NHS
Morecambe Bay
Clinical Commissioning Group

AGENDA ITEM NO: 7.0.

Meeting Title/Date:	Governing Body - 21 January 2020		
Report Title:	Bay Health and Care Partners Update Report		
Paper Prepared By:	Karen Kyle System Programme Director BH&CP	**Date of Paper:**	7 January 2020
Executive Sponsor:	Jerry Hawker	**Responsible Manager:**	
Committees where Paper Previously Presented:	N/A.		
Background Paper(s):	N/A.		
Summary of Report:	This paper presents an update on key activities for Bay Health and Care Partners (BH&CP) workstreams with a focus on:- a) BHCP Workforce Enabling Workstream. b) Digital Workstream. c) Communication and Engagement. d) Primary Care Networks. e) Population Health Management update. f) Integrated Care Communities/ Community Engagement. g) Clinical Workstream updates. h) Ministry of Health visit from Singapore.		
Recommendation(s):	The Governing Body is asked to note the current update of Bay Health and Care Partners.		

		Please Select Y/N
Identified Risks: (Record related Assurance Framework or Risk Register reference number)		
Impact Assessment: (Including Health, Equality, Diversity and Human Rights)		
Strategic Objective(s) Supported by this Paper:		**Please Select (X)**
Better Health - improve population health and wellbeing and reduce health inequalities		Y
Better Care - improve individual outcomes, quality and experience of care		Y

Delivered Sustainably - create an environment for motivated, happy staff and achieve our control total	Y
Please Contact:	Karen Kyle System Programme Director

BAY HEALTH & CARE PARTNERS UPDATE REPORT
JANUARY 2020

INTRODUCTION

1. This paper presents an update on key activities for Bay Health and Care Partners (BHCP) workstreams with a focus on:

    i) BHCP Workforce Enabling Workstream
    j) Digital workstream
    k) Communication and Engagement
    l) Primary Care Networks
    m) Population Health Management update
    n) Integrated Care Communities/ Community Engagement
    o) Clinical Workstream updates
    p) Ministry of Health visit from Singapore

EXECUTIVE SUMMARY

2. Over the last two months, Bay Health and Care Partners planning leads, in collaboration with the Integrated Care System have continued to focus on the refinement development of the long term plan which enables us to continue to refine the BCT 2 strategy. Key to our local delivery are the enabling workstreams to support transformational change now and in the future and the report highlights how these workstreams are developing as we refine and develop our Better Care Together strategy. As we continue to develop, the BHCP Workforce plan, the collaborative work focusing on 'Growing our own' workforce has now been established across BHCP with significant progress in activity and relationships over the last year in particular. Through regular touch points in meetings such as the Virtual Recruitment Hub, BHCP Apprenticeship Group and the wider ICS Apprenticeship Strategy Group, programmes of work have been growing in breadth and activity primarily due to the continuous efforts building relationships, understanding the different contexts of our partners and collaborating on the shared recruitment need of BHCP and to ensure that programmes of work span across the breadth of partnership with Social Care, Community, Primary Care and Acute sectors.

3. We continue to see progress in our digital infrastructure across Morecambe Bay. The iPlato product has been deployed to all but 2 small practices covering approximately 99% of the population of Morecambe Bay with 56,147 patients having now downloaded the myGP app, which is an increase of 4,755 since the last update report.

BH&CP WORKFORCE ENABLING WORKSTREAM

4. The Workforce Strategy Group continues to meet with strong and consistent membership, largely drawn from the HR & OD Community across Bay Health & Care Partners. The focus is on delivering against the five-year People & OD priorities, with 5 supporting work programmes established to support delivery of these initial priorities:

- Workforce Planning & Transformation
    - Critical Workforce Shortages
    - ICC Workforce Transformation

- Apprenticeships
- Careers & Engagement
- Virtual Recruitment Hub
- OD & Culture Change

5. Each work programme is currently developing their 12 month and 5 year deliverables, with the workforce planning programme being key to this as it will need to fully reconcile the workforce implications of the strategic financial recovery plan, the existing critical workforce shortages, workforce demography and expected supply. An initial narrative plan is to be brought to the ICP Leadership Team in February 2020 which will recognise that fundamental building blocks of such a plan are not in place currently, including detailed understanding of the existing primary care workforce and plans for expansion and new roles through PCN funding routes. This is an area that is being escalated for further discussion with the Clinical Lead (Out of Hospital).

6. Notwithstanding this, the out of hospital workforce modelling project continues to progress in the pilot Bay and Grange & Lakes ICC areas, supported by the NHS Transformation Unit. A number of transformation champions have been trained to develop the workforce model and are being supported in this through the Integrated Services Management Board (ISMB). Both pilot areas will present to the ISMB on 23rd January 2020 their delivery plans and timescales.

