Future Integrated Care Systems: Getting Primary and Community Care Reform Right

The future of the NHS depends upon how we deliver change and how we bring people into it

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Let's start with Joan’s story

Please note that this story is sourced from a combination of real patient scenarios gathered from clinicians and use of datasets. Names and facts have been altered for patient confidentiality. The main purpose of this case study is to highlight the opportunities for improving care in the current system

Missed opportunities to act earlier

Epilepsy, Diabetes, Hypertension

Lives alone with pet cat. Daughter in Manchester, keeps in touch by phone

Was an active local community centre member until she found walking there too tiring

Joan is under multiple specialist teams, community diabetes, neurology (epilepsy), virtual CKD clinic, specialist respiratory nurse.

Respiratory nurse has mentioned to the GP that Joan may be becoming **DEPRESSED**

Joan has hypertension and diabetes and is supported by local GPs predominantly apart from attendance in neurology clinic.
Due to her not feeling too well, she has significantly reduced her work in local community.
She doesn't have an identified goal and a plan

Oct 2022

COPD
Experiences breathlessness
Attends A&E, diagnosed with acute exacerbation of COPD

Observation ward
Total LOS = 12 days for CAP

Whilst at the hospital she developed Acute kidney injury

Oct - Dec 2022

Multiple apts with specialists and nursing teams

GP	Diabetes	Neuro
x12	x1	x2

Diabetes	Respiratory	Nephro
x1	x1	x2

Hospital apts with specialists

Feb 2023

Fall
Fall in public shopping mall due to a postural drop.
Member of public called 999

Admitted to hospital
LOS = 4 days for investigation;
Discharged with care plan

Feb - Dec 2023

Multiple apts with specialists and nursing teams

GP apts	Diabetes	Neuro
x28	x2	x2

Diabetes	Respiratory	Nephro
x2	x1	x4

Hospital apts with specialists

Jan 2024

Diabetic coma
Joan is admitted to hospital with a hypoglycemia

Observation ward;
LOS = 2 days
Discharged to GP

Why didn't we preempt & act

Far too many 'boxed' clinical appointments

Did we address the real issues?

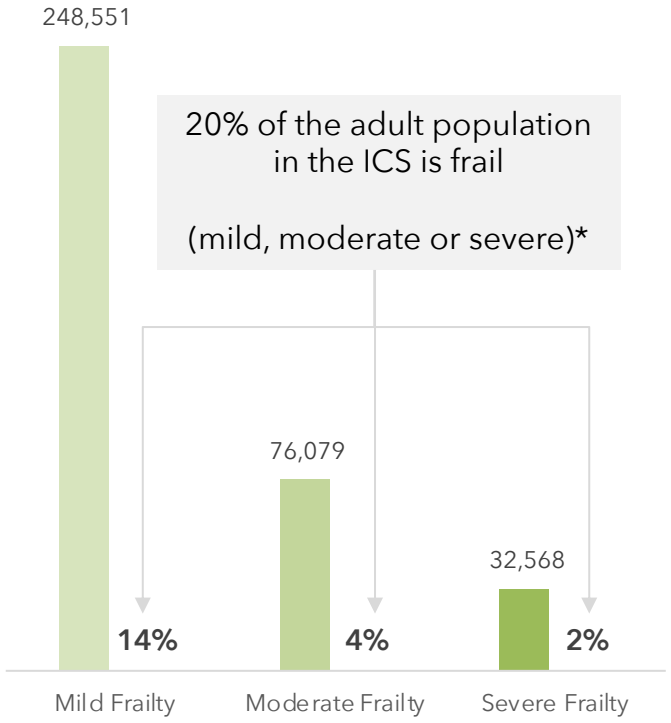
Missed opportunity

To sum it all, Joan's case shows how we as a system could be far more efficient in providing coordinated and meaningful care

