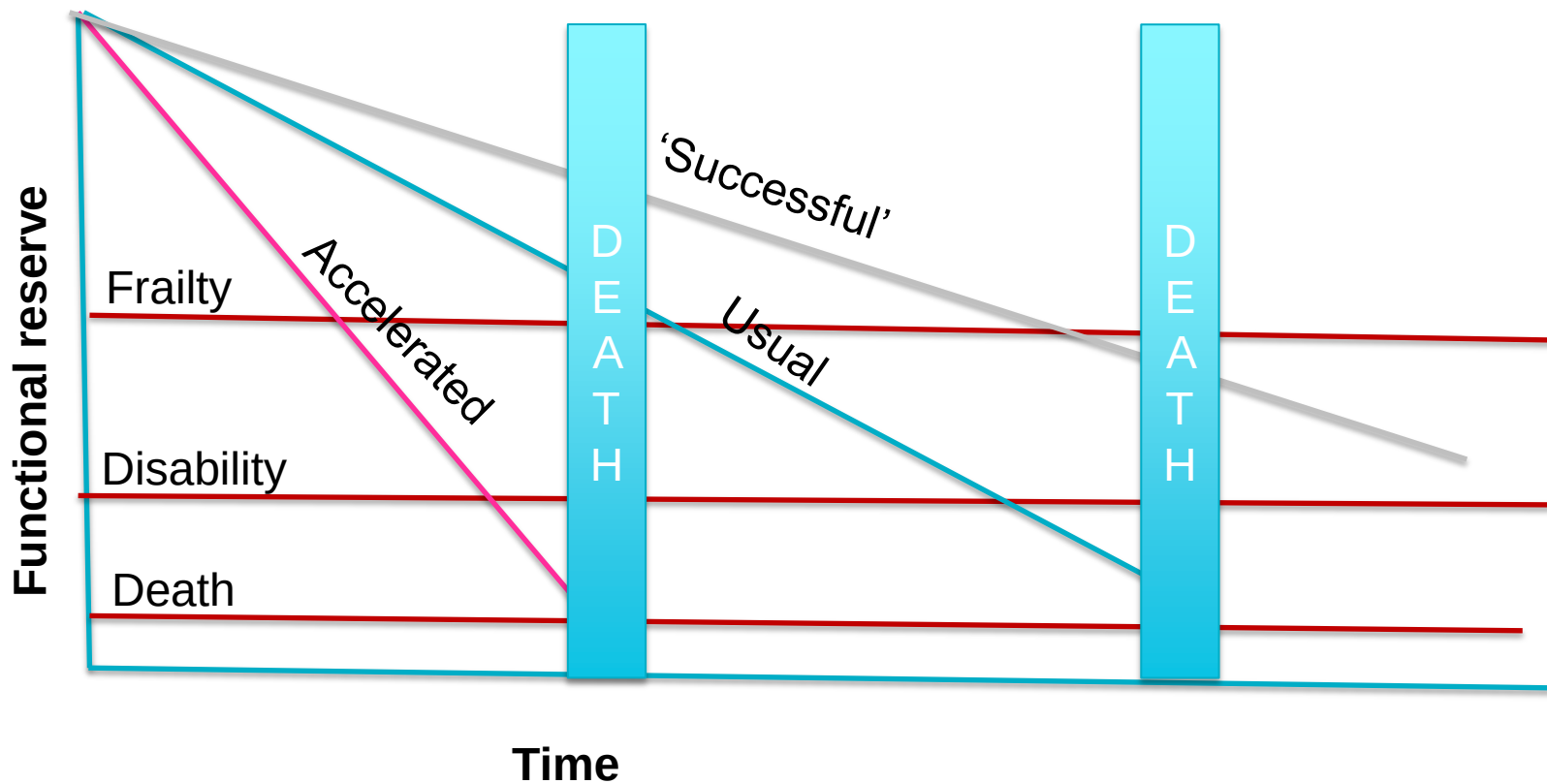
Community dwelling adults aged 85+ = 25% - 50%



