Buckinghamshire Integrated Care System

Integrated Operations Plan 2018-19
SECTION 1

Executive Summary
The vision of the Buckinghamshire integrated care system is ‘Everyone working together so that the people of Buckinghamshire have happy and healthier lives’

The purpose of this plan is to set out how we are aiming to achieve that vision. We describe our delivery priorities for 2018/19 and the infrastructure and governance arrangements we intend to put in place to ensure delivery.

The ICS is a collaboration of system partners brought together to create a place based care system in which we rise to the challenges and deliver a transformation that improves and integrates care and makes us operationally and financially sustainable over the long term.

The population, health and social care structures and the geography offer ideal opportunities for delivering outstanding integrated care. The health of people and life expectancy in Buckinghamshire is generally better than the England average. However, the overall health profile for the county masks localised variation in deprivation and poor health such as seen in Aylesbury and High Wycombe.

Our care model describes how, through segmentation of the population, we will use a whole population health approach to ensure that care is planned, taking into account the needs of local people and delivered in such a way that we focus care on those most likely to benefit.

Our ICS transformation programme is made up of four pillars:

• Population health
• Integrated care
• Five year forward view priorities
• Professional support services

The plan describes in each case the approach we will take to transformation and the outcomes we aim to achieve.

The 2017/18 ICS system underlying deficit versus control total reported is £38.6 million. The finance and activity section of the plan sets out the approach we are taking to achieve financial sustainability.
SECTION 2

Introduction
The ICS journey began in June 2017 and we are building a strong collaborative partnership which will be able to take shared accountability and responsibility to meet the health and care needs of the Buckinghamshire population. Our aim is to have the best health and social care outcomes in the country delivered by one of the safest and most efficient systems; establishing services that link physical and mental health, social care, general practice and the voluntary sector.


The Buckinghamshire ICS sits within the Berkshire West, Oxfordshire, and Buckinghamshire Sustainability and Transformation Partnership (STP). The STP identified priorities align with those of the ICS and are as follows:

- Shift the focus of care from treatment to prevention;
- Access to the highest quality, primary, community, and urgent care;
- Acute trusts collaboration to deliver equality and efficiency;
- Mental health development to improve the overall value of care provided;
- Maximise value and patient outcomes from specialised commissioning;
- Establish a flexible and collaborative approach to workforce;
- Digital interoperability to improve information flow and efficiency;
- Primary care at scale.

We are working with the other phase one ICSs and in particular Berkshire West (part of the BOB STP), Frimley and Milton Keynes, Bedfordshire and Luton, with which we have common interfaces and patient referral flows.

Chief executive officers from each system partner provide collegiate and strategic leadership to system wide programmes. There is a willingness to collaborate and this will be enhanced through the shared learning from new and emerging forms of commissioning and delivering care as the ICS matures.
The Integrated Care System partners are:

**Buckinghamshire Clinical Commissioning Group (BCCG)** responsible for commissioning health services;

**Buckinghamshire Healthcare NHS Trust (BHT)** responsible for delivering the majority of acute and community services for Buckinghamshire patients;

**Oxford Health NHS Foundation Trust (OHFT)** responsible for delivering all-age mental health care and continuing healthcare services in Buckinghamshire;

**Buckinghamshire County Council (BCC)**, a single contiguous upper tier authority responsible for commissioning and providing social and community services as well as population and public health services;

**FedBucks**, a GP federation covering 85% of the 51 practices in Buckinghamshire and Medicas, a GP federation that covers all but one of the remaining practices;

**South Central Ambulance Service NHS Foundation Trust (SCAS)** who provide emergency and non-emergency patient transport as well as 111 services.

A Buckinghamshire provider collaborative has been formed as a delivery mechanism to build relationships between organisations to deliver integrated care in the county in areas such as urgent care and mental health.

Seven localities operate within the system with a focus on developing and delivering primary and community care.

### ICS Localities

- **Amersham & Chesham Locality**
  - GP practices = 9
  - Population 75,600

- **Wycombe Locality**
  - GP practices = 9
  - Population 90,800

- **Southern Locality**
  - GP practices = 8
  - Population 84,200

- **North Aylesbury Locality**
  - GP practices = 6
  - Population 49,600

- **Aylesbury Central Locality**
  - GP practices = 7
  - Population 103,200

- **Aylesbury South Locality**
  - GP practices = 5
  - Population 48,400

- **Wooburn Green Locality**
  - GP practices = 8
  - Population 89,600
Recognising the changing needs of the population of Buckinghamshire, the Health and Wellbeing Board has developed priorities, outcomes and performance indicators in four key areas: Healthy lives; Children, young people and families; Good health and wellbeing in adults and Healthy workplaces, environments and thriving communities. These contribute to the vision of…

‘Everyone working together so that the people of Buckinghamshire have happy and healthier lives’

This operating plan sets out the ICS’s contribution to this strategy.

Over the next five years, the partners aim to rebalance the health and social care spend by using our funds collectively and allocating resources to support those with the greatest needs. We will develop new ways of working which will not be constrained by individual organisation’s funding arrangements and/or allocation but will focus on what is best for the system as a whole. This collaborative partnership approach will ensure best value for money and spend of the Buckinghamshire ‘£’ to improve outcomes for the people of Buckinghamshire.

As laid out in our Memorandum of Understanding with NHS England we accept a collective responsibility for resources and population health to:

• make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services;
• manage these and other improvements within a shared financial control total and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;
• integrate services and funding, operating as an integrated health system, and progressively to build the capabilities to manage the health of the ICS’ defined population, keeping people healthier for longer and reducing avoidable demand for healthcare services;
• act as a leadership cohort, demonstrating what can be achieved with strong local leadership and increased freedoms and flexibilities, and to develop learning together with the national bodies that other systems can subsequently follow.

This operating plan sets out the principles and approach for the Buckinghamshire ICS implementation.
Based on a five year average from 2011-2015, life expectancy for both men and women in Buckinghamshire is higher than the England average, however, there is wide variation. Life expectancy is 12.1 years lower for men and 13.7 years lower for women in the most deprived areas.

The infant mortality rate (IMR) in Buckinghamshire is 3.5 per 1000 live births which is similar to the England average of 3.9 (2016). However, in the most deprived fifth of the population it is significantly higher than in the least deprived fifth.

Unhealthy lifestyles present a major challenge in the population. In 2016, 26.7% of year 6 children and 62.6% of adults in 2014 (roughly 261,000 adults) were either overweight or obese.

The prevalence of smoking amongst adults in Buckinghamshire who were manual workers was reported as 28.1% in 2014 (compared to the average prevalence for all adults in Buckinghamshire of 15.1%). In Buckinghamshire, 1 in 5 adults are drinking at levels that lead to an increased risk of cancer, high blood pressure and other conditions.
The Buckinghamshire predicted population growth will impact significantly on the demand for health and social care within the county and therefore it is essential that we work as a system to address the challenges which we face.

In the time period 2018 to 2033 we will see a significant increase in the older population with the 65 plus population increasing by 40% (an extra 41,000 people) and the 80 plus population by 70% to 50,000 (an extra 20,500 people).

In the same time period the number of young adults 18-20’s will increase by 14% (an extra 2,100 people) and the number of children will increase by 9% (an extra 10,500). The BME population is expected to increase by 43,000 over 20 year period (2011-2031) to 20% of overall population.

There is expected to be a 4 fold increase in number of Buckinghamshire residents living in most deprived areas in the county with the population increasing from 113,000 in 2015 by 21,000 over the next 15 years to a total of 134,000 people in 2031 (23% of total population).
Section 2: Introduction - key system markers

16/17 to 17/18 Demand:
Activity continues to rise and we are developing innovative ways of meeting people's needs. Annual Performance Data for BHT A&E attendance increased by 5%; emergency admissions increased by 1.6%; delayed transfers of care increased by 18.5%.

Performance Pressures
ICS is committed to delivering the NHS Constitutional Standards. February Performance Data for the CCG:
ED Performance: 84.6%
RTT Performance: 90.46%
Cancer Performance: 80.0%

Financial Squeeze
is the longest & deepest in health and social care history: The ICS had a £38.6m underlying deficit against control total in 17/18 owing to rising demand and performance pressures

New Care Models
Developing and implementing new innovative adaptable and flexible ways of providing care to the population to live independent happy and healthier lives

Structural Change
ICS Transformation Programme is underway to ensure operational and financial sustainability; requires significant investment to develop leadership and system capacity and capability

Workforce Challenges
System-wide to drive change and to attract, recruit and retain the best staff. ICS sees opportunity to develop new roles with core competencies that can be flexible to meet patient needs
SECTION 3

Buckinghamshire’s Emerging Care Model
The emerging care model for the ICS builds on the clinically led change that has taken place so far to deliver improved clinical outcomes and the quality of patient care.

We will develop a care model which brings together all partners to deliver seamless patient pathways with shared responsibility and accountability at any point in the patient journey.

Population health management will be used to help us target care for those most likely to benefit. It is a process which takes a defined population, analyses its needs in detail and, as a result, creates tailored health and social care services.

Prevention of ill health and maximisation of wellbeing is core to the model, building on the Buckinghamshire County Council asset based approach.