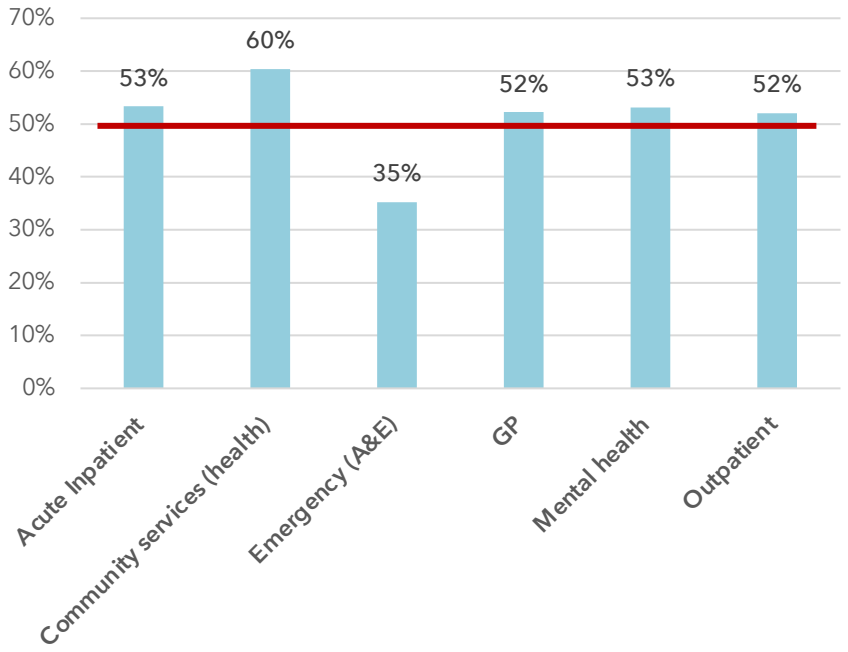
And over half of our admissions come from 'Joan'

This data is from a sample ICS

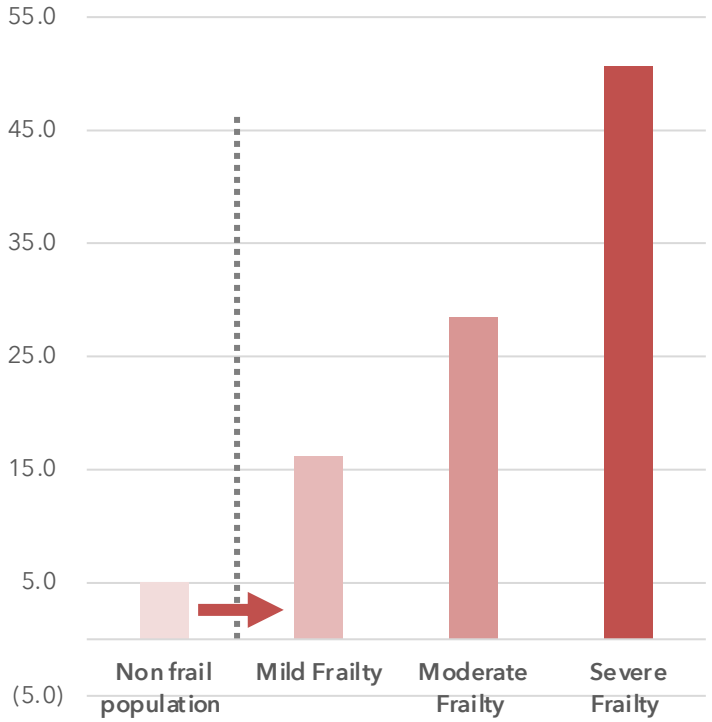
ICS population frailty composition



Utilisation of ICS services by those that are frail (mild, moderate, severe)



ICS Per capita utilisation index



70% of frail population is mild frail.

