The Oxfordshire Clinical View

Oxfordshire Population Health and Care Needs Framework:
Review of 'Innovation and Best Practice'

(July 2019)

Introduction

Background

An Oxfordshire Population Health and Care Needs Framework, developed with partners across Oxfordshire to support the planning of future health and care needs, was approved by the Oxfordshire Health and Wellbeing Board in November 2018. The framework, based on the principles of population health management, is being applied for the first time in the OX12 postcode area (Wantage and Grove and surrounding villages) working together on all stages of the framework with local residents, communities and stakeholders, including local councils.

A key part of this approach is the consideration of relevant 'Innovation and Good Practice'. The Oxfordshire Clinical and Care Forum made up of clinical leads from across the health and care system met together in the **Oxfordshire Clinical and Care Forum** on 3rd July 2019 to begin this work.

Initial Focus Areas

A half-day multi-agency workshop was held on Wednesday 22 May to review the information collected to date about the OX12 area. Based on the information shared, those present at the workshop agreed that the area is both **relatively healthy** and **relatively affluent**. There is a higher than average **older population** which creates more demand for age-related services (such as district nursing and podiatry) and more complexity in terms of care.[1] The high **number of care homes** in the area also increases the workload for GPs and community health professionals who support these residents.

Those present at the workshop also noted that **excess weight** and **poor mental wellbeing** are issues for both children and adults in OX12.

The workshop identified the following issues to address:

- Activity levels of the population and excess weight in both children and adults;
- Mental wellbeing of both children and adults;
- Proactive management of long term conditions including; Hypertension and Diabetes.

There are plans for significant housing growth locally that will put pressure on already strained primary care and community services. Local people have reported issues with travel and transport to access services and/or visit family and friends who are inpatients, both inside and outside OX12.

There are concerns about the temporary closure of Wantage Community Hospital and the provision of primary care and community based services locally

[1] It was agreed it would be useful to undertake work to further segment the needs of the 65+ population to establish whether there are differences between the different age bands within this population and this work is currently being undertaken.

Based on this information and the national and local direction of travel for health and care services three clinical areas were identified as being particularly relevant to OX12 and were the focus of discussion by the clinicians on the 3rd July. They included:

1. Proactive and responsive care to support people at home with long term conditions and frailty
2. Making services traditionally provided in acute hospitals more accessible; with a focus on outpatient and follow-up appointments
3. The potential benefits of an increased focus on primary prevention to promote health and wellbeing and on secondary prevention to reduce the impact of disease

Sustainable primary care was recognised as a key enabler of this work. The NHS Long Term Plan sets the aim of establishing Primary Care Networks (PCNs) serving populations of 30,000 – 50,000. The aim is to bring primary care, community services, social care and the third sector closer together to provide more personalised and co-ordinated health and care for local populations. This builds on the learning provided by the Primary Care Home Programme that has been running since 2015. The clinicians also took into consideration changes in the way Oxfordshire is developing its 'out of hospital' model of care to reduce the level of unplanned care.

A detailed paper on the national and local direction of travel and the new models of care that have emerged throughout the country (particularly through the NHS England 'vanguard programme') was considered by those present at the meeting alongside a more concise discussion paper.

The paper was supported by a review of innovation and best practice linked to the Vanguards, the NHS Long Term Plan, Oxfordshire's Health and Wellbeing Strategy 2018 – 2023 and Oxfordshire's 2019 Operational Plan.

The Oxfordshire Clinical View

This report summarises the outcome of the discussions of the Oxfordshire Clinical and Care Forum and the agreed '**Oxfordshire Clinical View**' in relation to these three initial areas, with a particular focus on OX12.

This clinical view will be used to support the implementation of the Oxfordshire Health and Care Needs Framework in OX12 and will be used to inform work on the final stages of the framework in OX12 that will focus on identifying what things need to change to better meet local need.

As the framework is implemented in other parts of Oxfordshire, it is anticipated that further meetings of the Clinical and Care Forum will be held and an 'Oxfordshire Clinical View' will be formulated for specific clinical issues as they arise.