Those with minor illnesses or long term conditions will have the confidence to manage their own health or have their needs met in primary care by a pharmacist or a general practice.

Our care model will deliver a shift in emphasis from reactive to proactive care where those with long term conditions will discuss their future needs with clinicians and contribute to the development of their care plan.

Focusing on a philosophy of “Home First” we will deliver care as close to home as possible.

The development of community based services, to support resilience of primary care, will improve access. We will develop community hubs to facilitate the delivery of care traditionally delivered in hospital, closer to home.

We recognise that some people will require on-going care. For this group, continuity of service is important where all who deliver their care have access to shared information.

As the complexity of a patient’s needs increases, we will work with the individual and their family to develop an integrated care plan to keep them independent in their own home as long as possible.

Where either a planned or unplanned hospital admission is necessary both the admission and the discharge will be co-ordinated to minimise the amount of time spent in hospital.

Integral to our model of care is the provision of specialist and local services, targeted to the needs of the population.

We will provide the right care, in the right place, at the right time so improving patient outcomes, the quality of care and deliver an effective and efficient care model for the population of Buckinghamshire.
Our aspiration as a first wave integrated care system is to develop a new model of care using the following design principles:

- Standardised processes to deliver safe and high quality care; evidence-based clinical decisions informed by peer support;
- Co-ordination across a whole system; ensuring coordination of care for patients across services eliminating unnecessary treatment or duplication;
- Population orientated; focused on the needs in a location, and/or population groups such as those with specific long term conditions or the frail;
- Person-centred and holistic; supporting patients to live independently at the centre of decision making about their care;
- Maximising care in the community setting when care can be more effectively delivered closer to home;
- Comprehensive access to multi disciplinary teams to meet patient’s health and social care needs; to include wellbeing and prevention, acute and chronic care;
- Accessible and responsive to the patient’s needs with appropriate waiting times for advice, diagnosis and care; maximising the use of technology;
- Sustainable care, ensuring financial and staffing resources are used effectively to deliver best value.

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**Integrated Care Models**
Coordination of care services for defined groups of people (e.g. older people and those with complex needs)

**Population Health (systems)**
Improving health outcomes across whole populations, including the distribution of health outcomes

**Individual Care Management**
Care for patients presenting with illness or for those at high risk of requiring care services

**‘Making Every Contact Count’**
Active health promotion when individuals come into contact with health and care services

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**The Focus of Population Health Systems** (Source: King’s Fund)
Section 3: The care model focuses on population segmentation according to risk

**Tier 1**
- Minimal Risk 50% population (250,000 people)
- People who live independently with occasional health needs e.g. short term illness, acute health needs require hospitalisation e.g. appendicitis, pregnant woman or children

**Tier 2**
- Low Risk 30% population (150,000 people)
- People who live independently with self directed care who may require support as required e.g. 1 long term condition

**Tier 3**
- Medium Risk 15% population (75,000 people)
- People in a stable condition requiring on-going support from clinicians based within primary care e.g. multiple long term conditions including pre frail

**Tier 3+**
- High Risk 4.5% population (22,500 people)
- People who are at high risk, requiring on-going care coordinated within primary care to provide seamless service delivery i.e. frail

**Tier 4**
- Extreme Risk 0.5% population (2,500 people)
- People with complex needs requiring consultant led specialist care
The model below describes the ICS Care Concept which is being developed within Buckinghamshire.
The Community model will be operationalised across a number of different geographies and organisations.

This model builds the progress already made in integrating care in Buckinghamshire.

The ICS is working with its constituent members and the public to confirm the specific definitions and features of each layer of provision in this model.

To date there has been alignment on the role of GP clusters / integrated teams (population 30-50,000) and the need for some services to be provided at a larger, 100 – 150,000 population.

There is a growing consensus that there will be a virtual or physical hub in each 100-150,000 population footprint and that all the hubs will provide a core offer with some co-locating with other services e.g. outpatients.
SECTION 4

Our Transformation Programme
We are a health and care system with a strong background of clinical leadership for our key projects. This has enabled us to deliver change to improve clinical outcomes and enhance the quality of care in Buckinghamshire.

The next phase of our transformation programme will be fast paced and provide support to:

- **Accelerate a system approach to improving outcomes** for our population with a shared understanding and holistic approach to meeting people's physical, mental health and wider social needs;

- **Co-design services** with the people that use them, continue our focus on prevention, expand self-care and promote health and wellbeing to reduce the demand on health and care services;

- **Focus on key priorities to embed our approach**, using risk stratification to segment our population to guide the need for more effective, targeted support;

- **Accelerate implementation** of our agreed integrated care roadmap - ensuring the whole Buckinghamshire system is focussed on population and health outcomes;

- **Align our work** to improve outcomes and ensuring appropriate service utilisation – right care, right setting, right time - to benefit all partners and allow a coordinated focus on key priority areas;

- **Access external support and rapid learning** with other like-minded systems, maximising efficiencies of collaboration and enabling us to move at a faster pace through our organisational development programme;

- **Develop an integrated data set** – one source of the truth, which is used to set capitated budgets, enable whole systems modelling and evaluation of services and the assessment of the relative benefit of services compared to one another;

- **Work as a system to develop a framework** which enables us to be held jointly to account for delivery of our transformation programme and achievement of key objectives.
Section 4: Transformation programme vision, objectives and core pillars

**Vision**
Everyone working together so that the people of Buckinghamshire have happy and healthy lives

**Objectives**
› People supported to live independently;
› Care integrated locally to provide better support closer to home;
   › Improved urgent and emergency care services;
   › Improved resilience in primary care services;
   › Improved survival rates for cancer;
› Improved outcomes for people suffering mental illness;
› Reduced unwarranted variations in quality and efficiency of planned care;
› Digital transformation implementing IT platforms that support integrated care;
› Long term operational and financial sustainability.

**Core & Enabling Pillars**
- **Population Health:** Working with localities to define and segment populations, understand their needs and monitor outcomes of interventions (including prevention and self-care).
- **Integrated Care:** Improving access to services for people with long-term conditions and frailty in particular. This will support people to live independently and reduce reliance on emergency and acute services.
- **FYFV:** National priorities including improving outcomes for cancer, improving resilience in primary care, improving access to urgent care and improving outcomes for people with mental health.
- **Professional Support Services (Enablers):** that ensure we have the support, expertise and technology to operate as an effective integrated care system.
### Section 4: Our Journey

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<th><strong>Working Together</strong></th>
<th><strong>Delivering Together</strong></th>
<th><strong>Looking Forward</strong></th>
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<tr>
<td><strong>2015</strong></td>
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<tr>
<td>Established Healthy Buckinghamshire leaders group – aligned to Health and Wellbeing board priorities</td>
<td>Launch of Primary Care strategy</td>
<td>Joint OD strategy initiated</td>
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<td>Established Transformation Delivery group</td>
<td>Agreed joint risk share</td>
<td>Implementation of ICS operating plan</td>
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<td><strong>2016</strong></td>
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<tr>
<td>STP footprint agreed; joint programme boards established</td>
<td>Pooled budgets for £30M Better Care Fund</td>
<td>Review of BITS/community hub pilots</td>
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<tr>
<td>Integrated commissioning executive team established;</td>
<td>Go live for interoperability Phase 1 (My Care Record) - real-time view of GP held record</td>
<td>Launch of primary care access hubs for extended service</td>
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<tr>
<td>GP federation established</td>
<td>Specification for integrated reablement and response service agreed</td>
<td>Extension of integrated teams supporting patients at risk</td>
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<td><strong>2017</strong></td>
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<tr>
<td>Awarded ICS 1st wave status</td>
<td>ICS engagement sessions take place including Big Tent events</td>
<td>Launch of IT interoperability programmes</td>
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<tr>
<td>Provider collaborative established</td>
<td>Launch of TV NHS111 service</td>
<td>Deployment of interoperability solutions (CareCentric &amp; Careflow and Person Held Record)</td>
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<td>Clinical engagement events across the county</td>
<td>GP streaming launched</td>
<td>System control total reporting begins</td>
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<tr>
<td>Partnership Board agree ICS vision, objectives, and core pillars</td>
<td>Go live for EMIS clinical services to support integrated working</td>
<td>Development of new models of care to meet needs of specific patient groups</td>
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<td><strong>2018</strong></td>
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<tr>
<td>Launch of 24/7 primary care access</td>
<td>Submission of ICS integrated operating plan</td>
<td>Development and implementation of capital programme</td>
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<tr>
<td><strong>2019</strong></td>
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<td></td>
<td>Community, primary care and social care providers delivering new model of care with local people that has redesigned pathways, supporting more people at home and eliminates delays in hospital discharge</td>
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<td></td>
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<td>Integrated care record: all core feeds live and context launch from main partners live</td>
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The Buckinghamshire health system has already started to deliver real change:

**Population Health**
- Population health programme focusing on local variation, aligned to national priorities e.g. growth in population aged 80+, prevalence of high cost diseases (COPD, coronary heart disease, dementia, diabetes, obesity, stroke)
- Finding cases using risk stratification and links to ‘high volume’ users
- Increasing patient education and supported self-care through the Live Well Stay Well programme

**Integrated Care**
- Community hubs pilots, providing community assessment and treatment services, extended range of outpatient clinics, more diagnostic testing e.g. one-stop blood tests and X-rays, and support from voluntary organisations
- Working together to transform re-ablement and social care services to help more people to live independently at home for longer
- Series of events with staff, stakeholders, members of the public and community groups to share the vision and seek views. New integrated musculoskeletal service for people with health conditions that affect their joints, bones, muscles and soft tissue – fully rolled out across the county by 2019
- Diabetes service transformation: over 1,000 Type 2 patients now being managed in primary care; successful bid for funding for structured education and training for diabetes

**Five Year Forward View**
- Delivery of cancer strategy including Thames Valley Cancer Alliance funded project
- Making it easier to get GP appointments at evenings and weekends, and developing new 24/7 primary care service which will include ‘primary care hubs’
- Improving and increasing access to mental health services

**Professional Support Services**
- Piloted GPs working together in networks (30,000-50,000 population) supported by integrated local teams (community nursing, mental health, social care, clinical pharmacy etc) - joining up care for older people and people with complex health needs, to help them stay healthy for longer supported by EMIS Clinical services to enable record sharing
- Established working groups focusing on Organisational Development, Quality, Population Health Management, Workforce, Finance, Communications and Engagement
Section 4: Our ICS Programmes

We are developing an integrated programme structure to support and deliver the key transformation. Key to our success is the availability of high quality informatics and decision support along with good leadership and support throughout the system.

