Bay Health & Care Partners delivering | bettercare together

NHS

# Better Care Together

## *Our Strategy for Improving Health and Care in Morecambe Bay 2019 - 2024:*

**Final: March 2020**

# *Strategic Support*

The Better Care Together Strategy is supported by the following Bay Health and Care Partners organisations:









# *Foreword*

This document sets out the Better Care Together Strategy for improving Health and Care in Morecambe Bay from 2019 to 2024. We believe what it says on the cover: that care is better when it is delivered together. Together – when it is delivered with patients and communities; together – when it is delivered by integrated teams of health and care professionals, together with third sector and voluntary sector professionals and volunteers.

This is our second Strategy under the Better Care Together approach, the first being produced 5 years ago in 2014. We are proud of what we have achieved since then: the development of Integrated Care Communities; the bringing together of disparate community and mental health teams; the implementation of new models and pathways of care, such as frailty, muskuloskeletal and respiratory; the development of new ways of working, such as Patient Initiated Follow Up and Advice and Guidance.

But we recognise that there is so much more that we still need to do: to address health inequalities, achieve national standards, improve quality and tackle our financial deficit.

As you would expect, this Strategy sets out how locally we will deliver the national NHS Long Term Plan commitments. It also shows how we will support the delivery of the Lancashire and South Cumbria Integrated Care System Plan.

But Bay Health and Care Partners have an ambition to be more than a set of health and care partners delivering good care. So within this strategy you will see four underlying themes:

- Delivering on our priorities and commitments: how we intend to deliver good quality care, achieve our constitutional standards and deliver services within our allocated resources
- Population health: given the rising demand for care, we recognise that we cannot go on just treating people when they become ill in the same way we have always done. That is why we want to invest in prevention and earlier intervention and work with mobilised, “thriving communities” to help people stay fit and well and independent for longer; and when people become ill, to support them better to manage their care and be as independent and in control as possible
- Integration: despite the best efforts of our dedicated health and care professionals to work together, health and care has become too fragmented with too many organisations and hand-offs. All too often patients have to ‘tell their story’ again and again to different staff or are passed on to a different team. That is why the development of Integrated Care Communities and the Integrated Care Partnership is vital: we want to bring services together and wrap them around the patient – not expect patients to have to fit into our teams and ways of working
- Economic, environmental and social responsibility. This document is not a Community Strategy or wider wellbeing strategy; but it does in effect, constitute the health and care chapter of a wider wellbeing strategy. And we want to go further, to work with local authorities, other public sector organisations and of course our business leaders and communities to play our part in improving wider economic, social and environmental wellbeing. We will need to work with partners on what this means, but as a first step, we have set out our strategic intentions to fulfil our responsibilities as ‘Anchor Institutions’ and to develop ‘The Bay Deal’. We will also support the Eden Project North in its ‘reimagining health and wellbeing’ and delivery of the ambitions set out in the Lancaster and South Cumbria City Region Prospectus.

***Aaron Cummins and Jerry Hawker***

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# Contents

# *Executive Summary*

***The NHS has recently marked its 70th anniversary and a national debate has been taking place about its future. There is national pride in the NHS and its achievements over the last 70 years. But there is also great concern about its ability to continue to improve outcomes given the rising demand for services, constrained finances and workforce challenges. There is also great optimism within Morecambe Bay that we can modernise services, improve outcomes and deliver financial sustainability. This Strategy sets out how we intend to do this over the next 5 years, in line with the NHS Long Term Plan published earlier in the year.***

**Chapter 1 sets out our vision and aims.** We have developed these over a number of years and they set the overall framework for achievement through this strategy. Our vision is: *"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".* In order to deliver this vision we have set out our triple aim: *Better Health, Better Care, Delivered Sustainably.*

**Chapter 2 sets out our approach to developing the Better Care Together (BCT) Strategy**. It recognises the national pride in the NHS and the many successes the NHS has had; but also recognises the need for modernisation to tackle the challenges of rising demand, an aging population, lifestyle factors and financial constraint. The Strategy has brought together four key elements: commitments set out in the NHS Long Term Plan; priorities from the Lancashire and South Cumbria Integrated Care System Plan; existing BCT priorities and commitments (such as integration and population health); and priorities arising from our local Needs Assessment and Case for Change. Chapter 2 also sets out the engagement work we have undertaken, the feedback on the strategy and our commitment to continue and deepen our engagement work.

**Chapter 3 sets out our Needs Assessment and Case for Change**. To support development of the Strategy we undertook a needs assessment drawing information from a range of sources including the Lancashire and Cumbria JSNAs and Health and Wellbeing Strategies. This indicated a number of challenges within four themes:

- There are significant health inequalities within the Bay and our long term outcomes for cancer, CVD and respiratory could be better, particularly in our deprived areas;
- We are not currently meeting national standards in key areas such as: the A&E 4hour target and 12 hour breaches; 62 day cancer target; 52 week waits for elective care;
- We are spending more money than we receive through our allocation and clinical sustainability (having the right workforce) is sometimes fragile;
- The quality of some of our services is not what it should be, as evidenced in CQC and other inspection reports (eg SEND).

**Chapter 4 sets out our strategic priorities** together with the rationale for why they are priorities, what we have done so far and the actions we will take over the next 5 years. Our 5 priorities are:

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** to support thriving communities
3. Deliver care that will prioritise real improvements in **mental health, cancer, emergency care and planned care** and **meet national standards**

4. Improve **financial and clinical sustainability** alongside the **quality** of service delivery
5. Develop and deliver more **integrated care** at three levels: Lancashire and South Cumbria Integrated Care System; Morecambe Bay Integrated Care Partnership; and Integrated Care Communities and Primary Care Networks

In Chapter 4 we have also set out five key commitments which are significant in terms of the impact in delivering our priorities as well as speaking to the values and ethos of BHCP; in 5 years' time we will have:

1. Embedded a population health approach in the Bay, with a 'Bay Deal' developed and agreed with our communities and the establishment of a wellbeing service that supports healthy living and prevention
2. Delivered a comprehensive approach to long term conditions through our ICCs which has significantly improved outcomes and patient experience for frailty, respiratory, CVD and diabetes and led to significant reductions in unnecessary outpatients and non-elective admissions
3. Deliver an integrated model of intermediate care across all partners through the "advancing integration" programme
4. Consistently achieved constitutional standards and targets with upper quartile performance for all key standards by the end of year 5 and for the 62 day cancer standard by the end of 2020/21
5. Achieved our control totals in each of the 5 years of the Plan.

**Chapter 5 sets out our view on what health and care will look like in 5 years' time.** This continues the direction of travel set in our last Strategy and in our Vanguard work and is now central to the NHS LTP. It has at its heart the continuation of the development of a population health approach; integration of care especially at a neighbourhood level through Integrated Care Communities; thriving general practice supported by primary care networks; an expansion of care in community settings and more efficient , higher quality hospitals; an expanded range of primary and community mental health services as well as 24/7 home crisis treatment services and enhanced hospital crisis support; and integrated childrens' services delivered through ICCs, with expanded CAMHS and eating disorder services working to a 'Thrive Model'. Chapter 5 also sets out more detail on our approaches in a range of care themes, including: population health; ICCs, long term conditions; mental health; cancer; urgent and episodic care..

**Chapter 6 sets out the new NHS infrastructure in which care will be delivered**. This reaffirms our commitment to work at three levels: ICC and neighbourhood level; the continued development of the Morecambe Bay ICP; and the continued development of the Lancashire and South Cumbria ICS. In Chapter 6 we also recognise the direction of travel towards: more integrated commissioning across the ICS and with local authorities; and the development of a group hospital model – although we acknowledge that much more work needs to be done to define what we mean by group hospital, and the benefits of integrated commissioning.

**Chapter 7 sets out what the Strategy means for our enablers.** This makes clear our commitment to deliver our health system financial trajectories for 2023/24 and to start to return the wider health and care system to balance; to make more effective use of digital technology for patient access, service delivery and to support the workforce; and our workforce plans including better recruitment, new and innovative roles, growing our own workforce, the development of a primary care academy and greater support to our existing workforce.

# *Chapter 1: Our Vision and Aims*

**Chapter 1 sets out our vision and aims.** We have developed these over a number of years and they set the overall framework for achievement through this strategy. Our vision is: *"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".* In order to deliver this vision we have set out our triple aim: *Better Health, Better Care, Delivered Sustainably.*

Bay Health and Care Partners (BHCP) is a partnership made up of local GPs, hospitals, local authorities as well as doctors, nurses, community staff such as district nurses and social care staff. We have been working together since 2014 to deliver better care and better health outcomes under the Better Care Together approach.

As part of our work we have set out a clear vision for the future:

**Our Bay Health and Care Partners Vision is:**

*"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."*

In order to deliver our vision we have also set out three aims:

**Our Bay Health and Care Partners Aims:**

To achieve our vision we will deliver our "triple aim":

***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 achieve our control total.

This Strategy shows how we will deliver the Vision and "triple aim" over the next 5 years.

# Chapter 2: Our Approach to Developing the Strategy

**Chapter 2 sets out our approach to developing the Better Care Together (BCT) Strategy**. It recognises the national pride in the NHS and the many successes the NHS has had; but also recognises the need for modernisation to tackle the challenges of rising demand, an aging population, lifestyle factors and financial constraint. The Strategy has brought together four key elements: commitments set out in the NHS Long Term Plan; priorities from the Lancashire and South Cumbria Integrated Care System Plan; existing BCT priorities and commitments (such as integration and population health); and priorities arising from our local Needs Assessment and Case for Change. Chapter 2 also sets out the engagement work we have undertaken, the feedback on the strategy and our commitment to continue and deepen our engagement work.

The NHS is constantly changing. It has made great strides since it was established in 1948. Nationally and locally, there is great pride in the NHS, its successes and the social commitment it represents. But the NHS also recognises the need to transform again if it is to effectively address the challenges it continues to face, including:

- So-called 'Lifestyle factors': such as poor diet, lack of exercise, drug and alcohol consumption and smoking
- Rising demand: we have record numbers of people attending GP practices, A&E departments etc
- Ageing population: a success of modern day Britain is that people are living longer; but unless they stay healthy and well, this can mean increasing numbers of frail elderly people need health and social care support
- Financial challenges: 10 years of relative financial constraint in the NHS alongside significant reductions in local authority and third sector funding are having a significant impact on the availability of care
- Workforce availability: coupled with financial challenges, the NHS and social care have not seen workforce numbers keep pace with demand. There are now significant gaps in all providers, including in the regulated care sector such as nursing homes and domiciliary care.

In January 2019, the NHS issued its Long Term Plan https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan . The Plan set out an approach to the re-design of patient care to address the challenges above and future-proof the NHS for the next decade. As part of the Plan, NHS England and NHS Improvement (NHSE/I) also asked local 'systems' to produce their own plans. In our context, this means the Lancashire and South Cumbria Integrated Care System.

In Morecambe Bay, Bay Health and Care partners (BHCP) have been working together for a number of years to improve health and care services, under the banner of Better Care Together. We published our first joint Strategy in 2014 and have had a number of successes. For example 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.
- Set out a population health framework and strategy and working with partners on a clear set of initiatives for the next five years,

- Started to make radical improvements in long term conditions pathways, such as respiratory, diabetes and frailty
- Established ground breaking approaches in elective care such as advice and guidance, patient initiated follow up and an integrated musculoskeletal service, all of which are being adopted by other health systems locally and nationally
- Brought together community health services from 3 different providers into 1 and brought mental health services from 2 trusts into 1, in order to help us deliver more effective integration with primary and acute services.

However, we feel the time is right to develop a new Strategy:

- The last Strategy was for five years so it is right we produce a new one
- We have learnt a lot over the last 5 years and want to reflect this in our new Strategy: for example, our focus on the integration of services and the need to take a population health approach
- Despite the many successes we have had , the health challenges for our population and the challenges of delivering services have both grown over the last 5 years, as they have done across the whole of England
- We need to respond to the priorities and challenges in NHS Long term Plan and support the development of a Long Term Plan for Lancashire and South Cumbria; so it is right that we reflect this in our local strategy.

## How we developed our Strategy

Our approach to developing our Better Care Together Strategy centred on bringing four key elements together with support of engagement from patients & communities, staff and stakeholders. This is set out diagrammatically in Figure 1 below.

**Figure 1: BHCP approach to BCT Strategy Development**

# Chapter 2: Our Approach to Developing the Strategy

## Engagement

As part of our Strategy development, Morecambe Bay CCG, on behalf of Bay Health and Care Partners, sought public feedback on its challenges and proposed priorities.

'*Better Care Together; developing our Bay Strategy for the next five years*' https://www.healthierlsc.co.uk/application/files/6715/6759/6345/ABHH_9807_Better_Care_Together_Public_Engagement_Document_FINAL_02.09.19.pdf was circulated to partners, and an online survey went 'live' on 21 August. A news release was issued to the media and the strategy and accompanying survey were also promoted via social media channels (Facebook and Twitter). The views of CCG, UHMB and other partners staff were sought through workshops and discussions.

The 'next five years' document also formed a part of the public engagement conducted around the setting up of a 'Public Assembly'. Meetings were supported by Healthwatch and the CVS and held in Barrow, Lancaster and Kendal. No specific feedback on the challenges and priorities was gathered at the Assemblies; some commentary on the style and language of the document was collated. Attendees were encouraged to complete the online survey.

More than 40 community groups were contacted, alongside elected representatives from both county councils and district councils, including those with a broad health and care focus (such as children's wellbeing, youth justice, scrutiny committees). In addition, more than 100 parish councils were contacted, alongside housing associations from the Health and Wellbeing group for the north west. Information was circulated to 300 recipients of the Cumbria CVS newsletter, as well as via the Better Care Together newsletter.

It is estimated that the consolidated 'reach' of these groups would be in the region of 15,000 adults and young people, though not all recipients will have shared the narrative with their constituencies.

Key findings from the survey included https://www.healthierlsc.co.uk/application/files/7915/7201/0178/Engagement_Sept_2019.pdf :

- 76% of those who replied agreed that the challenges were set out clearly
- Respondents selected "We are not meeting national standards of care" as the most important challenges to tackle, followed by "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."
- Forty-seven percent of respondents selected population health as the most important priority. This was followed by 'deliver more integrated care' at 22%. Financial sustainability was a priority for 20% of respondents.
- More than half of all respondents agree that the priorities would meet the challenges (51%). 44% answered that the priorities 'maybe' would meet the challenges.

