NHS
Morecambe Bay
Clinical Commissioning Group

AGENDA ITEM NO: 7.0.

Meeting Title/Date:	Governing Body - 23 May 2017		
Report Title:	Clinical Strategy for Health Services in Morecambe Bay - Better Care Together Update		
Paper Prepared By:	Darren Hargreaves/ John Taylor	**Date of Paper:**	15 May 2017
Executive Sponsor:	Andrew Bennett	**Responsible Manager:**	Darren Hargreaves
Committees where Paper Previously Presented:	Not applicable		
Background Paper(s):	Not applicable		
Summary of Report:	This paper describes the current status of the Better Care Together (BCT) programme and provides a progress update on the key elements of work.		
Recommendation(s):	The Governing Body is asked to:- • Note the current updated progress and position of the Better Care Together (BCT) programme.		
			Please Select Y/N
Identified Risks:			N
Impact Assessment: (Including Health, Equality, Diversity and Human Rights)			N
Strategic Objective(s) Supported by this Paper:			**Please Select (X)**
To Improve the health of our population and reduce inequalities in health			X
To reduce premature deaths from a range of long term conditions			X
To develop care closer to home			X
To commission safe, sustainable and high quality Hospital Health Care			X
To commission safe, sustainable and high quality Mental Health Care			X
To improve capacity and capability of primary care services to respond to the changing health needs of our population			X
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Clinical Strategy for Health Services in Morecambe Bay - Better Care Together Update

INTRODUCTION

1. This paper describes the current status of the Better Care Together (BCT) programme and provides a progress update on the key elements of work. The last two months has seen further progress achieved in the Better Care Together programme and this report highlights activity in the following areas:

    - New Care Models Team quarterly review
    - Development of the Accountable Care System (ACS)
    - Evaluation update
    - Work stream progress

New Care Models Team Quarterly Review

2. On 20 April 2017, the national New Care Models Team met with a number of Better Care Together leaders and senior programme managers for a combined Q3 and Q4 review meeting. This provided an opportunity to assess progress in the core work streams from the 2016-17 BCT Vanguard delivery plan as well as a forward look of the developments expected in 2017-18. The national team recognised the continued progress being made across Morecambe Bay with the on-going development of Integrated Care Communities (ICCs), planned care, women and childrens' services and the Accountable Care System.

3. The national team highlighted that there are specific deliverables and outcomes expected by the end of 2017-18 as outlined in the funding letter conditions sent in February 2017, and through the A&E funding condition outlined in the Five Year Forward View Next Steps document. These are that the Bay Health and Care Partners need to ensure:

    - There is full delivery of the BCT vanguard programme against the core components of the national Primary and Acute Care Systems care model framework.
    - BCT is required to develop a suite of replicable materials that will enable the spread of learning from the vanguard to the other health economies. As part of the spread and STP discussion, it was agreed that a joint approach with the Fylde Coast vanguard would be beneficial.
    - Continued reductions in emergency admissions, and that this should not exceed local emergency admissions contract volumes.

4. In addition to meeting these conditions, the key feedback from the national team was there was interest in accelerating work around the standardised ICC model and ensuring that ICCs develop maturity. For the Planned Care workstream, it was noted that it was important to ensure that referrals, admissions, pathways and discharge from secondary care were being addressed as part of a whole system solution. Morecambe Bay was commended for the initial progress on developing system wide dashboards and improved business intelligence, and there was interest in how this could be developed further.

5. It was agreed that the next quarterly review would focus specifically on the ICC standardised model, achieving improved integrated urgent care, an update on the Women's and Children's work stream, and the evaluation process.

Development of the Accountable Care System

6. In March 2017, Bay Health & Care Partners submitted its ACS Development Plan to the Boards and Governing Bodies of the partner organisations. This paper outlined how the delivery of accountable care in the Bay will lead to a greater emphasis on the impact BHCP has on integrated services and front-line delivery, ensuring a particular focus on the development of Integrated Care Communities in 2017/18. This will be done through strengthening the leadership arrangements and governance arrangements across the partner organisations to support the ICCs. This paper was received and discussed by the organisations which are supportive of realising these ambitions.