7. The collaborative work focusing on 'Growing our own' workforce has now been established across BHCP with significant progress in activity and relationships over the last year in particular. Through regular touch points in meetings such as the Virtual Recruitment Hub, BHCP Apprenticeship Group and the wider ICS Apprenticeship Strategy Group, programmes of work have been growing in breadth and activity primarily due to the continuous efforts building relationships, understanding the different contexts of our partners and collaborating on the shared recruitment need of BHCP and to ensure that programmes of work span across the breadth of partnership with Social Care, Community, Primary Care and Acute sectors. Programmes such as the work-based learning Employability programmes are co-designed and tailored specifically to target the development of skills needed to fill hard to recruit to entry level vacancies. Work Experience placements have recently been redesigned in order to maximise the number of people, helping BHCP increase numbers (potentially doubling) significantly across the Bay. Placements are available across all of the Bay Health and Care Partners.

8. There has also been a focus on increasing and expanding opportunities across the workforce pipeline through relationships with local colleges and courses to give specific support to those areas of the workforce which have significant challenges in recruitment. The 'College placement offer' now includes more than 140 Health and Social Care students (an increase from 14 the previous year), with placements in Catering, Finance, Engineering, Plumbing and Electrical and Maintenance. Again, these placements are focused across the range of partners, with students rotating across Social Care, Acute, Primary Care and Community.

9. A BHCP Apprenticeship group has been established to specifically look at the opportunities afforded through the Apprenticeship Levy to target some of the skills shortages and support the workforce pipeline. The group will look at innovative approaches, including optimising opportunities for shared/collaborative cohorts for those shortage areas where course numbers would be impossible to fill for individual partners and ensure that the apprenticeship levy is fully

utilised across the Bay. An upcoming workshop will develop a clear and joined up process to collaborative approaches which best suit the workforce needs and shortages within the ICP.

10. Finally, a Clinical Leadership Summit is being planned for early march with the intention of ensuring that senior clinical leaders across all partner organisations are focused on taking a system-wide approach based on delivering the triple-aims.

DIGITAL WORKSTREAM

11. **System Wide Decision Support Tools** – An ICS scheme, led by the BH&CP CIO, has been approved to help staff and patients better navigate the health and care system by:
    - Developing a referral decision support toolset using Starta;
    - Linking referral management into patient facing solutions e.g. myGP;
    - Embedding referral data into a system-wide flow and capacity dashboard;
    - Enhancing transfers of care by improving data flows between health and social care using Strata.

    The £6004 funding has now been drawn down for this programme and a project manager identified to manage this work. Further discussions will now take place with colleagues from across the ICS on developing the detailed implementation plan.

12. **Integrated Care System Primary Care Exemplars** – Bay Medical Group, Lancaster Medical Practice and East Integrated Care Community continue to implement iPlato patient triage functionality with an objective to digitally signpost patients to appropriate services based on their presenting condition in line with the plan.

13. **Biophysical Data Capture** – work has continued to develop the functionality to allow Health Care Professionals to request and support patients to record personal biophysical data, including Blood Pressure, Oxygen Saturation, Peekflow, etc. within the iPlato MyGP app. This enables remote patient monitoring and the incorporation of patient recorded data into general practice patient record (as appropriate). Testing is underway with real patients ahead of making this service more widely available to practices across Morecambe Bay.