Our wider conclusions from the engagement work included:

- Population health is a concept that is not well understood by the 'general' public.

- Human-interest, real-life stories should be collated and used where possible
- The use of simple-to-understand graphics and illustrations would facilitate easy sharing
- We need to work with existing forums and interest groups (ie “we need to go to people not expect them to come to us”)
- We need to provide more transparent ‘progress’ reports
- BHCP is not well understood as a concept / vehicle
- Engaging with the public requires meaningful effort and resources.

Overall we feel that there was support to continue to deliver the priorities we set out in order to tackle the identified challenges. We also recognised that whilst our engagement with the general public is improving, it could improve further. BHCP reaffirmed its commitment to continue to improve the way it engages with the public, patients, staff and the wider community in developing and delivering services. This includes continuing to develop the Public Assemblies as well as listening and responding to questions and comments, and providing transparent information on progress.

# Chapter 3: Our Needs Assessment & Case for Change

**Chapter 3 sets out our Needs Assessment and Case for Change**. To support development of the Strategy we undertook a needs assessment drawing information from a range of sources including the Lancashire and Cumbria JSNAs and Health and Wellbeing Strategies. This indicated a number of challenges within four themes:

- There are significant health inequalities within the Bay and in comparison to the national average; and our long term outcomes for cancer, CVD and respiratory could be better, particularly in our deprived areas
- We are not currently meeting national standards in key areas such as: the A&E 4 hour target and 12 hour breaches; 62 day cancer target; 52 week waits for elective care
- We are spending more money than we receive through our allocation and clinical sustainability (having the right workforce) is sometimes fragile
- The quality of some of our services is not what it should be, as evidenced in CQC and other inspection reports (eg SEND).

Bay Health and care Partners have undertaken a Needs Assessment to understand the challenges facing the Morecambe Bay population in terms of health and care. The document can be found at https://www.healthierlsc.co.uk/morecambe-bay.

Our Key Findings are set out under each of our three goals: Better Health, Better Care, Delivered Sustainably.

### Better Health

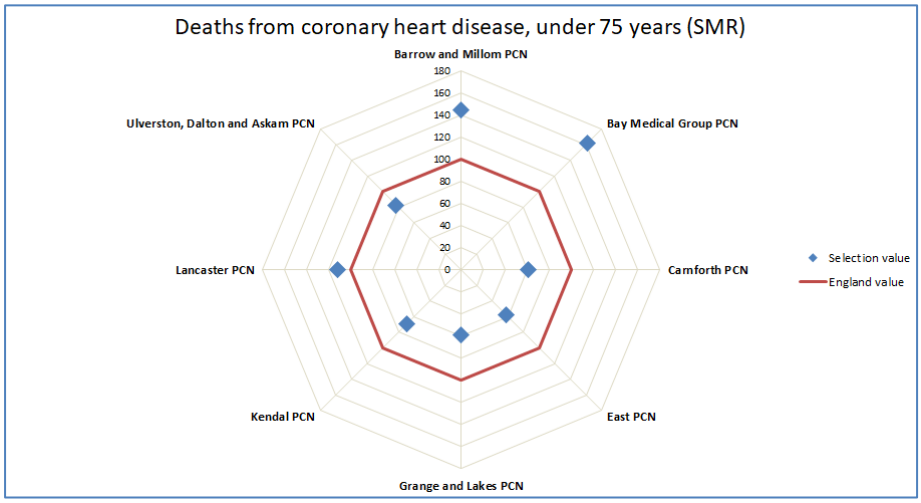
- We still have a significant challenge with health inequalities across our communities – there is a 14-16 year gap in life expectancy and years spent in poor health are much higher in deprived communities – figure 2 (there is a 14 year gap in life expectancy for men between the Hindpool and Poulton Wards in Barrow & Lancaster and the Kellet ward in Lancaster; and a 16 year gap for women between Central Ward in Barrow and Grasmere in South Lakes)

**Figure 2: Ward level life expectancy highest and lowest**

| Locality of CCG | Men age in years by ward | Women age in years by ward |
|---|---|---|
| Furness lowest inc Millom | Hindpool 71 | Central 75 |
| Furness highest inc Millom | Roosecote 82 | Roosecote 85 |
| South Lakeland lowest | Highgate 72 | Ulverston East 79 |
| South Lakeland highest | Sedbergh, Ulverston East, Windermere, Whinfell 82 | Windermere, Bowness North, Ambleside and Grasmere 91 |
| Lancaster lowest | Poulton 71 | Poulton 76 |
| Lancaster highest | Kellet 85 | Lune 87 |

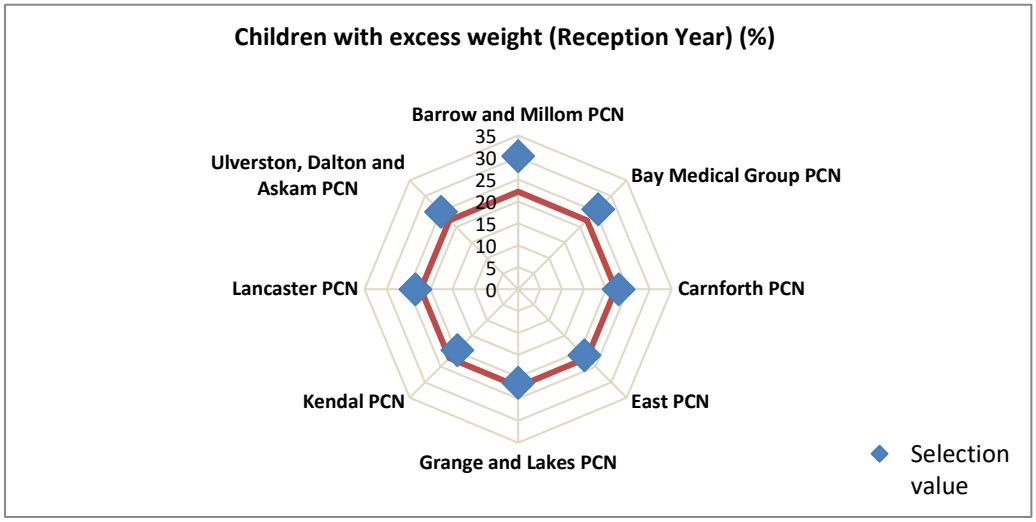
- The 3 biggest causes of premature mortality are cancer, CVD & respiratory and there are significant variations by community – Figure 3. We can improve life expectancy if we take action to improve care in these areas

**Figure 3: Premature death from Coronary Heart disease across the PCNs**




- We need to work with our communities on a population health approach, to improve healthy living for children and adults, particularly for smoking, obesity & exercise, mental wellbeing and alcohol and substance misuse (for example, challenges in healthy weight for reception children across our communities is shown in Figure 4 below)

**Figure 4: Reception year Data from the national weight measurement scheme by PCN**




- We need to work in partnership with others to help tackle the wider determinants of poor health (eg housing, education, employment)

### Better Care

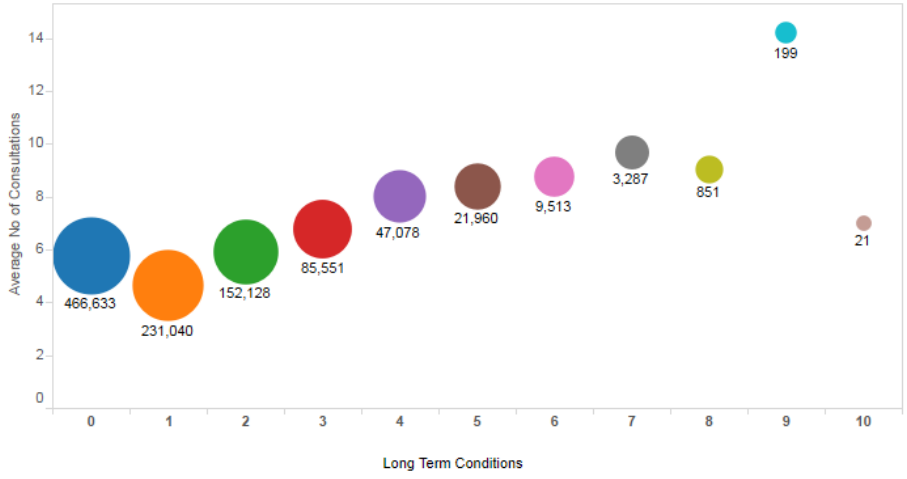
- Our population is older than the national average and ageing at a fast rate: there is a need to

have good pathways and models of care to support frail older people

- 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

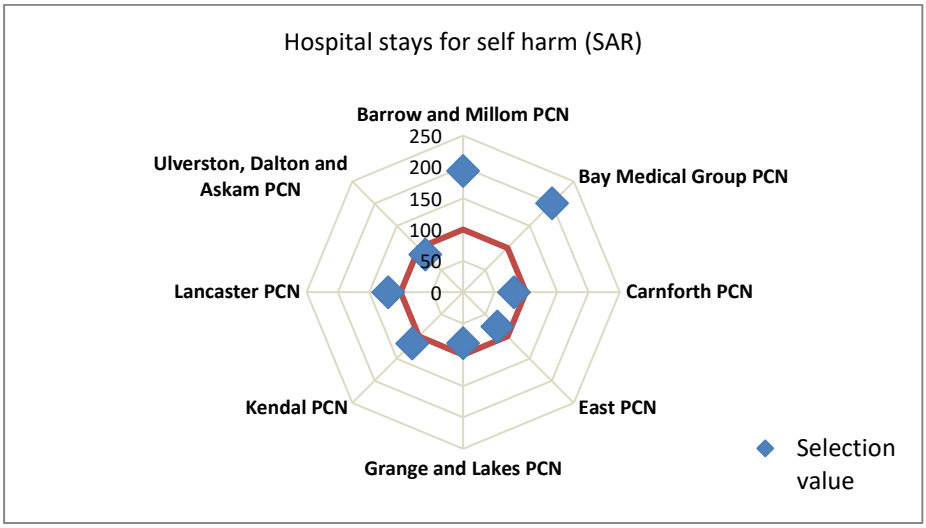
- We have a significant proportion of patients with 1 or more long term conditions, there are high levels of unnecessary hospital admissions and outcomes could be better for adults and children. Figure 5 shows high level of GP consultations for people with 1 or more Long Term Conditions compared to those without any conditions

**Figure 5: Practice consultations for people registered with a LTC across the Bay**




- We need to improve the quality of care and availability of primary and community mental health care services, for children and adults, particularly in our most deprived communities. For example, Figure 6 shows the levels of hospital stays for self harm by PCN

**Figure 6: Self-harm hospital stay data across the PCNs and England value**




- Our performance on some key national standards and quality measures is poor, especially for: cancer; urgent care; routine surgery; CAMHS access; and anti-microbial resistance

- 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

**Delivered Sustainably**

- We are spending more money than we receive from Government
- Many of our services cost significantly more than similar areas – even taking into account our geography and demography
- Local authority funding has reduced by an average of 40% over the last 5 years impacting on care support; and there is fragility in the regulated care sector
- National recruitment shortages lead to gaps in our workforce, creating fragility in many of our services and pressure on the existing workforce
- 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 (eg theatres and diagnostic equipment) need upgrading but a lack of national capital is preventing this

The next Chapter describes the priorities we have set in order to address the challenges arising from our Needs Assessment.

# *Chapter 4: Our Strategic priorities*

**Chapter 4 sets out our strategic priorities** together with the rationale for why they are priorities, what we have done so far and the actions we will take over the next 5 years. Our 5 priorities focus on: prevention and health inequalities through a '**population health'** approach; strengthening the sustainability of **general practice** and providing improved care through **Integrated care communities** and new **Primary Care Networks; d**elivering real improvements in **mental health, cancer, emergency care and planned care** and **meet national standards; i**mproving **financial and clinical sustainability** alongside the **quality** of service delivery; develop and delivering 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.

In Chapter 4 we have also set out five key commitments which are significant in terms of the impact in delivering our priorities as well as speak to the value and ethos of BHCP; in 5 years' time we will have:

1. Embedded a population health approach in the Bay, with a 'Bay Deal' developed and agreed with our communities and the establishment of a wellbeing service that supports healthy living and prevention
2. Delivered a comprehensive approach to long term conditions through our ICCs which has significantly improved outcomes and patient experience for respiratory, CVD and diabetes and led to significant reductions in unnecessary outpatients and non-elective admissions
3. Deliver an integrated model of intermediate care across all partners through the "advancing integration" programme
4. Consistently achieved constitutional standards and targets with upper quartile performance for all key standards by the end of year 5 and for cancer by the end of 2021/22
5. Achieved our control totals in each of the 5 years of the Plan.

To help us meet the challenges set ou t in our needs assessment, address future health and care needs and meet the national NHS requirements, we have set out 5 strategic priorities for the next five years:

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** to support thriving communities

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

4. Improve **financial and clinical 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

Our priorities align closely with the Lancashire and South Cumbria ICS priorities and we are confident that the ICP will support ICS delivery ambitions and vice versa: this is evidenced in Appendix 3. The following sections in this chapter set out more detail on why we have chosen our priorities and the actions we intend to take in delivering them.

In developing our priorities and the actions to support delivery, we have been conscious of the need to focus

on a small number of key commitments. These are important as they:

- are significant in terms of the impact they will have in helping to deliver our prioirties
- are crucial to delivery of our triple aim
- speak to the values and ethos of what Bay Health and Care Partners is all about.

These five commitments are:

In 5 years' time we will have:

1. Embedded a population health approach in the Bay, with a 'Bay Deal' developed and agreed with our communities and the establishment of a wellbeing service that supports healthy living and prevention
2. Delivered a comprehensive approach to long term conditions through our ICCs which has significantly improved outcomes and patient experience for respiratory, CVD and diabetes and led to significant reductions in unnecessary outpatients and non-elective admissions
3. Deliver an integrated model of intermediate care across all partners through the "advancing integration" programme
4. Consistently achieved constitutional standards and targets with upper quartile performance for all key standards by the end of year 5 and for Cancer by the end of 2021/22
5. Achieved our control totals in each of the 5 years of the Plan

# *Chapter 4: Our Strategic priorities*

## 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 – 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 smoking, obesity/exercise, mental wellbeing and alcohol 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 long term condition management
- 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 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 we do over the next 5 years?