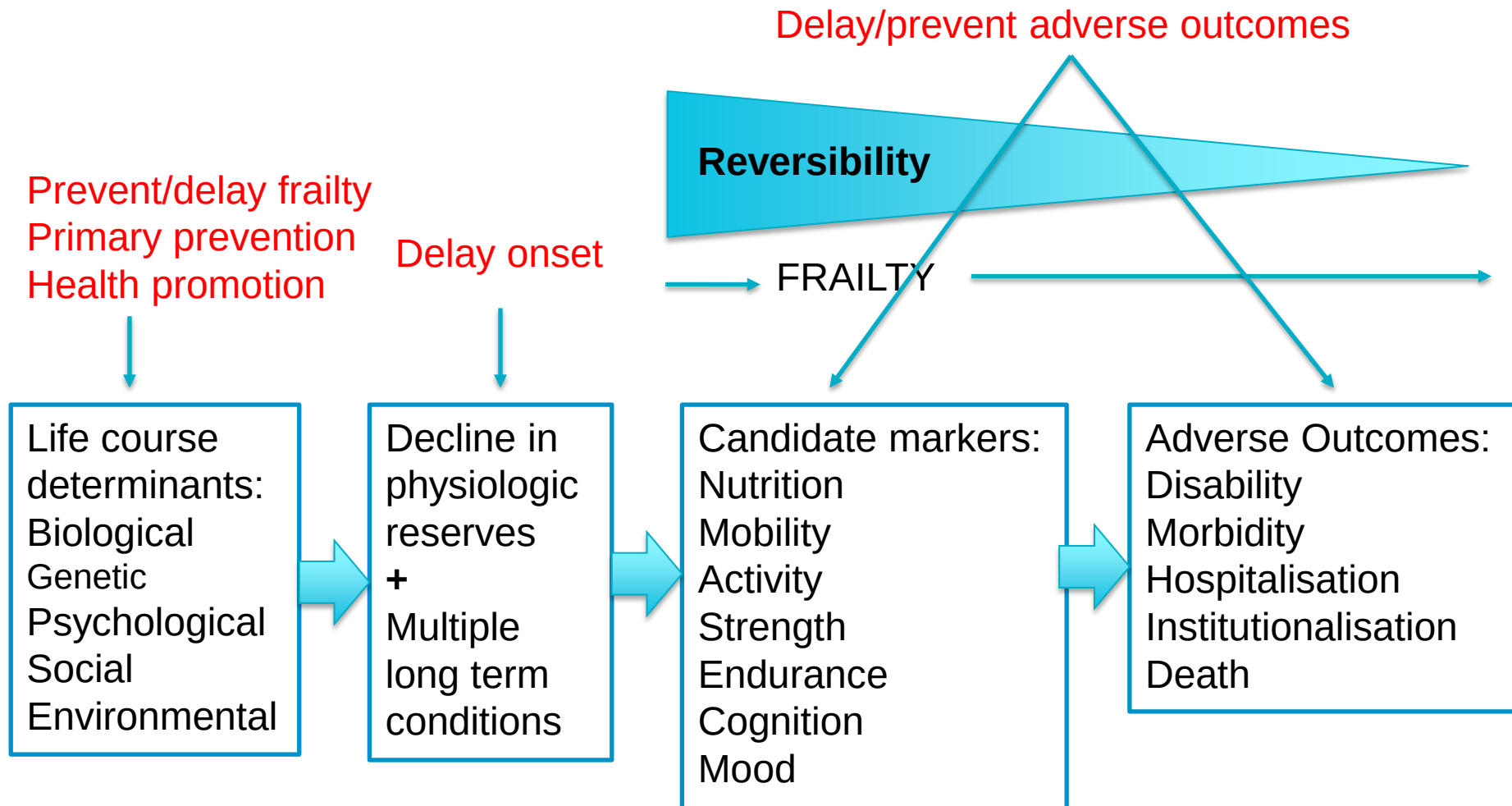
The Frailty Paradox
Not recognised
Not diagnosed
Not recorded

Chen, X, Genxiang, M, Sean X (2014) Frailty Syndrome: an overview. Clinical Interventions in Aging
2014:9 433–441