- Our aim is to ensure the wellbeing of patient/service users, staff and partners within the system to achieve long term stability and sustainability.
- The transformation programme initial priorities were agreed collaboratively to increase effectiveness and efficiency, creating system sustainability, and ensuring the success of the new model of care.
- We aim to create a lean process with the appropriate level of governance, rigorous system controls, and the appropriate level of decision making and assurance.

ICS core pillars

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Integrated Care</th>
<th>FYFV</th>
<th>Professional Support Services (Enablers)</th>
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</table>

Examples of delivery programmes/projects

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<tr>
<th>Preventive</th>
<th>Self-Care</th>
<th>Long Term Conditions</th>
<th>Frailty</th>
<th>Mental Health</th>
<th>Cancer</th>
<th>Estates</th>
<th>Finance</th>
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<tr>
<td>Adult Social care and children and young people</td>
<td>Population Health Data and Analysis</td>
<td>Community Services</td>
<td>Integrated Care</td>
<td>Primary Care</td>
<td>Urgent and Emergency Care</td>
<td>OD/Work Force</td>
<td>Portfolio Office</td>
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<tr>
<td>Medicines Management and Optimisation</td>
<td>Information Advice Guidance</td>
<td>Planned Care</td>
<td>Unplanned Care</td>
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<td>IT</td>
<td>Comm and Engagement</td>
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### Section 4: Key Transformation Drivers

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<th>Current Delivery Programmes</th>
<th>Outcomes</th>
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<tr>
<td><strong>Population Health</strong></td>
<td><strong>Promoting wellbeing through targeted initiatives and improving health outcomes</strong></td>
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<tr>
<td>• Preventative</td>
<td>• Promoting independence and self care.</td>
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<tr>
<td>• Self-care</td>
<td>• Promoting self-service through information held on digital platforms</td>
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<tr>
<td>• Targeted Intervention</td>
<td>• Signposting to the right services through information open to all</td>
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<tr>
<td>• Population Management</td>
<td>• Promoting use of voluntary services and communities</td>
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<tr>
<td><strong>Five Year Forward View</strong></td>
<td><strong>Manage levels of GP activity, providing other, more appropriate, support for patients</strong></td>
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<tr>
<td>• Mental Health</td>
<td>• Ensure optimisation of medicines management and prescribing.</td>
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<tr>
<td>• Primary Care (to be managed under Integrated Care Pillar)</td>
<td>• Manage the demand for ED attendances and admissions to hospital providing other more appropriate services</td>
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<tr>
<td>• Cancer</td>
<td>• Manage the demand for elective hospital services providing other more appropriate services</td>
</tr>
<tr>
<td>• Urgent and Emergency (to be managed under Integrated Care Pillar)</td>
<td>• Re-profiling / redesigning outpatients.</td>
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<tr>
<td><strong>Integrated Care</strong></td>
<td>• Redesign services to eliminate duplication and provide seamless services</td>
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<tr>
<td>• Urgent and Emergency</td>
<td><strong>Provide appropriate services to support independent living, reducing the number of people admitted into residential and nursing homes,</strong></td>
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<tr>
<td>• Care Homes</td>
<td>• Provide appropriate services to support independent living reducing the length of time people stay in residential and nursing homes and hospital settings.</td>
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<td>• Single Point of Access:</td>
<td>• Ensure best value for the provision of care packages.</td>
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<tr>
<td>• Community Hubs</td>
<td>• Provide appropriate services to support independent living reducing length of stay</td>
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<tr>
<td>• Planned Care</td>
<td>• Minimising delayed transfers of care.</td>
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<tr>
<td>• Long Term Conditions</td>
<td>• Increase the number of people dying in their preferred setting</td>
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<tr>
<td><strong>Professional Support</strong></td>
<td><strong>Maximising the use of the public estate to deliver integrated services and the most efficient use of the public pound</strong></td>
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<tr>
<td>• Estates</td>
<td>• Sustaining a system wide PMO; developing a flexible, cost effective and agile approach while reducing risk, complexity, duplication and ensuring best use of resources available</td>
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<tr>
<td>• Finance – Business Intelligence</td>
<td>• Improving capacity within the community workforce</td>
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<td>• OD/ Workforce</td>
<td>• Increasing the capacity of the primary care</td>
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<tr>
<td>• Portfolio Office</td>
<td>• Increasing support to professionals across the ICS by introducing tools to empower patients to manage their health and wellbeing and long term conditions, and ensuring staff have access to the right information to deliver safe, effective and efficient care</td>
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<tr>
<td>• IT</td>
<td>• Communication and Engagement</td>
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Section 4: Our transformation programme – 2018/19

Q1 (Apr-Jun)
- Rapid review and assessment report of current ICS related projects completed, together with high level Target Operating Model (TOM)
- Buckinghamshire ICS Integrated Operations Plan completed and submitted
- Transformation plan framework developed and aligned to operations plan.
- Projects established for priority projects assigned as Year One (2018/19) delivery
- System communications plan agreed
- Interoperability design and build, My Care Record (MCR) Phase 2, and continued rollout of EMIS Clinical Services
- Pilot BITs implementation at clusters

Q2 (Jul-Sep)
- PMO structure and delivery process developed and implemented
- Programme reporting, system finances and governance aligned
- Knowledge transfer to staff in terms of programme delivery and reporting requirements
- Detailed communications plan enacted
- Agreed new model of care
- Introduction of population health management analytical tools
- Performance dashboard and analysis function established
- Interoperability tools rolled out to nominated pilot locations and staff to fulfill ICS Programme requirements (CareCentric and careflow)
- Interoperability tools available to patients and public in a controlled pilot (Ask NHS)

Q3 (Oct-Dec)
- Interoperability tools rolled out to all locations and staff to fulfill Programme requirements (CareCentric and careflow). Tools made available to patients and public (Ask NHS)
- Implementation of GP 8-8 service
- Transformation plan for Primary Care 24/7 access developed and agreed
- First phase implementation of Hubs
- Performance dashboard and analysis function established
- Interoperability tools rolled out to nominated pilot locations and staff to fulfill ICS Programme requirements (CareCentric and careflow)
- Interoperability tools available to patients and public in a controlled pilot (Ask NHS)

Q4 (Jan-Mar)
- Interoperability tools rolled out to all locations and staff to fulfill ICS Programme requirements (Care records) (6 month process)
- Person held record made available to patients and public (Ask NHS) (6 month process)
- Delivery of Five year Forward View annual targets
- Continued implementation of Primary Care Hubs
- Fully develop 2019/20 program
- Lessons learned from 18/19
Structured system governance will be a key element to the ICS success. The ICS partners will establish and maintain a robust accountability and governance arrangement. Building on the existing ICS governance arrangements, we will ensure clear management reporting and oversight to provide the required level of assurance across the system.

The principles that will underpin the design of our governance:
- Clear, transparent and collaborative decision making
- Devolve decision making to empower teams on the ground to deliver the change required.
- Resources will follow responsibilities
- Process will be streamlined and standardised

These principles will allow us to test our governance arrangements and the degree to which they meet the needs of each individual organisation and the system as a whole. We will ensure appropriate controls and processes are in place to identify, manage and mitigate risk.
The focus of our communications and engagement plan is to ensure that all stakeholders are well informed and have the opportunity to contribute to the development, implementation and success of the ICS; through the most appropriate channels to meet their specific needs.

Public
- Involvement of Buckinghamshire residents in shaping the services we plan, commission and deliver;
- Understanding of all our audiences and how to reach all groups including those we don’t hear from;
- Improved patient and service user experience for those receiving NHS and/or social care services;
- Improved understanding of the system and how to navigate ensuring single points of access and seamless service delivery.

Staff
- Greater understanding of the system and what the changes in each organisation mean for each other;
- Involvement of staff in identifying opportunities for better integration;
- Increased knowledge of each others roles and how they contribute to residents health and well-being;
- Improved understanding of health and care as one system;
- Spreading good practice across the system;
- Using real examples and demonstrating the strengths in our system will support our recruitment and retention drives showing Buckinghamshire as a “good place to work”.