1. Work to embed a 'population health' approach in in health and social care, particularly working with ICCs, PCNs and empowered patients and communities; and work with partners such as VCS and district councils to address the wider determinants of health such as inequalities and environment
2. Develop and deliver a Wellbeing Service (to tackle weight management/exercise; smoking; alcohol/substance misuse; mental wellbeing) in collaboration with our local authority partners
3. Develop and deliver a comprehensive approach to long term conditions, particular focussing on prevent/detect/manage in primary/community setting through ICCs & PCNs with a focus on need in deprived areas [including LTP priorities respiratory, diabetes and CVD etc]
4. Work with partners and the public to develop a 'Morecambe Bay Deal', establishing a different approach to working with individuals, communities and community groups to improve wellbeing.

**What difference will this make?**

- There are over 1,500 people with Atrial Fibrillation on GP registers not currently receiving anticoagulation treatment: optimal treatment will avoid 240 strokes by 2024
- We will increase the number of people receiving a health check by 2024
- We will increase the number of people receiving support with weight management, smoking and alcohol advice by 2024

# *Chapter 4: Our Strategic priorities*

## Strengthen the sustainability of general practice and provide improved care through Integrated Care Communities and Primary Care Networks to support thriving communities

### 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 prevention and 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

### 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 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 support from consultants. This has reduced outpatient appointments by 60%. The model is being rolled out across the Bay with enhanced community nursing rapid response 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 we do over the next 5 years?

1. Continue to develop ICCs to support thriving communities, with a particular focus on delivery of an integrated Long Term Conditions approach, including full roll-out of the respiratory model
2. Develop PCNs and other measures such as the Primary Care Academy to improve the resilience of General Practice
3. Continue implementation of stroke pathway through roll out of stroke rehabilitation
4. Deliver an integrated model of intermediate care across all partners through the "advancing integration" programme

**What difference will this make?**

- Implementation of our respiratory pathway will reduce unnecessary hospital outpatients by 60%) and non-elective inpatient spells by 40% by 2024
- Our work on diabetes indicates that we can reduce the number of people with type 2 diabetes by 2024
- At present 65% of people with a long term condition say they confident in managing their own condition. We will increase this to 75% by 2024
- Will support more older people say they feel supported to live independently at home.

# *Chapter 4: Our Strategic priorities*

## 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 (116 breaches of the 52 weeks target year to August 2019)
- 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.

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 accepted as a '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.

# Chapter 4: Our Strategic priorities

## What will we do over the next 5 years?

**Mental Health:**

1. Improve and expand CAMHS services, particularly through: implementation of the Thrive model; delivery of the Mental Health in Schools Trailblazer project; and implementing a specialist eating disorder service in South Cumbria
2. Improve the urgent adult mental health model of care with a particular focus on: expanding community services to promote wellbeing and avoid crises; and improved/enhanced crises services (eg 24/7 home treatment and Core 24 model)
3. Complete the transfer of community services from CPFT to LCFT and establish 'the Bay Locality' with integration of services at ICC, ICP and ICS levels as appropriate
4. Delivering Transforming Care programme for people with learning disabilities

**Urgent Care**

5. Implement the urgent care recovery plan to ensure patients receive appropriate and timely care in line with new national standards, with a trajectory of improvement to achievement by 21/22

**Cancer**

6. Improve cancer pathways and diagnostic capacity to ensure consistent achievement of national standards, particularly 62 day standard by April 2021 and improve 5 year survival rates

**Planned care**

7. Transform the way we deliver outpatients: to radically reduce the number of unnecessary hospital appointments; to use technology to reduce travel and ensure a more patient centred booking process; and ensure most contacts for long term condition management are in a community setting through ICCs
8. Complete the transformation of the MSK model of care to reduce the number of unnecessary hip and knee operations through earlier physio intervention and support the resilience of general practice through new roles such as first contact practitioners
9. Work with other providers across the ICS to improve operating theatre utilisation to improve surgical capacity and reduce the waiting list and eliminate 52 week waits

**Women and Childrens**

10. Implementing the Better Births national programme
11. Supporting improvement activity in line with the SEND action plans for Lancashire & Cumbria

**What difference will this make?**

- Achievement of the national A&E standard will mean an extra 950 people per month will be treated within 4 hours by 2024; and no patient will wait more than 12 hours by 2024
- Achievement of the national 62 day cancer standard by 2021 will mean an extra 72 people per month getting their care within required times
- Going beyond the national standard that at least 35% of Children and Young People with a diagnosable mental health condition will receive treatment from an NHS funded community service by 2020/21 to 50% by 2023/24
- We will ensure that by 2023/24 no one will wait more than 52 weeks for their elective care treatment

# Chapter 4: Our Strategic priorities

## Improve financial and clinical sustainability alongside the quality of service delivery

### Why is this a priority?

- We are spending £60m 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.
- 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 we do over the next 5 years?

1. Work within the ICP and with the ICS on fragile services (see Chapter 6)
2. Achieve financial control totals through delivery of financial plans and cost improvement plans (see Chapter 6)
3. Deliver the BHCP workforce plan to meet future workforce needs with a focus on: new and different roles, particularly in primary/community settings; more effective recruitment; better use of technology;

and development of the Primary Care Academy (see Chapter 6)

4. Deliver the BHCP digital plan with a focus on patient self-management/self-care and digital support for transformation of clinical priorities set out above (such as LTCs etc) (see Chapter 6)
5. Deliver the BHCP estates plan with a focus on: immediate capital requirements for urgent maintenance issues such as operating theatres; reducing waste in the primary care estate through co-location and integration; long term delivery of improved/expanded primary/community estate in line with clinical strategy set out above (see Chapter 6)

**What difference will this make?**

- The NHS system is currently spending £60m more than its allocations and local government budget have been severely constrained. Unless we manage within our resource allocations we could be subject to outside intervention with financial restrictions imposed on us which don't align with local needs. We will meet our financial trajectories as financial sustainability is vital to ensure we can direct resources in line with local needs, maintain public confidence and provide assurance to regulators
- Improvements in quality as measured by regulators will ensure our patients and communities are getting the best possible care and provide confidence to the public and stakeholders
- Only 21% of local GPs surveyed say that work/life balance is good or the best it has ever been and this is a similar pattern to staff in other services. We want to increase staff satisfaction as we know that happy motivated staff with "a culture of joy" deliver better care
- Digital delivery of services will have make access easier for patients, help address staff shortages and improve the efficiency and effectiveness of service delivery.

# *Chapter 4: Our Strategic priorities*

## 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 in the Bay, this means working at three different levels locally:

- **Integrated Care Communities and Primary Care Networks:** 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 we do over the next 5 years?

Deliver plans to fully establish Lancashire and South Cumbria ICS and Morecambe Bay ICP by 2024/25 with interim arrangements by April 2021 (based on a move towards a single CCG and a group hospital model).

# *Chapter 4: Our Strategic priorities*

**What difference will this make?**

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

# *Chapter 5: What health & care will look like in 5 years*

**Chapter 5 sets out our view on what health and care will look like in 5 years' time.** This continues the direction of travel set in our last Strategy and in our Vanguard work and is now central to the NHS LTP. It has at its heart the continuation of the development of a population health approach; integration of care especially at a neighbourhood level through Integrated Care Communities; thriving general practice supported by primary care networks; an expansion of care in community settings and smaller, higher quality hospitals; an expanded range of primary and community mental health services as well as 24/7 home crisis treatment services and enhanced hospital crisis support; and integrated childrens' services delivered through ICCs, with expanded CAMHS and eating disorder services working to a 'Thrive Model'. Chapter 5 also sets out more detail on our approaches in a range of care themes, including: population health; ICCs, long term conditions; mental health; cancer; urgent and episodic care. Chapter 5 also covers our approach to the reconfiguration of services.

As a local partnership we have learned a good deal in our delivery of Better Care Together over the last 5 years, especially as a Vanguard New Care Model site between 2014 – 2017. Earlier this year we engaged a wide range of clinicians, managers, partners and stakeholders in a workshop to consider the BCT Model we established in 2014. In particular we asked people if the Model was still relevant or whether we needed to develop a new clinical model. The overwhelming response was that the Model was still relevant today and there was still strong enthusiasm for continued delivery. If anything the feedback was that we had not gone as far and fast as we had hoped. The impact of the model and how care will look in 5 years' time is set out in the box below.

# *Chapter 5: What health & care will look like in 5 years*

***What will Care Look Like in 5 Years' Time***

- *A 'population health' approach will be embedded within our services and will be delivering care with patients and communities, with a strong focus on prevention, self-management, care planning and health improvement to keep people fit, well and independent*
- *Care in Morecambe Bay will be integrated across primary, community, mental health, social and secondary care for children and adults*
- *We will deliver more care out of hospital model, particularly through our Integrated Care Communities, supported by Primary Care Networks of thriving GP practices. ICCs and PCNs will support those with long term conditions such as respiratory and diabetes, frail older people and others at risk of admission or wellbeing issues such as isolation and loneliness*
- *Urgent care rapid response teams will support patients for short term crisis intervention care when patients cannot be managed by the integrated care teams. The response team will form the bridge between community and hospital urgent care, helping patients move seamlessly and as quickly as clinically necessary in and out of hospital (e.g. for diagnostics or short term acute care) drastically reducing hospital admissions and mortality*
- *We will have a range of primary & community services for earlier support for mental wellbeing , together with expanded 24/7 home crisis treatment services to avoid unnecessary acute admissions and reduce unnecessary A&E attendances*
- *Integrated children's services working to the same model as adults services and integrated with the locality-based ICC teams*
- *Our hospitals will be smaller and of a high quality, more responsive to the needs of the people using them and the requirements of the community based teams they are supporting; but still providing core essential services where needed (such as accident and emergency and maternity services in Barrow). Increasingly hospital clinicians will work within the community based teams fostering a shared approach to staff development and improving pathways of care*
- *Pathways of care will be integrated across the system, with acute consultants working in the community supporting with education and skills enhancement and advice for complex cases; radically different ways of undertaking outpatient consultations (such as through electronic means or by patient initiated follow up); and referral management processes that support primary and community clinicians to improve decision making (e.g. through enhanced advice and guidance arrangements)*
- *There will be a single approach to commissioning healthcare across Lancashire and South Cumbria , integrated with local authorities and services will be commissioned and delivered at the 3 levels of Lancashire and South Cumbria, Morecambe Bay or ICC/Neighbourhood as appropriate*
- *There will also be a group hospital approach for acute services, with collaboration between hospital on front line care and back office delivery for improved patient outcomes and value for money.*

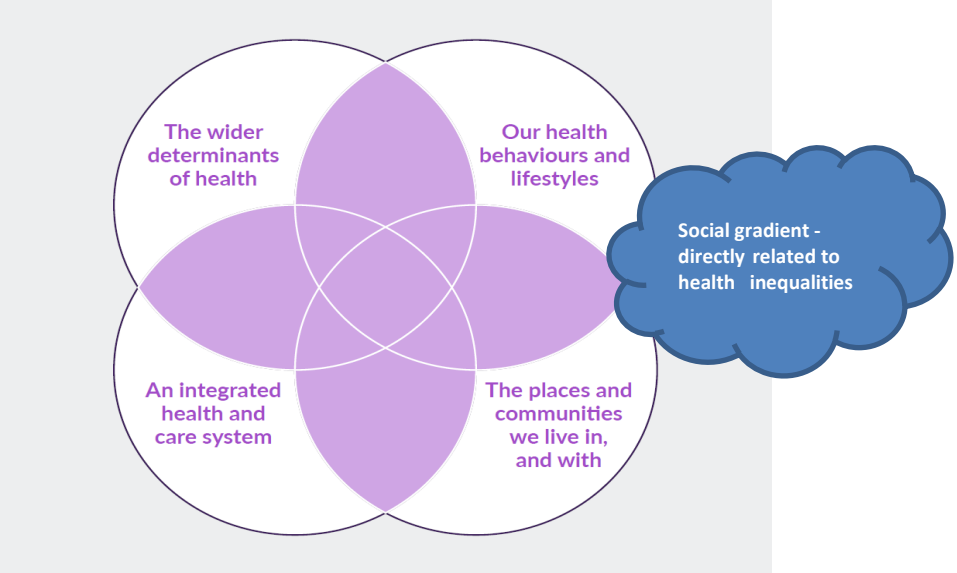
## Population Health

For nearly a decade, the NHS has experienced a significant slowdown in funding growth whilst demand for services and the cost of delivering those services has grown rapidly. Cuts to public health and social care funding have added further pressure. People in the most deprived communities and with disabilities have significantly worse health and a shorter life expectancy than those living in more affluent conditions. In order to address these challenges across Morecambe Bay we are taking

a new 'Population Health' approach, working with our population to support people to be as fit and well as possible and working with partners to address the causes of ill health. This is not a quick fix and requires sustained, coordinated action across an entire system and engagement with the local population.

Our definition of 'Population Health' is shown diagrammatically below in Figure 7.