7. The ACS Development Plan also set out defined plans as to how the core elements of our programme will be developed over the next year. These plans will be supported by an Integrated Delivery Plan and system performance report that will encompass all work programmes of BCT and the accountable care development plans. This will support the development of BHCP by:
   - Introducing critical milestones and stepped changes to ensure progress is made at scale across the BHCP;
   - Defining the partnership, governance and accountability arrangements that allow the delivery of system-wide change; and
   - Reviewing the leadership roles and responsibilities of the BHCP model, acknowledging that these need to be aligned with the devolution of authority and budgets.

8. The next three to six months will be focused on ensuring that BHCP has utilised the first half of the year to make tangible progress in plans; to trial or pilot changes that will support service and system transformation; and to create accelerated pace and scale of delivery to create a platform for determining the future function and form for an accountable care system that respond to the needs of our patients, communities and partners.

RESEARCH & EVALUATION

9. The University of Cumbria has presented their *Interim Report,* which was submitted to the New Care Models Team on 26 April and to the Better Care Together Programme Board on the 4th May 2017. The interim findings identified a number of emerging themes including the success of multi-disciplinary partnerships in Integrated Care Communities (ICCs). The report highlighted how these are helping break down barriers, addressing gaps in service and facilitating new ways of working such as telehealth and using different roles to assess patients. However, the report raised some practical challenges about ensuring there is access to sufficient data to support a quantitative evaluation and reinforced a continuing need for major culture change in services across the Bay.

10. The University is due to deliver the second of three Evaluation workshops on 23 May 2017. The purpose is to discuss the creation, collection and use of data from across health providers, support services and the community to support the New Care

Model. Workshops are open to clinical and non-clinical staff, support staff, local council officers, analysts and third sector representatives. A third workshop is planned for the summer to engage with patients, carers and members of the public and a major survey is planned for later in the year.

11. The Bay Health and Care Partners have recently been awarded a further £200k to continue evaluation of the vanguard through to March 2018. There will be an enhanced focus on particular areas such as economic evaluation and patient experience. The Interim Report has been presented to the Programme Board with recommendations regarding alternative evaluation approaches in 2017/18 which are currently being explored.

Workstream Progress

12. Each work stream has been making good progress on its priority programmes of work and milestones against the 2017/18 delivery plan that we submitted in November 2016 that we subsequently secured the Vanguard funding. A summary of current progress is set out below:

Out of Hospital

13. Work is continuing to develop a Bay-wide "Core Operating Model" for Integrated Care Communities (ICCs). A working draft has been circulated to ICC and organisational leaders and will be revised for adoption in quarter two. The ICC Steering Group meets monthly, chaired by the CCG Clinical Chair, to oversee the governance of the various clinical leader forums and locality meetings.

14. In recent months there has been a notable and sustained reduction in both hospital admissions and non-elective bed days attributable to the initiatives put in place within the community and in partnership between primary/ secondary care, other statutory organisations and the third sector. Progress continues to be made in establishing some core out of hospitals projects:
    - The Electronic Frailty Index (EFI) has been mandated and will be rolled out across the whole patch going forward with a view to better targeting of assessments, packages of care and referrals to support services.
    - The Respiratory pilot in Barrow Town ICC will now be replicated in the Alfred Barrow ICC to develop potential benefits to the overall system in terms of bed days and admissions.

Elective Care

15. Significant progress has been achieved with the implementation of the Community Ophthalmology Service for minor eye injuries and the spread and continued uptake of the Advice & Guidance scheme, the introduction of Physiotherapy led MSK community clinics, and the Patient Initiated Follow Up project putting patients in charge their appointments.

16. *Ophthalmology and the Community Eye Service:* Four community pathways have been implemented (minor eye conditions, glaucoma repeat readings, repeat paediatric refractions and post op cataracts) since the start of the contract at the

beginning of September 2016. This has seen a move in outpatient activity from UHMB to community optometrist services:

- 3,183 contacts since start of contract
- Activity from GP practices in all three Bay localities with highest use of service per population in South Lakes
- 75% advice/treatment then discharge/follow-up; 16% referred to Hospital Eye Service; 9% referred to GP

17. *Musculoskeletal Service:* GP referrals to the Orthopaedic service were opened up to the e-Referral Service and this has shown an increase in referral numbers with clinics being fully utilised since the beginning of March 2017. Plans are being finalised for a further five clinics to be introduced from July 2017. A new formal monthly multidisciplinary team meeting has been introduced to review clinical outcomes.