Deliverables in 2018/19
- Developing the ICS story including frequently asked questions to ensure a consistent message across all organisations;
- Understand knowledge of the ICS and each organisations preferred channels to help inform our plan;
- Through blogs and tweets, share our journey to greater integration;
- Continue to develop cross organisation communications networks;
- Maximise opportunities to share our messages both locally and nationally.
Section 4: Programme Communication and Engagement

We will involve people in what is changing through engagement, co-design and co-production to ensure we get it right first time whilst communication will be plain English and jargon free. We will ensure stakeholders have every opportunity to be involved.

<table>
<thead>
<tr>
<th>April – June</th>
<th>July – September</th>
<th>October – December</th>
<th>January – March 2019</th>
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</thead>
</table>
| • Staff Survey – level of understanding and suitable channels (April 2018) | • Continue delivery of work stream communications and engagement plans including:  
  - Buckinghamshire integrated teams  
  - 24/7 Primary Care  
  - Official launch of Urgent Treatment Centre  
  - Fulfilling Lives  
  - Prevention | • Continue ongoing staff communications  
• Review of engagement tools and introduction of new digital tool for ICS  
• Continue delivery of work stream communications and engagement plans  
• Planning for ICS website  
• Launch One Recovery Buckinghamshire  
• Support for communications and engagement activity for Community Hubs | • Continue delivery of work stream communications and engagement plans  
• Review Communications and Engagement Plan |
Section 4: Our Transformation Programmes – the detailed core pillars

The following slides drill down into the delivery of our core and enabling pillars for the Buckinghamshire Integrated Care System

**Core & Enabling Pillars**

**Population Health:** Working with localities to define and segment populations, understand their needs and monitor outcomes of interventions (including prevention and self-care).

**FYFV:** National priorities including improving outcomes for cancer, improving resilience in primary care, improving access to urgent care and improving outcomes for people with mental health.

**Integrated Care:** Improving access to services for people with long-term conditions and frailty in particular. This will support people to live independently and reduce reliance on emergency and acute services.

**Professional Support Services (Enablers):** that ensure we have the support, expertise and technology to operate as an effective integrated care system.
### What is PHM?
PHM is a critical priority for Buckinghamshire ICS. It is a process which takes a defined population, analyses its needs in detail and as a result creates health and social care services tailored to that specific population. It is a journey rather than a destination and the specific service which results will be unique to each population group/locality. We aim to:

- achieve parity of esteem for prevention and self-care;
- improve the health and wellbeing of our residents and reduce health inequalities;
- reduce clinical and financial risks to the system across health and social care.

### Why is PHM a priority for the ICS?

The need for adult health and social care services is being driven by an increase in the older population and increasing numbers of people with multiple long term conditions and frailty in the ageing population. Long term conditions and frailty are not an inevitable consequence of ageing – much of this is driven by unhealthy lifestyles coupled by a historic investment issues in prevention.

Multi-morbidity more than age is a key driver of cost activity and future risk and multi-morbidity occurs across the whole adult age range. Evidence also suggests that co-morbidity impacts resource use exponentially – not in a linear way. Multiple morbidity is not distributed evenly across a population and case-mix varies quite significantly between GP practices. The Buckinghamshire ICS and wider STP identified 3 main gaps which have direct impact on the health and wellbeing of our population and on our financial sustainability across the system. These gaps are:

1. **Lifestyle, information and motivational** – a gap in people’s ability to help themselves to a healthy lifestyle and to self-manage long term conditions. There are also gaps relating to people’s ability to help themselves when social problems occur;
2. **Service** – a gap in the way we organise, focus, commission or provide services in particular in the way that prevention, self-care and asset based approaches can be integrated in to routine contacts;
3. **Community gap** – a gap in the way we work together to build community skills and capacity in order to develop the community assets and social capital as a way to enable individuals to develop personal responsibility for their health and wellbeing.
## Section 4: Population Health Management (PHM)

### Our approach to PHM

1. To maximise the use of community assets, we will work with our communities to map their assets to utilise them to improve and maintain their health and well being;
2. Increase the importance of the prevention agenda, by ensuring that it is core to every intervention and contact with individuals;
3. Use data to support the targeting of interventions on those most likely to benefit, through understanding the specific needs of individuals within segments of our population;
4. Use data to inform the planning of services to meet the needs of local people, through understanding the population as a whole, how they are currently accessing health and care services and how these can be better met;
5. Devolve the delivery of services to locality and cluster level, to make sure that voluntary sector, health and care services work together to encourage people to live independently and manage their own health and well being.

### Outcomes and benefits

Unlocking the potential of PHM will support Buckinghamshire residents and our system to:

1. Integrate health and social care and voluntary services to use our collective resources to provide best value for the population;
2. Enable people to live independently and increase their confidence in managing their long terms conditions, so reducing demand for unplanned services;
3. Reduce the harm caused to people by smoking, obesity and drinking excess alcohol;
4. Keeping healthy people healthy for longer;
5. Supporting chronically ill people to successfully manage their conditions;
6. Embedding population health and prevention practices in all services.
### What work is the ICS currently doing?

Overall, we have identified three programmes of work that are already underway, which we will continue to develop to enable us to realise our vision for population health management in Buckinghamshire. In addition, based on the needs identified by data analysis (population segmentation and risk stratification) we will further refine our new care and service model to ensure they reflect the identified needs of our population. The three programmes of work are:

1. **Prevention at Scale programme** and **Live Well Stay Well** (an integrated lifestyle service) will help people to stay healthy and avoid getting unwell. These two programmes will form the foundation of our PHM work stream and underpin all of the work we will do on prevention;

2. **Integrated Community Services/Integrated Teams** together with care and support planning programmes that will support individuals who are unwell by providing high quality care at home and in community settings. These programmes will transform general practice, primary and community health and care services in Buckinghamshire, so that they are truly integrated and based on the needs of our local populations;

3. **Acute and Emergency care programme** will help those who need the most specialist health and care support, through a single acute care system across the whole county.

### Our priorities for 18/19:

1. Undertake a readiness assessment of our system for implementing PHM;
2. Profiling our GP Clusters to support primary care and community services transformation;
3. Ambulatory care intervention in primary care for medium risk patients;
4. Population Health Data and Analysis - Population Health Programme focusing on local variation;
5. Medicines Management and Optimisation – Embedded pharmacist in care homes and primary care;
6. Validate further our priority areas for further development and investment - Focusing on multi-morbidity and frailty;
7. Spread our Making Every Contact Count ethos across all care providers through focus on early intervention for low risk patients;
8. Information Advice Guidance – Increase access to information, advice and guidance in a variety of formats e.g. IT self-referral system and located information services within community hubs.
| ICS integrated care ambition | The Buckinghamshire Integrated Care programme aims to improve access to services for people with long-term conditions and frailty in particular. This will support people to live independently and reduce reliance on emergency and acute services. Supporting people to keep themselves healthy and live, age and stay well enabling more people to live independently longer, this will reduce the pressure on our hospitals, GPs and wider health and social care services.

The programme will provide timely access to services by helping the public to better understand how their care needs can be most appropriately met.

Our staff are our major asset, through integration we will improve their work life balance, develop their career, devolve decision making and make Buckinghamshire an attractive place to work through bringing joy back into the workplace.

We will work with our residents to encourage and enable them to manage their own mental and physical health and wellbeing. We want to ensure people are cared for at home wherever possible and that services are focussed on a home first philosophy, which has been confirmed by feedback from the public.

We are developing integrated teams across health and social care which will reduce duplication so increasing the capacity to deliver diagnosis, assessment and care in the community. This means we will provide proactive care planning, rapid response, reablement which means patients will be better informed to manage their condition and maintain their independence. We will implement enhanced access to general practice services to meet the needs for episodic care.

We are developing our new care model to provide access to good quality advice and care in the most suitable and convenient way possible, as early as possible. Through combining resources and expertise across the health and care system so that people receive joined-up care and provide care navigation/care coordination to improve the quality of care for individuals in the Buckinghamshire. We will also look to reduce the variance in quality for those suffering from serious enduring mental illness or learning disabilities.

We will support the development of multi agency working to allow staff to work together as one team across organisations through developing new ways of working including joint roles and empowering staff to make decisions. |
## Section 4: Integrated Care

### Our approach to integrated care
- To simplify access to care we will implement a single point of access for all referrals into community services;
- Develop hubs across Buckinghamshire to deliver expanded diagnostic, outpatient, health and wellbeing and ambulatory care services for local people;
- Expand rapid response and reablement services enabling a two hour community response to those in crisis;
- Care integrated locally to provide better support closer to home;
- Improved urgent and emergency care;
- Improved resilience in primary care services;
- Reduce unwarranted variation in quality of planned and unplanned care;
- Long term operational and financial sustainability.