**Figure 7: Morecambe Bay approach to Population Health**




There are some challenges in shifting to a system population health approach to improve the health of our population across Morecambe Bay:

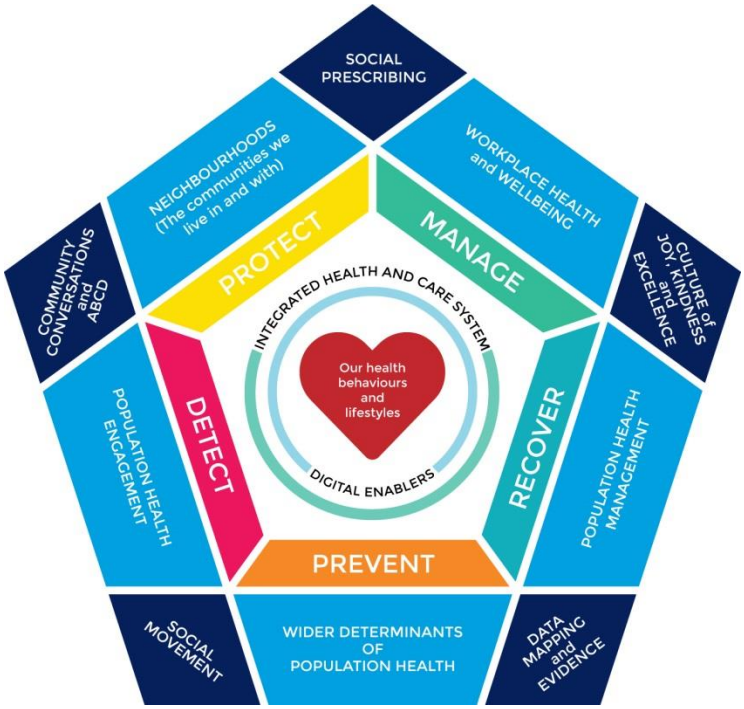
- The public sector and partners in the voluntary, community and faith sector (VCFS) are experiencing a sustained period of financial challenges. This has already led to significant reductions in preventative and early intervention services and is expected to continue over the coming years.
- We know that we can improve health and wellbeing by adopting healthier lifestyles, however making these changes is a challenge for individuals and families and is much more difficult for people who are already living with ill health, disability, low incomes or complex social challenges.
- The wider environment in which we live and work has a significant impact on our health and wellbeing and tackling these wider societal and environmental factors is challenging, with many of them dependent on national or even international action.
- The population health approach requires changes in the way that health and care services work with people and communities. It is a significant task to embed this new approach throughout our organisations so that every member of staff knows how they can contribute and is equipped with the skills to work in this way.
- The population health approach also requires changes in the way we prioritise our resources and in the way we deliver services so that they are more responsive to different local communities and more personalised to what individuals need
- We know a lot about the risk factors that cause ill health, however there are still significant

numbers of conditions that cannot be explained by these risk factors, suggesting there are more complex factors that need to be understood

There is already promising progress and Morecambe Bay is ahead of many other areas across the country in establishing its population health approach:

- There is strong support for the Population Health approach from leaders across the organisations that make up BHCP and a visible commitment in the form of investment in a Population Health Team to drive the approach
- Over the last year the vision has been refined and developed into a programme plan that will start to be rolled out over the next few months – see figure 8 below.
- We are part of the national Atrial Fibrillation Demonstrator Programme, which will help us reduce the numbers of stroke across the Bay
- We have established a programme of work to address the increasing numbers of people with diabetes and to reduce the numbers with type 2 diabetes
- Over eighty front-line staff have been trained in coaching techniques to promote patient activation and self-care
- We have held five "Art of Hosting" training sessions to develop skills in communities
- Schools across Morecambe Bay completed the 'Run a Mile' challenge
- Our Integrated Care Communities have a real focus on population health and the concept of "thriving communities". They also have a much better understanding of needs in the local area and are working in partnerships to meet these needs. Many local initiatives have been delivered which are improving health and supporting people to adopt healthier lifestyles. These are described elsewhere in this document

Figure 8: Population Health in Morecambe Bay



# *Chapter 5: What health & care will look like in 5 years*

As part of our Population Health development, we have been impressed with the work that partners in Wigan (led by the Council and NHS partners) have been doing to develop the 'Wigan Deal' and the outcomes the deal has helped to deliver. Whilst the environment in which Wigan developed this deal is different to the Bay, we believe that some of the core components – set out in Figure 9 below- are worthy of consideration to help us re-frame the way we interact with our communities to improve social, economic, environmental, health and wellbeing.

**Figure 9: The 10 Essential Components of the Wigan Deal**


| | |
|---|---|
| **Strong Narrative** - a simple concept that everyone can understand but is profound in its implications .<br>**A belief that this is a movement not a project** - rooting the approach in public service values: "sense of vocation".<br>**Leadership at every level** - commitment and senior sponsorship<br>**Workforce culture change** - training and core behaviours that define how we work, whatever the role.<br>**A different relationship with residents and communities** - building self reliance and independence | **Permissions to work differently** - leadership backing: 'we will support you'<br>**Redesigning the system** - testing our systems, processes, ways of working against our principles: 'do they make the culture and behaviours we want more or less likely?'<br>**Enabling staff with the right tools and knowledge** - using new technology to support new ways of working and new roles<br>**A new model of commissioning and community investment** - market development and new arrangements for commissioning<br>**Supportive enabling functions** - breaking down barriers to progress and facilitating the change |

The *Five Year Forward View* and evolution towards integrated care systems have placed greater expectations on the NHS to work across a geographical area and maximise its resources to improve the health of a local population. And while this focus on place-based systems of care has spurred developments in the way services are designed and delivered to help prevent ill health and promote wellbeing, limited attention has been given to how the NHS can influence the economic conditions that help create health in the first place.

The impact the NHS has on people's health extends well beyond its role as a provider of treatment and care. As large employers, purchasers, and capital asset holders, health care organisations are well positioned to use their spending power and resources to address the adverse social, economic and environmental factors that widen inequalities and contribute to poor health.

# *Chapter 5: What health & care will look like in 5 years*

Over the next 5 years, we want to work alongside local authorities (particularly our district councils) and others to explore and develop our role as an 'anchor institute'.

Our strategic focus for population health over the next 5 years is:

- To embed a 'population health' approach in the Morecambe Bay system, particularly working with ICCs and empowered patients and communities; and work with partners such as VCS and district councils to address the wider determinants of health such as inequalities and housing, education and the environment etc
- Develop and deliver a Wellbeing Service (to tackle weight management/exercise; smoking; alcohol/substance misuse; mental wellbeing) on a collaborative basis with local authorities making best use of both health and care resources
- Develop and deliver a comprehensive approach to long term conditions, particular focussing on prevent/detect/manage in primary/community setting through ICCs with a focus on need in deprived areas [including LTP priorities respiratory, diabetes and CVD etc]
- Work with partners and the public to develop a 'Morecambe Bay Deal', establishing a different approach to working with individuals, communities and community groups to improve wellbeing.

## Integrated Care Communities and Primary Care Networks

Integrated Care Communities (ICCs) and Primary Care Networks (PCNs) have been set up to address some of the fundamental challenges we have in today's care system – we have become too removed from the needs of our populations, to focused on providing care in a hospital setting, we provide too much care that does not address what the individual might want.

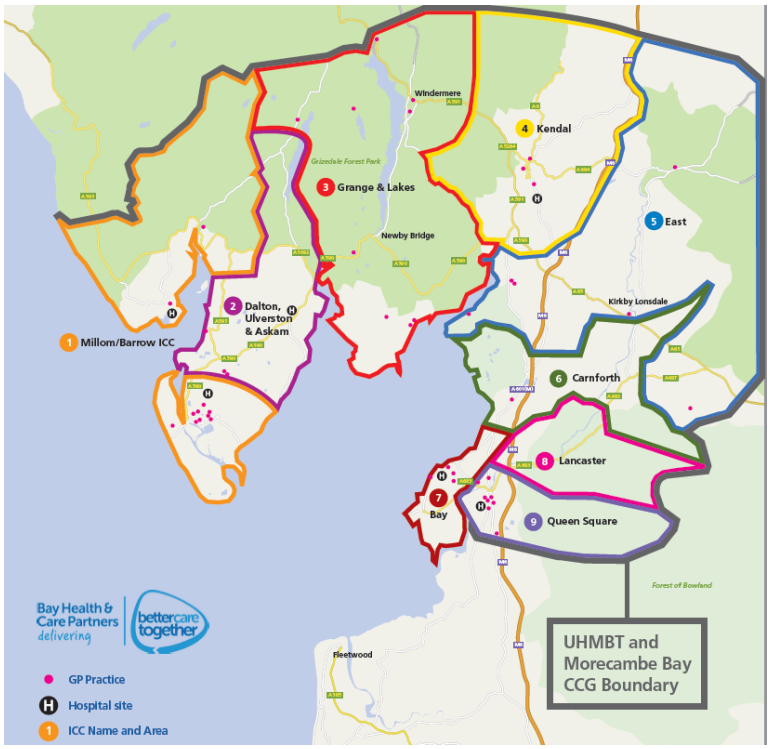
Integrated Care Communities were first set up in Morecambe Bay in 2014, and most are now into year 4 of a 10 year journey to localise care and ensure the provision is aligned with communities. ICCs are:

> *'integrated teams of health and care workers, voluntary organisations and wider community assets who work together to practice population health with a mobilised population' (ICC Operating Framework 2019/20).*

ICCs link neatly with local authority work on neighbourhoods and the "thriving communities" concept, particularly in terms of the focus on prevention, early intervention and resilience.

There are now nine ICCs across the Bay area, based on populations of between 20 and 70,000, based on GP practice populations – see map below. Some have changed geography over the years as they have developed with their communities.

# Chapter 5: What health & care will look like in 5 years




All ICCs have a Lead from Primary Care and a Management Development Lead to support the management functions. All also have care co-ordinators to support with care planning and all work extensively with their local care services, voluntary sector organisations and populations to understand local need and develop projects that engage those in need within their populations in a more person-centred way(recognising the need to avoid over-medicalising solutions to complex individual circumstances). Each year there are expectations on ICCs to support partnership developed initiatives such as risk stratification and care planning, multidisciplinary team working and self-care and community engagement as well as locally agreed projects to reflect local need such as intergenerational projects, supporting children with complex needs, mental health support, improving activity and mobility; all based on understanding local demographics.

More recently all ICCs are taking up the challenge to ensure that they are using Population Health Management (PHM) approaches to underpin their data analysis and further ensure the work they are doing supports communities to use all their own assets to become more resilient as well as improving outcomes and reducing clinical variation.

The BCT Strategy has a clear priority for continued development of ICCs as the bed rock to improved service delivery at a local level and key component of our approach to population health. In particular, they will be essential in supporting delivery of a comprehensive approach to long term conditions, building on our early pilot work in respiratory and diabetes. This will help us improve outcomes and patient experience as well as reduce unnecessary hospital outpatient attendance and non-elective admissions.

The New Care Model set out in the NHS Long Term Plan to develop Primary Care Networks (PCNs) is partly modelled in the ICC concept developed in Morecambe Bay and other Vanguard sites. The development is welcome and brings much needed investment into Primary Care to help to stabilise

and support the service to move forward. The key features of PCNs are very similar to ICCs, but in their initial years are focused on stabilising Primary Care and improving the quality of care provided by primary care to its population. There is every expectation that PCNs will, as they develop, work with a range of other providers and communities to ensure a greater focus on population health and community engagement over time.

Morecambe Bay has eight PCNs, mostly co-terminus with ICCs, although there are some notable differences in the East of the area. The key challenge for the area is to continue the work that ICCs have been undertaking, whilst supporting PCNs to develop their new role and focus and then to develop these two entities to work together within their communities building towards integration over the period of the Strategy.

It is also important that our ICCs/PCNs in working together now continue their journey of understanding. Over the last few years this has been focused on understanding the local population need and what assets and other organisations can be worked with to support the communities – these skills are invaluable going forward but the next step in the journey is to understand the financial relationship between expenditure and the local community.

## Long Term Conditions

Nationally, there are 15 million people in England with a long term condition. According to NHS England, they have the greatest healthcare needs of the population (50% of all GP appointments and 70% of all bed days) and their treatment and care absorbs 70% of acute and primary care budgets in England. Across Morecambe Bay CCG, 34% of patients have at least 1 long term condition and the percentage of people in the Bay living with a limiting long term illness and disability is approximately 20% against the England level of around 17%; however, this rises to 25% of people living in Barrow, Millom and Morecambe.

Recently, we have begun work to improve a number of our key long term condition pathways. For example:

- We have piloted a new respiratory network approach in Lancashire North which has led to 60% reduction in outpatient appointments. We are rolling this approach out to Barrow as well as investing in enhancing our rapid response nursing team to support patients at risk of an unplanned admission and improving our pulmonary rehabilitation service capacity
- We have implemented a new approach to frailty, with greater risk stratification of patients (into high, moderate and low risk) and enhanced care planning and case management to support more people to live independently at home and avoid unnecessary unplanned hospital admissions
- We are part of a national pilot programme on Atrial Fibrillation where 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 have started work on new models of care for diabetes, including supporting people to avoid type 2 diabetes (through our population health work) or to 'walk away' from type 2 diabetes through better exercise, diet and management of the condition.

