Bay Health & Care Partners delivering

bettercare together

NHS

BETTER CARE TOGETHER

Developing our Bay Strategy for the next five years 2019 – 2024

Shaping our plans

Bay Health and Care Partners (the Partners) - made up of local GPs, hospitals, as well as doctors, nurses and community social care - have been working together since 2014 to deliver a plan, "Better Care Together", to improve health and social care services across the area.

Developing our plan for the next five years

We are now developing a five-year plan for health and social care in Morecambe Bay. We haven't worked out all the details yet and so your feedback will help us to clearly understand our priorities for the next five years and make sure we are targeting the things that are most important to you, your family and your community.

Our first step in preparing our plan is to listen to people's views and to share our challenges and the priorities we intend to work towards. We are inviting the public, patients and the wider civic community of Morecambe Bay to give their views on the effectiveness of our priorities to meet the challenges ahead.

We are asking for views on our next steps for the local long-term future for health and social care services in the Morecambe Bay area. This also links to the long-term plan for the NHS which has set national priorities and the regional plans for the whole of Lancashire and South Cumbria.

Since 2014, Better Care Together has:

- Become part of the national Atrial Fibrillation programme: we are identifying patients on GP registers who are at risk of a stroke and would benefit from anti-coagulation medication. This will reduce strokes and prevent unnecessary hospital admissions
- Developed nine Integrated Care Communities (ICCs) around the Bay. These ICCs are integrating primary and community care (such as district nurses, social workers and physios) closer to home, particularly working with patients with complex needs and reducing the need for hospital admissions.
- Set out a population health framework and strategy and working with partners on a clear set of initiatives for the next five years,
- Developed a new frailty pathway to help to identify older people who may need earlier support (both health and social care) to maintain their independence in their own home.

More information on the work of Better Care Together is described alongside each draft priority.

We are asking for views on our next steps for the local long-term future for health and social care services in the Morecambe Bay area.

Our vision

To see a network of communities across Morecambe Bay enjoying great physical, mental and emotional wellbeing, supported by a health and care system that is recognised as being as good as it gets.

To achieve our vision, we have three goals:

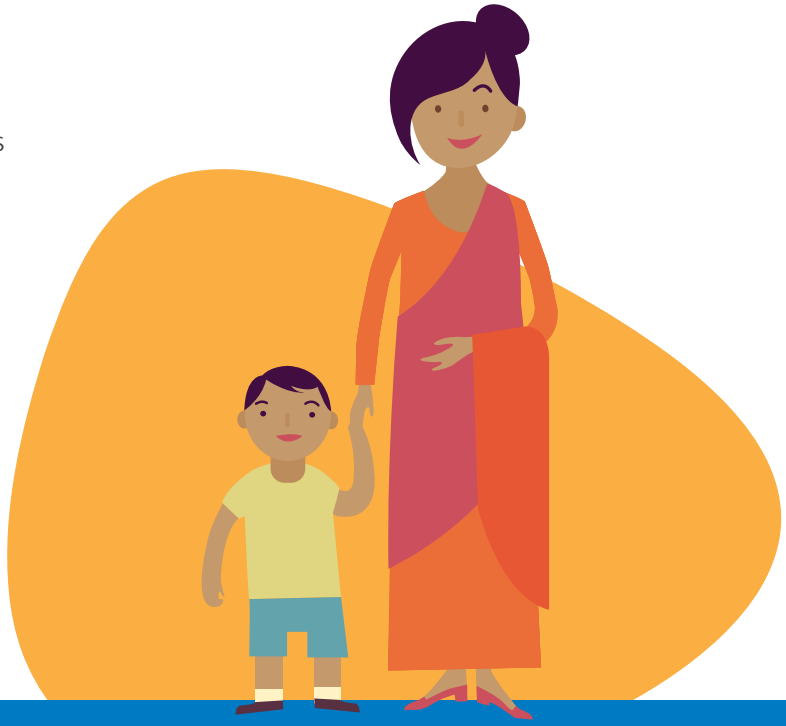
- **Better Health** we will improve population health and wellbeing and reduce health inequalities
- **Better Care** we will improve individual outcomes, quality and experience of care
- **Delivered Sustainably** we will create an environment for motivated, happy staff and live within our means.