### Outcomes and benefits
- Improve health outcomes through integrated, responsive and innovative primary and community health and care services;
- Encourage collaboration to ensure that family doctor services are safe and sustainable, and play a leading role in the successful delivery of new models of care; provide timely access to general practice, so reducing the need for urgent care;
- Ensure patients have fewer crisis that lead to unplanned hospital and institution care;
- Increase the number of people clinically assessed through NHS 111 to 30% by March 2018;
- Work to achieve 95% on the 4 hour A&E standard;
- Improve the working of community based multi-disciplinary teams through training and development;
- Use technology to drive innovation, underpin integration of services, improve efficiency and empower patients;
- Through investment we will develop flexible infrastructure and estate needed to support and promote our ambition.
### What work is the ICS currently doing?
- Enhanced and improved access to primary care services from 2018 onwards;
- Implementing surgery sign-posters to help patients navigate care;
- Urgent and Emergency Care – Implementation of Improved Directory of Services/increased clinical triage, embed GP Streaming Service; Launch of Thames Valley NHS 111 IUC service;
- Community Services – Established community hubs, piloted Buckinghamshire Integrated Teams (BITS) in 3 localities covering population of approx. 100,000;
- Planned Care – iMSK transformation programme with care delivered through provider collaborative;
- Telemedicine Support for Care Homes – using advanced nurse triage service which reviews patients and offers advice on continued treatment in the home setting. The service reduces the number of hospital admissions and the workload for General Practice.
- Primary care: We have worked with our general practices to align them into 13 clusters. The aim of this work is to encourage collaboration between practices and so enhance their resilience. In 2018/19 our GP federations will lead the implementation of improved access to general practice. We will invest £8.8m in developing our primary care estate. Our general practices will work together to design the best solutions for their local populations. Through this collaboration and the federation support, time will be released to support general practice to transform their services and become active delivery partners with other parts of the system.

### Our priorities for 18/19:
- Development and implementation of a Community Care Model;
- 24/7 primary care implemented with extended GP access 8am to 8pm;
- Expansion of the Directory of Services and clinical triage;
- NHS 111 online;
- Through collaboration between practices enhance primary care resilience;
- Keep patients safe by improving safety of medications, recognition of sepsis, reducing infections and recognition of deterioration of patients.
The Five Year Forward View sets out a clear direction, showing why change is needed and the expectations of service delivery in the future. Delivering the vision contained within the report for Buckinghamshire will require a system based approach with the input of all our partners. The ambition for Buckinghamshire is set out in the ICS Memorandum of Understanding with NHS England.

In 2018/19 we will make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services. The ICS is committed to working with its partners across the STP to ensure that we are delivering these services on the most effective footprint.

| ICS urgent care ambition | Our Memorandum of Understanding with NHS England sets out the following ambition;  
- Urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance services;  
- Primary care – deliver extended access by October 2018 and use collaboration between practices to increase primary care resilience, contribute to a proactive, whole population health model of care and improve retention of GPs.  

We will manage these and other improvements within a shared financial control total and collaborate to maximise the system-wide efficiencies to deliver within budget, improving outcomes and patient experience. To achieve this we will integrate services and funding, operating as an integrated health system, and progressively build the capabilities to manage the health and care of the population, keeping people healthier for longer and reducing avoidable demand for healthcare services. |
### Outcomes and benefits

- Reduce the number of people relying on A&E and GP OOH to access care through increasing the range of service available and streamlining access;
- Increase the percentage of people who, on calling TV IUC and NHS 111, receive a clinical triage;
- Improve the access to routine primary care;
- Speed discharge from hospital by increasing the number of CGC assessments taking place in the community;
- Reduce the number of patients who live in a care home who are transported unnecessarily to hospital.

### What work is the ICS currently doing?

- To maintain current performance on DTOC, through the BCF, partners have worked to (i) stabilise care market (II) streamline the reablement function (iii) increase support from voluntary care services for people in own home (iv) influence the self funder market;
- In 2017/18 we achieved 92.3% of CGC assessments taking place out of hospital;
- £1m capital funding has been invested to deliver front door primary care streaming in A&E;
- Specialist mental health teams are based in A&E and work as an all age mental health liaison across the Trust;
- As part of the joint TV IUC and NHS 111 mobilisation we ensure that 30% of calls receive a clinical assessment;
- In April 2018 the re-commissioned primary care 24/7 service went live. This service is provided by a provider collaborative which includes all the providers across the ICS;
- During the winter of 2017/18 we piloted an increase in GP appointments in the Buckingham locality. This will be rolled out across Bucks in 2018;
- We have commissioned Airedale to provide nurse practitioner use technology to support care homes in reducing conveyances to A&E.
### Section 4: Five Year Forward View - Urgent Care

**Our priorities for 18/19:**

- Buckinghamshire has many of the urgent care elements identified in the MOU in place however the challenge for 2018/19 is to integrate these elements into a single, seamless service for patients so maximising the benefits;
- Deliver the 8 high impact changes to reduce DTOC;
- Mobilise urgent care treatment centres;
- Integrate primary care 24/7 service with wider teams;
- Expand GP appointments – see Primary care slide;
- Development and implementation of a Community Care Model;
- 24/7 primary care implemented with extended GP access 8am to 8pm;
- Expansion of the Directory of Services and clinical triage;
- Through collaboration between practices enhance primary care resilience;
- Keep patients safe by improving safety of medications, recognition of sepsis, reducing infections and recognition of deterioration of patients.
The national cancer strategy is set out in “Achieving World Class Cancer Outcomes: a strategy for England. The delivery of this strategy will be through membership of the Thames Valley Cancer Alliance. The focus of the strategy is threefold:

- To increase early diagnosis;
- Streamline treatment;
- Support those living with and beyond cancer.

The cancer programme interacts with all of the other programmes across the ICS.

The Population Health programme will support us in reducing the incidence of preventable cancers through our smoking cessation, obesity and avoiding harmful drinking programmes.

The primary care programme, through integration of teams and the focus on proactive care planning will support patients in managing their disease in the community and maximising their wellbeing.

The urgent care pathway supports patients who need rapid access to care e.g. immuno compromised patients with sepsis to access prompt treatment so improving recovery rates.
### Outcomes and benefits

- Earlier diagnosis of cancer with more people diagnosed a stage 1 and 2 resulting in better outcomes for individuals;
- Delivery of the 62 day pathway resulting in faster access to treatment and better co-ordination of complex care pathways;
- Faster identification through screening of those with non-symptomatic disease.

**Living with and beyond cancer programme**  
This programme is funded by Macmillan until March 2019 to develop a local model to support those living with cancer and will ensure:

- Easier and more streamlined access to services e.g. pain relief and fatigue;
- Supporting people to get back to being active members of the community;
- Primary care resilience to deal with projected increases in incidence.

### What work is the ICS currently doing?

- Funding has been invested through the Primary Care Quality Incentive Scheme to support primary care in the delivery of quality improvement initiatives to improve screening uptake;
- Project to increase the use of e-Referral Service for the 2WW pathways;
- Delivery of chemotherapy in community hubs reduces the need to attend hospital.

**Living with and beyond cancer programme**  
The first phase of the programme has been engagement with the public. Consultation with the public began in Oct 2017 and ran until March 2018. This engaged over 117 patients in face to face workshops and used over 64 community venues to give access to those not on line, backed up by an anonymous online survey.
Our priorities for 18/19:

- Piloting of the ‘vague/atypical symptoms’ clinic, supported by the TV Cancer Alliance;
- Redesign of the urology pathways to improve the 62 day performance;
- Speed access to CT on the lung pathway to streamline diagnosis.

*Living with and beyond cancer programme*

After public consultation with over 300 residents there will be a workshop on the 24 May to co-design the solutions with members of the public. This will then be translated into a delivery plan. Issues identified include integrating services into the ICS directory of services; workforce training plan to support non-cancer specialists in managing cancer and related issues.
<table>
<thead>
<tr>
<th>ICS primary care ambition</th>
<th>Buckinghamshire ICS is committed to delivering the GPFV through local GPs working together in networks which will encourage collaboration between practices, provide a footprint suitable to enable integration with community services, including mental health and social care.</th>
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</thead>
</table>
|                           | Our Memorandum of Understanding with NHS England sets out the following ambition;  
|                           | • Unplanned care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance services.  
|                           | • Primary care – deliver improved access by October 2018 and use collaboration between practices to increase primary care resilience, contribute to a proactive, whole population health model of care and improve retention of general practice staff.  
|                           | To achieve this we will develop our 13 clusters of practices to improve their resilience, so enabling them to play a full role in the system.  
|                           | We will support practices by implementing new roles e.g. care navigators and add to our programme of support for care homes by increasing the number of pharmacists in the team.  
|                           | The integrated care slides demonstrate the intention to develop integrated teams, of which general practice will play an essential part. |
| Outcomes and benefits | • Patients will be able to access pre-bookable appointments 8-8 Monday to Friday and at times to suit population needs at the weekend;  
• Through a more proactive model of care delivered by the integrated teams, reduce the reliance on urgent or unplanned care services;  
• Make Buckinghamshire an attractive place to work in primary care so increasing GP recruitment and retention. |
| What work is the ICS currently doing? | • The CCG has procured an integrated 24/7 primary care service from the Provider Collaborative which brings together all the providers (FedBucks, BHT, SCAS, OHFT) under a single umbrella. This will provide the basis for transformation of the service in 2018/19;  
• Working with KPMG, FedBucks led a piece of work to support practices in thinking through the most effective collaborative footprint for them;  
• £8.8m capital funding has been allocated to develop primary care estate to support the delivery of improved access and out of hospital care;  
• Four footprints of 30-50,000 population have been identified to mobilise the first integrated teams. |
**Our priorities for 18/19:**

**Health offer**
- Improved access to primary care by October 2018;
- Mobilise four integrated teams and use the learning to inform the mobilisation of the subsequent teams across the county;
- Expansion of the Directory of Services and clinical triage;
- Build on the KPMG work to foster collaboration between practices and enhance primary care resilience.
- Recruit to care home pharmacists roles and establish a locality based service
- Through the care model work identify and develop the services to be delivered through hubs
- Facilitate collaboration between practices through the development of cluster working.