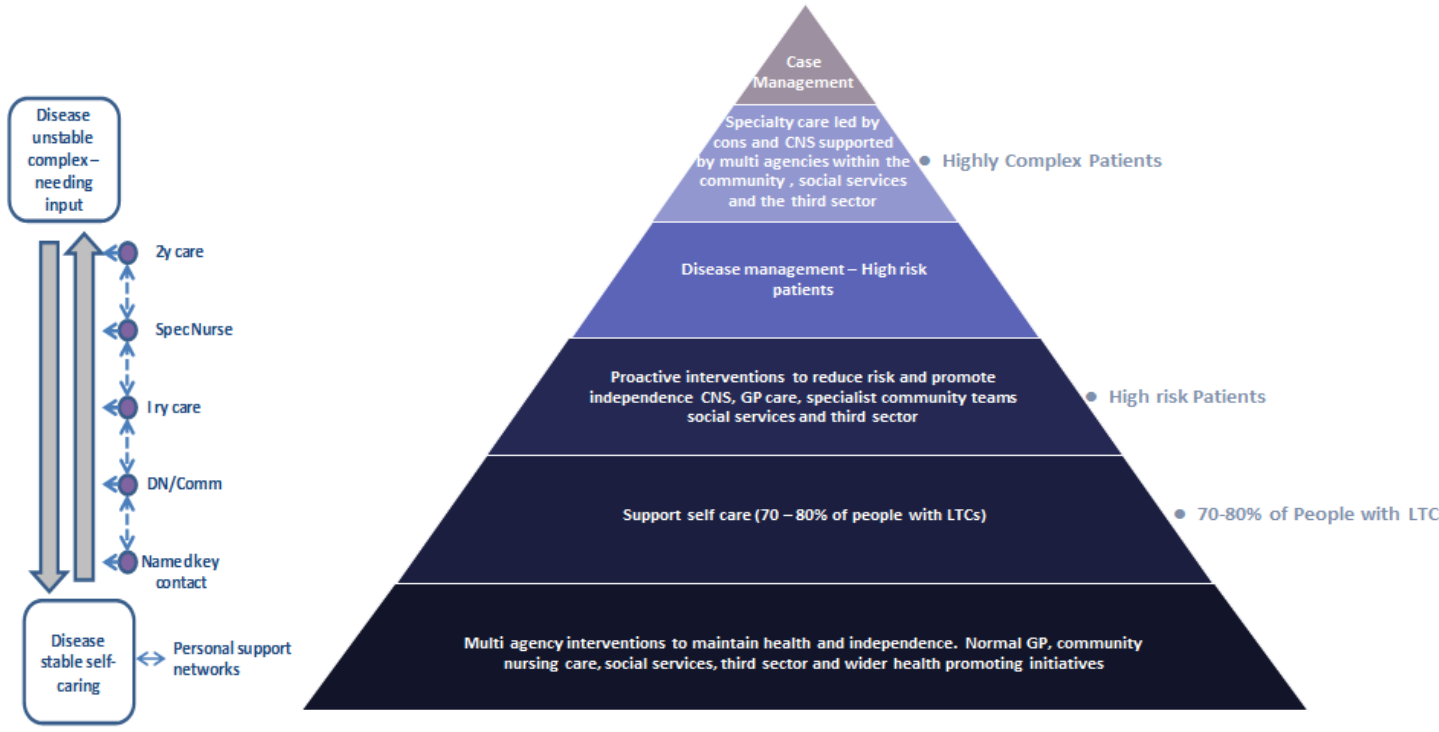
# Chapter 5: What health & care will look like in 5 years

The strategic focus of our work over the next 5 years is to bring this great work together into a comprehensive approach to long term conditions, building on the learning from each area. Central to this work are the key features in each of the individual pathways, such as:

- Wellbeing and prevention work through our population health programme
- Co-production of care with patient and their families, based on enhanced education and supported self-care
- Risk stratification of patients (high/moderate/low risk) and active case finding of hard to reach patients and those at risk
- Enhanced care planning with the patient and their family/carers in Integrated Care Communities. So most LTC care will be in a community setting, with GP leadership, specialist nurse support and outreach advice and guidance from consultants and MDTs for complex cases
- Case management and care navigation
- An expansion of the rapid response nurse teams to support patients with exacerbations to avoid unnecessary hospital admissions

These features are shown diagrammatically in Figure 10 below.

**Figure 10: Long Term Condition Proactive Care Planning Process**




Based on our respiratory work, we aim to reduce outpatient spells by 60% across all long term conditions and to reduce non elective spells by 40%. We also aim to be in the top quartile for all primary care long term condition indicators (such as patients with atrial fibrillation and high risk of stroke receiving anticoagulant therapy; diabetes patients that have achieved all the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure for adults; and HbA1c for children).

## Mental Health

The Morecambe Bay system strongly supports the principle of parity of esteem – there can be no physical wellbeing without mental wellbeing, and vice versa. The Bay system has faced many of the same challenges locally for mental health as have been seen nationally, ie:

- Shortages of service and access to services following years of underinvestment in mental health services in comparison with physical health services
- There has been a significant rise in demand in recent years, inevitably linked to the austerity but also in a positive way, to the decreasing stigmatisation of mental health. This has led to unacceptable waits to access services in all parts of the system, poor service user experience and adverse impacts on partners, particularly Acute Trusts
- There are significant workforce shortages, particularly in terms of psychiatric consultants and specialist nurses
- A need to modernise pathways of care and in particular to increase capacity in prevention and early intervention/support in primary and community settings, available 24/7; this has led to too many exacerbations and unnecessary attendances at A&E and admissions to acute mental health beds
- Locally within the Bay, we have also been challenged by the legacy of different service offers commissioned by different commissioners and provided in different ways by different providers
- Our provider Trusts have had quality challenges, as evidenced through CQC reports
- All the above challenges have been particularly acute in childrens' mental health services, with significant concerns over CAMHS and eating disorder services in South Cumbria.

We have seen some improvements in recent years:

- We are investing record levels of resources in mental health through the Mental Health Investment Standard
- This investment has been used to expand community services such as IAPT (Improving Access to Talking Therapies, such as Cognitive Behaviour Therapies) and community mental health teams
- We have invested in crisis support services through the national Core 24 model, such as additional psychiatrists and mental health nurse support at A&E and on the ward
- We have also invested in third sector support, such as with Richmond Fellowship and The Well, eg for patients with dual diagnosis mental health and alcohol problems
- We have transferred mental health services to one Trust for the Bay – Lancashire and South Cumbria NHS FT (LSCFT): this will ensure consistent models of care across the Bay (and to pathways agreed across the ICS). LSCFT are also being supported to improve the quality of services through a strategic partnership with Northumberland Tyne and Wear FT (as an 'excellent' provider)
- We are working to consolidate the commissioning of mental health services across the Lancashire and South Cumbria ICS

Nevertheless, there is still a long way to go. Our strategic focus for mental health for the next 5 years is to:

- Support mental wellbeing and resilience, particularly for children and young people, through our population health approach
- Continue to invest in an expansion of primary and community mental health services to support early intervention; these services will also be integrated with physical health services, particularly through our Integrated Care Communities
- Significantly improve services for children and young people through implementation of the 'Thrive' model, increased CAMHS capacity, the Mental Health in Schools Trailblazer project and implementation of an all age eating disorder service
- Modernise the urgent adult pathways of care and implement the recommendations of the 'NTW review
- Implement a new pathway for people with personality disorders
- Deliver Transforming Care programme for people with learning disabilities
- Complete the integration of South Cumbria services with Lancashire North services following the transfer from CPFT to LSCFT, develop the 'Bay Locality' and continue to modernise pathways of care and improve the quality of services.

## Urgent and Emergency Care

Through our priorities on population health and ICCs, we aim to work with communities to help people to stay fit and healthy for as long as possible and to manage their health care for the best possible outcomes. We recognise, however, that there will be times when people require urgent or emergency care and need to provide a timely and high quality response.

Nationally, demand on the urgent and emergency care system has been rising significantly for some years, with higher levels of attendances at A&E departments leading to a reducing percentage of people seen within the 4 hour national standard.

Over the last 3 years, the ED 4-hour 95% standard in Morecambe Bay for concluding the management of patients within four hours in our emergency department has not been met. The causes of the problems within the urgent and emergency care system, and the solutions to address them are complex and reflect wider pressures on the NHS and social care across the system. These include -

- **Rising demand:** The rising demand is beyond the increased rates seen nationally - between April 2018 and March 2019, our emergency departments treated over 8,000 more patients than they did in the same period the year before representing a 8% increase on 2017/18.
- **Mental Health:** There has been an increase in the number of ED cubicle hours occupied by mental health patients. The number of cubicle hours occupied by mental health patients continued to rise with circa 500 hours used on average every month - a 40% increase when compared to the previous two years.
- **Recruitment**: Despite positive recruitment in some areas there remains a stubborn deficit in middle grade recruitment within ED and also within primary care recruitment – a 1.6% year on year reduction nationally. This is against a national backdrop of almost a 10% vacancy rate in the nursing sector in the NHS.
- **Care Home sector:** The care home sector remains fragile. This market is a key stakeholder in

delivering programmes such as Discharge to Assess. Staffing and sustainability pressures across the care home and social care sector have resulted in increased financial pressures and longer lengths of stay and delays in discharge from hospital.

- **Capital and space constraints:** Estate across the Health and Social economy is limited and frequently not fit for purpose. UHMBT has submitted an Emergency Capital Bid which includes resources for a redesign of the A&E 'front door' at both the RLI and FGH.

We have made a number of improvements in recent years:

- Implementation of the Discharge to Assess model – releasing over 70 beds across bay
- 50% reduction in patients medically fit for discharge waiting in acute hospital beds, releasing 50 beds across bay;
- Cumbria Care Reablement development including a new shift based commissioning service for domiciliary care supporting patients to be at home;
- Integration of health and social care discharge teams – developing further into the Lancashire ICAT and Cumbria ICAT in development – expediting integrated care and reductions in delays;
- Commissioning of additional EMI Nursing beds to support the south Cumbria population and reducing DTOC at FGH.

In line with the NHS Long Term Plan, our main strategic priority for next 5 years in the Bay is to use the new models of care in our ICCs and transformation of services in the hospital to achieve the national A&E Standards and eliminate 12 hour breaches for both physical and mental health. Our vision of a transformed UEC service is for:

- A clinical advice service that meets the patient needs in a timely way. People will be empowered to take responsibility for their own minor health needs and will be encouraged access to self-care, make use of pharmacies and the NHS 111 service – online and telephone services
- For adults and children with urgent care needs, we should be supporting patients in the community to maintain their skills and functioning for daily living and provide a highly responsive service that delivers this care as close to home as possible, minimising disruption and inconvenience for patients, carers and families
- Those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, streamlined processes including timely and effective discharge and facilities to maximise the prospects of survival and a good recovery.

To achieve this vision, we have set out 4 key areas of focus:

- **Priority 1: Integrated Urgent Care -** supporting patients in the community to maintain their skills and functioning for daily living
- **Priority 2: System improvement at the Hospital Front Door and in A&E Departments** - A range of initiatives to improve A&E performance through effective system working prior to at the hospital front door.
- **Priority 3: Improving patient flow in the hospital -** A range of schemes being implemented in the hospital to reduce delays and unclog bottlenecks to improve flow between and within hospital wards and departments.
- **Priority 4: Improving discharge and rehabilitation in the community –** enabling timely and effective discharge with the required support to improve the skills and functioning of individuals for daily living or to receive ongoing care and support for daily living.

# Episodic Care

The key focus for episodic care over the next 5 years is to:

- Transform the way we deliver outpatients
- Continue to deliver improvements along our musculoskeletal pathway
- Drive productivity improvements in the delivery of elective care to ensure we better align capacity with demand in order to eliminate 52 week waits and over the 5 year period of the plan begin to improve our performance against the national 18 week target
- Work with the Lancashire and South Cumbria ICS to support 'fragile services'.

## Outpatient Care

The vast majority of patient interactions with secondary care are through outpatient clinics and we know that the various parts of the outpatient journey do not always deliver the best experience: they toooften experience uninformative appointment letters; the wait for the appointment; the cancellations and other antiquated manual booking processes; the journey often at inconvenient times; the waiting around in clinic, and in many cases the repetition of the entire process for unnecessary follow up review leaving patients frustrated and wondering what the point of the consultation was. The apology of "that's how it has always been done" is no longer acceptable and the traditional model of outpatient care is no longer fit for purpose.

The overarching purpose of outpatient care has always been to allow patients who do not need to be in hospital to seek a specialist opinion. But what can be achieved in an outpatient setting has changed significantly over time. Improved survival, advances in diagnostics and treatments, new modes of communication, changing patient expectations and less hospital-centric models of care have had a huge impact. Outpatient care in many places and this includes Morecambe Bay, has not kept pace and this, coupled with increasing and inconsistent referrals/ demand which out-strips core baseline capacity has resulted in thousands of additional out-patient clinics being held each year at premium cost and a system under pressure.

There are additional challenges with the critical mass and capacity of some specialties and sub-specialties being split across our three hospital sites not always matching demand geographically which leads to differential waits geographically; a high self-induced follow up rate that in one year adds up to just under 6 million patient miles travelled (together with the associated patient time) contributing significantly to the systems carbon footprint; single step linear clinical pathways with queues at each step, resulting in long waits to be seen and significantly so in some specialties; high levels of churn resulting with high numbers of clinic cancellations and high numbers of rebooked clinics at relatively short notice which in turn adds to the churn and extends waiting times, and; poor patient and staff experience.

We have made a number of improvements so far, although these have been relatively opportunistic:

- New national initiatives such as Choose and Book and ESR have been successfully implemented;
- One Stop clinics are available in a number of specialties;
- PIFU (Patient Initiated Follow Up) – a creative solution designed for typically patients with long term conditions to self-refer when they need to as opposed to a regular 3 or 6 month review to monitor their chronic disease – is in place in some specialties. This is being rolled out across the episodic care specialties;
- Morecambe Bay developed and implemented a bespoke Advice and Guidance tool some years

back which is well utilised by colleagues across primary and secondary care – again there is further opportunity to be realised

We intend to segment outpatient care in 3 ways:

- Long term condition management: – this should be managed predominantly in a community setting, with care planning and a 'multidisciplinary team' approach involving GPs, practice and specialist nurses, consultants outreaching from hospital and other care workers such as physios and occupational therapists – see section on Long term Conditions. This approach, as exemplified through respiratory pilot work, will significantly reduce unnecessary outpatient appointments (respiratory appointments were cut by over 40%)
- Cancer: we will improve our cancer pathways to ensure patients get speedy and effective diagnosis and treatment with a risk-stratified approach to follow up that appropriately balances surveillance with empowering patients to get on with life
- Episodic care: our approach to episodic care is set out below.

Our vision of a re-imagined, episodic out-patient service is a service that is patient centric and minimises disruption to patients, it is efficient and minimises delay and is wrapped up in technology and digital opportunities. This vision is made up of a number of component parts:

- Our bespoke digital Advice and Guidance service is further developed and serves as an alternative approach supporting primary care colleagues and other referrers;
- A referral management system, incorporating a process of audit and peer review, aligned to clinical pathway guidelines and protocols;
- Appropriate flexible capacity to meet the demand with a mix of generic pooling and sub specialty appointments;
- Efficient booking processes with minimal waste and easy access to an appointment with patients directly involved in selecting a time and date for their appointment – this may be via telephone, an app or electronically on-line;
- Alternatives to face to face consultations e.g. video consultations, remote consultations and monitoring, use of telemedicine;
- Strong focus on PIFU with increased emphasis on self-management and self-care;
- All clinical information available including notes, test results and information for the patient, prior to the appointment;
- Technology rich with the use of apps for self-serve, Web forms, video and remote consultation, digital dictations and automated transcription and telemedicine.

In achieving this vision, we believe we can deliver the aim of the NHS LTP to reduce outpatients by 30% across the 5 years of the Strategy. The majority of this work will be through avoiding unnecessary outpatient appointments or by providing outpatients in a radically different way. We are clear that if this means moving work into a community setting that appropriate resources will follow the work to ensure we do not place an inappropriate additional burden on already stretched primary and community practitioners.