18. *Patient Initiated Follow Up (PIFU):* PIFU communications for GP colleagues have been finalised and disseminated. Clinical engagement remains good with clinical governance systems now finalised for some health specialties. The Respiratory PIFU pathway for patients with COPD is due to is due to go live in May 2017 and this will be followed by Orthopaedics, Gastroenterology and Urology.

19. *Advice and Guidance:* The Advice & Guidance scheme has seen continued success during 2016-17 with the increase in conversations between GPs and hospital specialists resulting in 1668 patients being treated closer to home. There has been continued interest nationally in the Advice & Guidance system, with the clinical lead supporting its further development of an electronic referral service.

20. *Chronic Disease Management:* A Cardiology Rapid Access Heart Failure service in Heysham has been established and the Respiratory pilot continues. Initial evaluation for both projects has been positive with reducing emergency admissions, hospital re-admissions and outpatient attendances.

Women's & Children's Services (WACS)

21. The WACS work stream has progressed well. Concrete steps have been made towards establishment of the Integrated Children's Nursing Teams with an existing hospital-based post transferring into a community team. Progress has also been made in the North Lancashire area with a trial of community nurses working closely with families who are frequent attenders to the hospital paediatric services, linking in with a local ICC to discuss this group's needs at multi-disciplinary team meetings. The initial evaluation of this indicates a 33% reduction in admissions for identified patients.

22. This work stream can demonstrate success in the reduction of Paediatric Bed Days and Paediatric outpatient referrals from GPs. As of the end of February the work stream was achieving; a 7.9% reduction in paediatric bed days for the year to date (target was 5% reduction) and a 6.4% reduction in paediatric outpatient referrals for Q4 to date (target was 5% reduction in Q4).

Communications and Engagement

23. Bay Health and Care Partners celebrated the second anniversary of becoming a Vanguard in the last quarter of 2016-17 with a number of announcements regarding

the successes they have achieved, which included an appearance on the BBC National News about the “run a mile” project in Carnforth and Morecambe. March also saw the first community conversation for the Grange and Lakes Integrated Care Community (ICC) take place, with a further meeting held in Windermere in May.

24. BHCP will shortly launch a new website to include dedicated ICC pages to help bring ICC communications more to the fore. This will be supported by a number of activities for the public to showcase the successes of the programme to date as well as sharing the programme that is planned for the future.

Workforce

25. BHCP are working closely with Health Education England (North West) to trial a new workforce transformation tool, the STAR. This is to be utilised for the Urgent Care pathway, and will initially review the current Urgent Care workforce to highlight any gaps before using the STAR model to highlight the workforce transformation opportunities available.

26. Work continues on developing the cross-organisation recruitment website, www.betterwithyou.co.uk, including uploading of GP vacancies to NHS jobs, aligned to establishment of a professional recruitment service across GP practices and care homes. The aim is to widen the scope of the pilot in the next month to cover the whole Bay and will be supported to by a partnership with the Choose Cumbria marketing initiative.

27. Work is continuing on developing a Bay-wide apprentice strategy to optimise use of the Apprentice Levy and to meet future workforce development needs. This includes a plan to enhance apprenticeships across community, regulated care and primary care, as well as the hospital sector.

IM&T

28. Development and usage of the Business Intelligence platform is increasing, with specific focus this year to support the Integrated Care Communities and the emerging Population Health work stream. Development of the first dashboard incorporating acute and GP data will commence this month. Underpinning this work is the ongoing development of the Bay Health Community Data Warehouse - a single view of patient data from multiple health systems across the BH&CP footprint. Information Governance is in place to support the integration of Lancashire North GP data with data from the Hospital Electronic Patient Record.

29. Following a workshop in March involving clinical colleagues from Bay Health & Care Partners, a draft paper setting out a proposal for a new model of consent for the sharing and distribution of patient records has been distributed for agreement.

RECOMMENDATIONS

The Governing Body is asked to note the current updated progress and position of the Better Care Together (BCT) programme.