Forward View into Action

REGISTRATION OF INTEREST

Q1. Who is making the application?

This application is from eleven organisations that have been working in partnership for almost two years on the Better Care Together programme in the Morecambe Bay health and care system. The partners for this application include:

Five NHS Trusts;
Two NHS Clinical Commissioning Groups;
Two Local Authorities;
Two GP Federations covering the Morecambe Bay area.

Other partners are working on elements of the Better Care Together programme and include local academic institutions, the NW Coast AHSN, Healthwatch organisations and several voluntary organisations. A full listing is provided in Appendix A.

The programme contact (SRO) is Andrew Bennett, Chief Officer, Lancashire North CCG. His email address is Andrew.Bennett@lancashirenorthccg.nhs.uk. Telephone contact details are 01524 519 213.

Q2. What are you trying to do?

The quality, safety and financial challenges we face in Morecambe Bay are well known. The difficulties in our hospitals have been widely reported but we know that some of the root causes of our hospitals' problems begin in primary, community and social care. In the recent past we have sometimes let our patients and their families down with devastating consequences. In addition we are failing to live within our financial means, and at times struggle to sustain essential services. The challenges of our patch are unusual in being very rural, with pockets of isolated towns which contain significant deprivation and a Hospitals Trust providing service on sites over fifty miles apart.

Tinkering with the system will not deliver the scale of change we need. For this reason 22 months ago the partners in this application embarked on an ambitious programme to design and deliver an integrated health and care system for our population of 365,000 residents. It has become clear that we need to create an *Accountable Care System of Provision* that will take responsibility for the whole health and care needs of our population, working to a single set of objectives under a single delegated capitated budget. Such an approach will create the right incentives for the whole system to focus on keeping individuals, families and communities healthy, and to develop and grow our capacity in general practice and other community based services, while our hospitals can focus on delivering what they alone can deliver.

The Better Care Together partners have already developed a five year Strategy and a two year Delivery Plan of transformational service change to address our key health challenges, namely:

1. Improving the sustainability of our services to meet the current and future health needs of our local communities
2. Improving the quality, safety and experience of patients using local health services.
3. Reducing the health system financial deficit – assessed at £26m at the start of 2014/15.

4. Addressing the specific issues faced in 1-3 above in a local health and care economy that is geographically dispersed, financially challenged with distinct areas of deprivation and health inequality.

This strategy is based on successfully managing the transition to a smaller, more productive hospital sector working interdependently with a much more integrated out of hospital sector.

As we implement our strategy, individuals and their families will not experience a radical upheaval in local services; rather they will experience care and support that works exactly the way it should, all of the time. They will also experience a quantum change in the support available that allows them to take control of their health and wellbeing. Most of their care and support will be provided within their local community based around their GP practice, with access to safe and high quality specialist care as and when needed.

In essence, Better Care Together will see the development of multidisciplinary core teams based within natural communities across the Bay, built upon increased, more effective general practice capacity and capability, with an expansion of community based specialist services. All leading to significant reductions in hospital admissions for both emergency and planned care. Hospitals will be smaller, safer and more responsive to the needs of the people using them and the requirements of the community based teams they are supporting. Increasingly hospital clinicians will work within the community based teams fostering a shared approach to staff development and improving pathways of care.

Some of the most far reaching changes will be experienced by general practice, which needs to move away from the traditional corner shop model to working both at scale and as part of integrated community based teams. The challenge is to achieve this in such a way that patients still feel they are looked after by GPs and teams who know and understand them. The Millom Alliance, described later, illustrates how this change is already occurring locally. GP leaders are up for this challenge and both CCGs and the two GP Federations are working together to take general practice to a place where it is sustainable, delivers consistent high quality care, and is part of a new integrated system of care.