## MSK

Improving the musculoskeletal (MSK) model is a priority in the NHS LTP, for the ICS and for the Morecambe Bay ICP:

- nationally, around 30% of GP consultations are MSK-related and the introduction of first contact physiotherapy practitioners could significantly reduce GP workload and support general practice sustainability

- in benchmarking against other areas, Morecambe Bay has significantly higher levels of hip and knee replacement than the national average and most of our 'RightCare' peers (in 2015/16 we were within the top 10% of CCGs for the number of both hips and knee replacements and the 5th highest CCG for hip replacements)
- We have high numbers of hospital outpatient appointments for MSK activity.

We have made a number of changes to the MSK pathway and are already seeing improvements:

- We have introduced an Integrated Musculoskeletal Service (iMSK) with extended scope physiotherapists who can provide advice and physio to patients to help avoid the need for more invasive treatment. This has already led to a 60% reduction in outpatients
- We are piloting First Contact Practitioners in general practice which is supporting national data that a 10% reduction in GP appointments can be achieved
- We are piloting decision support tools with patients to help them to determine the right treatment course for them. For example, patients who might otherwise have had surgery have decided to undertake further enhanced physio and exercise/weight reduction
- We are working within our population health programme to improve access to healthy living services to support people with weight loss and smoking cessation

Our strategic focus for the next 5 years will be to complete the implementation of the MSK model.

## Cancer

Nationally, it is estimated that 330,000 people each year are diagnosed with cancer and that more than one in three people (33%) will develop cancer at some point in their lifetime. Locally within the Bay, cancer is one of the biggest causes of premature mortality, with a disproportionate impact in deprived areas such as Barrow, Morecambe and Millom. As highlighted above, there are close ties with our transformation work on outpatients and also with our work on the long term conditions and the population health, including potential triggers such as weight management, alcohol consumption, smoking and diet.

The Morecambe Bay system has mixed performance in relation to national standards on cancer:

- We are achieving the two week wait target for all cancers, although the two week wait performance for breast symptoms has been challenging
- We achieve the 31 day targets for sub treatment targets for surgery and drugs
- We have not consistently achieved the 62 day treatment standard.
-

Underperformance is due to a complex mix of issues similar to other areas such as elective care and urgent care, ie:

- National recruitment shortages lead to gaps in our workforce, creating fragility in services and pressure on the existing workforce. Local examples include a shortage of gastroenterologists impacting upon the upper GI, colorectal pathways and bowel screening pathways and a reduced establishment for Consultant Radiologists.
- Delays experienced in care pathways for patients referred to tertiary centres within Lancashire for treatment or diagnostic tests.
- Lack of national capital to increase diagnostic capacity for CT, MR and Endoscopy in line with increasing demand.
- Patient choice of date at all stages of the diagnosis and treatment pathway, placing treatment within 62 days at risk.

We have made a number of improvements so far:

- We are mapping and making improvements to cancer pathways for Lung, Prostate (within Urology) and Gynaecology with upper GI and colorectal pathway improvements to come
- We are implementing a risk stratified follow-up approach within Breast cancer pathway with work to implement a similar approach within Colorectal
- Development and implementation of the Level 4 Psychology Service
- UHMBT led the Cancer Alliance wide work to clarify capacity and demand for the cancer 2 week wait standard, MR and CT.
- Implementation of the 3 Macmillan Cancer Support and Information Centres on the main hospital sites.
- The Living With and Beyond agenda has developed with an increase in the number of Holistic Needs Assessments (HNAs) completed.
- In line with NICE guidance, facilitated the commencement of FIT testing in primary care, with a laboratory established to process FIT samples.

In line with the NHS Long Term Plan, our main strategic priority for next 5 years in the Bay is to consistently achieve national standards, including the Faster Diagnosis Standard from April 2020, and working towards the two key ambitions in the NHS Long term plan for Cancer which are:

- By 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients; and
- From 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis

In order to deliver these priorities, the main focus of our work over the next 5 years will be to continue to improve our pathways of care, stabilise our workforce and provide sufficient diagnostic capacity.

## Children & Young People and Maternity

Our vision for children and young people is that working together, we will empower families and communities to reach their potential and create a brighter, healthier future for our children and young people. We recognise that improving the health and wellbeing of children and families will lead to a healthier generation of adults across Morecambe Bay.

We have made a number of improvements in recent years, including:

- Significant progress towards developing an Integrated Childrens Nursing Team, particularly in Lancashire North where childrens community services are now integrated within UHMB.
- The development of an MDT approach for frequent attenders with paediatricians, GPs and Community Nurses working together to help ensure that families are able to access the support they need to address needs and thereby avoid unnecessary hospital attendances
- The alignment of childrens and maternity professionals to ICCs, supporting local partnership working to meet the needs of local communities
- The launch of a number of self help pathways for families and new clinical pathways for a number of conditions
- Been successful in securing Mental Health Teams in Schools as part of the trailblazer project –

these teams will start to be established in January 2020
- We have designed and implemented a new ASD diagnostic service and ADHD service in Lancashire North
- We co-produced with families an integrated maternity pathway and care for women with perinatal mental health needs has been improved with a new Mother and Baby unit providing inpatient care and a specialist outreach team with links to local pathways

We face a number of challenges with regards to services for childrens and families, similar to other conditions:

- There are significant recruitment and retention challenges in a variety of professional posts which is having an impact in a number of services, for example paediatric physiotherapy and CAMHS
- There is a continuing trend of increasing numbers of children and young people having emotional wellbeing and mental health needs, and a sense across the area that these needs are becoming more complex and seem to be escalating more quickly. Referrals to CAMHS services continue to rise, particularly in South Cumbria where referrals have increased by 30% in the past year; and a large proportion of children and young people needing inpatient care (sometimes up to 80% of inpatients on the paediatric wards) are in hospital because of their emotional and mental health needs
- The National Better Births Transformation Programme has set clear requirements for the improvement of maternity services. These changes are welcomed and a lot of work is underway across the ICS to deliver them, however there are some real challenges in delivering to the expectations
- There are increasing numbers of children and young people with complex health and care needs and we need to get better at working together to support them and their families in an integrated way. The SEND inspections in both Cumbria and Lancashire have given us a clear direction for improvement

The Strategic direction for childrens & young people and maternity services is to:

- Implement the Better Births national programme
- Support improvement activity in line with the SEND action plans for Lancashire & Cumbria
- Improve and expand CAMHS services, particularly through: implementation of the Thrive model; delivery of the Mental Health in Schools Trailblazer project; and implementing a specialist eating disorder service in South Cumbria

## Intermediate Care

Intermediate Care is not a term that anyone outside of NHS and Social Care would understand; but it refers to the care we provide to people who need more than can be provided by GPs, district nurses or is provided by some specialist care staff for individual diseases and is provided to either support someone to stay in their own home and have additional care, preventing an unnecessary hospital admission or to support them to be rehabilitated following a stay in hospital. One of the key aspects of intermediate care is the focus on rehabilitation or reablement; ensuring that the service user regains confidence to remain as independent as possible.

The types of services that are included in this element of care are:

- Home based support services such as Rapid Response including nursing and therapy services, often in conjunction with social support; usually supporting people who have developed the need for additional care and without the services would be admitted to a hospital bed.
- Reablement services, usually provided by social care, aimed at supporting patients to improve their mobility and functioning.
- Early supported discharge services that support patients for a period after discharge from hospital, often related to conditions such as stroke. These services are often multi-disciplinary.
- Bed based services which may be provided in a residential or nursing setting, but again focus on including therapeutic intervention.
- Discharge to assess services are a much more recent development and provide support prior to assessment of need in a more appropriate environment.

We face a number of challenges for intermediate care:

- We have a range of intermediate care services in Morecambe Bay with different provision in Lancashire North and South Cumbria (related to historical commissioning and provision)
- Services in Lancashire North are largely home based, with some residential rehabilitation, whilst in South Cumbria there are some home based services but also greater emphasis on nursing bed based community hospital services. Services in both counties have an element of alignment in the commissioning processes between health and social care, but are not jointly commissioned. Pathways in and out of services are also different and require alignment.
- New services and pathways have yet to be fully aligned with existing services and the link between ICCs and PCNs has not been fully established to ensure that the greatest benefit for the population is obtained from these services.
- The development of intermediate care services is seen as positive from a number of perspectives, not least the service user, however, it brings with it additional pressures to the system in terms of requirements for medical oversight in a community setting. We have yet to agree a robust way forward with this given pressures on all medical staff; primary and secondary

Our key Strategic focus for the next few months is to develop and deliver a clear strategy for Intermediate Care in the Bay with a new care model based on full integration across all partners using the “Advancing Integration” model. Alongside this, we need to embed a culture of rehabilitation across all services; all interactions with patients can have an element of reablement. This is likely to be a culture shift for some services, but is one that we need to make in order to gain the best outcomes for service users.

## Configuration of services

As BHCP, we firmly believe that it is services that matter most – not bricks and mortar. But we recognise that patients and communities are rightly concerned that service change may lead to access issues, particularly given our rurality and geographical footprint.

Given the scale of the challenges we face (as set out in Chapters 2 and 3) it is inevitable that we will need to consider the configuration of services. Our view on what services will look like in 5 years’

time (Chapter 5) highlighted our intention that we will have more care delivered in primary and community settings alongside a smaller hospital footprint: the latter being the inevitable consequence of the former. Our intention for provider collaboration through a group hospital model is for collaboration to deliver services with sustainable staffing and consistent pathways of care. It is not code for centralisation. For example, digital technology will allow Trusts to collaborate in the way they read diagnostic scans remotely from other sites to support each other with workload and workforce issues.

At this stage we have no concrete plans for any significant reconfiguration or consolidation. We cannot say that services will not be reconfigured or indeed consolidated over the 5 years of the plan. If this does take place it will be undertaken with a clear rationale, in a transparent way and in line with some clear principles, such as:

- We will not put patients' safety at risk. For example, we cannot continue to provide services on multiple sites where small numbers of procedures or patients mean clinicians may not be maintaining the necessary skills and experience to provide safe services
- We cannot continue to provide services where it is clearly significantly uneconomic to do so given our financial challenges, unless clinicians and the public feel there is an overwhelming requirement to provide essential services in the local area
- We cannot provide services unless we have safe staffing levels. We will do all that we can to recruit and we will use digital technology to provide innovative solutions. We will also work with the public to support recruitment (as the Millom Alliance helped to recruit to the GP practice in Millom to sustain the local community hospital).

At time of writing there are three services we have classed as 'fragile services' due to the concern over staffing levels and the small numbers of procedures being performed across 3 sites: ophthalmology, urology and ENT. These are likely to be consolidated onto one site but in doing so we will ensure a centre of excellence approach. We have highlighted these examples to the Lancashire and Cumbria Joint Scrutiny Committee and will continue to work with the Committee in a transparent way should further issues arise in future. Similarly, there may be other services across the ICS which become fragile and require change; but again there are no concrete plans for change at present and we will continue to work the Scrutiny Committee as needed.

We also feel that there is scope to maximise the benefits of Westmorland General Hospital as an elective centre. At present there are periods where there is significant pressure on elective care due to winter pressures or spikes in trauma activity which mean planned care activity is, inevitably, affected. Use of WGH as more of a dedicated 'elective centre' for the Bay (and potentially, the ICS) gives an opportunity to build an excellent service delivery model and reputation: improving outcomes; performance; staff and patient satisfaction.

We are also committed to sustaining essential hospital services in Barrow, particularly urgent care and maternity services. This recognises the geographically remote nature of the town, the high levels of deprivation and the importance of health services to delivery of the local economy: for example, the role the town plays in the construction of the new nuclear submarine fleet at BAE on behalf of the nation's defence. This commitment is also shared by the Lancashire and South Cumbria ICS and work is ongoing to determine the 'structural deficit' costs associated with providing services at Barrow.

The NHS LTP also set out the intention to develop a standard model of delivery in smaller acute hospitals who serve rural populations, such as at FGH and RLI (and indeed WGH). Smaller hospitals

have significant challenges around a number of areas including workforce and many of the national standards and policies were not appropriately tailored to meet their needs. The national work aims to develop a new operating model for these sorts of organisations, and how they work more effectively with other parts of the local healthcare system. Locally, we will use the outcomes from this national work as part of work over the next 5 years.

# Chapter 6: The new NHS infrastructure

**Chapter 6 sets out the new NHS infrastructure in which care will be delivered**. This reaffirms our commitment to work at three levels: ICC and neighbourhood level; the continued development of the Morecambe Bay ICP; and the continued development of the Lancashire and South Cumbria ICS. In Chapter 6 we also recognise the direction of travel towards: more integrated commissioning across the ICS; and the development of a group hospital model – although we acknowledge that much more work needs to be done to define what we mean by group hospital, and the benefits of integrated commissioning.

The NHS Long Term Plan sets out a new way of working for health and care in England (Chapter 7). This is focussed on integration of services and the development of place based decision making and care delivery known as Integrated Care Systems and Integrated Care Partnerships.

For Morecambe Bay this means working at three levels (shown diagrammatically below in Figure x):

- **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).

**Figure 11: Integrated Working in Lancashire and South Cumbria**

# *Chapter 6: The new NHS infrastructure*

Bay Health and Care Partners are committed to supporting continued development of ICCs, the Morecambe Bay ICP and the Lancashire and South Cumbria ICS – see our Priority 5 in Chapter 3. Within this there are two important elements:

- We recognise the direction of travel to more integrated commissioning. This is likely to mean a single CCG for Lancashire and South Cumbria within the lifetime of the plan. However, we need to determine what commissioning functions continue to be delivered locally within the ICP (eg local health needs assessment, strategic planning, transformation work and commissioning of local or neighbourhood services). We also want to work with our local authorities on the approach to joint commissioning for more effective integrated care delivery (eg for care of the elderly or childrens services) and also as anchor institutions in support of wider economic regeneration and wellbeing
- We also recognise the direction of travel towards a 'group model' of integrated providers. Again, we will need to set out in more detail what we mean by the group model. But at a high level, this means a move away from the competition approach associated with the establishment of foundation trusts, towards a collaborative provider network, with sustainable staffing levels and consistent pathways of care.