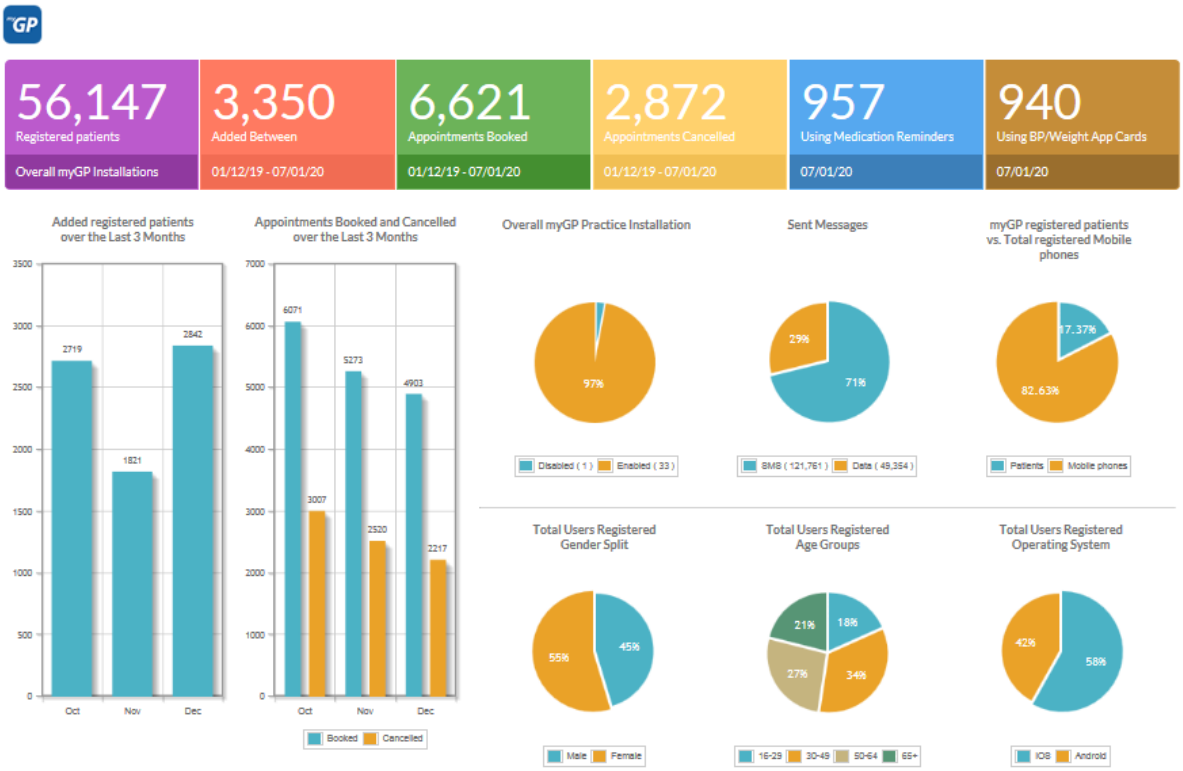
14. **GP Practice Record Data Sharing with North West Ambulance Service (NWAS)** – work in Morecambe Bay to help NWAS more effectively triage patients and enhance Paramedic decision making through GP Practice data sharing has now been completed, however we are continuing to support and encourage NWAS utilisation to fully understand the impact and benefits. The three Rapid Response Vehicles covering Barrow, Kendal and Lancaster are equipped with laptops with access to Morecambe Bay primary care records. The team is currently awaiting further proposals from NWAS on next steps in increase utilisation.

15. **Primary Care Streaming** – A project has been initiated to implement a digital solution at the front door of the Emergency Department in Lancaster. The proposed system (eConsult) uses structured questions and a set of clinical algorithms to triage walk-in patients and stream them to ED and GP led services as appropriate. The eConsult system is scheduled to go-live in January 2020.

16. **Strata Supported by NHSI** – NHSI have awarded UHMB circa £700k of funding to support patient navigation from Ambulatory Care (Phase 1) and a wider implementation of Strata across Morecambe Bay (Phase 2 & 3). Following Phase 1 go-live on the 20th of December of the Strata Pathways Frail Elderly form in the Emergency Department in the Royal Lancaster Infirmary feedback has been positive. The usage and outcomes of the new form will be presented in due to course to understand the impact and opportunities for improvement. A detailed assessment of Strata utilisation across Morecambe Bay has been undertaken and this will be used to develop plans for a systematic implementation of Strata throughout 2019/20 and

2020/21. The rollout of Strata into general practice has now commenced and is being supported by PRIMIS. A project manager has been recruited to provide additional support to the deployment of Strata across Morecambe Bay.

17. **Citizen Engagement Platform** – the iPlato product has been deployed to all but 2 small practices covering approximately 99% of the population of Morecambe Bay. See current utilisation metrics below. 56,147 patients have now downloaded the myGP app, this is an increase of 4,755 since the last update report, if current adoption rates are maintained circa 85,000 patients will have potentially download the App by the end of December 2020. Following receipt of £100k of investment from the ICS a draft specification has now been produced to facilitate functionality that will enable patients to record their own data into the myGP App, prior to, in between and post consultation. It is envisaged that this new development will help to reduce avoidable appointments and support early discharge.



18. **Digital Strategy** – to develop a high level digital strategy in-line with the national 'digital placemat' format of Empower the Person, Support the Clinician, Integrate Services, Manage the System Effectively, Create the Future and Live Services & Infrastructure. A draft strategy has been developed that will be explored at a workshop rescheduled to take place on the 30th January, 2020. The workshop includes representation from across BH&CP who it is hoped will support further co-creation and development of the digital strategy.

COMMUNICATION AND ENGAGEMENT

Engagement on Integrated Care System (ICS) 5 Year Strategy in Morecambe Bay

19. Following discussion at the System Leadership Executive meeting on 18 December, Healthier Lancashire and South Cumbria (HLSC) has produced an engagement plan covering proposed activity up to April 2020 in relation to their 5 year strategy.

    The ICS will produce material to support local engagement on ICP plans and a plain English version of their 5 year strategy for stakeholders, staff and partners.

BHCP Annual Report 2018/19

20. Final comments are being gathered on the draft BHCP Annual Report. The report summarises the highlights and progress over 2018/19, including some of the key achievements, and sets out the next steps for 2019/20 and beyond.