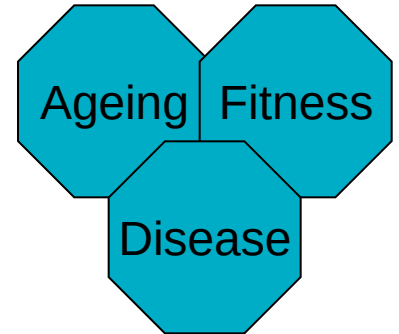
Frailty – why prevalence is increasing



Frailty – a complex syndrome of increased vulnerability

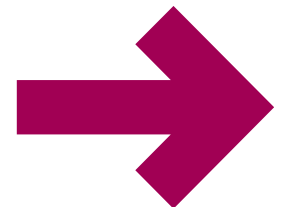


A definition of frailty

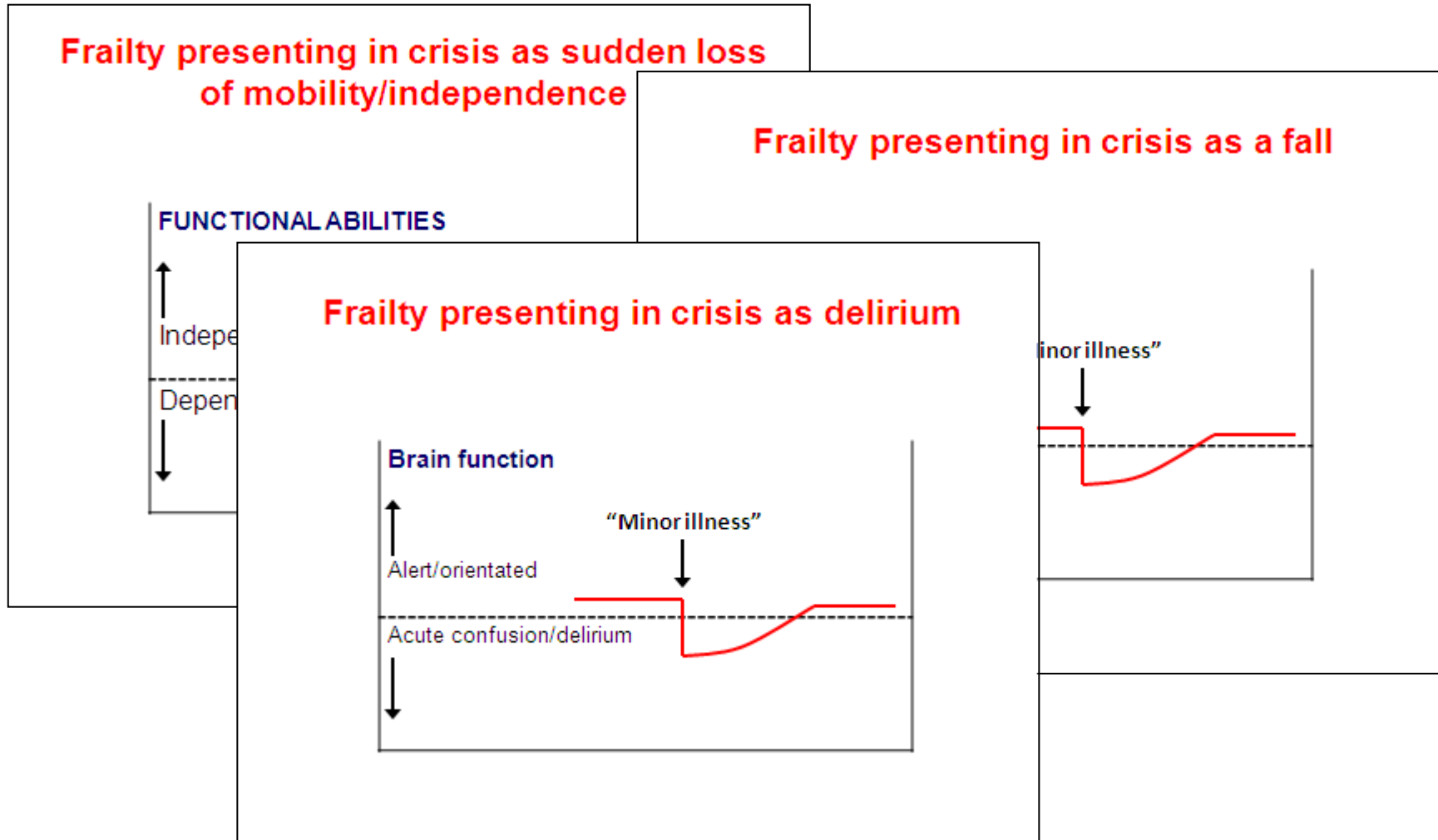


- Frailty is not a disease but a combination of the natural ageing process and a variety of medical problems.
- It focuses on the loss of reserve, energy and wellbeing.
- A useful definition is: “Multidimensional loss of reserves - energy, physical ability, cognition and health”

Rockwood et al (2005)



Frailty is a loss of physiological reserve



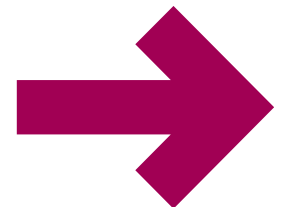
Frailty as a Long Term Condition?

A Long Term Condition is:

“A condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies” (DH 2012)

Frailty is:

- Common (25-50% of people over 80 years)
- Progressive (5 to 15 years)
- Episodic deteriorations (delirium; falls; immobility)
- Preventable components
- Potential to impact on quality of life
- Expensive



Proactive interventions in frailty

"I'm not as steady on my feet as I was"

Frailty as a Long-term Condition

Ten years ago

Two years ago

One month ago

"Minor illness"