Part of planning for the future includes reviewing what we already do, to make sure our services meet our goals and, if needed, to make changes now that will respond to the needs of the future.

Our review, alongside evidence gathered from a needs assessment, tells us that we have distinct challenges to overcome and we need to change now to achieve our goals in the future.

Briefly, our challenges include:

- An ageing population, which is already older than the national average,
- Many residents are living with one or more long-term condition
- We are not meeting national standards of care especially for: cancer; urgent care; routine surgery; Children and Adolescent Mental Health Services access; and anti-microbial resistance.
- The three biggest causes of premature mortality locally are cancer, cardio-vascular disease & respiratory disease and we can improve life expectancy if we take action to improve care in these areas
- We need to improve healthy living services and education for children and adults, particularly for smoking, obesity and exercise, mental wellbeing and alcohol and substance misuse. We will work locally and collaboratively on a population health approach
- Getting the right workforce, with the right skills and in buildings that are fit-for-purpose
- We need to deliver our goals for a sustainable budget.



Our draft priorities

Our priorities for the next five years have been developed to help us meet future health and care needs, as well as improving standards and meeting national NHS requirements. We have chosen these as our priorities because they are the areas where we can make most difference, with the resources and skills that we have.

Priorities

To tackle the needs we face we have created five priorities for how we will reach our goals:

1. Taking more action on prevention and health inequalities through a **'population health'** approach
2. Further strengthen the sustainability of general practice and provide improved care through **Integrated care communities** and new **Primary Care Networks**
3. Deliver care that **will prioritise real improvements** in mental health, cancer, emergency care and planned care and **meet national standards**
4. Improve financial sustainability alongside the quality of service delivery
5. Develop and deliver more integrated care locally using the new NHS infrastructure at three levels: Lancashire and South Cumbria Integrated Care System; Morecambe Bay Integrated Care Partnership; and Integrated Care Community and Primary Care Network.

Taking more action on prevention and health inequalities through a '**population health**' approach

Why is this a priority?