**Social care offer**
- Development of greater community capacity to support people at home;
- A new integrated approach to prevention (universal preventative services, including health-related services);
- Digital Front Door and the First Point of Contact providing access to social care.
The Five Year Forward View for Mental Health sets out the ambition for the transformation of mental health services in England. Central to this is the integration of physical and mental health. We need to deliver better community support for those with severe mental illness including early intervention in psychosis, streamlined access to crisis service and support in the community to self manage before crises arise. For those with common mental health problems we need to expand access to psychological services.

Children and young people and perinatal mental health are priority groups where we need to ensure there is access to early intervention using evidence based treatments.

Mental health is a cross cutting theme in all our work streams. Population health work stream will support people to maximise their wellbeing and live healthier lives. We need to ensure that those with severe mental illness can access the support they need both on-going and when in crisis. This means that, for instance, our primary care and urgent care work streams need to have a response for the mentally ill hard wired into their offer.
### Outcomes and Benefits

- Reduced variation and health inequalities across all pathways to improve outcomes and maximise value
- Better quality of life and enhanced health and well-being
- Fewer crisis that lead to unplanned hospital and institution care
- Enhanced experience of care through better coordination and personalisation of health, social care and other services
- Improved patient experience
- Improvements in staff engagement and retention

### What work is the ICS currently doing?

The ICS is committed to partnership working, exploring the use of 3rd sector providers alongside the specialist mental health services. A new ‘all age’ MH strategy will be developed through 2018/19, based on the FYFVMH but setting the system wide vision for Mental Health services in our ICS.

**Children and Young People (CYP)**

Our transformation plan was published at the end of October, building on our original model established in October 2015 and more young people have been able to access the service year on year. Our plans for 2018/19 include further development of the training package, by widening access to parents and carers. We are developing a self-help resource, and reviewing the positive behaviour support offer to widen access to this support. The service has active engagement of service users and the voice of the young person continues to be of influence in service developments.
### What work is the ICS doing?

**Perinatal Mental Health**

Perinatal mental health services in Buckinghamshire are delivered by working closely with midwifery / health visiting and psychological therapy services to provide a blended and inclusive approach to service delivery. There are strong links with services in Berkshire (as successful implementers of transformational service change) and Oxfordshire as partners in the BOB STP, with a clear pathway in place developed with people that have lived experience of the condition.

**Mental Health Urgent Care**

Significant work has taken place to ensure parity of delivery, Buckinghamshire has a liaison mental health service on site at Stoke Mandeville hospital which is now operational 24/7 meaning that people receive expert treatment and support from a mental health professional, this service will continue to develop and be operating at ‘CORE 24’ standard in line with national ambitions.

### Our Priorities for 18/19:

- Development of an overarching mental health strategy across all age groups, to include;
- Increase access to evidence-based CAMHS interventions for 32% of young people who met the criteria by the 31 March 2019 in line with National Trajectory.
- Continue to implement new care models across the STP for specialist mental health services (forensic, CAMHS and Eating Disorders) to improve quality and reduce out of area placement by one third in this year.
- Increase access to perinatal mental health services
- Sustain delivery of the core 24 service
- Further develop responsive mental health urgent care pathway
- Extend access to IAPT services to a stretch target of 19.5%
- Implement physical health checks for patients with severe mental health
### ICS ambition for professional support services

The ICS recognises the essential role that our support services have in enabling delivery of our aim of providing the best services and outcomes for our residents. Through our tailored programmes, we will provide the expertise, guidance, and tools to support our staff to deliver and, to the residents of Buckinghamshire, to access and manage their care needs.

The transformation of health and social care systems is a complex programme of change which requires sophisticated methods and techniques for designing and implementing new care models which will deliver coordinated, integrated care.

We will work with the market to identify a strategic partner to support us in this work, so increasing our capacity and capability at pace.

Each of our support services within the system (HR/OD, IT, Finance, estates, and PMO) has a key role to play in supporting our programme of change and in developing the ICS business model which will underpin it in the future.

The purpose of transformation is to support better outcomes and ensure system sustainability so improving the health and quality of life for residents. A focus on professional support services within the system will create the infrastructure, architecture, skills, and capabilities which will enable the system to increase its cross-organisational efficiency whilst being adaptive to meet the future needs of the population into the next five years and beyond.
### Our approach to professional support services

- Maximising the use of the public estate to deliver integrated services and the most efficient use of the Bucks pound;
- Develop a system wide Programme Management office that is value based, flexible, effective and lean;
- Increasing support to professionals across the ICS to enable them to communicate and collaborate more efficiently by aligning our system delivery;
- IT interoperability and infrastructure fast track delivery of record sharing to support patient flows and improve outcomes;
- Increased effectiveness and efficiency of enabling services provided to the system;
- Improving capacity within the community and primary care workforce;
- Clinical Leadership and Engagement – tailored programmes to support identified leadership values, skills and behaviors within the ICS.

### Outcomes and benefits

- Buckinghamshire ICS is an employer of choice encouraging existing workforce to stay and develop their careers whilst attracting new workforce into the health and care system;
- Strong clinical engagement and leadership, utilising our clinical expertise to develop new service models;
- Improvement in our staff engagement scores;
- Implemented interoperability tools and services to improve efficiency, safety and the quality of care delivered across the Bucks ICS, providing the tools required to support integrated teams;
- Reduction of the risk associated with providing care without access to full patient records;
- Reduced administrative burden and duplication of processes;
- Increased programme/project support and oversight across the system ensuring consistent approach;
- Dedicated support to develop business cases to ensure return on investment and benefits realisation;
- Transform our estate to maximise integration opportunities;
- Implement capital investment to improve service delivery and working environment;
- Enhance our capacity to meet future demand;
- Increase percentage of estate used for clinical services;
- Reduce backlog maintenance and increase opportunities for disposal of unused estate.
## What work is the ICS currently doing?

As our most valuable asset our staff and their wellbeing are at the centre of all we do. We engage with our staff and their representatives to ensure we capture their views; to help inform our plans to ensure delivery of the ICS aims and objectives.

During the first quarter of 2018 we ran a clinical engagement programme attended by over 160 staff from across 40 organisations in Buckinghamshire. The feedback from the sessions was utilised to develop a clinical leadership strategy and inform the development of the clinical and care community senate. The senate will be a key enabler in the delivery of new models of care and in informing our workforce planning for the future.

We have already begun to use an approach to workforce development that considers the existing skill mix and takes different approaches to managing high demand areas such as using paramedics to undertake primary care home visits and support practice based urgent care, clinical pharmacists in primary care and care homes, and GPs supporting community based geriatric day assessment.

We are working with strategic partners to develop our workforce plans and in the development of our organisational development strategy to meet the changing needs of our staff and patients.

## Our priorities for 18/19:

- Develop and implement a system wide clinical and care community senate to provide clinical leadership and represent the wider “clinical voice”;
- Develop and launch leadership programme; supporting current leaders and developing leaders of the future;
- Development and implementation of an Organisational Development /Workforce strategy;
- Health Education England commissioned specific support for Bucks to model the future state workforce required for BITs. We have started with two clusters and will then apply this learning to the other eleven during 2018/19;
- Implementation of new service models to include: integrating the diabetes service across primary, acute and community care; continued roll out of care and support planning for people with long term conditions; developing care co-ordinator and primary care navigator roles; integrated respiratory service across primary, acute and community care.
**What work is the ICS currently doing?**

We have an agreed road map for the delivery of IT interoperability across the ICS and STP.

There a number of key enablers within the strategy to realise our vision – delivery of population health management and risk stratification to inform our service delivery; shared care records across the system and the introduction of technology to empower patients to more effectively manage long term conditions.

As an ICS we recognise the importance of being able to both understand our population health needs at a granular level to inform current service delivery and also the ability to complete predictive modelling of our future population segmentation and changing needs to inform our workforce strategy and models of care in the future. Our investment in digital solutions is supporting delivery of this requirement and will enable us to meet future population health needs.

Building on previous work which delivered a real time view of the Primary Care Record across the system, we are now implementing a number of tools/systems including a shared record which will provide access for health and care professionals to the information they need from all the key IT systems used across the ICS to deliver the best possible care. In addition, we are working to deliver person held records (PHR) to support the population in the management of their health and wellbeing and long term conditions with the aim of integrating this with an app to support Patient Self Triage, self-care and direct booking into Primary Care (online consultations).