A General Principle

Consideration of the County-Wide Context

Clinical leads welcomed the opportunity to inform local solutions to meet local health needs but recommended that any proposals arising from the use of the framework should be considered within a **county-wide or an Integrated Care System context** being mindful of any wider projects or initiatives that are being taken forward at either of these levels.

To ensure an equitable service for all patients in Oxfordshire, they also noted that some health needs (such as support for child and adolescent mental health) will need to be addressed at a county level.

Proactive and Responsive Care to Support People at Home: with a focus on long term conditions and frailty

People in England now live for far longer, but extra years of life are not always spent in good health. Older people are more likely to live with multiple long-term conditions and complexity or live with frailty or dementia. Older people don't always get the care they need in the right setting and at the right time and hospital interventions for many people with complex needs can result in extended lengths of hospital stay, risking unwarranted and harmful healthcare outcomes.

Out of Hospital Model of Care

The Oxfordshire Clinical and Care Forum strongly supported **an 'out-of-hospital model of care' as the preferred approach to managing frail and vulnerable people** (including those with mental health crisis issues). The clinical group agreed however that there will always be some patients who will absolutely require hospital based care.

An out of hospital care model aims to bring together primary, community and social care as the foundation for integrated care for adults, children and young people. The development of Primary Care Networks (PCNs) serving populations of 30,000 – 50,000 creates opportunities to provide more personalised and integrated health and care for local populations. The two GP practices in OX12 have come together to develop as a PCN and will support this model of care.

Drawing on national research they recognised that there is a considerable evidence base to demonstrate that a hospital environment is frequently not the best place for care to be delivered, particularly for frail older people (see box below).

National Research Around Inpatient Care

There is a considerable evidence base to demonstrate that a hospital environment is frequently not the best place for care to be delivered, particularly for frail older people:

- Hospital stays increase the risk of infection, especially in older people.
- Extended hospital stays can affect people's confidence in their ability to live independently and can be confusing or distressing for people with dementia.
- Patients in hospital are frequently less mobile leading to deconditioning of muscles, particularly in older people. Indeed, research has found that ten days in a hospital bed leads to the equivalent of 10 years aging in the muscles of people over 80 years of age.[2]
- Some patients might develop a period of vulnerability in the 30-day period after discharge and require to be re-admitted, often for an acute medical problem unrelated to their original admission but linked to stress and information overload

[2] Kortebein et al 'Functional Impact of 10 Days of Bed Rest in Healthy Older Adults' *The Journals of Gerontology: Series A*, Volume 63, Issue 10, October 2008, Pages 1076–1081

experienced during their in-patient stay caused for instance by sleep deprivation, meeting so many new people (health professionals) in a short space of time, coping with severe pain and anxiety and their ability to comply with post-discharge[3]

- Delays in discharges from hospital (often because services are not structured to facilitate discharge with appropriate support as soon as patients are medically fit to leave hospital, especially at weekends) means that beds are not available for other people who need to come into hospital, often leading to disruption to planned care operations or delaying the movement of a patient from another area of the hospital (e.g. A&E) into the bed.

An example of the work being developed in Oxfordshire is **'Home First'**

'Home First' aims to provide patient centred pre-emptive care for people in, or as near to, their own home in order to keep the length of stay in a hospital bed as short as possible.

It is recognised that patients recover quicker when they are in the familiar surroundings of their own homes and have a much greater chance of regaining their independence. They are also less likely to need social care and other support in the longer term.

The Clinical and Care Forum discussions took into consideration innovative service delivery models that have been successful in other parts of the country including; approaches taken by the vanguards, NEW Devon CCG's model of intermediate care, All Together Sunderland: Recovery at Home, Community In-Reach: Principia Partners in Health MCP Vanguard (South Nottinghamshire).