BHCP Public Assembly

21. The Bay Health and Care Partners Public Assembly has completed a series of meetings across Barrow, Lancaster and Kendal. These events were attended by a small number of the existing 350-400 Assembly membership. The Assembly aims to help the public both better understand and have an influence on the development of services in Morecambe Bay. A programme of work is being planned for 2020 and a schedule of meetings will be published.

Winter Campaign animations

22. Three new animations have been created by Bay Health and Care Partners to support the winter communications campaign messages. The videos reiterate key messages to help people to stay well during winter and help them to know how to look after themselves and where to go if they do need medical help. The videos are branded simply with the NHS logo so all NHS organisations and partners are able to use these animations to promote these winter health messages.

Alfred Barrow Health Centre opening

23. As reported in November, the Alfred Barrow Health Centre officially opened on November 11th 2019, following an event on November 6th to mark the completion of the project. The Centre has received considerable positive media coverage but there have been comments about the appropriateness of the car parking and road-crossing arrangements.

Beyond Radio

24. Beyond Radio, the local radio station for Lancaster, Morecambe and Carnforth started broadcasting a series of 1 minute Health advice slots in November. The broadcasts will air 6-8 times a day until March 2020.

St Mary's Hospice

25. The public has been made aware that the inpatient unit at St Mary's Hospice in Ulverston is set to reopen by May 2020 following recruitment of the speciality service needed. The Hospice will be supported from afar by a bank of digital consultants who are specialists in palliative care allowing the unit to reopen after a period of familiarisation.

Askam Surgery Notification

26. Morecambe Bay CCG has been asked for a position statement on Askam Surgery, Askam-in-Furness and has issued the following:

"*Dr Jain, the General Practitioner at Askam Surgery is currently unable to provide patient care. Patients visiting or telephoning the surgery will be redirected to other NHS services whilst interim arrangements are made to provide a GP service cover. We apologise for any disruption this may cause*."

PRIMARY CARE NETWORKS (PCNs)

27. Nationally, the PCN Development fund has been released, locally the process is being led by the ICS and a recent process has been shared to PCN's on submitting requests for standardised and bespoke support which will support PCN's deliver on their objectives. The PCN Clinical Directors are being supported by their GP Federation and the CCG in creation and submission of an appropriate proposal.

28. In late December 2019, NHS England launched a consultation on the PCN service specifications, these documents will form part of the national DES contract, and will outline the delivery requirements of PCN's. The consultation covers 5 specification areas:
    a. Structured Medication Reviews and Optimisation
    b. Enhanced Health in Care Homes (jointly with community services providers)
    c. Anticipatory Care (jointly with community services providers)
    d. Personalised Care
    e. Supporting Early Cancer Diagnosis

29. As can be seen from the areas covered and the integrated nature of delivery with community services, the outcome of the consultation will be of keen interest to local providers and commissioners, as well as practices.

Primary Care Priorities

30. Progress is being made on two areas of significant priority within Primary Care:
    a. a pilot to test alternative arrangements in relation to phlebotomy, and specifically blood tests that do not originate in primary care
    b. a multifaceted solution to wound care activity, which will see wound care dressings being more sustainable supported across the community and acute interface

31. It is timely that progress be made, as a number of practices have recently highlighted their concerns regarding these two workloads, and the financial and service pressures they create. The GPPA is at the forefront of developing resolutions to these two issues, and will work with local partners to review, implement and monitor these over the next quarter.

POPULATION HEALTH MANAGEMENT UPDATE

32. The NHS ten year plan (2019) has placed the spotlight on the importance of improving population health. Referring to 'population health' rather than the more traditional phrase 'public health' helps avoid any perception that this is only the responsibility of public health colleagues. Population health is about creating a collective sense of responsibility across many organisations and individuals, in addition to public health discipline, in order to improve the health and well-being of the entire population, reduce the burden of disease and reduce the strain this puts on the system to support it.

NHS Ten year Long Term Plan & Population Health Approach

33. The NHS Long Term Plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. The Integrated Care Systems (ICS) will be the main mechanism for achieving this and will increasingly focus on population health through place based approaches. The plan emphasises that NHS organisations will need to work in partnership with local authorities, the voluntary sector and other local partners to improve population health. From 2019, population health management tools will be rolled out, enabling effective identification of groups at risk of adverse health outcomes and inequalities and to plan services accordingly.

Population Health Lancashire & South Cumbria ICS View

34. Across the Lancashire and South Cumbria ICS, approximately twenty percent of our population live in the ten percent most deprived areas compared to nationally; this means we have varying health needs underpinned by intractable pockets of deprivation requiring much more focus on addressing health inequalities and organising care that is responsive in rural and remote areas;

35. As an ICS, health outcomes are significantly worse compared to the national average and there are significant health inequalities between the most and least deprived areas. The major causes of ill-health include cardiovascular, respiratory, cancer, mental health, and neurological conditions;

36. Premature mortality from all causes, circulatory disease, cancers and deaths from causes considered preventable is worse than the England average. Emergency admissions for all causes, Coronary Heart Disease, stroke, MI and COPD are worse than the England average with approximately forty percent of ill health in our system is determined by smoking, physical inactivity, obesity and substance misuse;

37. A significant proportion of children experience adverse living conditions including child poverty leading to significant variation in their level of development and school readiness. There are also a rising proportion of people with five or more long term conditions and those experiencing social isolation and loneliness. There are also areas with significantly higher than average rates of suicide within the L&SC population.