Underpinning the changes we envisage is the need to build our services on a strong platform. Key components of this platform are:

- Workforce planning - ensuring we have the right people with the right skills, and developing innovative and challenging roles that attract the best;
- Organisational development capacity – although this expression of interest is about a new model of care, at the heart of what we are delivering is service change which requires the people we employ (from system leaders to frontline staff) to think, behave and work differently. Our health and care system must become one that is “devoted to continual learning and improvement of patient care, top to bottom and end to end”;
- An integrated electronic health record and the wider use of information technology.

Q3. Which model(s) are you pursuing?

As we have said, we are working to create an Accountable Care System of Provision that will take responsibility for the whole health and care needs of our population, under a single delegated capitated budget. The end point of this journey will be a PACS.

However, we believe our rurality and the centrality of a new community-based model of provision mean that elements of our delivery system will behave like a MCP. At the same time our Hospitals Trust is absolutely central to our strategy and is looking to move a number of specialists and teams into the community, to work much more closely with general practice and community teams – clear features of the PACS model. So, the journey we have already started is taking us on a path to a hybrid model. This approach allows form to follow function, a principle that has underpinned much of our planning to date.

Q4. Where have you got to?

An established programme of whole system change
We have already established a firm foundation upon which our expression of interest seeks to build:

- Over the past two years Better Care Together has drawn **a range of health and social care organisations into a mature partnership**. We have clear and well-defined governance structures, processes and systems which have recently been commended by NHS England. We already have a group of system and clinical leaders working with a common purpose to endorse our expression of interest in the new care models;
- Our **clear and ambitious Strategy and Delivery Plan have been clinically led with wide patient and stakeholder engagement.** More than 200 health and care professionals were involved in the development of our clinical models. We submitted these to NHS England and Monitor last October as part of an agreed system approach and now want to use the new models programme to accelerate the delivery of our proposals for an Accountable Care System of Provision;
- We believe that the future care models developed by our care professionals are closely aligned to the characteristics set out in the Five Year Forward View. Our local **clinical senate has agreed to act as a critical friend** as we begin to implement and evaluate changes to our services. As part of this process, we have committed to provide evidence of improvements in quality standards both where we make major changes and also where existing services are maintained (such as A&E and Maternity services);
- We have already **invested in transformation**, in developing the Strategy and now in identifying partner organisations to support our approach to continuous improvement and learning. These include the the Advancing Quality Alliance (AQUA) and the Cumbria Learning and Improvement Collaborative (CLIC) which will support a consistent approach for continuous improvement in quality to all organisations on the patch, as advocated by Don Berwick;
- We have **an agreement with the Ribera Salud organisation in Spain** to develop a mentoring relationship with us. In Alzira, Ribera Salud functions as an Accountable Care Organisation with a capitated budget for delivery of all health care to the local population. This demonstrates many of the attributes of service integration to which we aspire and has delivered major improvements in health outcomes and cost effectiveness. A team from Ribera Salud are coming to Morecambe Bay in late March/early April;
- Following a recent review by colleagues from NHS England and Monitor of the Better Care Together programme, we were encouraged that our plans to submit this expression of interest were fully endorsed.

Commitment and Investment
Several of the partners have already invested in the development of the new care models we are proposing. This is in addition to the commitments made by both CCGs towards the Better Care Fund plans in Cumbria and Lancashire. During 2014/15, **investments of £1m have been made in the new out of hospital service model** in South Cumbria and further commitments may be made in 2015/16 subject to the financial planning round. A similar commitment of further £0.5 - £1 million will be invested by Lancashire North CCG in local out of hospital services during 2015/16.