To date the 'Home First' work has been led by Oxfordshire's A&E Delivery Board and primarily focused around managing demand for urgent care. Current best practice initiatives include:

- The provision of the right care at home, or as close to home as possible, supported by integrated multidisciplinary neighbourhood teams linked to the new Primary Care Networks.
- Short-term HUB beds supported by a multidisciplinary team from across the system to enable 'step up' for ill patients in the community, provide initial treatment, facilitate multidisciplinary clinical assessment, development of care plans and streamline the approach to discharge from acute hospital beds back into the community.
- Improvements to the HART therapy-led reablement service by pooling therapy resource to support quicker discharge

Partners in the Oxfordshire system have also developed new models of care to support the management of 'winter' and the delivery of its Frailty Pathway. As part of a winter initiative to reduce non elective admissions Oxford Health piloted a scheme of admission avoidance. Ambulatory care was provided to frail older patients with acute medical conditions in their usual place of residence, using ANPs out reaching from an established ambulatory care unit, supported by an Interface Medic. A daily "virtual" review of those patients was undertaken. Over a three month period 53 patients were seen (mean age 86 years). 50 patients avoided

[3] Harlan M.Krumholz,M.D. Post-HospitalSyndrome –An Aquired, Transient Condition of Generalizes Risk *The New England Journal of Medicine* , 10 January 2013

direct admission to the acute Trust with an estimated gross occupied bed saving (OBD) of 274 days (mean 5.2 days per patient).

Consistency with the National and Local Direction of Travel

This Oxfordshire clinical view is in line with the NHS *Long Term Plan* which makes a commitment to "*boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services."*

It also supports the current clinical and strategic direction in Oxfordshire. Oxfordshire's *Joint Health and Wellbeing Strategy*, *2018-2023,* commits to increasing the number of people supported at home rather than in beds and makes a commitment to provide care close to, or at, patients' homes in order to reduce urgent admissions to hospital. In addition the Oxfordshire *Operational Plan, 2019-2020* outlines the work that is planned to deliver this aim and demonstrates Oxfordshire's intention to deliver the NHS *Long Term Plan's* commitment to breaking down the divide between community and primary care.

Making Services Traditionally provide in Hospital more accessible with a focus on: outpatients and follow-up appointments

The Oxfordshire Clinical and Care Forum strongly supported the development of **alternatives to face-to-face delivery of outpatients and follow-ups in an acute setting**. They also recommended moving **more outpatients and follow-up appointments closer to where people work and live**, where it is feasible.

Clinicians acknowledged feedback from local residents that travel to and parking at the acute hospitals in Oxfordshire is difficult and that this creates problems and added stress. Drawing on best practice elsewhere and the success of this approach in Townlands Hospital, Henley (see summary in the box below) they agreed that increased near patient testing and digital technology has the potential to allow many traditional outpatient and follow-up appointments to be delivered virtually or at a community location. This will improve patient's experience as well as often making more efficient use of clinical resources.

The Royal College of Physicians report on the future of outpatients [4] notes that parts of the outpatient journey don't always deliver the best patient experience and that the NHS should be more flexible allowing patients more control over when and how they receive care. A key element of the redesign process is better utilisation of the technology already available.

National Best Practice: Outpatients and Follow-Ups

Across the country many areas are moving outpatient appointments closer to patients' home and making use of technology. For example:

- many diagnostic tests can be undertaken closer to a patient's home in primary care or other community-based facilities;
- specialist advice on diagnostics, follow up reviews after hospital procedures, and specialist guidance on the management of a long-term

[4] Outpatients: The Future, Adding Value Through Sustainability; J Isherwood, Dr T Hillman, Professor A Goddard; RCP; November 2018

conditions, can be delivered via telephone or video teleconferencing to avoid patients having to travel to appointments;

- direct conversations between secondary care clinicians and GPs can enable many conditions to be managed within primary care.

Advances in technology also provide opportunities for clinically monitoring a wider range of complex conditions and can support people to self-manage. Treatments such as oxygen therapy, nutritional support (artificial feeding) and continuous glucose monitoring that used to require a hospital visit can now be done in the home. Assistive technology, from simple can openers to 'high tech' equipment that monitors vital signs, can support people to live independently and communicate with care staff.

Provision of outpatients, follow-ups and near patient testing by staff from the Royal Berkshire Hospital Foundation Trust has already proved successful in Henley's Townlands Hospital and has saved patient traveling to Reading for these services.