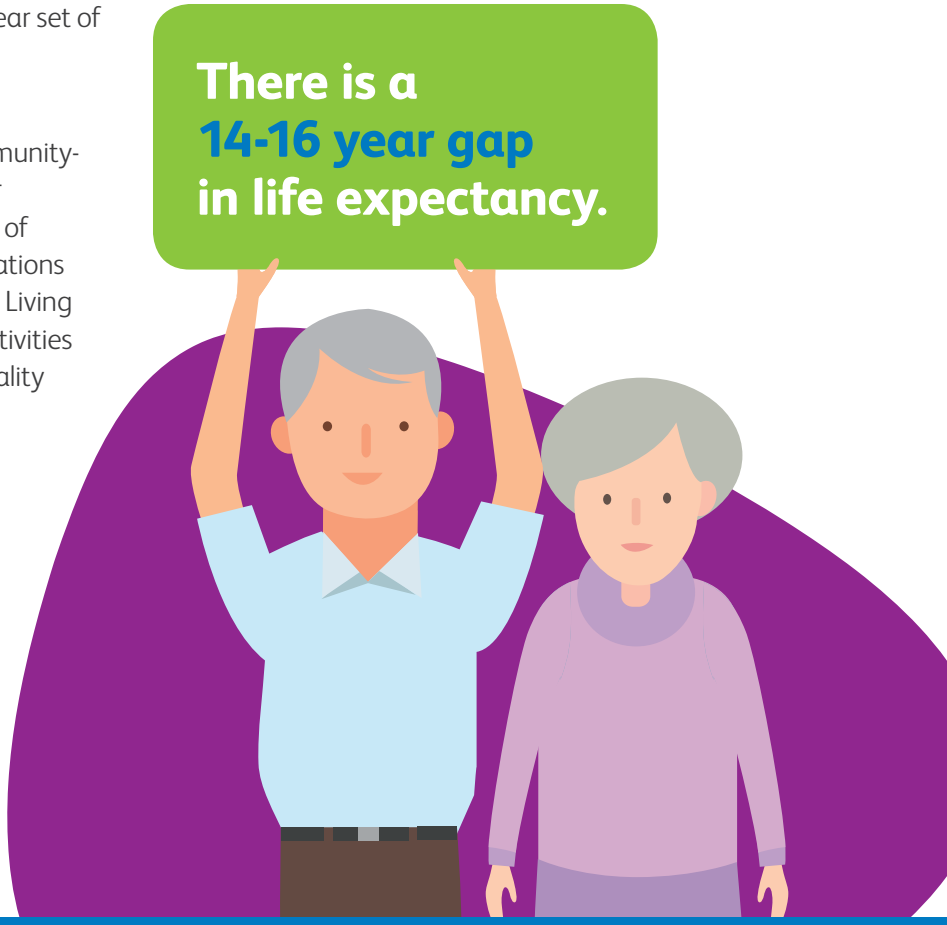
- We still have a significant challenge with health inequalities across our communities – there is a 14-16 year gap in life expectancy between wards and years spent in poor health are much higher in deprived communities
- We need to work with our communities on a population health approach, to improve healthy living for children and adults, particularly for so-called lifestyle challenges of smoking, obesity and exercise, mental wellbeing and alcohol and substance misuse
- The three biggest causes of premature mortality are cancer, cardio-vascular disease and respiratory and we can improve life expectancy if we take action to improve care in these areas
- We need to work in partnership with others to help tackle the wider determinants of poor health (e.g. housing, education, employment).

What have we done so far?

- We have set out a population health framework and strategy and working with partners on a clear set of initiatives for the next five years
- We have worked with our integrated care communities to support a number of community-based health events, such as the Lancaster Healthfest (a four-day festival with a series of events across the city to help start conversations about health and wellbeing) and St Mary's Living Well Centre which offers a range of free activities enabling more people to enjoy a better quality of life
- We are part of the national Atrial Fibrillation programme: we are identifying patients on GP registers who are at risk of a stroke and would benefit from anti-coagulation. This will reduce strokes and unnecessary hospital admissions
- We are also developing a diabetes pathway aimed at drastically reducing the number of people with type 2 diabetes and supporting those who have diabetes to manage their own condition better.

What will this priority mean for me?

It will mean health services that focus more on preventing ill health and reducing the need for people to visit hospital. Help will still be there when you need it for things like operations, or in emergencies, but we are planning more health services (for example, managing a condition that is long-lasting, such as diabetes) available to you in your community, through your GP working with nurses, or by working with pharmacists and other specialists in your community. Above all, we want to help you to take action to stay fit and well, and to feel in charge of your care 'plan' if you are ill.



Strengthen the sustainability of general practice and provide improved care through Integrated Care Communities and Primary Care Networks

Why is this a priority?

- Our population is already older than the national average and ageing at a fast rate: there is a need to have good pathways and models of care to support frail older people
- We have a significant proportion of patients with one or more long-term conditions, there are high levels of unnecessary hospital admissions and outcomes could be better for adults and children
- Too often care isn't joined up leading to waste and poor patient experience; the way the NHS (and social care) is organised nationally and locally needs to change to support integration
- In many cases services are still organised the way they were 20-30 years ago or around the NHS and not around patients: we need to empower patients to manage their own care, increase care in community settings and radically change the way we deliver services such as outpatients
- The proportion of children within the overall population is falling and outcomes and services are not what they need to be if we are to give young people the best start in life.

What have we done so far?