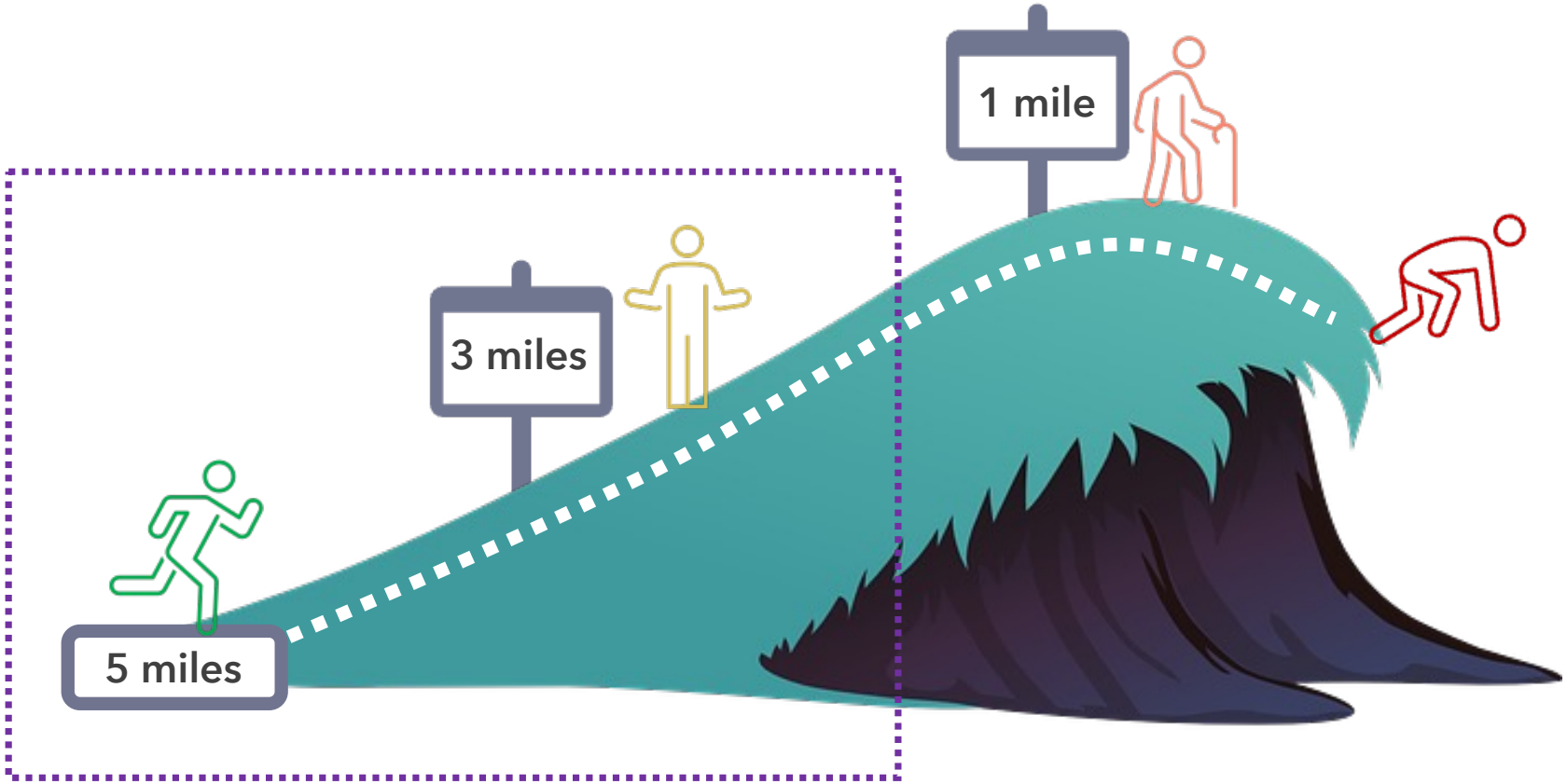
A big opportunity to mitigate growth in demand in future and improve outcomes.

Over 50% of all services (except A&E) were utilised by those who are frail.

Over half of that utilisation is by 6% of the population (severe / moderately frail).

Utilisation index increases more than 200% as people move from non frail to frail segment.

Why would we allow this to happen?



