APPENDIX TWO

#BecauseWeCare
Cheshire East Partnership

Cheshire East Corporate Policy Committee

03/10/2024

Care Communities Operating Model

#BecauseWeCare
Cheshire East Partnership

Date of meeting:	03/10/2024
Agenda Item No:	
Report title:	Care Communities Operating Model
Report Author & Contact Details:	Anushta.sivananthan@nhs.net
Report approved by:	Strategic Planning and Transformation

Purpose and any action required	**Decision/ Approve** →	**x**	**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	

Committee/Advisory Groups that have previously considered the paper
Care Community development group Strategic Planning and Transformation Place Leadership Group

Executive Summary and key points for discussion
This is a proposed model for improving population health and reducing health inequalities by strengthening the governance, functions and autonomy of our Care Communities (integrated neighbourhood teams). Using our population health data, the team (of existing teams) will "segment" the population and use a biospychosocial model to improve outcomes, ensuring a more targeted and coordinated approach for those with the most complex needs and highest inequalities. There will be a requirement for services to move to alignment to the Care Communities, with a view to offering improved consultation and advice via multidisciplinary team support. The teams are grounded in their neighbourhoods/communities and will ensure that the community and community assets are integral to any health, wellbeing and care offer.

Recommendation/ Action needed:	1. Partners to take the document back to their own organisations (including clinical leaders) to understand impact and changes that maybe required in how colleagues will work. 2. Undertake the further work that is required - especially financial modelling, use of population health data (CIPHA), wider engagement within organisations and the public. 3. Confirm details and phased piloting of the model from April 2024

Which purpose(s) of the Cheshire East Place priorities does this report align with?	
Please insert **'x'** as appropriate:	
1. Deliver a sustainable, integrated health and care system	X
2. Create a financially balanced system	X
3. Create a sustainable workforce	X
4. Significantly reduce health inequalities	X

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e., date, method, impact e.g., feedback used)
	Financial Assessment/ Evaluation		X		There is currently an ongoing piece of work by CFOs to understand the financial impact.
	Patient / Public Engagement		X		Further work via the Comms workstream is required to get improved patient and public engagement.
	Clinical Engagement	X			There is engagement with health provider partners, social care, Local Authority communities team, Public health, Place ICB, Healthwatch and VCSFE. Further work is required after approval in principle of the operating model, to engage wider. The Care community operating model is a key component to delivering the Cheshire East System Blueprint. The model is based on the Fuller stocktake, published last year.
	Equality Analysis (EA) - any adverse impacts identified?		X		Health equity and reducing health inequalities has been central to the development of the model.
	Legal Advice needed?		X		
	Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External)	X			Internal place governance oversight and input.

Next Steps:	All organisations will need to take the proposed operating model through their Boards and their clinical/professional structures to consider impact. Understand the financial modelling/impact. Undertake wider engagement. Confirm details and phased piloting of the model.

Responsible Officer to take forward actions:	Anushta Sivananthan, Joint Medical Director, Cheshire and Wirral Partnership NHS FT Mark Wilkinson, Cheshire East Place Director

Appendices:	Operating model

Operating model for Care Communities

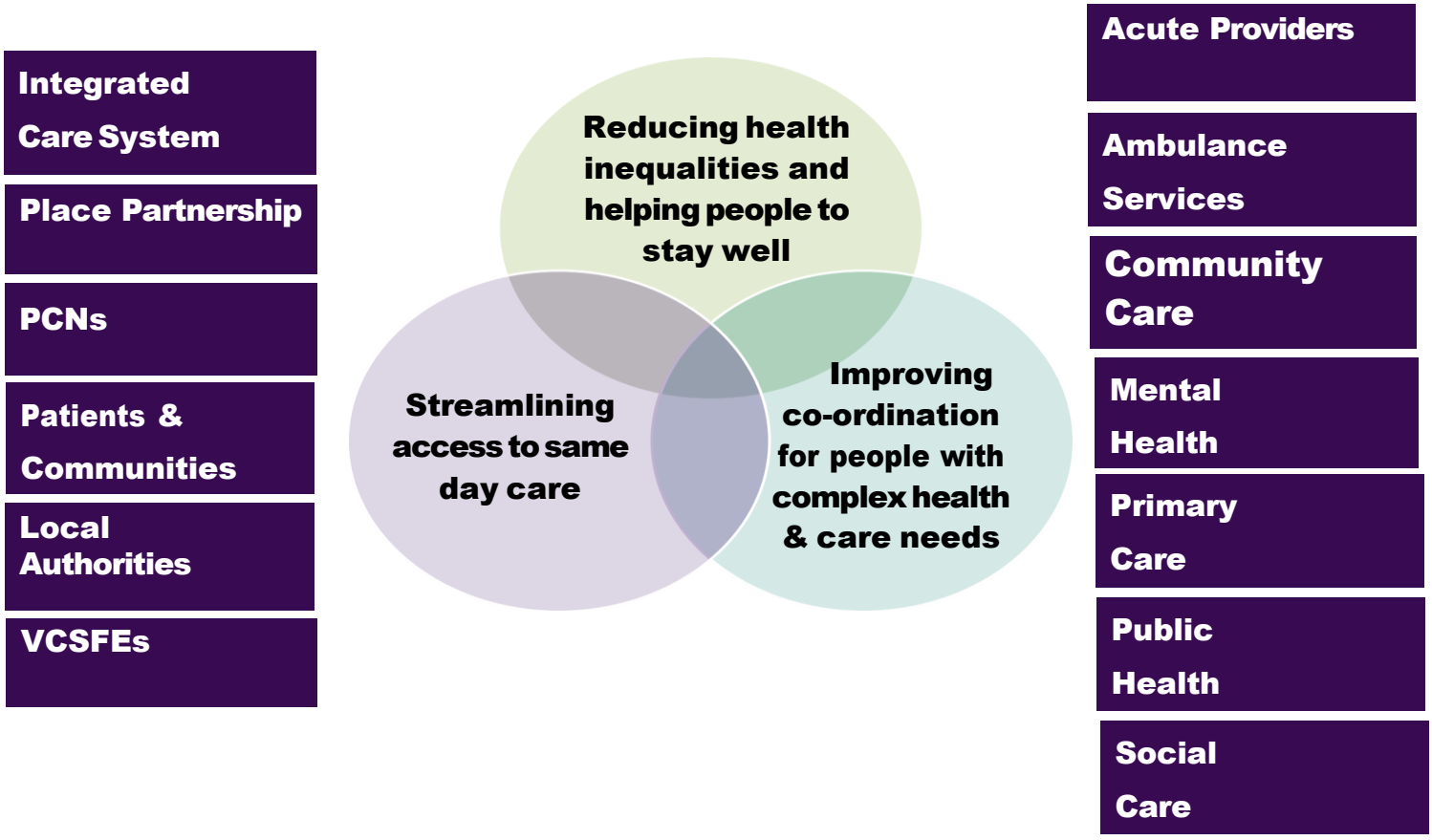
"At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations"
Fuller Stocktake