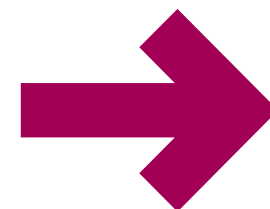
FUNCTIONAL ABILITIES

Independent

Dependent

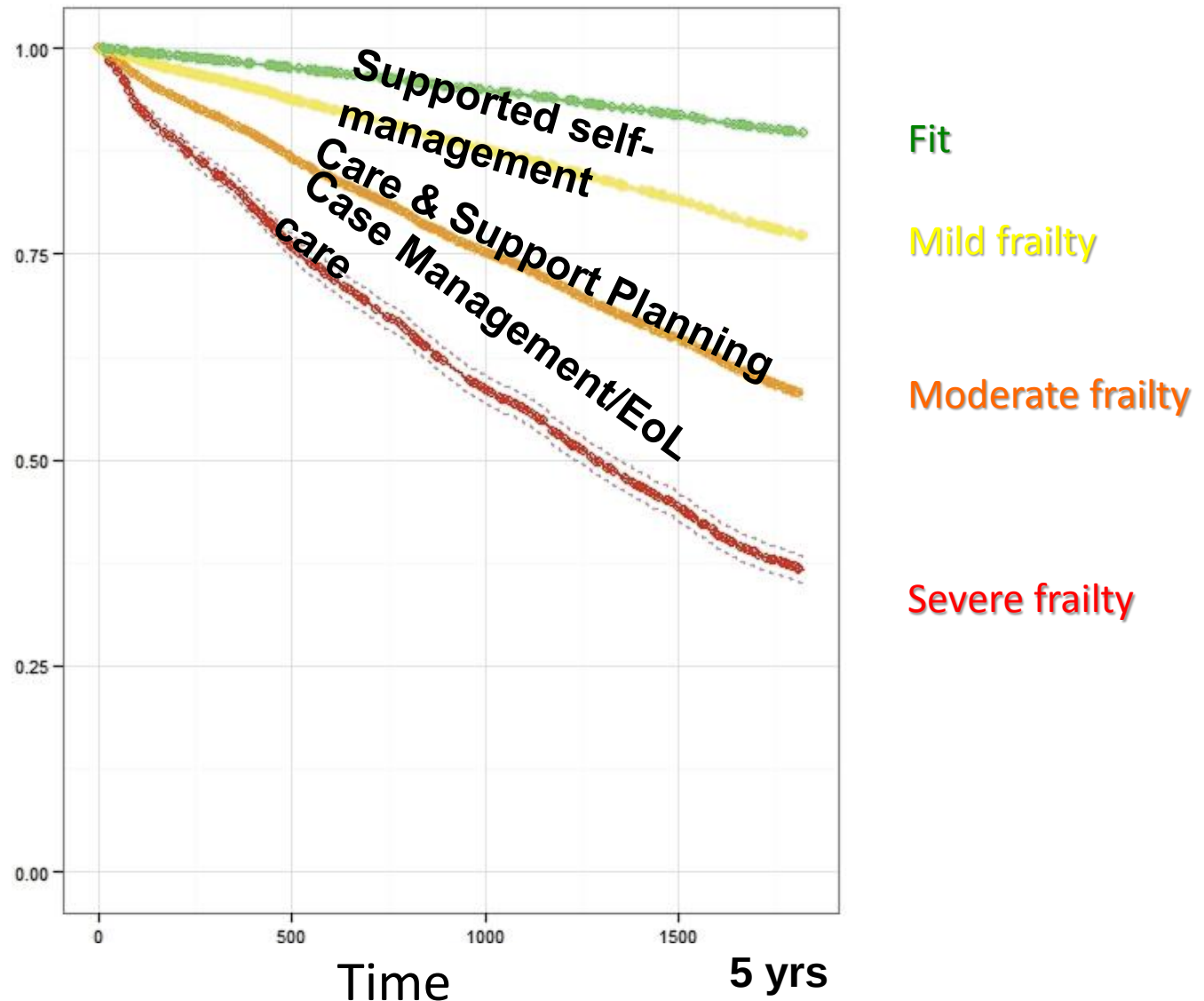
"Dad is slowing down"

'He is a fall waiting to happen'



Primary care electronic Frailty Index (eFI): survival plots ($n=227,648$; $>65y$)

Proportion
alive



Supported Self Management for Frailty

What its not....



Provision of information;
leaflets, booklets, web links
etc

What it is.....



About acknowledging the
person's central role in the
management their own care
and empowering them and
their family and carers to
handle their condition as
effectively as possible.

What to focus on.....

Potentially modifiable risk factors associated with functional decline in community dwelling older people.

- Alcohol excess
- Cognitive impairment
- Comorbidity
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems

**MORE
THAN
MEDICINE**

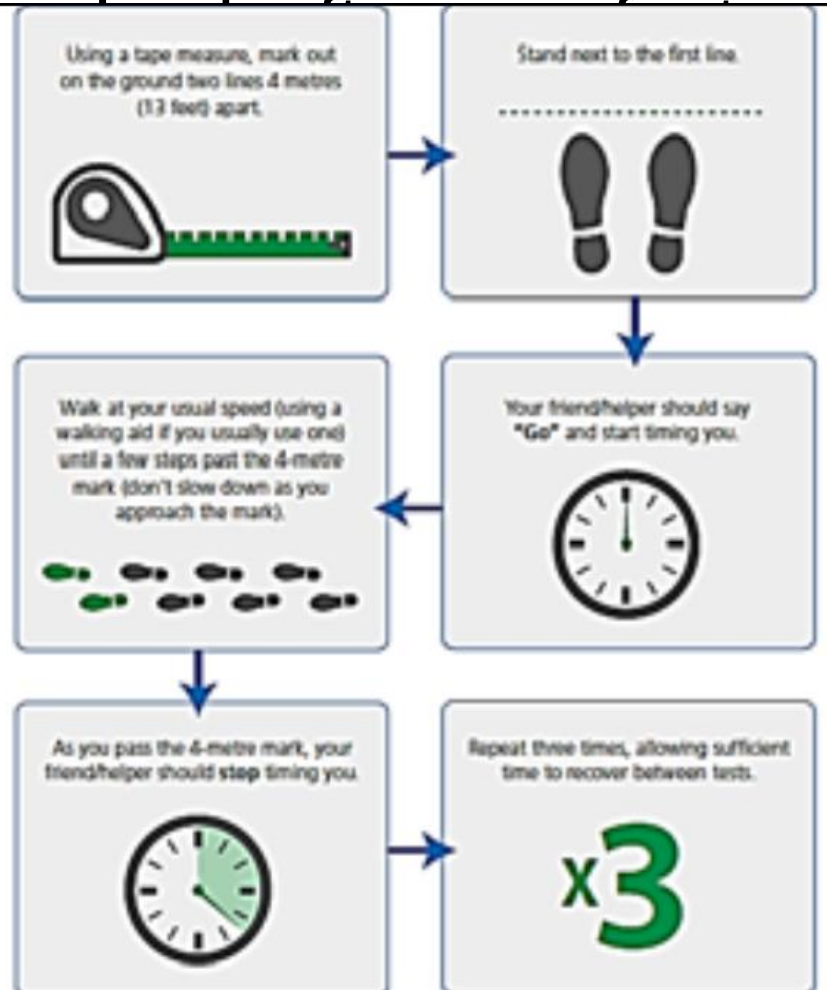
Try this at home



Have you noticed it's taking longer to get to the bus stop than it used to? Or that your weekly supermarket shop takes longer than before?

These can be signs that you've started slowing down.

If you've noticed you're a little slower than you used to be, or even if you haven't, you may want to try this simple test which will let you know if the 'slow-down' process of later life is affecting you. It is called the Walking Speed Test. You can do it easily at home. All you need is a tape measure and a watch with a second hand or mobile phone with a stopwatch function.



If you take more than 5 seconds to walk, at normal speed, a measured distance of 4 metres (13 feet), then it is likely you are affected by the slowing down process of later life. Of course, some people walk slowly for other reasons – perhaps knee or hip arthritis, for example. But the test will give you a good indication of your general fitness. If you have slowed down you may want to try some simple exercises. If you have any concerns, you may wish to see your GP or nurse to discuss things further.

Supported Self Management for Frailty: Key Messages

1. Language:

- “I am frail” v “slowing down”, “things taking longer” or “less energy.” This is reflected in the guide. Focus on “health and wellbeing” in later life.

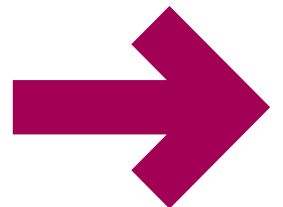
2. Self-discovery and self-activation:

- Gait speed test, then menu of items – the person’s choice

3. Independence:

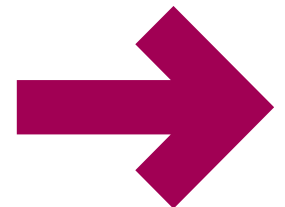
- focus on maintaining and promoting independence - this is an issue that is both important and well understood by older people.

4. Social Isolation and Loneliness



Loneliness and Social Isolation

- 59% of older adults who report poor health say they feel lonely some of the time or often compared with 21% who report excellent health.
- Social isolation is one of the top five causes for admissions to care homes.
- People who are socially isolated visit their GP more often, use more medication and have more falls.
- Lacking social connections is a comparable risk factor for early death to smoking 15 cigarettes a day and is worse for our health than obesity and physical inactivity.



Living Well

Pioneer for Cornwall
and the Isles of Scilly

Supporting people to
live the lives they want

OUR THREE AIMS

IMPROVED
HEALTH AND
WELLBEING



IMPROVED
EXPERIENCE OF
CARE AND SUPPORT



REDUCED COST
OF CARE AND
SUPPORT



THE PRINCIPLES

STOP CREATING
NEW LAYERS

support existing groups
and connect people together



COMMUNICATE
WHAT'S AVAILABLE

and where in a way
that people find useful



ENCOURAGE
LOCAL
LEADERSHIP AND
ENGAGEMENT



BE BOLD
AND BE
BRAVE!