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<th>Our priorities for 18/19:</th>
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<tbody>
<tr>
<td>• Implementation of the Graphnet Care Centric and Care flow systems to deliver shared care record across all care settings</td>
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<tr>
<td>• Connecting My Care Record in Buckinghamshire with Connected Care (Berkshire) to serve patients of GP practices in the South of the county accessing services in Berkshire</td>
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<tr>
<td>• Wider implementation of the EMIS Clinical Services solution to support integrated teams in accessing the records of their caseload across a defined group of GP practices with real time view of any activity within the registered GP practice and vice versa.</td>
</tr>
<tr>
<td>• Delivery of national requirements including the roll out of the Electronic Referral Service (ERS) and advice and guidance</td>
</tr>
<tr>
<td>• Implementation of the MyCare Centric Person Held Record and self triage, self care and direct bookings through the Sensely Ask NHS system.</td>
</tr>
</tbody>
</table>
| **What work is the ICS currently doing?** | We are establishing a system-wide shared ICS PMO function to support delivery of ICS priorities and the delivery of the transformation programme.

Our initial focus has been on:
- Creating a baseline opportunities and benefits assessment to enable the system to advance delivery;
- Working with programmes/projects to enable them to rapidly develop and enhance system delivery;
- Agree options and approach to support development of the ICS operating model;
- Agree the delivery mechanisms that support improved outcomes for our residents.

This is an ongoing development process and will continue to improve as we move through the process and lessons learned as well as identify and drive the delivery of outcomes and benefits supporting a better patient experience and ensuring best value for Buckinghamshire pound. |
| **Our priorities for 18/19:** | • We will continue to work with our system partners to agree ICS PMO objectives and priorities;
• Agree strategy on how to share PMO resource across the system;
• Develop and agree ICS PMO portfolio and framework structure across the system;
• Develop a streamlined governance process that supports programme delivery and decision making;
• Produce programme/project documentation requirements for key programme/projects and priorities;
• Review the current project tool (VERTO) and ensure fit for purpose. |
The models of care and service delivery we are planning will need a flexible and fit for purpose estate able to efficiently and effectively deliver the new ways of working.

As an ICS we actively participate in the Buckinghamshire One Public Estate programme which focuses on opportunities to maximize our public service estate to integrate services and drive efficiency. The ICS is working as part of the STP on an estates workbook to highlight opportunities, use our capital effectively and seek additional investment from NHS and other sources.

We have been successful in accessing capital funding through the STP to support our vision for integrated care. £4.2m to transform A&E on the Stoke Mandeville site and £8.8m to develop primary care hubs in the community to bring care closer to home.

In addition we are working with our partners in the third sector to ensure that we share resources to provide information, advice and guidance to our population across as wide an estate as possible.

<table>
<thead>
<tr>
<th>Our priorities for 18/19:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full business case and implementation of A&amp;E and primary care hubs schemes;</td>
</tr>
<tr>
<td>• Continue developing the Bucks One Public Estates programme seeking opportunities for joint working and estates development across the ICS;</td>
</tr>
<tr>
<td>• Submission of estates workbook and priorities as part of the STP Estates Strategy by July 2018;</td>
</tr>
<tr>
<td>• Transfer a GP practice onto the Wycombe hospital site next to the Urgent Treatment Centre to enhance patient experience and support integrated care;</td>
</tr>
<tr>
<td>• Implement in-year plans to integrate services, reduce backlog maintenance, enhance opportunities for disposal and increase the efficiency of our estate.</td>
</tr>
</tbody>
</table>
SECTION 5

Finance and Activity
The 2017/18 ICS system deficit versus control total (“CT”) reported is £28.6 million. This is made up of:

- CCG £19.2m (community stock moved out of risk and into FOT)
- BHT £9.4m after receipt of £2.5m of STF from general distribution
- The drivers of this deficit in terms of outturn are shown on the next few slides

<table>
<thead>
<tr>
<th></th>
<th>Control total 17/18 £m</th>
<th>Actual 17/18 £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT</td>
<td>6.5</td>
<td>(2.9)</td>
<td>(9.4)</td>
</tr>
<tr>
<td>BCCG</td>
<td>0.1</td>
<td>(19.1)</td>
<td>(19.2)</td>
</tr>
<tr>
<td>2017/18 actual control total</td>
<td>6.6</td>
<td>(22.0)</td>
<td>(28.6)</td>
</tr>
</tbody>
</table>

The ICS underlying deficit exiting 2017/18 is £38.6 million (CCG £32.6m & Trust £6.0m).
### Section 5: BHT variance to control total – key drivers

<table>
<thead>
<tr>
<th>Description</th>
<th>BHT £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT 17/18 control total</td>
<td>6.5</td>
</tr>
<tr>
<td>STF not earned</td>
<td>(5.9)</td>
</tr>
<tr>
<td>CIP delivery shortfall</td>
<td>(4.6)</td>
</tr>
<tr>
<td>Gross over performance on Buckinghamshire CCGs of £13.0m at assumed margin of 20%</td>
<td>2.6</td>
</tr>
<tr>
<td>MRET above plan / contract assumption</td>
<td>(1.6)</td>
</tr>
<tr>
<td>Risk share per the contract</td>
<td>(1.4)</td>
</tr>
<tr>
<td><strong>Loss on additional activity</strong></td>
<td>(0.4)</td>
</tr>
<tr>
<td>Under performance of £2m on other contracts at assumed margin of 20%</td>
<td>0.4</td>
</tr>
<tr>
<td>Non recurrent costs of £2.0m less contingency in plan of £2.0m</td>
<td>-</td>
</tr>
<tr>
<td>Premium costs of temporary staffing (M9 extrapolated)</td>
<td>(2.1)</td>
</tr>
<tr>
<td>Other mitigations delivered by the Trust</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>2017/18 forecast outturn reported at month 9</strong></td>
<td>(3.2)</td>
</tr>
<tr>
<td>Elective cancellation and loss of spinal income</td>
<td>(1.2)</td>
</tr>
<tr>
<td>Additional MRET and contractual risk share</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Escalation costs</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Backlog remediation costs</td>
<td>(0.4)</td>
</tr>
<tr>
<td>PFI legacy costs</td>
<td>(0.6)</td>
</tr>
<tr>
<td>Year end adjustments</td>
<td>0.7</td>
</tr>
<tr>
<td>STF General distribution</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>2017/18 outturn</strong></td>
<td>(2.9)</td>
</tr>
</tbody>
</table>
CCG outturn is £19.1m deficit (which is £19.2m variance to CT). The 5 main reasons are:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Plan and Unscheduled Care-main contracts</td>
<td>17.4</td>
</tr>
<tr>
<td>2</td>
<td>Plan and Unscheduled Care-other</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Sub total</td>
<td>21.9</td>
</tr>
<tr>
<td>3</td>
<td>CHC</td>
<td>11.5</td>
</tr>
<tr>
<td>4</td>
<td>Prescribing</td>
<td>2.1</td>
</tr>
<tr>
<td>5</td>
<td>Joint Care</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>Sub total</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>Reserves/Recovery Plan/Other</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>Sub Total Mitigations</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>Movement</td>
<td>19.2</td>
</tr>
</tbody>
</table>
The focus in 2018/19 will be on improving BHT operational productivity (1), joint working to deliver system Financial Recovery Plan (“FRP”) (2) and (3).

1. **BHT**
   - Target c.£20m

2. **System pathways**
   - Focus on system priorities
     - e.g. Frail Elderly, MSK, Diabetes

3. **System wide initiatives**
   - Focus on improving healthcare across the Buckinghamshire system
     - e.g. Cost of Care, Integrated Care, CHC, PC Resilience

**System-Wide Shared PMO**
An aligned system approach is required to recover a sustainable position and the ICS will explore a:
- jointly owned demand and activity plan, based on population forecasts and recent experience;
- jointly owned transformation and service plan that can handle the activity forecast;
- jointly owned capacity plans for primary care, community care and acute services;
- joint system-wide management of activity.