Introduction

Care communities are geographically aligned, local teams of individuals drawn from general practice, community health, mental health, acute trusts, social care, the VCSFE, local Healthwatch, optometry, dentistry, and community pharmacy to focus on the local population's health and well-being and their needs; helping people to stay in good health for longer (population health)

The concept of the Care Community is to support people to be in good health and when needed, to arrange care, interventions and provide innovative personalised solutions. These solutions will be co-delivered and co-produced in partnership with the local community, drawing on local assets and engaging with services wider than traditional health and care (eg housing, police, fire & rescue, schools).

Working in partnership is the fundamental principle to delivering not only a successful Care Community but a community that cares. The Care Community is a "team of teams" based on a registered population footprint.

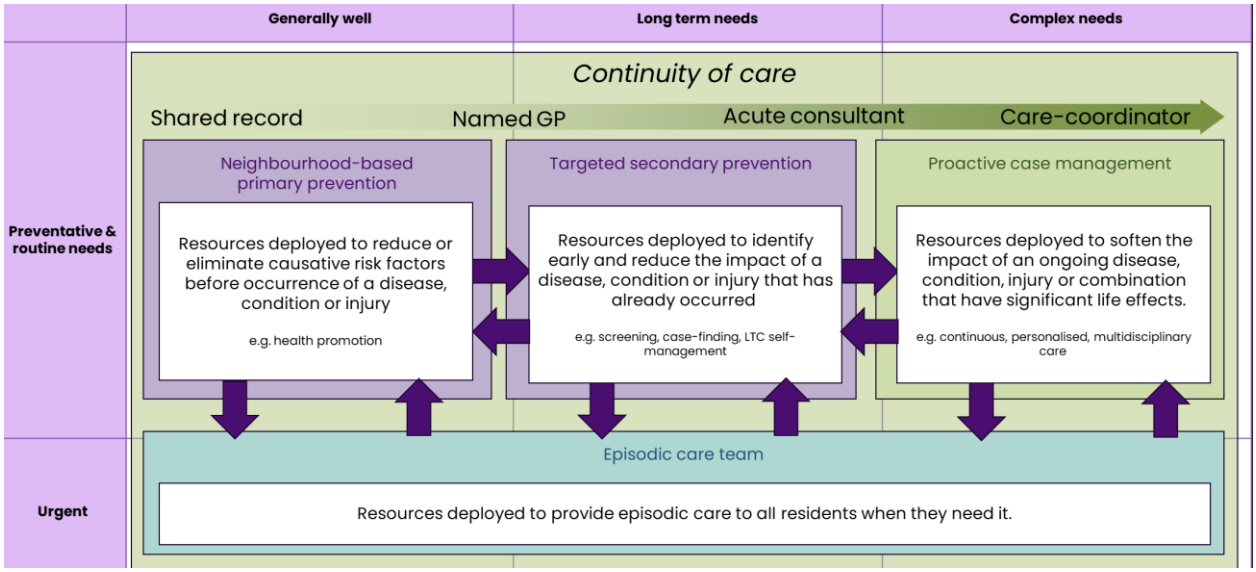


Characteristics of a Care Community

The Fuller Stocktake identified several key enablers - “conditions for success”.
These included:

- A more psychosocial model of care and a more holistic approach to the health and wellbeing of a community, with “teams of teams” rooted in a sense of shared ownership.
- Realignment of associated resources, for example, aligning community health services and secondary care specialists to neighbourhood teams.
- An improvement culture and a safe environment to learn and experiment, with support to PCNs to play their part in innovation and transformation of local services.
- A shared, system-wide approach to estates with a “one public estate” approach to development.
- Data and digital infrastructure that enables information about patient care to be appropriately shared.
- Locally-led investment and support with a firm understanding of current spending distribution across primary care, weighted by deprivation and other elements of the Core20PLUS5 approach.
- A high-quality and sustainable model of primary care delivery within the existing GP contract.