The rhetoric does not reflect reality on the ground

Rhetoric

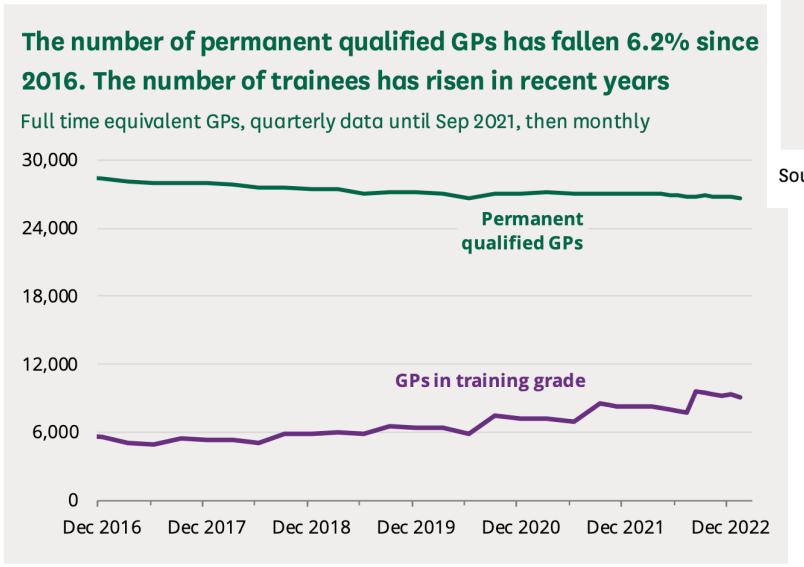
Long term plan

.. properly joined-up care at the right time in the optimal care setting.

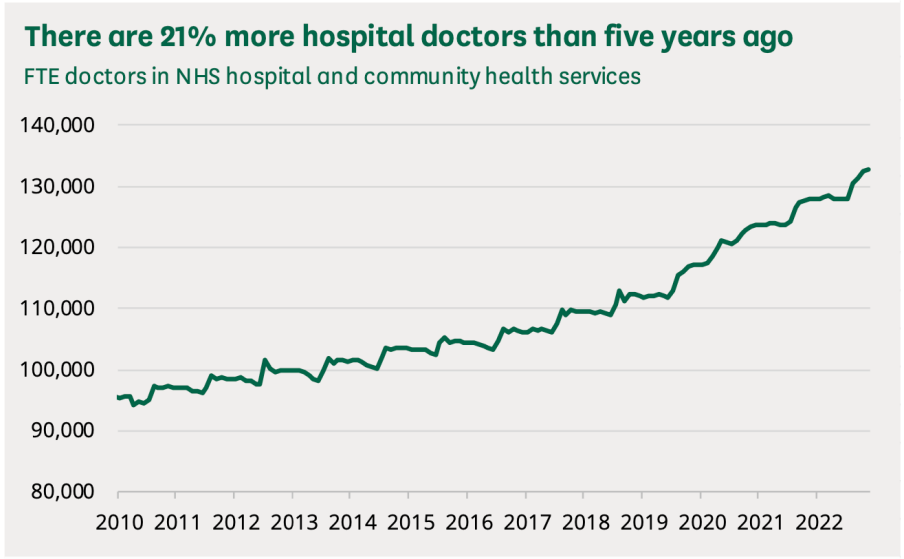
Current workforce pressures will be tackled, and staff supported.

Focus on preventive and proactive care, including focus on community care

Reality



Source: NHS Digital, General Practice Workforce January 2023, Bulletin Tables



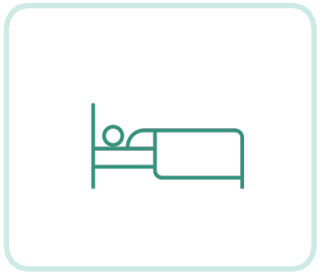
Source: NHS Digital, NHS Workforce Statistics November 2022, England and Organisation

Community development remains a notion, most of our resources are tagged to reactive care

The system is passively creating a second pandemic

20-30% of hospital admissions are avoidable

Frailty and growing socio-economic complexities



We have failed our workforce, and the result is low morale, and change fatigue.
We are reorganising our house yet again

In 2023-24, 14/42 integrated care systems (ICSs) forecasted a combined deficit of £650m according to NHS England's chief finance officer.
The NHS is bursting at its seams.