38. The leading causes of ill health across the life course and district level analysis shows a marked variation in the life expectancy gap between the ICS and England. There is also a significant variation in the healthy life expectancy within our local authorities. Circulatory diseases (includes coronary heart disease and stroke), cancer, respiratory and digestive diseases (includes alcohol-related conditions such as chronic liver disease and cirrhosis) are the major reasons for the gap in life expectancy between the L&SC local authorities and England. In summary, as an ICS we have added years to life but we haven't added life to years;

39. In order to address the challenges highlighted above the ICS has developed a set of strategic objectives for improving population health and reducing inequalities which include:
    - Achieving a best start for children and families.
    - Achieving a fully engaged scenario with communities and people mobilised for improving their health and wellbeing.
    - Address the unwarranted variation in management of risk factors and care pathways.
    - Proactively meeting demand by identifying and supporting individuals and families with complex needs.
    - Improving socio economic and environmental determinants (SEEDS) of health by embedding health in all policies including housing, employment and productivity, planning and licensing, transport, and advocating for national healthy public policies.

40. Building on collective strengths across the ICS, the following five key priorities have been identified for implementation across the ICS over the next five years.
    - First 1000 days
    - Healthy Behaviours
    - Suicide prevention
    - Neighbourhood development
    - Work and Health

Health Needs Assessment Morecambe Bay

41. In July 2019 a Health Needs Assessment (HNA) for Morecambe Bay (MB) was produced. Unsurprisingly and in line with health outcomes identified in the Long Term Plan and in the ICS Population Health Strategy, MB HNA reveals some alarming issues for us to face together as a health and care partnership and system. The starkest of these are the difference in 'life expectancy' and 'years lived in good health'. Over all we have a difference in life expectancy of 16 years for women and 14 years for men across MB, with an overall average difference in healthy life expectancy of 17 years between our areas of highest and lowest affluence. To make matters worse, our health outcomes in key areas, which lead to this inequality, are significantly worse than our neighbours as highlighted across the ICS, particularly in early mortality from cancer, cardiovascular disease and respiratory disease. This is simply not acceptable.

Population Health Strategic Vision for Morecambe Bay

42. In line with the population health ambitions laid out in the NHS LTP, the ICS Population Health Strategy and the priorities set out by Bay Health and Care Partners, over the next ten years, it is our ambition to focus on prioritising the following in our Population Health Strategy:

    a) Fully connecting the Wider Social Determinants of Population Health – building robust relationships - all partners being accountable,
    b) A focus on Population Health Management in a place based way within the Primary Care Networks (PCNs) and Integrated Care Communities (ICCs) to address the unwarranted variation in management of risk factors and care pathways
    c) Improving work place health and wellbeing – across all Bay Health Care Partnership (BHCP) employers and the wider workplace
    d) A fully engaged neighbourhood /community in taking preventative approaches to address health behaviours that impact adversely on Health and Wellbeing – working through PCN's and ICCs to deliver this
    e) Population Health Engagement – Working collaboratively with our Community, Voluntary and Faith sector (CVFS) and the neighbourhood themselves to achieve a fully engaged scenario with communities and people who are mobilised for improving their own health and wellbeing

43. By focusing our ambitions on the above areas in line with national, regional and local priorities; over the next ten years we aim to close the gap in life expectancy and healthy life expectancy by fifty percent in order to deliver an eight year improvement in life expectancy and an eight year improvement in healthy life expectancy for those in our poorest communities.

44. However, the solutions to closing these gaps are complex and multi-factored. If we are to make this kind of difference it will require not only a shared vision, but real action by all partners involved, including a much more collaborative approach to working with our communities. We will need to agree on the shared principles and then ensure we put our resources into the right places to see this necessary shift occur, with agreed milestones and key performance indicators and measurements.

Morecambe Bay Population Health Ambitions in each priority area:

Fully connecting the Wider Social Determinants of Population Health – building robust relationships - all partners being accountable:

45. Many of the factors which affect health and wellbeing are outside the usual remit of the NHS. However, with wider partnership working and a determined effort, evidence from other parts of the UK, like Preston and Wigan, have shown that we can make more difference than we have previously realised. Our ambition is for Bay Health and Care Partners to become a set of 'Anchor Institutions' within Morecambe Bay and playing an active role in the economic partnership of Morecambe Bay with our district and county councils. We will also be working in partnership with The Eden Project, who has clearly set out their vision to work with local partners and communities to help improve the health and wellbeing of the people of Morecambe Bay. We also recognise the importance of giving children the best start in life.