SO FAR WE ARE SEEING...

RECRUITED
COHORT
NOW AT

800

20%

OF PEOPLE IN THE
PROGRAMME GO
ON TO BECOME
VOLUNTEERS
THEMSELVES

67 VOLUNTEERS and
12 CO-ORDINATORS



Living Well Penwith

WELLBEING
20%
improvement

SOCIAL
CARE COSTS
8%
reduction

ACUTE
HOSPITAL
COSTS
41%
reduction

COMMUNITY
HOSPITAL

of
which

EMERGENCY
36%
reduction

INPATIENT
ACTIVITY
28%
reduction

NON-
ELECTIVE
ADMISSIONS
49%
reduction

LENGTH OF
STAY
20%
reduction

OUT-PATIENT
13%
reduction

THE CRITERIA

A MINIMUM OF
2 LONG TERM
CONDITIONS

or

A SOCIAL CARE
PACKAGE IN PLACE
WHERE

from the following:
diabetes, dementia,
respiratory (COPD),
heart failure, stroke,
memory loss, parkinson's,
hypertension, osteoporosis,
have a history of falls, risk of
repeat infection (urinary tract
infection or pneumonia)

- The value is £50 per week or below.
- The value is £200 per week or above. This includes lunchtime visits.
- The person has received support from the Early Intervention Service 3 times or more within the last 12 months.
- The person has been supported through an urgent response or emergency duty 3 times or more within the last 12 months.

£2500+

AVERAGE UNPLANNED
HOSPITAL ADMISSION
COST FOR THIS COHORT



£400

THE MAXIMUM
COST OF SUPPORT
PER PERSON



WE ARE SEEING
A 3:1 RETURN ON INVESTMENT

OUR BUILDING BLOCKS

CONVERSATION
AND GOAL SETTING



AIDING RECOVERY WITH
HELP FROM VOLUNTEERS



COMMUNITY SUPPORT AND
NETWORK DEVELOPMENT



SPECIALIST
SUPPORT



CARE CO-ORDINATION BY INTEGRATED TEAM



CULTURAL CHANGE ELEMENTS

LOCAL PEOPLE
LOCAL CONVERSATION



STRONG
GP BUY-IN



PRACTITIONER CO-DESIGN



INFORMATION
SHARING



BUILDING TRUST AND RELATIONSHIPS

THE FACTS

670

COMMUNITY GROUPS
MAPPED IN PENWITH



45+
COMMUNITY
MAKERS

31,000

HOUSEHOLDERS DESCRIBING
THEMSELVES AS OFTEN OR
ALWAYS LONELY



34,000

PEOPLE AGED
65 OR OVER
LIVE ALONE



£1.7m

WHAT VOLUNTEER TIME GIVEN
SO FAR WOULD EQUATE TO BASED
ON THE MINIMUM WAGE

PROJECT TEAM SPANS HEALTH, SOCIAL CARE,
INDEPENDENT AND VOLUNTARY SECTOR, DRIVEN BY
LOCAL GP CHAMPIONS



ONLINE REPOSITORY
THE [KNOWLEDGE BUCKET]
WWW.KNOWLEDGEBUCKET.ORG

WINNER OF HEALTH
SERVICE JOURNAL
AWARD 2013 FOR
MANAGING LONG
TERM CONDITIONS



SHORTLISTED FOR HEALTH
SERVICE JOURNAL AWARD
2014 FOR PRIMARY AND
COMMUNITY SERVICE
REDESIGN

FIRST LOCAL SCHOOL
OF HEALTH AND CARE
RADICALS FOR NHS
IMPROVING QUALITY



SHOWCASED IN NHS ENGLAND'S
FIVE YEAR FORWARD VIEW AS A
FUTURE MODEL OF CARE

60+

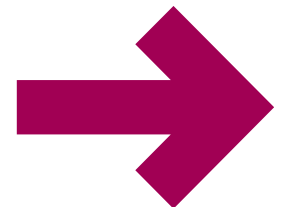
ORGANISATIONS ACROSS THE UK
LOOKING TO US TO SHARE A NEW WAY OF WORKING

SO FAR 6 CLINICAL COMMISSIONING GROUPS IN THE UK HAVE
AWARDED REVENUE FUNDING OF OVER £0.5M TO LOCAL
AGE UK AND OTHER CHARITIES, BASED ON OUR MODEL

Frailty Prevention in Practice

Cornwall 'Living Well'