Model of delivery of Care Communities



Membership of Care Communities

Whilst local teams and local people are all key to delivering a successful Care Community, a core group of individuals made up of colleagues from each of the partner organisations will be central to decision making within their Care Community. The “core team” will be named individuals, from services within the Care Community, have a commensurate level of autonomy for decision making and play an active role in developing elements of the Care Community.

The Core Team will continually seek to build relationships within the Care Community, understand the skills and experience of colleagues within the local areas and deliver on building stronger integration to deliver improved population health.

The core team will operate within the principles of equal voice, equal value and equity in driving forward improvement actions determined by the group. The core team will meet regularly, with frequency determined by the team.

Each of the core team members will take on leadership roles for innovation and change within their respective area. The team members will focus on the population health status of the whole population, be collaborative, offer people using services access to information and be allowed to invest where they see improvements in population health.

Local Innovation and Decision Making Core group:

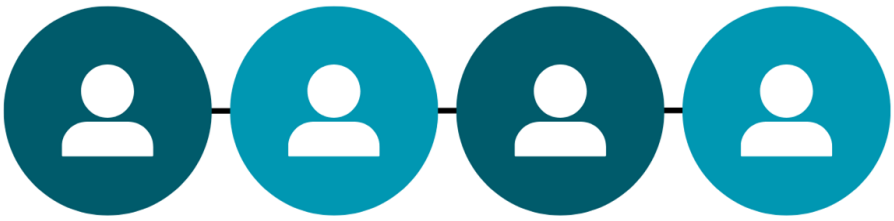
- Primary Care Network Clinical Director
- Care Community Clinical Lead
- Coach / Service Manager
- Social Care
- Public Health
- CWP Mental Health
- Healthwatch
- VCFSE

Wider members of the Care Community should include local councillors, other Local Authority links, operational support from health and care services, Police, Fire and Rescue and local housing providers. This list is not exhaustive and Care Communities will have other members of their communities with whom they would wish to engage. Care Communities will engage their populations and find ways to connect with their entire communities using the assets that are available locally.

Local secondary care providers should align clinical leaders within their organisations to each Care Community to ensure effective pathways of care between primary and secondary care, and move to supporting the Care Community multidisciplinary team.

Management structure

In addition, there will be an integrated leadership and management team drawn from the Core Group membership. The Leadership and management team will consist of a Care Community Clinical/Practitioner Lead, a PCN Clinical Director, a Community Manager/Coach, nursing or AHP lead and a Social Care Lead.



The leadership function will be responsible for the oversight of effectiveness, quality, and safety of integrated service delivery and for the stewardship of resources. The leadership element of the core team will also be the “key influencers” at “Place” with clear visibility, demonstrably contributing to Place plans and be able to articulate their local Care Community priorities.

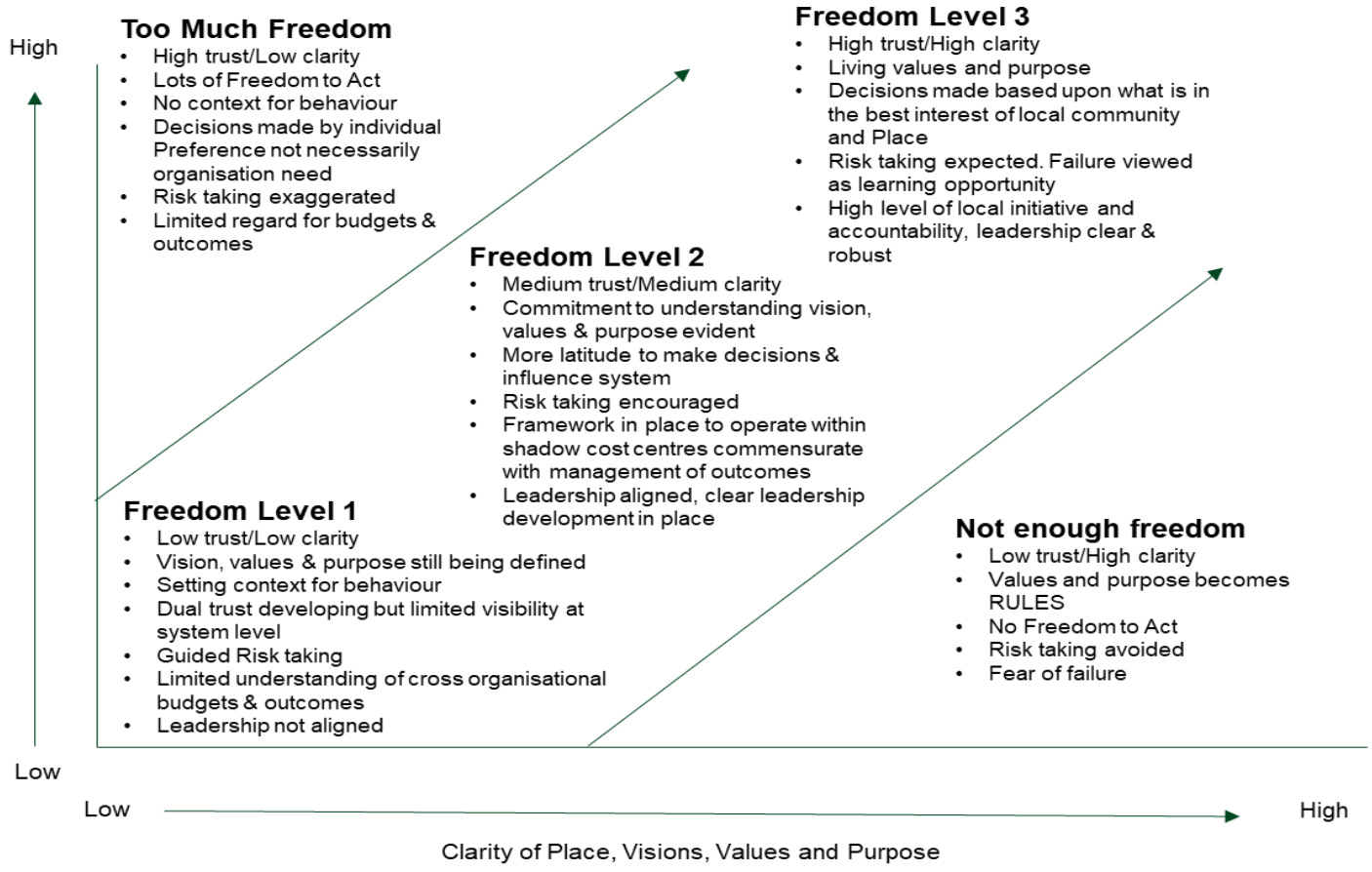
The leadership team will have:

- Responsibility to report priorities and performance into Place
- Influence Place plans through the use of local data
- Oversight of effectiveness, quality and safety
- Stewardship of resources, determining local spend within cost centres
- Support innovation and improvement
- Engage with their local populations using assets available.

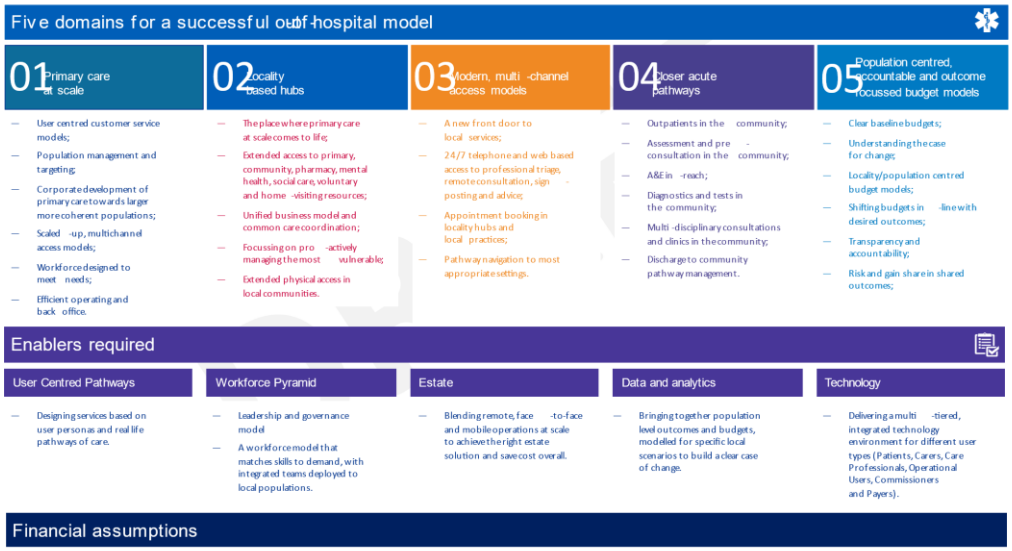
Freedom within a Framework

To operate successfully, the operating model will evolve over time within a framework initially determined by current status, with an aim to operate with greater freedom within a framework.