Nationally 13,000-15,000 (Feb 23) people are remaining in hospital beds each day with no clinical reason to stay in hospital
The resulting impact on our patients through deconditioning is unforgiving

The determinants of health outcomes are largely lifestyle and socio-economic (e.g. obesity and deprivation)
And we do not have a medicine to fix them

NHS cannot do this alone

(We know that) .. but where we fail is to create the right environment for organisations to come together without baggage, a freedom for frontline to work for people / patients without historical contract led chains and for us to be brave and do it at scale

Can a genuinely collaborative model can change things for Joan?

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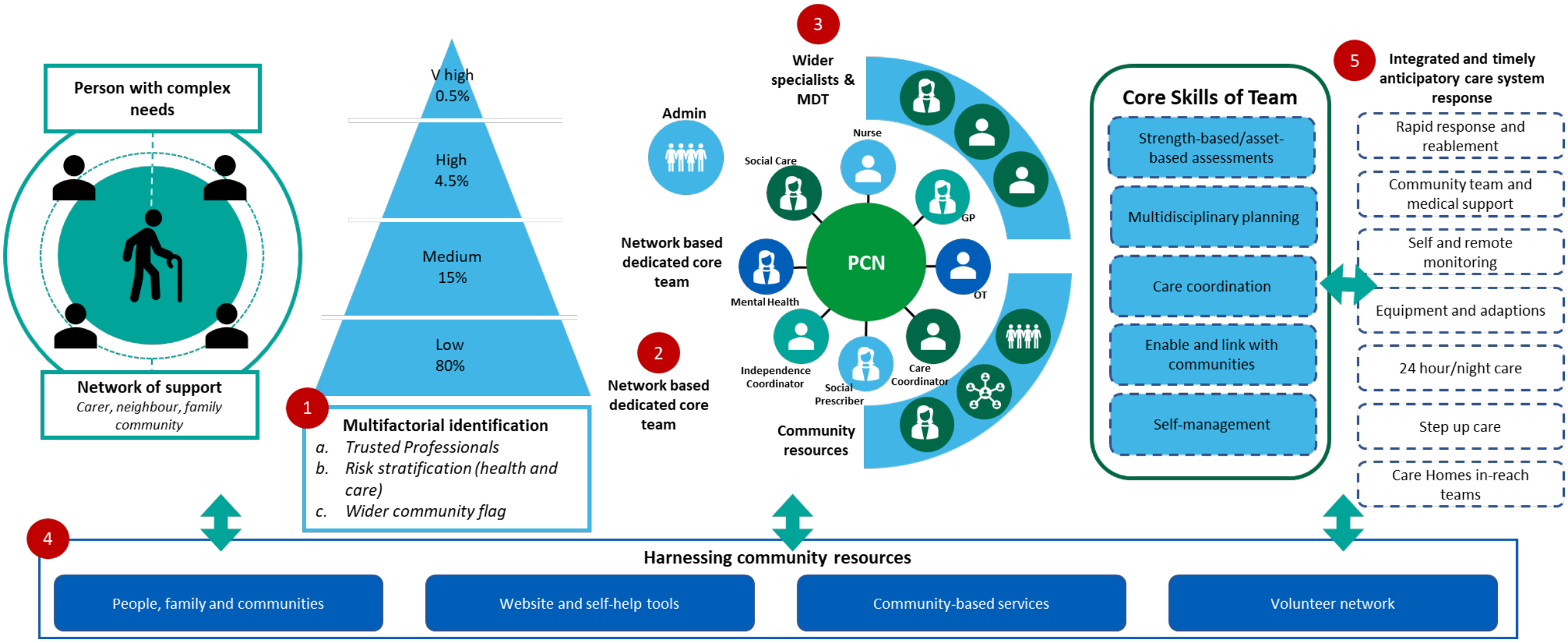
Pulling together to deliver a new normal

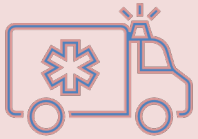


This example is how a locality worked together to go beyond the current rhetoric.