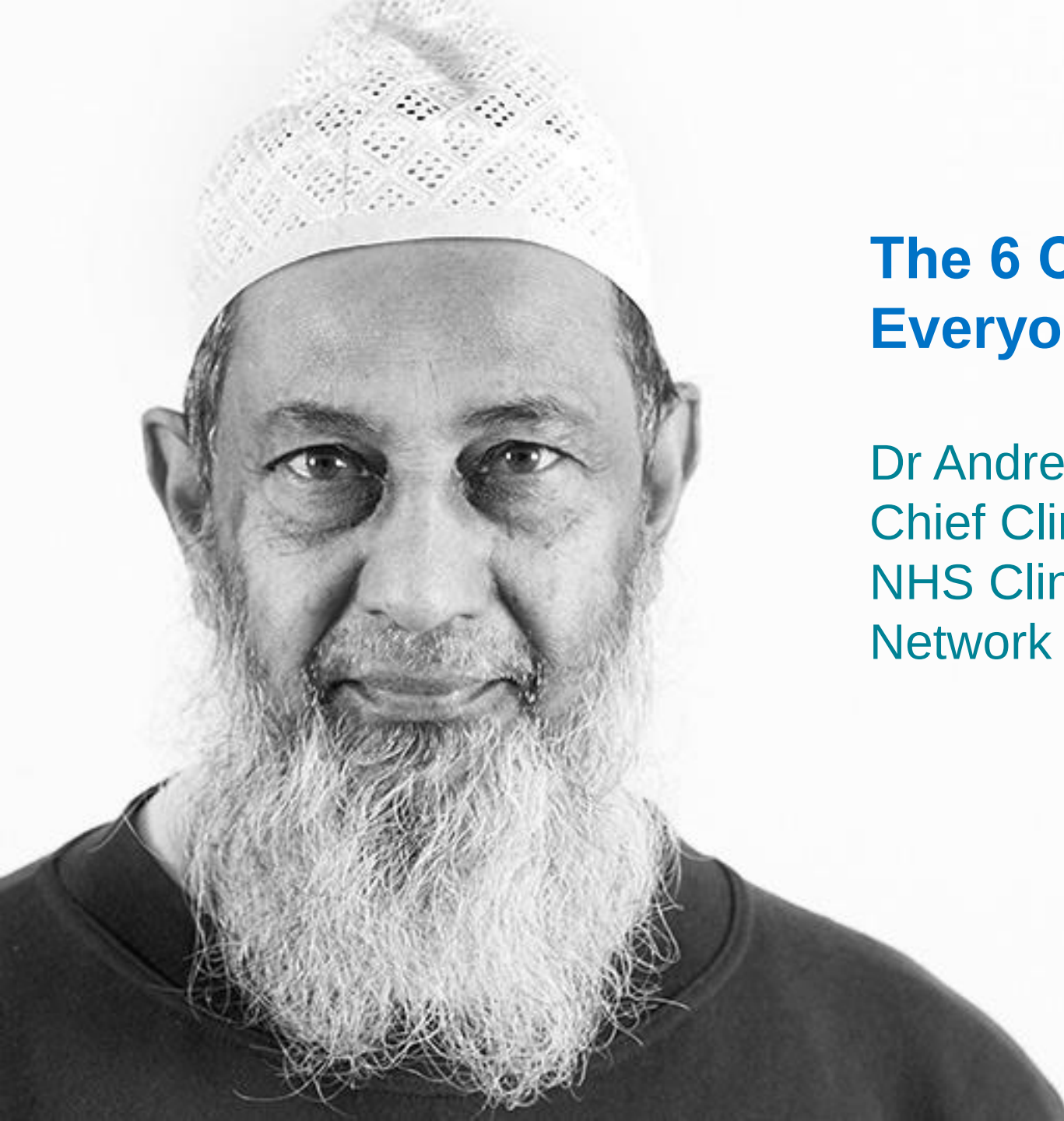
- Community nursing activity has increased in the LW areas possibly due to shift in care from acute to community but there is less crisis and a more planned care approach.
- The impact of Living well on Community nurses is the importance of behavioural change.
- Instead of following a structured assessment they have learnt better communication skills and a different approach to personalised care despite service pressures.





The 6 C's for Everyone

Dr Andrew Coley
Chief Clinical Officer
NHS Clinical Leaders
Network





6Cs for Everyone

Values for the Future of the NHS



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So you know the 6Cs



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But what does the future hold?