Freedom within a Framework Diagram



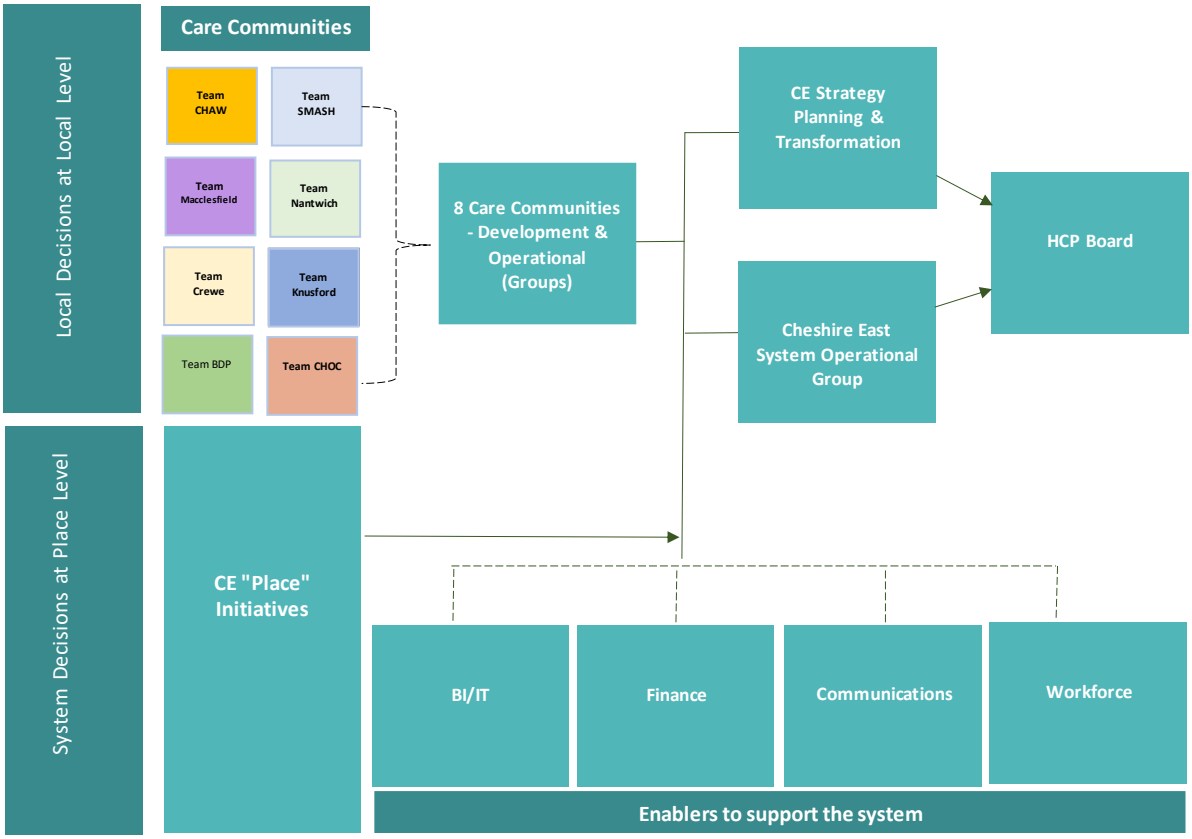
To support these freedoms, the progress against the maturity matrix (already in use) will be assessed subjectively and objectively.



Governance & reporting

To support development and delivery, the 8 Care Communities will report into the 8 Care Community Development and Operational Groups. The 8 Care Communities Leadership function will meet bi-monthly for development and reporting purposes. In addition, the Care Community Coaches/Service Managers will also meet bi-monthly with a focus on operational delivery. It is proposed the Care Community development group will report into the Strategy, Planning and Transformation Board by way of a report; and the Operational Delivery Group will report into the Cheshire East System Operational Group, by way of a nominated representative.

Governance & Decision-Making Structure



Quality and safety

Individual partner contracts will continue to be monitored through the relevant contractual arrangements. However, as part of the work to increase maturity (and thereby increased responsibility and accountability), all Care Communities will be asked to provide 2 quality goals in 23/24 based on their current intelligence (whether this be for example complaints, incidents, compliments etc). This will form a process by which the Care Community develops systems and processes for Quality Management (Joseph Juran). There are 3 main aspects of quality management which are Quality Planning /goal, Quality Improvement and Quality Control. The enabling support to develop this approach will come from all partners and be led by the Care Community Leadership team. The reporting of the achievement of these quality goals will be through the routine Care Community reports to the 8 Care Communities Development & Operational Group.As Care Communities mature, they will take on more responsibility and accountability for quality of care of integrated services.

J.M. Juran's Trilogy Diagram

Budgetary responsibility and alignment of financial drivers

Each care community will have a cost centre which will comprise of the cost (including on costs) of all the personnel aligned to that care community. The care community will also have access to financial data on prescribing, admissions, Right Care and long-term care placements to begin with. This will allow the care community to make changes to existing personnel structure (or use vacancy monies) to meet the goal to improve population health. There is a requirement for delegation of some resources from partner organisations to be able to enable this. Changes in existing investment/personnel must be reported to the 8 Care Communities Development & Operational Group and an impact assessment must be completed. A timeline to develop a level of delegated autonomy will be developed, in partnership with relevant stakeholders.

Enabling support

To enable Care communities to deliver improved population health as well as system priorities, several enabling actions will need to be taken by partners. The care communities will have access to: -

- Business intelligence - population health as well as performance and impact (development of Care Community dashboards)
- Finance professionals - to support cost centres
- Integrated IT access
- Estates plans
- QI capability & capacity
- Leadership and management development

Care Communities need delegated authority from provider partners to change the way resource is used. The ICB may wish to trial a different contracting mechanism to support integration, focusing on population health outcomes.

Population Health and the needs of the population.