Early Wins
Progress made in 2014/15 includes the:

- Establishment of the **Millom Alliance where local GPs have created a joint agreement with Cumbria Partnership NHS FT, University Hospitals of Morecambe Bay NHS FT, the voluntary sector and other community stakeholders** to work on a number of local health priorities. This has already led to gains in terms of intensive care home support, the assessment of older people before discharge from hospital and GP recruitment. Success in Millom will help accelerate learning for other multidisciplinary core teams (more details on this case study are outlined in Appendix B);
- Roll out of an **innovative Advice and Guidance** service developed jointly by GPs working with hospital consultants and IT leads to facilitate electronic referral advice, reducing demand for outpatient appointments (more details on this case study are outlined in Appendix C);
- Extended working in general practice is being delivered 8am-8pm each day in Morecambe after a successful bid under the **Prime Minister's Challenge Fund**.

Leaders in the use of Technology

We are a recognised **leader nationally in the use of technology** to support service integration and in managing change. In 2014 our health system was selected as **one of three national rapid "accelerator" sites** for the use of technology in patient care and two key projects are delivering real benefits on the ground. Firstly, our electronic referral and resource matching system (in partnership with STRATA Health), which acts like an air traffic control system for health and social care, guiding patients round the system and matching capacity and demand. Around 1000 referrals per month are now being made by electronic transfer between various parts of the system, which also enables staff to track progress of the referrals and proactively manage blockages in patient pathways between different parts of the system, including between health and social care.

The second project relates to the **sharing of a patient's clinical information across the health system using Emis Web and the Medical Interoperability Gateway (MIG**), which currently facilitate the sharing of clinical information across key services including general practice (in and out of hours), A&E, community teams, community wards and the local hospice. Our plans are to support increasing service integration through the development of a fully interoperable clinical record system, along with resource planning and scheduling tools for use by our clinical teams. We are also further developing our assistive technology plans to offer greater support to people in our many remote communities. Our plans are dependent on access to further capital and we continue to bid to attract NHS Technology fund support. A recent article by e-Health Insider gives further details of our progress to date - http://www.ehi.co.uk/insight/analysis/1356/chocks-away

Q5. Where do you think you could get to by April 2016?

Out of Hospital Model

Given our current state of readiness, we believe that by April 2016, we can establish a network of at least 10 multidisciplinary integrated core teams based in the community around groups of general practices. These will be supported by enhanced community specialist services to provide care focused on frail elderly and those with long term conditions. These developments will provide rich data from which to evaluate the effectiveness of different team approaches on preventing admissions to hospitals and improving the health status of our populations.

The focus of the programme will also include:

- A self-care programme pilot available for evaluation which will seek to maximise existing community assets;
- The design of a care co-ordination service across the communities to streamline access to services, particularly for patients with urgent care needs;
- A new urgent care service at Furness General Hospital to provide a greater range of enhanced emergency ambulatory care pathways integrated with primary care;
- Further development of clinical information systems to move nearer to a single electronic patient health record used by all members of the multidisciplinary integrated core team.

Our forecast is that the above developments will reduce our admission rates by 3% per annum based on current trends, which equates for 25-30 admissions per week. This will lead to a reduction in 24 beds or 4% of existing capacity by April 2016. Our ambition is that these rates should reduce by 7% (50-55 per week) by the end of 2016/17.

Planned Care

By April 2016, we are planning to:

- Provide evidence of improved patient experience and outcomes based on revised pathways of planned care in at least 4 high volume services.
- Complete the implementation of our advice and guidance service to include the majority of specialties across Morecambe Bay, providing GPs with electronic access to specialist opinion and reducing the need for onward specialist referral;
- Implement a referral support service offering information and expertise to patients and GPs which leads to a significant reduction in outpatient attendances.

Our plan is reduce outpatient activity which equates to 14 clinics per week by April 2016 rising to 48 clinics per week by April 2017;

Use of Resources
We have also set specific goals regarding the better use of resources. By April 2016 this includes:

- Realising savings of £6.6m (gross) from existing services, reinvesting a proportion of these in expanding the capacity of community based teams;
- Reducing our reliance on temporary staff by around 150-200 wte within our hospitals;
- Completing preparations to introduce a shadow delegated capitated budget for the provision of health care across Morecambe Bay in 2016/17.