In 2018/19 the system will work to the following financial governance principles:
- Review all discretionary spend and investments;
- Mandatory requirements will be subject to robust business case and outcomes based decision making;
- Review headcount and vacancies ensuring appropriate to business need;
- Review and implement NHS England’s investment decisions guidance;
- Support repatriation of out of county activity to Buckinghamshire Healthcare NHS Trust whilst ensuring patient choice.
The ICS is planning a two year recovery trajectory to achieve its system control total. For 2018/19 it is looking to recover the deficit to a position of £17.5 million (from an underlying deficit exiting 2017/18 of £38.6 million)

<table>
<thead>
<tr>
<th></th>
<th>17/18 Plan £m</th>
<th>17/18 Actual £m</th>
<th>18/19 Plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCG</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>680.4</td>
<td>684.1</td>
<td>694.3</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(680.4)</td>
<td>(703.2)</td>
<td>(709.8)</td>
</tr>
<tr>
<td>Deficit</td>
<td>0.0</td>
<td>(19.1)</td>
<td>(15.5)</td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>398.9</td>
<td>412.6</td>
<td>410.0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(401.0)</td>
<td>(399.1)</td>
<td>(412.0)</td>
</tr>
<tr>
<td>Deficit</td>
<td>(2.1)</td>
<td>(2.9)</td>
<td>(2.0)</td>
</tr>
<tr>
<td><strong>ICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deficit excluding Provider STF of £11.9m</td>
<td>(2.1)</td>
<td>(22.0)</td>
<td>(17.5)</td>
</tr>
</tbody>
</table>
### Section 5: Savings required to deliver an £17.5m ICS deficit in 2018/19

<table>
<thead>
<tr>
<th>Description</th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG allocation</td>
<td></td>
<td>694.3</td>
</tr>
<tr>
<td>BHT income per 8&lt;sup&gt;th&lt;/sup&gt; March submission (to be updated for final planning submission) - NB excludes 24/7 income of £7.0m</td>
<td>423.6</td>
<td></td>
</tr>
<tr>
<td>Less BHT income from Buckinghamshire CCG - NB excludes 24/7 income of £7.0m</td>
<td>(253.1)</td>
<td></td>
</tr>
<tr>
<td>BHT external income</td>
<td></td>
<td>170.5</td>
</tr>
<tr>
<td><strong>Total Buckinghamshire ICS income</strong></td>
<td></td>
<td><strong>864.8</strong></td>
</tr>
<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt; March planning submission ICS savings requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHT</td>
<td></td>
<td>20.0</td>
</tr>
<tr>
<td>CCG</td>
<td></td>
<td>21.4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>41.4</td>
</tr>
<tr>
<td><strong>Savings as a percentage of total income</strong></td>
<td></td>
<td><strong>4.8%</strong></td>
</tr>
</tbody>
</table>

**Note:** Demand Management savings of £41.4m across the ICS (4.8%)
## Section 5: Combined savings plan for the partners within the ICS

<table>
<thead>
<tr>
<th>Category</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC</td>
<td>7.2</td>
</tr>
<tr>
<td>Urgent and emergency care demand</td>
<td>3.4</td>
</tr>
<tr>
<td>Elective</td>
<td>1.5</td>
</tr>
<tr>
<td>Acute Operational Productivity</td>
<td></td>
</tr>
<tr>
<td>Model Hospital specialties</td>
<td>11.0</td>
</tr>
<tr>
<td>Back office</td>
<td>1.9</td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td>2.5</td>
</tr>
<tr>
<td>Procurement</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>1.9</td>
</tr>
<tr>
<td>ICS Prescribing (including BHT prescribing)</td>
<td>2.5</td>
</tr>
<tr>
<td>Contract management, budgetary control measures, holding investments</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£41.4</strong></td>
</tr>
</tbody>
</table>
Work with ICS system partners to deliver integration of services to increase efficiency and reduce level of cost/activity across the system to cover:

- Integration and transformation of urgent and emergency care services to increase utilisation of existing capacity and reduce demand for hospital acute care (A&E, GP streaming, 24/7);
- Integration and transformation of primary and community care to build capacity and provide care closer to home;
- Work with GPs to reduce clinical variation in planned care through clinical pathways in areas such as diabetes, MSK and Long Term Conditions linked to Rightcare and GIRFT;
- Collaborative work between BCCG Medicines Management and BHT Pharmacy to reduce prescribing spend;
- Strengthen control over authorisation of NHS CHC expenditure in line with eligibility criteria and review historic cases and work with BCC as a system to manage CHC market;
- Identify efficiency opportunities from changes to system ways of working to reduce running costs;
- BHT to deliver efficiencies and cash savings from the transformation above.

BHT to identify and BCCG to facilitate opportunities to repatriate BCCG activity from out of county and/or increase market share from out of county CCGs.
Improve BHT **Operational Productivity** as measured through the Model Hospital

- Delivery of 2018/19 cost improvement plan of £20m;
- Demonstrate clinical productivity improvements through adoption of best practice and reducing clinical variation through GIRFT;
- Deliver efficiencies across the procurement and back office functions, pharmacy and pathology services;
- Deliver benefits in the wholly owned subsidiary pharmacy business case;
- Deliver progress on hospital optimisation of medicines and transition to use of biosimilars;
- Deliver cost effective estates management, human resources and finance functions as evidenced through benchmarking;
- Deliver reduction in estates and facilities running costs;
- Delivery of cost improvements and control surplus to allow repayment of Trust borrowings.
Deliver **Capital** plan that reduces system backlog and invests in our clinical estate

- Manage risk in capital backlog (Medical equipment, IT and estates);
- Develop strategy for investment in estates backlog work;
- Secure access to NHSI/NHSE additional capital funding for digital transformation (Global Digital Exemplar, e-prescribing, GS1);
- Drive IT Interoperability with Buckinghamshire CCG (“BCCG”) through Careflow implementation;
- Implement E-Observation system funded by BHT Charitable Funds across all wards by end of March 2019;
- Outline Business Case (“OBC”) Primary Care hubs development to be approved by BCCG Governing Body in June 2018;
- Outline Business Case for A&E Phase 2 development of £4.2m to be approved by BHT Board in March 2018 to implement prior to 2018/19 winter.
SECTION 6

Closing Statement
Section 6: Closing Statement

1. **National Priorities**
   - Primary Care
   - Urgent and Emergency Care
   - Mental Health
   - Cancer

2. **ICS Pillars**
   - Population Health
   - Integrated Care
   - Five Year Forward View (FYFV)

3. **Professional Support Services**
   - IT Interoperability
   - OD/Workforce
   - One Estate
   - System wide-PMO
   - Communication and Engagement
   - Finance

Change needs to happen as close to people as possible, putting the person at the centre of what we do. This is why local relationships are the basis of our plans; moving from traditional cultures to embracing a transformational system approach, where we help each other to better deliver continuous improvement;

Community Service Hubs will bring social, physical and mental health care closer together and local health and care partnerships will come together to deliver care where council and NHS commissioners plan and pay for services together;

We are committed to meaningful conversations with staff and communities and we will continue to engage people in the design, development and delivery of our plans;

Housing, employment and access to green spaces can have the biggest impact on health. Local government has a key role to play and health research is helping us to target those people at risk.
We must balance the social, physical, and mental health care against a financial deficit while meeting operational needs creating long term sustainability and maintaining investment in people.

We will invest in the development and skills of our workforce to enable them to provide the best possible care. We have produced a plan to achieve this which also covers recruitment and retention.

The financial challenge we face is the biggest in a generation. Our response is around getting the best value from every Buckinghamshire pound. We will also be very open about the choices we have to make to live within our means.

Over the past twelve months our partnership has made major strides towards working together to improve social, physical and mental health care.

What will this all mean:

- Buckinghamshire people supported to live independently
- Care integrated locally to provide a better support closer to home
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs.

‘Everyone working together so that the people of Buckinghamshire have happy and healthy lives’
SECTION 7
System Partners
The ICS Integrated Operations Plan consolidates the transformation and operations plans from across the system. These plans are referenced below:

- BHT Ops Plan
- Buckinghamshire CCG Ops Plan
- BHT Clinical Strategy
- SCAS Ops Plan
- BCC ASC Strategy
**Buckinghamshire Integrated Teams** is a team of health and care professionals working together transforming, integrating and improving care services and support.

**Business Intelligence** comprises of the strategies and technologies used by industry for data analysis or business information. Business Intelligence technologies provide historical, current and predictive views of business operations.

**CareCentric** is a clinical portal which opens up the electronic health record to authorised users on smartphones and tablets. It gives care professionals access to patient data wherever they need it, whether at various locations within a hospital or GP practice, at other hospitals, in the community or at home.

**Careflow** is a communication platform available on any mobile or web device delivering faster clinical communication, better collaboration and safer care.

**Clinician** is someone whose prime function is to manage a sick person with the purpose of alleviating the total effect of the persons illness.

**Commissioning** is the process of procuring health services. It is a complex process, involving the assessment and understanding of a population's health needs, the planning of services to meet those needs and securing services on a limited budget, then monitoring the services procured.

**Continuing Healthcare** is the name given to a package of continuing care which is, arranged and funded solely by the NHS, for people with ongoing healthcare needs who meet the national NHS continuing healthcare eligibility criteria.
Egton Medical Information Systems (EMIS) supplies patient electronic records and software.

Frailty is related to the ageing process, that is, simply getting older. It describes how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment. In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care.

Integrated Care also known as integrated health, coordinated care, comprehensive care, seamless care, or transmural care, is a worldwide trend in health care reforms and new organisational arrangements focusing on more coordinated and integrated forms of care provision.

Interventions is an effort that promotes behaviour that improves mental and physical health, or discourages or reframes those with health risks, as part of a public health promotion program.

Memorandum of Understanding is an agreement between two (bilateral) or more (multilateral) parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

Person Held Record is a health record where health data and information related to the care of a patient is maintained by the patient.

Planned Care are health services and treatments that are not as a consequence of a health accident or emergency. This type of care is arranged in advance and, generally, follows a referral from a GP.
Population Health is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes.

Population Segmentation is based on identifying segments of the population whose needs could be better met in delivering benefit against the quadruple aim. Often this will initially be based on a presenting problem, e.g. fall, but behind the presenting problem will be a more complex set of health and well-being needs that need to be more fully understood to enable better care and support models to be developed and delivered.

Reablement is the service usually provided to people for up to six weeks to encourage them to achieve their goals and to be as independent as they can be.

Social Prescribing sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.