Population health includes:

- *A shift in focus from Illness to Wellness* ie health promotion, disease prevention, health literacy
- *Holistic care needs* ie a personalised or MDT approach to care that focuses on the person affected and their supporters

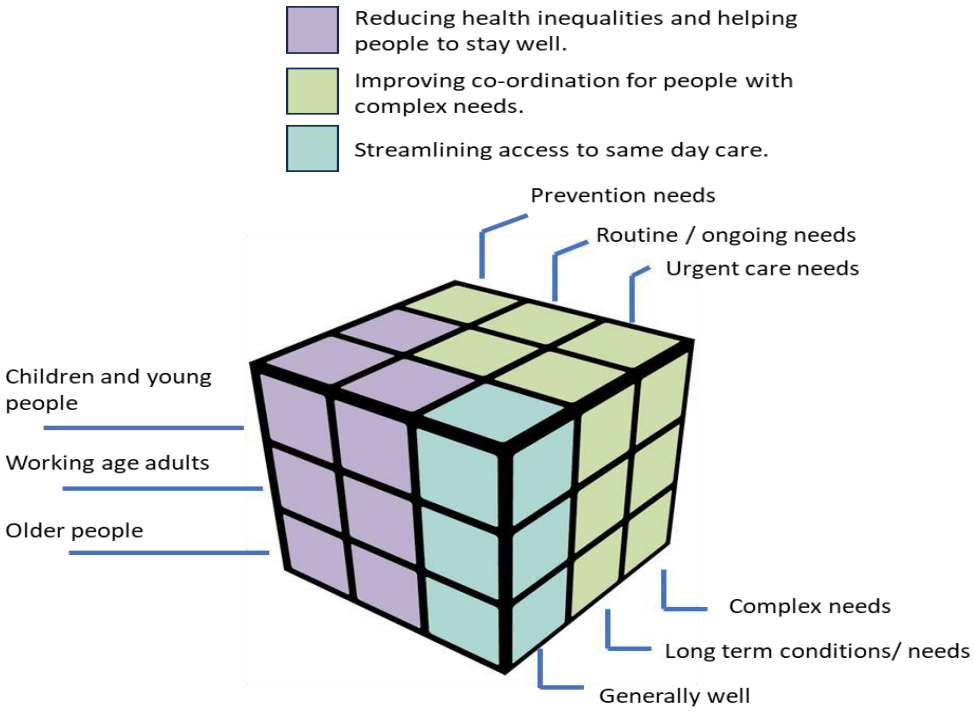
To improve population health each Care community needs to:

- KNOW the population health needs
- ENGAGE with the population
- MANAGE the entire population through segmentation

NAPC's Primary Care Home cube provides a simple, accessible model for looking at population health management in three dimensions:

Stage of life: children & young people, working age adults and older people.

Holistic health and care needs: currently well, people with long-term conditions (LTCs), and those with complex biopsychosocial health needs.



Current capacity

The Place will help develop a collective view of the assets and resources available to respond to identified local needs. It will not just look at primary care or wider health services, but also the capacity within wider public services including adult & children's social services, public health, and the local VCFSE services**.**
Care Communities will be supported to map:

- Individuals engaged in primary and secondary prevention, including wider primary care, VCFSE services, and public health
- Individuals involved in the care of those with complex needs, including adult and children's services, primary, community and acute specialists, and existing multi-disciplinary teams
- Individuals involved in provision of same day care, including primary care and those supporting urgent & emergency care pathways

Care Community People Plan

In recognition that our workforce is our greatest asset, the Care Communities will need to be fully conversant with the Care Community People Plan. The plan has been developed by our Care Communities over the last year and is now in first year mobilisation phase. The following 4 component parts make up the plan: -

- Growing our workforce
- New ways of working
- Creating a health leadership culture
- Caring for our people

Support for delivery will be by way of provider Workforce/OD colleagues. The role of Care Communities is to embrace the plan and support delivery by way of the Core Groups.

Risk management and escalation

The Leadership team are required to review their business information, performance, and quality of care to put improvement actions in place. Care Communities can escalate risks or issues to the 8 Care Communities Development & Operational Groups.

Performance reporting and management

Operational performance, quality of care including safety, effectiveness, and experience as well as use of resources will be reported once every 2 months to the Place Operational group. Each Care community will hold a risk register which will help Cheshire East Place to understand the risk to delivery and support to mitigate risk. By providing this information, Care Communities can provide assurance to providers and the ICB as to their progress against Place and Care Community objectives, as well as escalation for support.

Transformation & Intelligence

Each Care Community will be supported to further develop their local dashboards, determined by their local intelligence and local needs and priorities. The intelligence will be drawn from several data sources to understand both positive and negative variation in experience, effectiveness and outcomes of health and care.

Social Value

Care Communities will be supported to meet the requirements around social value of services commissioned and delivered, their progress towards Net Zero and to support delivery of the Cheshire and Mersey Prevention Pledge. The Pledge is integral to the delivery of population health.

Fair Society, Healthy Lives

Using our population health data, including premature mortality, Care Communities will be supported to understand health inequalities within their population so they can work with partners to deliver innovative solutions to reduce health inequalities.

Development and support

The 8 Care Communities Development & Operational Groups will continue to support development and maturity of the Care Communities, accepting that each Care Community is at differing levels of maturity and may require different levels of help and support. The progress to delegation of budgets, authority to use resources differently and risk and reward mechanisms will be iterative and developmental.

Appendix 1.