46. Working with partners in 'Women's and Children's work stream' we will embed a 'First 1000 Days' project across the Bay and build on our great relationships with schools in the area. In July 2020, we will be co-hosting a 'Love Education' conference with teachers from around the Bay, part of which will explore how we work together effectively to improve the physical and mental health and wellbeing of our children and young people, giving them the best start in life and therefore improving health outcomes for years to come.

47. Each of our District Councils have signed a 'Climate Emergency' declaration, and we will partner with them and our County Council partners to improve air quality across the Bay, especially due to its well-known effects on respiratory conditions and dementia. We will also look to develop a 'green/active transport' policy around the Bay for those working as part of BH&CP, to ensure we play our part in environmental sustainability.

A focus on Population Health Management in a place based way within the Primary Care Networks (PCNs) and Integrated Care Communities (ICCs) to address the unwarranted variation in management of risk factors and care pathways.

48. In order to reduce overall health inequality, there is much more we can do as a health and care system to ensure people live in optimal health for longer. We need to be audacious with our goals if we are going to make a difference and ensure our priorities align with our health needs assessment. The biggest causes of early death in Morecambe Bay are: cancer, cardiovascular disease and respiratory disease, and the single largest causative factor is smoking. Our aim is to see a 50% reduction in morbidity and mortality over the next 10 years, in our more deprived populations from: cancer under the age of 65, cardiovascular disease (through myocardial infarction, heart attacks and strokes) under the age of 75, respiratory disease under the age of 75 and suicide in people under the age of 50.

49. We are currently developing a new Quality Improvement Scheme (QIS) in conjunction with our colleagues in the Primary Care. With appropriate resource allocation, each PCN will be asked to particularly focus on their populations who are most at risk and who suffer the poorest health outcomes and take a more proactive 'preventative and early detection' approach to each of these conditions. We are developing a plethora of outcome measures to ensure that conditions which lead to increased morbidity and early mortality are managed in line with best practice. These will include improved management of pre-diabetes and early type 2 diabetes, hypertension, atrial fibrillation, asthma, COPD and mental health conditions. The relationship between PCNs and ICCs will also be key, as we ask ICCs to help focus on some of the lifestyle issues which sit as precursors to the conditions aforementioned. Connecting communities together is a key part of breaking down health inequalities.

A fully engaged neighbourhood /community in taking preventative approaches to address health behaviours that impact adversely on Health and Wellbeing – working through PCN's and ICCs to deliver this.

50. Our Integrated Care Communities are already working in very innovative ways in and with the local communities they serve. Currently, many of the KPIs and measurements they are working to are not aligned to a population health approach. If we are going to decrease the burden of disease and poor health outcomes for the people of Morecambe Bay, we need to work with our communities in a more proactive way around the precursors of ill health.

51. We will be working with our ICC colleagues to co-design fresh approaches to working with our communities around: smoking, healthy weight/obesity, loneliness/social isolation, alcohol and drugs and immunisation/screening programmes. In each of these areas, we would like to see a 50% improvement over the next 10 years. This will include initiatives like:
    - pre-habilitation clinics to ensure that no one has elective surgery without the opportunity to achieve optimal health before hand
    - embedding the Ottawa Model across UHMBT
    - working with our county and district councils and our CVFS to improve healthy eating in our communities
    - increased uptake of exercise programmes in our most deprived communities
    - increased availability and access to green spaces – in partnership with our district and county council colleagues
    - the ongoing roll out of the daily mile in schools
    - improved outreach and referrals for people struggling with alcohol and drug addiction
    - increased uptake of vaccination and screening programmes

Population Health Engagement – Working collaboratively with our Community, Voluntary and Faith sector (CVFS) and the neighbourhood themselves to achieve a fully engaged scenario with communities and people who are mobilised for improving their own health and wellbeing.

52. In conjunction with NHS England, we have developed training for our staff across several of our teams in 'Patient Activation Measures'. This is a way of helping people take more responsibility for their own health and understanding how they implement those changes in their lives. We have a rolling programme in which we will be working with more teams over the coming years and therefore working more effectively with our communities. By September 2020 we will have over two hundred and fifty people from the BHCP workforce trained to deliver health coaching and patient activation.

53. The 'Poverty Truth Commission (PTC)' has played a key part in Morecambe Bay over the last two years in helping us understand the maxim that 'nothing about us, without us, is for us'. Over the next ten years, we will continue to work with the PTC to develop such an approach of working with our communities. We have developed a particular approach to engaging with our communities through the 'Art of Hosting' network. We have now trained over 200 people in this 'technology' and look forward to embedding this approach in further community conversations, through the citizens assembly and other local events. Our vision is to encourage our community organisers and train 2500 community champions, over the next five years, who will take a leading role in growing the social movement for better health and wellbeing around Morecambe Bay, with further health festivals along the way as points of cohesion and celebration.