The current governance models for the ICS and ICP are set out in Appendix 3. These will change and evolve as our detailed plans take shape and are delivered over the lifetime of this strategy.

# *Chapter 7: What this means for our Enablers: Finance, Workforce, Digital & Estates*

**Chapter 7 sets out what the Strategy means for our enablers.** This makes clear our commitment to achieve our control totals and bring the system back towards financial balance over the 5 years of this strategy; to make more effective use of digital technology for patient access, service delivery and to support the workforce; and our workforce plans including better recruitment, new and innovative roles, growing our own workforce, the development of a primary care academy and greater support to our existing workforce

## Finance

As set out in the case for change, the Morecambe Bay system has a significant financial challenge. We are currently spending £60m more than we receive in allocation. We have set out our ambition in Chapter 5 to achieve our control totals and bring the system back towards financial balance over the 5 years of this strategy.

The financial principles underpinning the strategy over the 5 years of the Strategy are as follows:

- The Morecambe Bay system will achieve the control totals as set out by NHSE/I – as detailed in Figure 12 below
- The Health System will deliver a year on year reduction in its financial deficit, returning to a more balanced financial position within 5 years. Delivering this improvement is aligned to the national financial improvement trajectory (FIT) and is dependent on ICS support for the structural deficit within the Bay, particularly the additional costs of services at FGH. Wider system financial sustainability is also dependent on a national settlement for long term care to ensure sustainability for social care and local authorities as well as health
- The system will achieve the Mental Health Investment Standard in each of the 5 years of the strategy, with an additional 1.7% on top for 2020/21, increasing mental health spend by £16m (25.7%) by 2024. The focus of investment will be in line with priorities in Chapter 4, ie: addressing significant quality and access challenges; improving prevention & wellbeing and early community support to avoid exacerbations; and reducing the impact on the urgent care system, particularly 12 hour breaches
- The system will increase primary and community spend by the minimum of the CCG allocation increase in each of the 5 years of the Strategy, increasing spend by £13.7m (11.7%) by 2024. This investment is offset by continuing planned efficiencies. Investment will be targeted towards priorities in Chapter 4, ie: population health and reducing unnecessary A&E attendances and non-elective admissions to offset growth in demand for the acute sector
- Investment in acute spend will grow by a maximum of 1% per year for growth and 1.55% tariff uplift (ie uplift of 2.4% less deflator of 1.1%; plus an additional 0.25% for CNST) in each of the 5 years of the Strategy, giving an increase before QIPP and Transformation work reductions are applied of £23m by 2024. Linked to this, we will move away from a payment by results contract to a 'block'/assured or blended payment contract
- Our non-clinical spend will reduce by 15% over the 5 years of the strategy, after taking into account inflation and cost of living rising – estimated to be -£1m by 2024
- BHCP already spend significant resources linked to population health, as this is a priority within the Strategy (Chapter 4) we will grow this commitment by establishing a population health

innovation fund of £500k in 2020/21 with a subsequent increase of 10% per annum up to 2024 (ie an increase to £665k by 2024)

- Our QIPP and CIP will be a minimum of 2% per year for the CCG and 3% for providers – see table 14 below. In order to deliver the QIPP/CIP targets, we will deliver the SFRP key programmes, for example:
    - Delivering our ambition transformation plans for outpatients, which will also reduce outpatients by 30% (10% reduction in first outpatients and 20% reduction in follow ups) by 2024
    - Our ICC focus on long term conditions will reduce outpatients by 40% and non-elective admissions by 50% for key condition groups in respiratory, diabetes, cardiovascular and frailty. This will halve the cost of admissions for unnecessary ambulatory care sensitive conditions
    - Our investments in mental health will eliminate 12 hour A&E breaches and reduce unnecessary A&E attendances for mental health exacerbations by 50%
    - We assume the projected 5% growth in prescribing will be significantly offset by QIPP schemes
    - We will completely redesign our Continuing Health Care (CHC) services in line with ICS plans delivering a service which focuses on prevention and maximising our community assets; assumed growth in CHC in line with the allocation growth each year, will be mitigated to an overall growth of 14.5% by QIPP initiatives over the course of the LTP.

Any shift in activity from one area to another as a consequence of our transformation work or in line with the Long Term Plan (eg acute to primary care) should lead to a more cost effective and improved model of care and will be accompanied by appropriate increases in resources to avoid an unfair redistribution of work.

**Figure 12: NHSE/I Financial Trajectories**

| University Hospitals of Morecambe Bay NHS FT | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| Baseline | (60,099) | (55,280) | (49,550) | (41,470) |
| Net performance improvement requirement | 4,819 | 5,730 | 8,080 | 3,310 |
| **Financial Improvement Trajectory (pre FRF)** | **(55,280)** | **(49,550)** | **(41,470)** | **(38,160)** |
| Indicative FRF | 39,843 | 39,843 | 41470 | 38,160 |
| **Indicative Financial Improvement Trajectory (including FRF)** | **(15,437)** | **(9,707)** | | |

| NHS Morecambe Bay CCG | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| **Financial Improvement Trajectory (pre FRF)** | **3,190** | **5,520** | **2,600** | **0.190** |
| Indicative FRF | - | - | - | - |
| **Indicative Financial Improvement Trajectory (including FRF)** | **3,190** | **5,520** | **2,600** | **0.190** |

Based on the assumptions above, Figure 13 below sets out the total system spend by sector for each year up to 2023/24.

# Chapter 7: What this means for our Enablers: Finance, Workforce, Digital & Estates

**Figure 13: Total Health System Spend**

| Area | 2019/20 FOT £'000 | 2020/21 Plan £'000 | 2021/22 Plan £'000 | 2022/23 Plan £'000 | 2023/24 Plan £'000 |
|---|---|---|---|---|---|
| Acute Services | 288,575 | 291,722 | 296,784 | 301,321 | 307,043 |
| Mental Health - Adult | 56,568 | 59,679 | 61,890 | 64,103 | 66,278 |
| Mental Health - Children and Young Persons | 5,219 | 5,506 | 5,710 | 5,914 | 6,115 |
| Community Health Services | 50,002 | 52,048 | 55,675 | 59,225 | 62,859 |
| Continuing Care Services | 39,119 | 39,386 | 40,638 | 43,104 | 45,626 |
| Other Primary Care | 17,523 | 17,455 | 17,164 | 17,950 | 18,737 |
| Primary Care (Co-Commissioned) | 46,585 | 48,544 | 50,652 | 53,049 | 55,807 |
| Prescribing | 50,509 | 49,893 | 49,403 | 48,903 | 48,390 |
| Other Programme Expenditure | 9,743 | 14,120 | 18,882 | 20,002 | 20,505 |
| Running Costs | 6,142 | 6,142 | 6,142 | 6,142 | 6,142 |
| Contingency | 0 | 2,709 | 5,518 | 8,425 | 11,431 |
| **Total** | **569,985** | **587,206** | **608,457** | **628,138** | **648,934** |

Figure 14 below summarises the level of cost improvement required across the health system from 2019/20 to 2023/24 in order to meet our agreed control totals and the health system spend outlined above. Robust arrangements are in place to ensure there is a clear and deliverable programme of transformation and other cost improvement projects to deliver the challenging levels of financial improvement required for each of the 5 years. Through the considerable efforts of clinical and managerial colleagues across the Bay a significant level of evidence relating to activity, capacity, workforce and money is available to substantiate these projections.

**Figure 14: Morecambe Bay Financial Recovery Plan: Cost Improvement Requirement for 2019/20 to 2023/24**

| | | | | | |
|---|---|---|---|---|---|
| Cost improvement requirement £000s | 16,221 | 12,603 | 12,271 | 12,712 | 13,153 |

We accept that this finance section relates largely to health. Local authority spending has been significantly constrained over the last 10 years which has impacted on social care and childrens services as well as wider community support which underpins the wellbeing agenda (such as smoking cessation and weight management services; youth clubs and activities for children and young people; support for the third sector etc). We will work with local authorities to better align budgets around key priorities and to consider how we can work together to make better use of the Morecambe Bay pound through a framework to share risks and rewards across health and social care.

# *Chapter 7: What this means for our Enablers: Finance, Workforce, Digital & Estates*

## Workforce

Morecambe Bay's geographical location, economic context and rurality mean that it is significantly impacted by national skills shortages. There are over 7500 individuals directly employed across the BH&CP organisations across 121 unique roles. Of these:

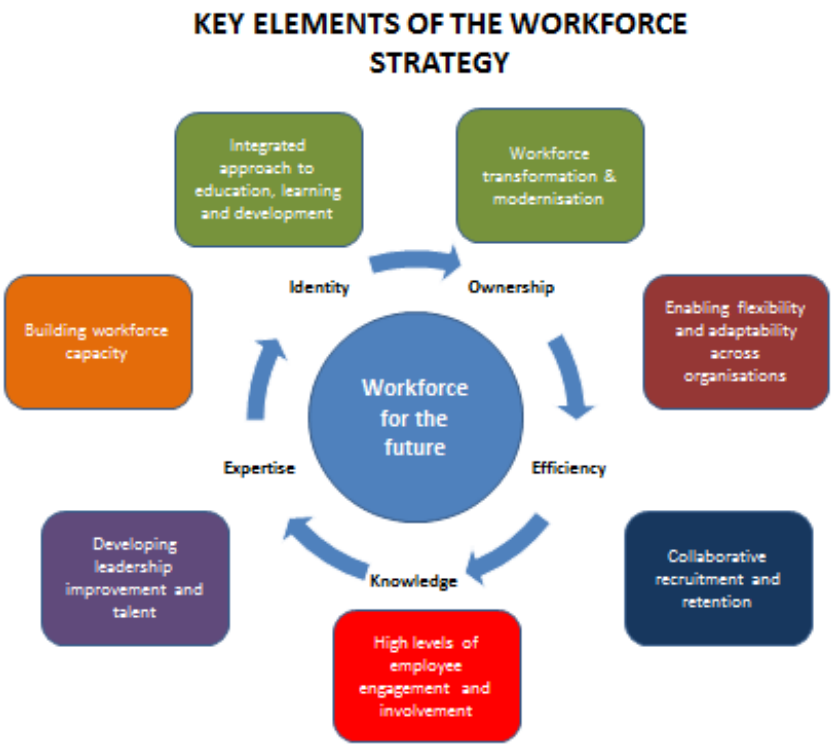
- 39% are aged 50 and over
- 78% are female
- 28% are part-time

Engagement across BHCP partners has identified that the most pressing workforce challenges across the geography result from high levels of vacancy in the following areas:

- General Practitioners
- Consultants Medical staff
- Nurses & Midwives
- Social Workers
- Therapists
- Support Workers (Care Homes)

The strategic workforce approach for Morecambe Bay is being built using the model set out below:

**Figure 15: BH&CP Proposed Workforce Strategic Model**




In line with this model, the following priorities for People & OD across the Bay have been identified:

- Developing our overarching People & OD Plan (what we want to do linked to the Interim People

Plan)

- Supporting our existing workforce - connecting Live Well & Flourish – as model employers for H&WB
- Developing new and different roles, particularly in primary/community settings – linked to PCNs (see below);
- More effective recruitment;
- 'Growing our own' workforce: with particular reference to the development of the Primary Care Academy (see below)
- Better use of technology (see digital section below).

### General Practice

As with the rest of the health and care system, general practice has significant staffing issues that could destabilise the delivery of general medical services to our population. A recent survey of GP practices found that:

- 47% of practices felt that workforce was steady compared to 2-3 years ago; 32% felt it was going down; and 21% thought it was going up
- 54% of practices *always* worked outside 'regular' hours; 33% said often or very often; only 12% said never or rarely
- Around 18% of practices said work/life balance was dreadful and 39% said poor; compared to 5% who said it was the best it had ever been and 16% good
- Workload, inability to recruit and reorganisation were stated as the biggest 3 factors impacting on morale; advice & guidance, ICT developments and mergers were the three best things to have happened in addition to the general resilience, energy and determination of general practice to deliver for patients.

These issues are probably not uncommon with other areas of health and care in the Bay; but worryingly, there will be a disproportionate impact on general practice in many areas – particularly in deprived areas or high levels of elderly patients, both of which can impact on workload and recruitment.

The proposed approach to support general practice workforce challenges is to similar that for the system workforce as a whole, ie:

- Support the existing workforce to Live Well and Flourish
- Expand the local Enhanced Training Hub to incorporate a Primary Care Academy which will support the attraction, recruitment, training, education and retention of a primary care workforce of the future. The model will focus initially upon retention and recruitment but in the longer term will focus upon 'growing our own' workforce with clear, attractive and attainable career paths for local Morecambe Bay residents
- Expanding the numbers of 'other qualified staff' providing direct patient care in general practice. This links to the development of Primary Care Networks and the use of roles such as first contact physiotherapists, social prescribers, medicines managers etc.

# *Chapter 7: What this means for our Enablers: Finance, Workforce, Digital & Estates*

## Digital

Technology is changing the way we live our lives, from the way we shop to the way we communicate with friends and family. Most people have a mobile phone or tablet and are using apps. People are using the internet to book holidays, manage their finances or even ask Google for medical advice.

However, for patients in the Bay and staff working in health and social care services, it can feel like all this is left at the door when you step into the care environment, with many people feeling that solutions are often feel piecemeal and poorly designed. Yet most feel technology has an important part to play in transforming care.

Within Morecambe Bay we have had a number of successes with digital initiatives:

- We set an ambitious priority for a single care record for the Bay, putting in place the IT infrastructure to ensure all NHS partners have access to the patient's record to improve care and patient experience
- We have used technology to improve access and reduce the need for travel: for example we established video conferencing links between Millom Community Hospital and Furness General Hospital
- We have established an electronic patient referral platform, delivering the national eRS requirement for GP referrals to consultant outpatients and using Strata for community and social care referrals.

But we know that we can do more.