- We have developed nine Integrated Care Communities (ICCs) around the Bay. These ICCs are integrating primary and community care (such as, district nurses, social workers and physios) closer to home, particularly working with patients with complex needs and reducing the need for hospital admissions
- We have developed an Integrated Musculoskeletal Service in the Bay where patients can get enhanced physiotherapy as an alternative to more invasive surgery. This is reducing outpatient referrals by 50%. We are now piloting 'ESCAPE – pain': a programme supporting patients with arthritis to improve self-management of their pain
- We have piloted a new respiratory model in Lancaster and Morecambe, with enhanced care planning and management of the condition in a community setting, led by GPs with enhanced support from consultants. This has reduced outpatient appointments by 60%. The model is being rolled out across the Bay with enhanced community nursing support
- We have developed a new frailty pathway with 'risk stratification' by GP practices and ICCs to help to identify older people who may need earlier support (both health and social care) to maintain their independence in their own home.

What will this priority mean for me?

By creating the nine integrated care communities we are integrating services and focusing our resources on the needs of local communities. It will also help us to strengthen the links between health and social care. Most importantly, it means we can work with you to help prevent poor health in the first place but if you do become ill, to work jointly with you to plan to meet your needs in the best way possible. When we get this right we know it reduces unnecessary hospital appointments and admissions.

In practice, this means that we will use a range of information to manage the health of the community proactively, by using predictive studies and early diagnosis to better identify and support people to stay healthy. We will be able to provide more coordinated care for the increasing number of people with long-term health conditions, by working in partnership. Individuals, families and communities will have a bigger role in managing their own health and wellbeing.

Our population is already older than the national average and ageing at a fast rate.

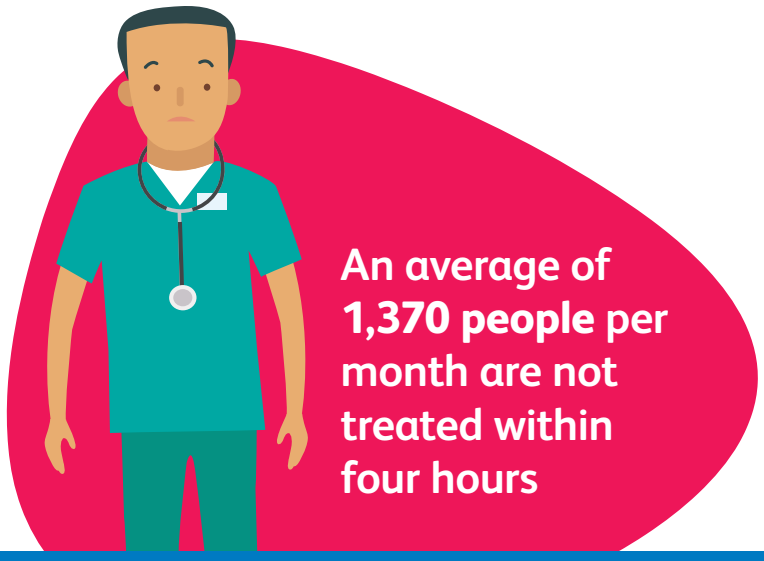
Deliver care that will prioritise real improvements in mental health, cancer, emergency care and planned care and meet national standards

Why is this a priority?

We are not as good in providing these services as we would like to be. For example:

- The NHS expects to treat 95% of patients who attend A&E within four hours: at present we are only treating 82%. This means that an average of 1,370 people per month are not treated within four hours
- Where patients are not seen within four hours, no patient should wait longer than 12 hours. But at present an average of 65 patients per month wait 12 hours or more – many of these patients have mental health needs and A&E is not the right environment for their care
- The NHS expects that 85% of people who require cancer treatment receive that care within 62 days of being referred: at present only 77% are being treated. This means that 72 people a month are not being treated within the required timescales
- The NHS expects to treat 92% of patients within 18 weeks and no patient should wait longer than 52 weeks. At present only 82% of people are treated in 18 weeks and in 2018/19 many patients waited longer than 52 weeks. There were 116 breaches of the 52 weeks target (may include double counting of patients).