Building Strong Care Communities - the next level (High level plan 2023/24)					
Model features					**Resulting in**
Care Community Blueprint	Care Community development group sessions - revisit model & functions of a Care Community, host development events with local stakeholders (Making the Care Communities real for residents)			Care Community Blueprint - gain system agreement	**A consistent approach to the model and functions of a Care Community**
Integrated Teams	Strengthen the Care Community Core Groups - Team building & further developing roles, values, behaviours & priorities.		Develop the wrap around support functions, inlcuding Workforce, BI, project support, development of proposals.		**Care Community Core Groups operating as unified providers of services**
Leadership Structure	Working with Care Community Core Groups, define & design the leadership structure, roles and levels of decisions making		Design & test an accountability framework (freedoms within a framework)		**Care Communities as decision making units, for local population & local delivery**
Leadership Development	Review current leadership offers across the Place & begin to define potential requirements	Accessible leadership programmes for Care Community Core Groups	Accessible leadership programmes for Care Community Core Groups	Accessible leadership programmes for Care Community Core Groups	**Local leaders with commensurate skills to lead local integrated teams**
Assurance	Develop the governance & consistent reporting framework for Care Communities	Initiate meetings with clear terms of reference & reporting requirements	Ongoing review of governance & reporting, dynamic amendments as required	Formal review of governance & reporting	**Care Communities which report into the system, are held to account for delivery & hold a position of "influencing" future service delivery**
Quality Improvement (capability & capacity)	Baseline review of current QI capability & capacity across all Care Communities	Develop & agree the framework for increasing QI capability & capacity (inc catalogue of offers)	QI programmes for all Care Community Core Group members	QI programmes for all Care Community Core Group members	**The beginning of a consistent approach to QI across the Place**
Bi & Finance	Business Intelligence support, developing local dashboards for each Care Community		Bi & finance working group to develop an understanding of service demand, cost and outcomes.		**Meaningful dashboards which support local decision making**
Devolved Budget	Working group to establish current costs in each Care Community		Working group to develop a framework for devolved budgets		**Framework prepared for testing devolved budgets, for each Care Community**
IT	Support required – re: activities				
Align Secondary Care	Develop forums for linking Care Communities & Secondary Care colleagues, building relationships around a common purpose		Hold workshops to develop end to end pathways (2 x clinical areas)		**Closer working relationships, delivering on simplified service user pathways**

Acknowledgements :

National Association of Primary Care (NAPC) Primary Care Home model
NHSE/PPL/Nuffield Trust- Modelling Integrated Neighbourhood Working- draft
J Jurans Quality Management System Trilogy Diagram.

Proposed definition of complexity:

- Residents living with two or more long term conditions
- A person with a Learning Disability and or autism
- Having Serious Mental Illness
- Moderate to severe frailty *and* one of the following: Hypertension, Depression, Asthma, Diabetes, CHD, CKD, Hypothyroidism, Stroke or Transient Ischaemic Attacks, COPD, Cancer, Atrial Fibrillation, Heart Failure, Epilepsy, Dementia.

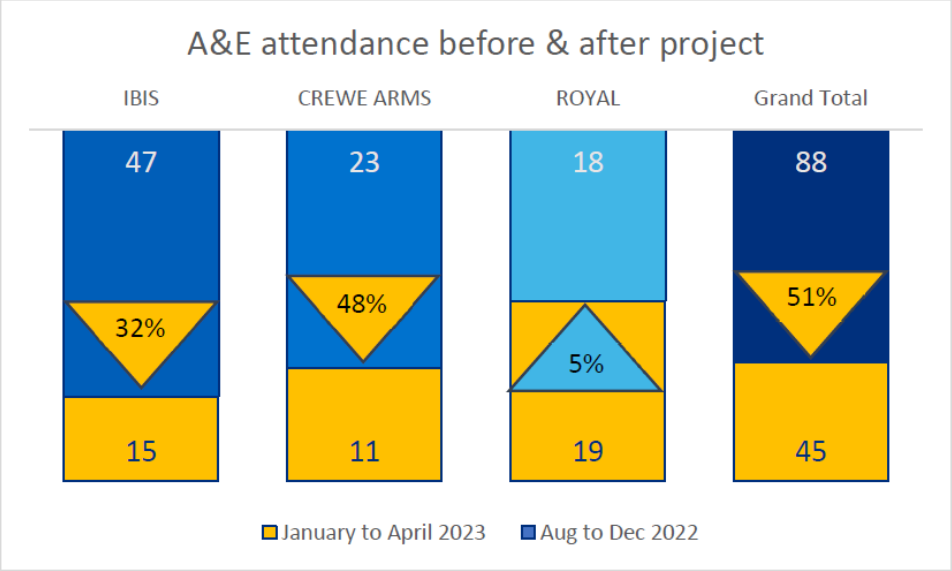
Case studies from Care Communities.

Team Crewe

The Asylum Outreach Project

Asylum seekers are placed temporarily into Crewe hotels either whilst awaiting status change or for onward relocation. For many this is a bewildering and frustrating time. The majority have experienced both physical and emotional trauma along their journey to the UK, and some within

their countries of origin. These are vulnerable, socially excluded people who need support to adjust to UK systems and to interpret health information and services.
Patients presenting at A&E were often unable to express their needs or explain underlying issues linked to the symptoms they were presenting with. The drop-in clinics provided a safe space for patients to present their immediate health concerns. The clinics were popular and provided opportunities to interact and to educate on self-care



Team Knutsford

Cardiology Virtual Clinics

In April 2022, Knutsford Care Community began to trail cardiology virtual clinics with Dr Rob Egdell, Cardiologist Consultant at Macclesfield Hospital. The clinics took the form of a weekly virtual question & answer clinic and clinicians within Knutsford PCN could refer 3 cases per week, one from each GP surgery. The clinics have been a success however ongoing support is required for this to become business as usual.