Clinicians, however, noted that **not all specialities are suitable to be provided in the community**, particularly those that require specialist equipment. It will, therefore, be important that each specialty is considered separately.

Consistency with the National and Local Direction of Travel

This clinical view is in line with the NHS *Long Term Plan* which proposes to mainstream digitally-enabled primary and outpatient care across the NHS, including an expectation that digital-first primary care will become an option for every patient and outpatient services will be fundamentally redesigned.

The CCG's *Operational Plan, 2019-2020* echoes the NHS *Long Term Plan's* focus on alternatives to face-to-face delivery and includes outpatient transformation as a key action. This includes work to reduce both first and follow-up appointments and a move to alternative methods of delivery including:

- ensuring patients are directed to the service closest to home that can meet their need (through increasing utilisation of the 111 service, availability of directly bookable appointments and front door streaming)
- Increasing the ambulatory care offer

There is an Oxfordshire-wide project taking forward the transformation of outpatient appointments, building on earlier projects focused on improving performance on waiting times for the 'Top 10 specialities' for referral. Any proposals for more local provision of outpatients and follow-ups for people in OX12 will be linked to this work and an analysis of current patterns of referral.

The Benefits of an Increased Focus on Prevention

A Focus on Prevention

The Oxfordshire Clinical and Care Forum **endorsed an increased focus on prevention**, to embed primary and secondary prevention in all clinical and care pathways the benefits of which are summarised in the box below:

Benefits of Prevention

- Improve the quality of life by creating and promoting health and wellbeing. Supporting people to stay well and self-care is important to their personal wellbeing. When people are involved in managing and deciding about their own care and treatment, evidence tells us they have better outcomes, are less likely to be hospitalised, tend to follow appropriate drug treatments and avoid over-treatment.[5]
- Reduce health inequalities
- Save our public services from rising costs of treating avoidable illness and on-going needs

This approach aims to intervene early or provide support earlier, to prevent and/or delay ill health and to deal with it more responsively when illness does occur. It includes addressing the wider determinants of health like social deprivation, loneliness and poor mental health and working with carers, voluntary organisations and other community organisations.

Consistency with the National and Local Direction of Travel

This Expert Clinical View is in line with the NHS *Long Term Plan* which describes how the future NHS will be "*more proactive in the services it provides"* and makes a commitment to:

- support more people to age well in their own home through proactive prevention-focused support from teams linked to primary care networks, the use of home-based monitoring equipment, and improved recognition / support to carers.
- move to more personalised health services and more support for people to manage their own health, particularly 'supported self-management' of long-term health conditions.

It also supports the current strategic direction in Oxfordshire. Oxfordshire's *Joint Health and Wellbeing Strategy* aims to shift the focus to: preventing ill-health before it starts; promoting a co-ordinated approach to prevention and; 'healthy place shaping'. Prevention measures throughout the system will allow people in Oxfordshire to:

- Live longer lives (prevent illness), by helping them keep themselves healthy;
- Live well for longer (reduce need for treatment) by identifying any health issues early and supporting people to manage their long-term conditions;
- Stay independent for longer (delay need for care) by providing the right support at the right time.

The strategy takes an approach that covers all ages and stages of life ensuring *A Good Start in Life,* enabling adults to continue *Living Well,* and paving the way for *Ageing Well.* Many factors underpin good health and in Oxfordshire this means tackling inequalities, where they exist, and tackling the wider issues that determine health. The CCG's *Operational Plan, 2019-2020* also makes a commitment to *"embedding prevention in everything we do."*

Conclusion

1. The Oxfordshire Clinical and Care Forum strongly supported **an 'out-of-hospital model of care' as the preferred approach to managing frail and vulnerable people.**

[5] *NHS Call to Action*, Department of Health, 2013

2. The Oxfordshire Clinical and Care Forum strongly supported the development of **alternatives to face-to-face delivery of outpatients and follow-ups in an acute setting**.
3. The Oxfordshire Clinical and Care Forum **endorsed an increased focus on prevention**, and to embed primary and secondary prevention in all clinical and care pathways
4. **Sustainable Primary Care was identified as a key enabler**