BHCPs are working closely with the ICS digital leads and there is a well-established digital workstream, supporting the delivery of clinical priorities and helping partners to achieve system sustainability. The aim of this programme is to mobilise the workforce, to harness the digital revolution and bring about a radical transformation, which will:

- Empower people to be more active in managing their health and wellbeing
- Enable more patients to self-care and live independently for longer
- Pinpoint, predict and prevent disease through better use of data
- Increase the amount of time for care on the frontline
- Create a flexible working environment that helps retain the workforce
- Improve operational efficiency across back-office services

Our local digital strategy for the next 5 years will align to the ICS digital strategy and will focus on supporting delivery of the wider priorities set out in this Better Care Together Strategy:

- **Patient self-management: we will implement standard patient-facing Apps** (such as iPlato and the national NHS App) to give patients access to their medical records and enable them to book appointments and manage care online
- **Self-care**: Patient-facing Apps (such as the NHS App and iPlato) will also allow use of tools for self-care, such as monitoring of weight and blood pressure etc to help patients improve their management of long term conditions, such as respiratory and diabetes

- **Workforce productivity**: for example, we will invest in mobile technology and different ways of working to support community staff such as district nurses to reduce the administrative burden and increase patient contact time
- **Use of data to drive improved outcomes**: through better use of health data, we can predict care needs and offer earlier intervention. For example, we can use risk stratification to identify patients at risk of a stroke and ensure appropriate anticoagulation treatment is in place.
- **Using technology to better manage demand and flow through our systems**: for example, we believe that making our outpatient booking systems fully electronic and online will help patients to get the right choice of appointment improving patient experience and reducing DNA rates

**Support the resilience of general practice**: a number of practices in the Bay are using new technology to transform the way they interact with patients, through telephone and video conferencing consultations. This has improved productivity in the GP practice helping to reduce workload pressures at a time of recruitment shortages as well as improve patient experience and access. We will also digitise all the patient records for the GP practices moving into the Alfred Barrow Health Centre in Barrow, improving access and reducing the costs associated with storage

## Estates

At present we have significant capital challenges: our general practice buildings are poor in many areas, with significant backlog maintenance needs; our community services estate is mixed and insufficient to meet our future aims and ambitions to provide more care out of hospital; our acute hospitals buildings have significant problems: operating theatres and diagnostic equipment break downs; there is backlog maintenance in heating systems and wards; the general estate, particularly at RLI, does not provide for modern pathways of care in areas such as urgent care(the critical backlog maintenance issues (excludes Diagnostic and IT) at UHMB total c£70m within the overall need for a minimum of £96m capital investment in the acute setting).

As Chapter 5 indicates, the long term direction is for more care to be provided in primary and community settings. Whilst some of this care will be provided in patients' own homes or in alternative settings (such as community centres) much will continue to be provided through primary and community buildings. This will be particularly challenging for primary care; we have recently evaluated general practice estate, using a '6 facet survey' approach. This evaluation shows:

- Whilst the physical condition of 95% of buildings were classified as "Satisfactory", 5% were deemed "Poor – exhibiting defects and/or not operating as intended".
- 57% of buildings have "outstanding/ backlog" maintenance work at a value of c£1m with a further £1.1m of maintenance is required between 2020 and 2025.
- 82% premises are fully-used, and 3% are over-crowded.
- 93% buildings were classed as requiring general maintenance investment to improve the quality of the environment and 7% were classed as less than acceptable quality
- 80% of buildings were assessed as dangerously below standards of statutory compliance, the remaining 20% had known contraventions

Historically, capital planning has tended to focus on acute hospital estate. Over the next 2 years we

will develop a BHCP Estates Strategy which has a clear focus on 'out of hospital' estates strategy covering primary and community estate (for both physical and mental health) aligned with capital strategies in the two County Councils (particularly for integration of social care) district councils (to support the wider wellbeing agenda in ICCs) and the third sector. The announcement in September 2019 that the Bay will receive 'seed funding' as part of the NHS Health Infrastructure Plan will provide the opportunity to set out a long term plan to reimagine the health and care estate in line with the ambitions set out in this Strategy.

The Estates Strategy is important not only in setting out and delivering the capital infrastructure necessary to deliver our health and care ambitions, but also as part of our role as 'Anchor Institutions' in the supporting the wider economic, social and environmental wellbeing of our communities.

## Appendix 1

# Glossary of Terms

| Glossary | |
|---|---|
| **A&E** | Accident and Emergency |
| **A&G** | Advice and Guidance |
| **ADHD** | Attention-deficit/hyperactivity disorder |
| **AF** | Atrial fibrillation |
| **ASD** | Autism spectrum disorder |
| **BAE** | British Aerospace |
| **BCT** | Better Care Together |
| **BHCP** | Bay Health and Care Partners |
| **C&YP** | Children and Young People |
| **CAMHS** | Child and Adolescent Mental Health Services. |
| **CCG** | Clinical commissioning group |
| **CHC** | Continuing Health Care |
| **CIP** | Cost Improvement Programme |
| **CPFT** | Cumbria Partnership Foundation Trust |
| **CQC** | Care Quality Commission |
| **CT** | Computed tomography scan |
| **Cumbria CVS** | Cumbria Council for Voluntary Service |
| **CVD** | Cardiovascular disease |
| **D2A** | Discharge to assess services |
| **DHSC** | Department of Health and Social Care |
| **DNA** | Did Not Attend |
| **DTOC** | Delayed Transfer of Care |
| **DTOC** | Delayed transfer of care |
| **ECDS** | Emergency Care Data Set |
| **EMI** | Elderly Mentally Infirmed |
| **eRs** | Electronic Referral System |
| **ESR** | Electronic Staff Record |
| **FGH** | Furness General Hospital |
| **FIT** | Financial Improvement Trajectory |
| **FRF** | Financial Recovery Fund |
| **GP** | General Practice |
| **H&WB** | Health and Well Being |
| **HNA** | Holistic Needs Assessment |
| **IAPT** | Improving Access to Talking Therapies, such as Cognitive Behaviour Therapies |
| **ICAT** | Lancashire ICAT and Cumbria ICAT in development |
| **ICC's** | Integrated Care Communities |

# *Appendices*

| | |
|---|---|
| **ICP** | Integrated Care Partnerships |
| **ICS** | Integrated Care System |
| **ICT** | Information and Communication Technology |
| **iMSK** | Integrated Musculoskeletal Service |
| **ISMB** | Integrated Services Management Board |
| **IT** | Information Technology |
| **JSNAs** | Joint Strategic Needs Assessment |
| **LCFT** | Lancashire Care Foundation Trust |
| **LoS** | Length of stay |
| **LSCFT** | Lancashire and South Cumbria Foundation trust |
| **LTC** | Long Term Condition |
| **LTP** | Long Term Plan |
| **MDT** | Multi-Disciplinary Team |
| **MRi** | Magnetic resonance imaging |
| **MSK** | Musculoskeletal |
| **NHS** | National Health Service |
| **NHSE** | National Health Service England |
| **NHSi** | National Health Service Improvement |
| **NICE** | National Institute for Health and Care Excellence |
| **NTW /CNTW** | Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (Mental Health Provider in the North East of England and North Cumbria |
| **OD** | Organisational Development |
| **PCN** | Primary Care Networks |
| **PHM** | Population Health Management |
| **PIFU** | Patient Initiated Follow up |
| **QIPP** | Quality, Innovation, Productivity and Prevention |
| **RLI** | Royal Lancaster Infirmary |
| **RTT** | Referral to treatment |
| **SEND** | Special Educational Needs and Disability |
| **SFRP** | Sustainability and Financial Recovery Plan |
| **UEC** | Urgent and Emergency Care |
| **UHMBT** | University Hospitals of Morecambe Bay Trust |
| **UTC** | Urgent Treatment Centre |
| **VCFS** | Voluntary, community and faith sector |
| **VCS** | Voluntary and Community Sector |
| **WGH** | Westmorland General Hospital |

# Appendix 2

# Lancashire and South Cumbria ICS Partners & Governance

### Figure 16: ICS & ICP Partners

**Lancashire and South Cumbria ICS partners**

**Central Lancashire**
Chorley Council
Chorley & South Ribble CCG
Greater Preston CCG
Lancashire Teaching Hospitals NHS Foundation Trust
Preston City Council
South Ribble Council

**Fylde Coast**
Blackpool CCG
Fylde & Wyre CCG
Blackpool Teaching Hospitals NHS Foundation Trust
Blackpool Council
Fylde Council
Wyre Council

**West Lancashire**
Southport & Ormskirk Hospital NHS Trust
West Lancashire CCG
West Lancashire Council

**Morecambe Bay**
Barrow Borough Council
Cumbria County Council
Lancaster City Council
Morecambe Bay CCG
South Lakeland Council
University Hospitals of Morecambe Bay NHS Foundation Trust

**Pennine Lancashire**
Blackburn with Darwen CCG
Blackburn with Darwen Council
Burnley Council
East Lancashire CCG
East Lancashire Hospitals NHS Trust
Hyndburn Council
Pendle Council
Ribble Valley Council
Rossendale Council


**Organisations working across the ICS**
Lancashire County Council
Lancashire Care NHS Foundation Trust
NHS England & Improvement
North West Ambulance Service NHS Trust

### Figure 17: Current ICS Governance Arrangements

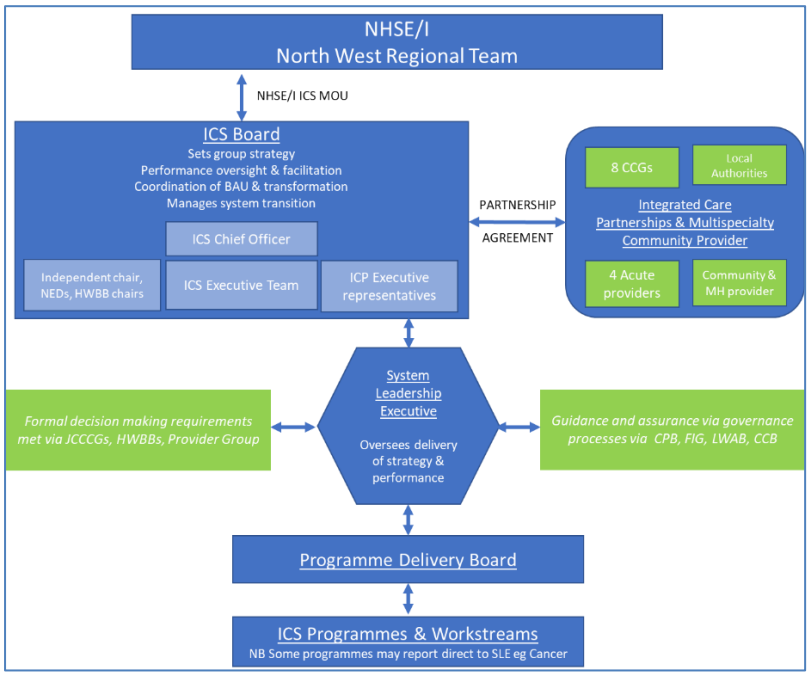
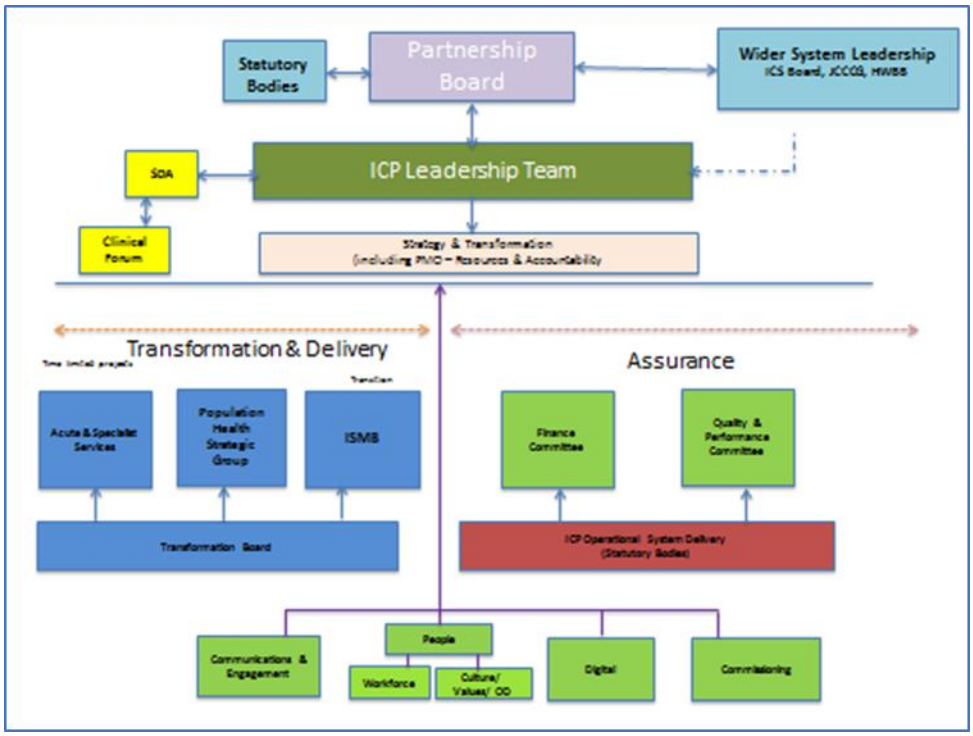


**Figure 18: Current ICP Governance Arrangements**



## Appendix 3

# Morecambe Bay ICP and Lancashire & South Cumbria ICS Priorities

| ICS Priorities | ICP Priorities | Comments |
|---|---|---|
| 1. Out of Hospital/PCNs | 1. Prevention, health inequalities and population health<br>2. Sustainability of general practice, ICCs & PCNs | ICP P1 is implicit in ICS P1 and so good match<br><br>ICP P2 strong match to ICS P1 |
| 2. Urgent and emergency care (to include respiratory) | 3. Improvements in mental health, cancer, emergency care and planned care | ICP P3 strong match to ICS Ps2, 3, 4, & 5<br>(NB Respiratory is part of ICP LTCs programme under population health)<br>ICS P6 is included under ICP P3 |
| 3. Cancer | | |
| 4. Mental health, and learning disability/autism | | |
| 5. Planned care | | |
| 6. Better births | | |
| 7. Stroke | 4. Financial and clinical sustainability | ICS P 7 is included ICP P2 for stroke rehab and ICP P4 |
| 8. Fragile services | | |

Bay Health & Care Partners delivering

bettercare together

NHS