Steps to Integration
By April 2016, it is expected that a Memorandum of Understanding will be agreed between system partners including NHS England, CCGs, providers and local authorities stating how we will commit to the successful delivery of the new care models and the development of Morecambe Bay as an Accountable Care System of Provision.

For the coming financial year the two CCGs have agreed to use contractual forms with our Morecambe Bay providers that encourage rather than hinder our journey towards greater integration. Lancashire North CCG and Cumbria CCG have already agreed to pursue a system-wide approach to commissioning in Morecambe Bay with the development of a Better Care Together Commissioning Team by the autumn of 2015. In turn this will support the introduction of a shadow delegated capitated budget for the developing Accountable Care System of Provision from 2016/17.

Q6. What do you want from a structured national programme?

We believe the involvement of Better Care Together in this national programme can offer an evidence base for health economies with an imperative to change that is similar to ourselves. We would welcome the opportunity to work with other systems and national experts to support our learning and improvement and help us to address the challenges we face in areas such as:

- Redesign of the clinical workforce;
- Achieving cultural change across multiple organisations with a focus on multidisciplinary team working and leadership at all levels;
- Developing a genuine 'whole-system' financial model which sets a clear baseline and helps track financial flows as we move towards a capitated budget for the Accountable Care System;
- Expertise on developing new contractural forms which will enable the organisational partners to move towards integration;
- Commissioning an independent evaluation on the outcomes of our proposed service changes and move to a radically new model of care.

In addition, our programme will benefit from access to the following resources:

- Analytical and health economics expertise to develop a real time, system-wide performance and outcome framework which will allow us to assess and manage the extent to which we are achieving the triple aim of improving outcomes, experience (both patient and staff) and cost effectiveness;
- "Best in class" programme management resources.

Appendix A - Applicant names

The partners for this application are all members of the BCT Programme Board comprising of

- Five NHS Trusts:
  - University Hospitals Morecambe Bay NHS Foundation Trust
  - Cumbria Partnership NHS Foundation Trust
  - Blackpool Teaching Hospitals NHS Foundation Trust
  - Lancashire Care NHS Foundation Trust
  - North West Ambulance Service NHS Trust (NWAS)
- Two NHS Clinical Commissioning Groups:
  - NHS Lancashire North Clinical Commissioning Group
  - NHS Cumbria Clinical Commissioning Group
- Two Local Authorities:
  - Lancashire County Council
  - Cumbria County Council
- Two GP Provider Federations
  - North Lancashire Medical Group
  - South Cumbria Primary Care Collaborative

Other support applicants who are working on elements of Better Care Together programme:

- Local Academic partners (Lancaster University, University of Cumbria, North West Coast Academic Science network, Cumbria Local Enterprise Partnership, Cumbria Rural Health Forum)
- Health Watch in Cumbria and Lancashire
- Many voluntary organisations (over 20 in total)

NORTH WEST COAST ACADEMIC HEALTH SCIENCE NETWORK

The North West Coast Academic Health Science Network fully supports this application from the Better Care Programme as a means to achieve the vision for a new model of care for the population of Morecambe Bay.

AHSNs have an agenda to drive adoption and spread of innovation across all areas of healthcare provision and population health, they bring together the resources and assets in their geography to create a synergy between researchers in universities, industry and entrepreneurs, and the NHS to identify and exploit innovations that will have national and international significance

The regions' senior leaders have fully engaged with the innovation agenda of the AHSN. Two of the Trust Chief Executives and the Clinical Chair for Lancashire North CCG sit on the AHSN Board to ensure that the AHSN responds to the needs of local residents. The AHSN has contributed to the Better Care Together programme and there are a number of ways in which it supports the application for the Forward View into Action.