What this delivers for the population

In one year …

54% reduction in non-elective admissions



25% reduction in GP appointment

Improvement in both patient and staff experience

And the impact continues till date …

We will need these many similar collaborative models at locality level to free beds and resources to support elective recovery, support those who are end of life and complex and divert resources towards improving resilience within communities

What could Joan's life look like?

- Multiple LTCs & Hypertension
- Not feeling well, paused voluntary community work
- Respiratory acute episode & diagnosis of COPD
- Fall in supermarket and loss of confidence + optimism

- Joan's confidence in managing her health improves
- Reduced number of appointments and admissions
- Due to better controlled breathing, resumes community centre activities and as a result Joan's mental health drastically improves

POPULATION HEALTH TRIGGER

Identification of Joan: escalating risks with unmanaged recurrent exacerbations and recent fall.

GP refers Joan to complex care hub

INTEGRATED NEIGHBOURHOOD TEAM

- ✓ Biopsychosocial assessment
- ✓ Holistic care planning
- ✓ Digital self-care tools
- ✓ Wellbeing lounge

COORDINATED CARE & CONNECTIVITY WITH WELLNESS NETWORK

- Care lead takes ownership of coordinating care holistically and liaises with PCN MDT
- Speaks with Digital Hub to install equipment and educational package for Joan to access Telehealth services and support self-care
- Notices Joan is feeling depressed and arranges support from voluntary mental health services and connects her to wellbeing network

Joan feels her mental wellbeing improve and feels more in control and is referred back to her **PCN MDT & GP**

JOAN'S LIFE IN THE NEW WORLD

Regular check-up with GP twice a year

Group consultations for diabetes

Virtual consultation meetings with clinicians

Member of COPD peer support network

Joins local church choir

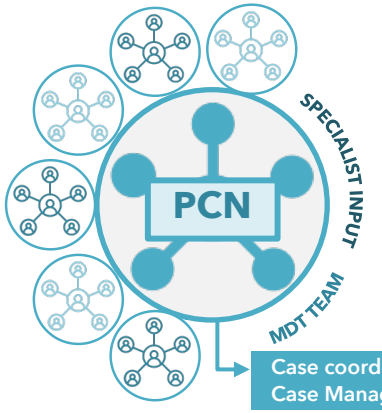
Resumes volunteering at community centre

Connected to local walking group

Continued meetings with social prescriber quarterly

Monitors own health using digital self-management tools

Telehealth, Telecare, Telemedicine e.g. Gait analysis



- ✓ Continued maintenance support from PCN based MDT
- ✓ Practice based social prescriber

We cannot depend upon goodwill of our frontline
We need to trigger changes at level of
Policy, Power and Permission

What do we need to do?

What is the mandate?

Depoliticise
Whatever we decide as an NHS strategy, including its logical steps going forward for the people that we serve, must be agreed and adopted by all parties so that the direction is sustained across parliaments.

Demedicalise
The impactable determinants for ill-health are largely social or lifestyle generated. NHS will have to work with local authorities (incl public health) and local communities.

To do that, we need to go beyond the usual rhetoric of 'integration and collaboration', be clear on what that means and right create the environment – policy, power and permission

Agency and accountability at the right level

Create agile adaptive systems with shared accountability of funds

DEVOLVE

- Devolve joint health and social care budget to local level (Place and locality) in stages
- Create power, leadership and accountability at locality level with inclusion from people
- Enable agency and accountability at the right level (when everyone is responsible, no one is responsible)

Define the locality ecosystem

DEFINE

- Real clarity on what it means at a practical level
- How and why would partners within a locality work differently.
- Set expectations and commitments
- Understand your resources and how they could be utilised best

One step at a time – it is a ten-year commitment

DELIVER

- Clear roadmap for delivery – a number of strands
- Staged delivery with learnings from establishing localities
- Embed a learning and development culture, with quality improvement cycles.

The real question is – how do we devolve power to people who deliver

There is no other way to generate ownership, interest and accountability

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