Improving work place health and wellbeing – across all Bay Health Care Partnership (BHCP) employers and the wider workplace.

54. Bay Health and Care Partners are committed to ensuring great workplace health and wellbeing for all our staff. We will continue to work with our colleagues to expand the 'work well' and flourish at work' programmes. We will also continue to embed a 'culture of hope, inclusivity, joy and kindness' across our partnership and enable the development of a 'Bay Deal' with our staff to agree our behaviour framework.

Population Health Deliverables for Morecambe Bay to March 2021

55. Outcome and enabler deliverables have been produced in line with the population health programme of work to March 2021 are available on request.

INTEGRATED CARE COMMUNITIES / COMMUNITY ENGAGEMENT

Community service developments

56. The development of the Integrated Community Stroke Team is progressing with key posts out to advert, new operating processes being developed and key equipment and other clinical equipment being ordered. We are working closely with both County Councils to secure partnership working with their reablement services. We hope to commence operational delivery in Q1 of 2020-21.

57. The engagement about 'Where would you like to be cared for' has concluded and the comments are being evaluated. These will inform the options for appraisal in relation to how both community beds and services will be modernised.

58. We hope to be in a position for progress the development of support to Care Homes now that the expectations of Primary Care Networks have been published. We will spend Q4 exploring ways of progressing this.

59. The work of ICCs continues - importantly, we have agreed with partners a core minimum data set built around the aims of Improved Patient Experience, Improved Population Health, Improved Efficiency and Improved Experience these metrics are now being reported consistently across all ICCs. In addition to attendance, admission and length of stay data, the following elements are reported:

    - WEMWBs - Number of baseline assessments in period (The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing)
    - WEMWBs - Number of secondary assessments
    - Care Plans (cumulative year-to-date and in month)
    - Onward Referrals to other services and agencies
    - MDTs Held in period and number of patients reviewed in period

60. Primary Care Network (PCN) Social Prescribers are also coming into post and we plan to ensure that the existing services work well with these. A meeting is planned for early 2020 with HAWCs, Social Prescribers and Care Navigators to clarify linkages, systems and processes to understand each other's roles and avoid duplication.

Performance

61. We have extended the reporting on ICCs to include activities related to:

- Signposting
- Carer needs identification
- Referrals for Reablement
- Patients' Patient Activation Measure assessments (The Patient Activation Measure is a commercial product which assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare. Individuals who measure high on this assessment typically understand the importance of taking a pro-active role in managing their health and have the skills and confidence to do so. Health Coaching can improve an individual's orientation towards self-care)

We expect that measurement will be further built upon to ensure that the outcomes and changes in activities and processes are adequately captured.

BHCP CLINICAL WORKSTREAM UPDATES

62. Outlined below are the updates on the BHCP transformational workstreams.

Service area	Key activities
Respiratory	• In autumn 2017, a new approach to caring for patients with respiratory disease was established in North Lancashire and Barrow Town through the development of the Morecambe Bay Respiratory Network (MBRN) and monthly respiratory Multi-Disciplinary Team (MDT) meetings. The network consists of healthcare professionals from primary care, specialist, community and hospital teams. • The focus of the MBRN is to improve the management and care of patients with respiratory conditions by significantly increasing the numbers of respiratory patients that are cared for by their GP and within their communities without needing to see a hospital specialist. The changes made since Autumn 2017 have meant fewer patients have needed to come to a hospital outpatient clinic to receive their care. • During 2019/20, the plan is to: extend the MDTs and respiratory clinics to additional GP practices in Barrow and Millom; increase the provision of Pulmonary Rehabilitation in North Lancashire and Furness; and introduce an innovative new pathway of care in North Lancashire. The MBRN project team is progressing well against the plan. • The ultimate aim is to further increase the number of respiratory patients that receive care in the community, and subsequently reduce the need for patients to come to hospital as an outpatient or inpatient.
Pain Management	Pain Management - As the Pain Management Project moves into 2020, it has been decided that a refresh should be carried of the pain management project. This will be an opportunity to look at the model, examine progress to date, identify next