Yours sincerely

Liz Mear

Dr Liz Mear

Chief Executive, North West Coast Academic Health Science Network

Appendix B

Millom Case Study – Better Care Together in Action

Millom is a small geographically isolated town in South Cumbria and is an example of early collaborative working as part of the Better Care Together Programme. Its population is just 8500 yet there are over 17,600 journeys out of the town every year for a clinic, A&E appointment or admission. This journey that takes 50 minutes on extremely poor roads, and costs £40 in a taxi. The local general practice tried for 18 months to recruit to vacancies without a single applicant and could no longer cover Millom community hospital which closed temporarily. Within days a march of 2000 people occurred in the town to complain about the crisis in health services.

In response the GP practice, University Hospitals Morecambe Bay FT and Cumbria Partnership FT are working together through an overarching agreement to create the first multi-speciality practice in Cumbria. We are turning Millom from the most geographically isolated community in South Cumbria into the most connected. We are working in close partnership with the community itself and with social care, North West Ambulance Service and the out of hours GP provider. The community group that organised the march through the town is leading on all our communications.

By working together in just 6 months we have:

- Produced a community led GP recruitment video with 5000 views in the first week. This was spread by social media and tweeted by large numbers of the community. This has led to the successful recruitment of 3 general practitioners with another GP joining in August when she finishes her training'. For a link to the community led recruitment video click here: https://www.youtube.com/watch?v=8rky8n7Co5U
- Moved the general practice surgery from its old premises into refurbished clinic space in the hospital.
- Re-opened the hospital ward
- Placed the first advanced community paramedic in the North West in Millom fully integrated within the clinical team.
- Promoted the pharmacy minor illness scheme resulting in massive increase in the use of this as an alternative to GP attendance in Millom.
- Co-opted a shop window in Millom for health promotion and updates for the town and created a new town newspaper 'Around the Coombe' full of health promotion messages
- Distributed leaflets on how best to use your health services at Millom carnival.
- Surveyed the town to ask their views and priorities for healthcare and designed our services to meet these priorities
- Begun to implement the Better Care Together out of hospital clinical model with intensive care home support and care coordination.

"The NHS are really listening to the community, and I don't think anything like this has been done before."

Local newspaper quote from the Millom Action Group who weeks before were organising protest marches in the streets.

Appendix C

Advice and Guidance – Better Care Together in Action

'Advice and Guidance' is an innovative and collaborative project between Lancashire North Clinical Commissioning Group and University Hospitals of Morecambe Bay Foundation Trust. The project team set out to develop and pilot a bespoke, user-friendly, secure web-based IT system to allow GPs to obtain patient-specific advice from local hospital specialists. The system encourages closer collaboration and communication between primary and secondary care, enabling GPs to manage more patients in the community.

The system was designed with a focus on ease of use, data-security and accessibility at the point of care, allowing GPs and consultants to work **in partnership on behalf of a specific patient**. The new system was jointly developed by clinicians and managers from the CCG and the Trust, supported by the local Informatics team. Plans are now in place to extend this successful initiative across Morecambe Bay and to increase the number of specialties and providers available within the system.

Clinical benefits

- Quick access to specialist advice for GPs, empowering them to manage a patient's problem themselves where appropriate.
- Enhanced collaborative, team-working approach between doctors around a patient's care.
- A more structured approach to specialists offering advice compared with ad-hoc methods previously used on an informal basis.
- Offers information and support in the context of continuing professional development.

Patient benefits

- Quick access to specialist advice and guidance for both diagnostic and treatment options.
- A reduction in the need for patients to travel to hospital for outpatient appointments.
- Appropriate investigations/treatment suggestions authorised and actioned by the specialists prior to any subsequent initial outpatient appointment.

Advice and Guidance is having a positive impact on how patients are managed within our local healthcare system. Of the cohort of patients who have received advice and guidance, GPs have reported a 47% reduction in the number of patients that they would have previously referred for an outpatient appointment.

"The best invention in this area in a very long time"

Local consultant commenting on the new Advice and Guidance system.