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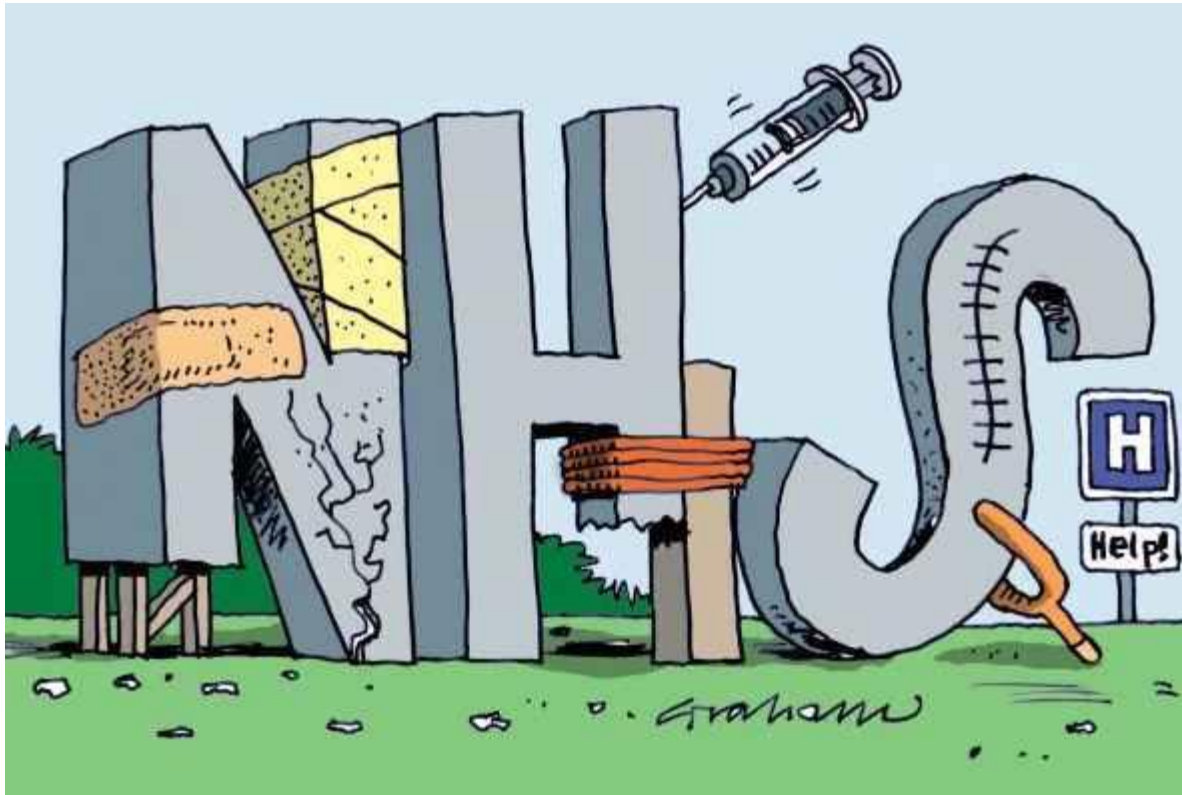


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Things need to change and quick



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But who are the Clinical Leaders?



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It's you, it's always been you



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We are here to help



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Sustainable and Improved Care



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Does the truth exist in numbers?



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Good Care...



comes in a can?



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Commissioning



How do you commission?
How do you set the targets?



Palliative Care



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A change in culture



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Not just for Nurses...



- If it was just based on numbers, who is most important?
 1. 53 million Patients in England
 2. 1.5 million Social Care Workers in England (not just NHS)
 3. 369,686 Nurses in the NHS
 4. 171,567 AHPs registered with the HCPC (of which 86,920 are in the NHS, and the remainder mostly in Social Care)
 5. 153,472 Scientific, Therapeutic and Technical Staff
 6. 148,075 Doctors
 7. 37,314 Managers



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The 6Cs: values for compassionate care



✓ Care

Care is our core business and that of our organisations; and the care we deliver helps the individual person and improves the health of the whole community.

Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

✓ Compassion

Compassion is how care is given through relationships based on empathy, respect and dignity.

It can also be described as intelligent kindness and is central to how people perceive their care.

✓ Competence

Competence means all those in caring roles must have the ability to understand an individual's health and social needs.

It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

✓ Communication

Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say. It is essential for 'No decision without me'.

Communication is the key to a good workplace with benefits for those in our care and staff alike.

✓ Courage

Courage enables us to do the right thing for the people we care for, to speak up when we have concerns.

It means we have the personal strength and vision to innovate and to embrace new ways of working.

✓ Commitment

A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.

We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.



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It's a journey we must face together



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It's in your hands!



- What is your ambition?
- How are you going to achieve it?
- Who are you going to take on your journey?



Share your thoughts and connect with us
on social media or email:

england.sixcslive@nhs.net



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Panel Q&A's



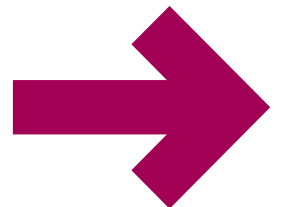
Commissioning Workshop

Top 3 Priorities for Development/Action:

1.

2.

3.



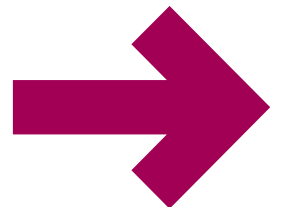
Education Workshop

Top 3 Priorities for Development/Action:

1.

2.

3.



Provider Workshop

Top 3 Priorities for Development/Action:

1.

2.

3.