Aims

• Discuss and seek advice virtually face to face for patients with complex heart failure within the community
• Formulate advance care planning for patients with advanced heart failure
• Improve learning opportunity for patients with advanced heart failure in Primary Care
• Improve communication between Primary and Secondary care • Improve the patient's experience • Reduce hospital attendance

Heart Failure MDT's

Dr Russell also holds a monthly Heart Failure MDT which offer the opportunity for clinicians to discuss or seek advice. The initiative started in Knutsford Care Community and has since been rolled out across the Care Communities in East.

Cardiology Virtual Clinics – Outcomes

Pilot period results (4 months)

- 7 clinics on a Wednesday lunchtime lasting 30 mins to 1 hour
- 21 patients in total discussed
- In 19 patients a referral to secondary care outpatients' was saved (90%)
- In 2 patients direct access to secondary care investigation was achieved and then follow up arranged

A total of 60 patients have been discussed in the virtual clinics from August 2022 – July 2023

Cost Saving: average cost of attendance at cardiology outpatient clinic in acute setting - £136 without tests or £242 including tests (ECG; Echo)

Case Study

A 67 year old anxious male was investigated for PAF. His ECHO was normal and a holter monitor was performed remotely which showed 4 beats of VT. The man was discussed during a virtual cardiology clinic. His heart was normal, his examination was normal and he had no worrying symptoms. The patient was reassured with safety netting. This saved 3 hospital attendances (2 x Holter monitor, 1 x cardiology OPD), lead to a faster diagnosis time and improved patient satisfaction. This was a shared learning experience.

Team Macclesfield

Hypertension Case finding- Outcomes / Impact

We have started to collect process measures around the number of health checks delivered and onward referrals made.

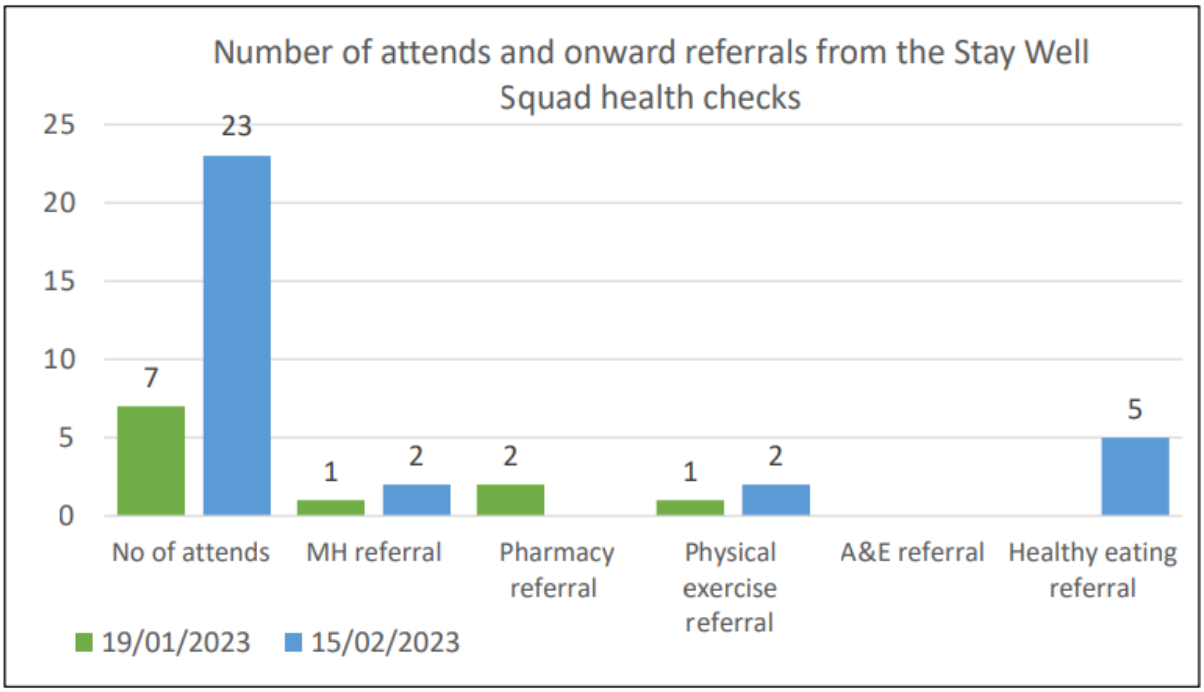
Ageing well roadshows

Event	Total BPs taken	How many elevated BPs but on Hypertensives	BPs over 180/80 escalated to next day clinic
Ageing well event 1	300	50	10
Ageing well event 2	60	20	1
Ageing well event 3	200	15	0

The Macclesfield Care Community worked collaboratively with Macclesfield PCN and wider partners to present an ageing well roadshow seasonally. The event is delivered with a tailored approach to mild, moderate and severe frailty. The roadshows present opportunities to identify residents with undiagnosed hypertension and nursing staff were able to signpost to other

services and give advice accordingly regarding blood pressure readings and other lifestyle domains.

Community health checks



The total number of people who attended for a health check with the Stay Well Squad equated to 7.5 hours in saved primary care hours, based on seeing 4 patients per hour in a clinic. Unfortunately, the stay well squad was decommissioned in May 23. We are currently working with other partners to deliver health checks in the community.