The causes of this underperformance are complex and varied. In most cases, rising demand and workforce recruitment are key factors – getting enough staff, with the right skills to live and work locally.



These are also priorities identified by NHS England for all healthcare services. But we can do more locally: for example, we know we need to improve the quality of care and availability of primary and community mental health care services for both children and adults.

What have we done so far?

- We are investing in additional community mental health services to support people before they reach crisis point. For example, we have expanded Improving Access to Psychological Therapies (talking therapies to help people with conditions such as anxiety and depression); we are also working with third sector organisations such as the Well and Richmond Fellowship to support people with a mental health crisis in the community as an alternative to A&E
- We are working with children and young people on a 'thrive' model for wellbeing and resilience. We have also been awarded accepted as 'trailblazer' to pilot new Mental Health Support Teams for early intervention on mental health and emotional wellbeing issues within school and college settings
- We are implementing new cancer pathways aimed at speeding up cancer diagnosis and treatment
- We are looking to new models of care in the community and efficiencies in the hospital to ensure more people are treated in A&E within four hours
- We are working with other providers (such as high street opticians and the independent sector) to ensure we have sufficient capacity to treat more patients as well as taking action to improve our local operating theatre efficiency and improving the way we organise outpatients.

What will this priority mean for me?

Better, faster access to expert diagnosis and advice at the right time and in the right setting. It will also see more children and young people getting support for their mental health at an early stage, as well as cancer patients receiving treatment more quickly. All this will improve long term outcomes and patient experience.

Improve financial sustainability alongside the quality of service delivery

Why is this a priority?

- We are spending £70m more than we receive from Government and many of our services cost significantly more than similar areas – even taking into account our geography and demography
- National recruitment shortages lead to significant gaps in our workforce, creating fragility in many of our services. For example, we have 27 vacancies for GPs in the area – 11% of the total GP workforce; and we have 160 nurse vacancies in hospital – 9% of total nurse workforce
- There is still too much waste in many of our services: for example, we have a 'did not attend' rate of 8%, (46,000 appointments) where patients did not come to an appointment or operation booked. This means staff can't use their time efficiently. With a monthly average of nearly 5,000 missed outpatient appointments that's £50,000 per month we could invest in improving services elsewhere
- Local authority funding has reduced by an average of 40% over the last five years impacting on care support; and there is fragility in the care sector, such as residential care and nursing homes
- We are not always maximising the use of digital technology to improve the way we deliver care to support sustainability of services
- Parts of our estates and some of our key equipment (e.g. theatres and diagnostic equipment) need upgrading but a lack of national capital is preventing this.

What have we done so far?

- More patients get treatment more quickly and now do not need to travel to hospital for an outpatient appointment, as GPs can speak to a hospital specialist easily: from April 2018 to April 2019, 10,426 conversations took place between GPs and hospital specialists.
- Nearly 16,000 patients who previously travelled to hospital for eye care have instead been seen at their local opticians. As well as reducing travel and associated costs for patients, it also means less waiting time. It also frees up appointments for people with more complex conditions that can only be managed in a hospital
- Patient Initiated Follow Up (PIFU) means that patients choose whether they are coping well with their condition and don't need a follow up appointment. This frees up clinical time for more complicated cases. Beginning in February 2017 in rheumatology, PIFU has expanded to cover 1,466 patients in four specialities: rheumatology; respiratory; gynaecology; and diabetic medicine
- More than 44,000 people across Morecambe Bay now book and cancel GP appointments, receive appointment reminders and add any important details to their personal calendars using the myGP iPlato app. People use the myGP app to order repeat prescriptions online, monitor the medication they are taking and share this information with healthcare professionals if needed.

What will this priority mean for me?