	steps, address any issues preventing delivery and finally how best to implement any changes. The refresh will be carried out at a workshop dedicated to Pain Management on 8th January with all stakeholders.
iMSK	• Sustained 50% (400 patients per month) deflection of referrals to iMSK from orthopaedics following Referral Assessment Service (RAS) launch in July 2019. • RAS II case for change agreed by MBCCG Executive for assessment of Independent Sector referrals and recruitment adverts in place with plan to go live from April 2020. • Two ESCAPE pain cohorts now complete and three more underway in Furness and Carnforth. • Initial meeting with PCN leads to scope economy-wide plan for First Contact Physiotherapy. • Six fracture pathways commenced at Kendal Urgent Treatment Centre.
Frailty	**Community Step-Up/ Step-Down Beds** The public engagement focussing on Langdale Unit at Westmorland General Hospital, Abbey View at Furness General Hospital and Millom Community Hospital has now closed. Since it started on 2nd September 2019, 215 responses to the public survey and 55 to the staff survey have been received. We have attended a number of groups to engage with the public including: • Windermere Wellbeing Fair • Move it or lose it classes in Kendal, Ulverston and Dalton • Furness Carers in Dalton • Citizens Assemblies in Barrow, Kendal and Lancaster • Millom drop-in session Through these sessions we have spoken about the work to 105 people. In addition, information about the engagement was shared with Carers groups, South Lakes & Furness University of the Third Age (U3A) and Catholic Parishes across South Cumbria. The work was featured in the Furness U3A newsletter which is shared with approx. 600 members and the Furness Carers Newsletter posted to approximately 1300 people. Staff sessions were held at Westmorland General, Furness General and Millom Hospital where staff could speak to representatives from the UHMB Integrated Community Care Group, Morecambe Bay Clinical Commissioning Group and UHMB Workforce. The engagement was shared with all UHMB staff through UHMB Corporate Communications and UHMB Weekly News. **Falls Prevention** Agreement achieved to deliver Otago programme pilot in Barrow from January 2020 jointly staffed by Community and Core Clinical Care Groups.
Diabetes	**Improving Type 2 pathways** The work continues to redesign and improve the diabetes patient journey. This project aims to improve the care provided to type 2 patients which will mean that patients will be seen in

	the right place, in the right time and by the right Health Care Professional. The suggested changes will include wrapping services around patients according to their individual needs; in order to reduce their risk of developing diabetes related complications.
Atrial Fibrillation Programme	**AF Programme – Optimising treatment** • The aim of the AF Patient Optimisation programme is to improve the management of people who have been diagnosed with Atrial Fibrillation (AF) by optimising their treatment • To date, 94% of Morecambe Bay GP practices have signed up to the programme and 90% of high risk AF patients have been audited • GPs and Pharmacists are to agree management plans for high risk AF patients jointly. To date, 77% of joint sessions have been completed for interested GP practices and the 23% have been arranged to take place in January 2020. **Optimising Detection of missing AF patients** • Morecambe Bay CCG is working on improving the detection of AF and closing a prevalence gap of 2,149 patients. • 100% of GP practices have expressed interest in using the Alivecor/Karia mobile ECG devices for the accurate detection of AF. Devices have been allocated to GP practices as per weighted population and education sessions have been delivered to 88% of GP practices to date.
Outpatients Programme	Service reviews are progressing well with work completed in a number of areas to improve the alignment between Capacity and Demand. This will reduce the time new patients are waiting for an appointment and the cost of providing our services. A number of small projects are underway and due to be completed by March in order to: • To reduce the number of times clinics and appointments are amended to improve the service we provide to our patients and the efficiency of the booking centre. • Working with our GP partners to improve the referral process for our patients by reviewing the information we provide on our services. A key area of focus over the next 1-2 years is to work with our colleagues and patients across the Bay to review our Pathways. We will be identifying and implementing new processes and systems to improve the way we deliver services to our patients.

And finally…..

Ministry of Health visit from Singapore

63. Following a late request from NHS England to Bay Health and Care Partners on New Years Eve 2019, Bay Health and Care Partners hosted a successful visit by three visitors from the Ministry of Health Office of Health Transformation (MOHT) in Singapore on Friday 10th January 2020.

64. The MOHT team had seen the work that BHCP has progressed as a Vanguard site but also the work we continue to progress on Population Health as we move forward and progress Better Care Together for 2020 and beyond. They were keen to learn from our experiences and how they could take back some of the learning to support community engagement and involvement in Singapore.

65. The visitors included Dr Loke Wai Chiong (Director), Mr Manish Nair (Manager) and Ms Moira Png (Executive). During the visit, they observed meetings about the care of adults and older people and about population health and engagement hosted by Bay ICC at Heysham Primary Care Centre and a meeting of the Morecambe Bay Poverty Truth Commission at Moor Lane Mills in Lancaster. They were also given presentations about the strategic context of the healthcare system in Morecambe Bay, population health in Morecambe Bay and about the work which has been undertaken to engage with local communities using Art of Hosting techniques. Further discussions also took place about Integrated Care Communities (ICCs), Primary Care Networks (PCNs), Health Needs Assessments, broader aspects of population health engagement and the possibilities for future collaboration and shared learning between BHCP and MOHT.

From L to R: Mark Wight, Dr Andy Knox, Moira Png, Claire Niebieski, Karen Kyle, Manish Nair, Dr Loke Wai Chiong.