The NHS requires us to balance expenditure with the level of funding we have been allocated – or action could be taken by people from outside our area who do not understand our needs or the impact of their decisions. But very often, getting the right model of care leads to efficiency and savings: as the community eye care example above showed. Increasing our financial stability means that we can focus our long-term investment on the staffing and services that we need for the future. Increased staffing or new types of role mean more support for patients in the right setting: for example, new roles in primary care (such as first contact physiotherapists, social prescribers and more pharmacists) means patients will find it easier to access GPs when they need to.

5,000 outpatient appointments are missed each month. That's £50,000 we could invest in improving services

Develop and deliver more integrated care locally using the new NHS infrastructure at three levels: Lancashire and South Cumbria Integrated Care System; Morecambe Bay Integrated Care Partnership; and Integrated Care Community and Primary Care Network

Why is this a priority?

In the **Long Term Plan**, NHS leaders have set out a new organisational structure for the NHS. This structure focuses on delivery of health and care on geographical 'place' basis, with more collaborative planning to integrate services. All NHS organisations are developing plans to implement this new way of working.

For us, this means working at three different levels locally:

- **Integrated Care Community:** typically based on population of 30-60,000; with a focus on integrating care at neighbourhood level for long term conditions (such as respiratory and diabetes) with a population health focus on prevention and wellbeing, as well as better social care and managing frailty
- **Morecambe Bay Integrated Care Partnership:** based on the 345,000 people of Morecambe Bay; with a focus on general hospital services (such as A&E and surgery) and mental health and community services best delivered on a wider footprint than ICC (such as Integrated Musculoskeletal Service and community mental health teams)
- **Lancashire and South Cumbria Integrated Care Systems:** based on the 1.7m population; with a focus on setting consistent standards, allocating resources in line with need and organising specialist services best delivered on a bigger footprint (such as radiotherapy or hyper acute stroke units).

What have we done so far?

- We have already established nine Integrated Care Communities, who are integrating community health services and social care around GPs and patients and improving outcomes and patient experience in areas such as respiratory and frailty
- We have established Bay Health and Care Partners (BHCP) as an Integrated Care Partnership to ensure we plan and deliver health and care together in the best interests of people in Morecambe Bay
- We are also part of the Lancashire and South Cumbria Integrated Care System
- BHCP has combined services from Blackpool Teaching Hospital Trust, Cumbria Partnership Foundation Trust and University Hospitals Morecambe Bay Trust into one organisation to support integration and ensure consistent approaches to our pathways of patient care
- BHCP is bringing mental health services currently provided by two different Trusts under one organisation with plans to transform care for adults and children and ensure more integration with physical care within integrated care communities.

What will this mean for me?

Collaborative working means that we can collectively achieve more than we can individually, with each member of the partnership contributing skills, resource and expertise to provide the best services possible for the communities of Morecambe Bay. All too often patients tell us 'they get passed around between teams' and have to 'tell their story' multiple times.

We want to break down these barriers and integrate care: between hospital, GP and community care; between health and social care; and between physical and mental health care.

Developing new models of organisation that are responsive and agile will reinforce our ability to meet future challenges. They will:

- Support our communities and our staff,
- Strengthen partnerships to improve care and promote innovation
- Plan to improve our population's health and our use of resources.

Developing our Strategy for the next five years

Listening to others is our first step toward creating a five-year strategy for health and social care in Morecambe Bay. We haven't worked out all the details yet, as your feedback will help us to make sure we are targeting the things that are most important to you, your family and your community.

So, we **need to hear from you** and all the communities around the Bay to check that you understand our challenges and agree with our goals and that they are meeting your health and care needs now and into the future.

How can I give my views?

Please tell us what you think by completing this survey

bit.ly/BCT-survey

When will your strategy be final and will it be shared?

Our strategy will be developed in the autumn and shared in November 2019. It will be published on our website and shared widely with our partners across the Morecambe Bay area. If you would like to be kept informed, please let us know.