INTEGRATED ADULT COMMUNITY SERVICES BIDDER DAY
HOUSE-KEEPING

Karen Tordoff
Head of Service Redesign

Jackie Moran
Head of Contracting, Performance and Quality
Logistics & Housekeeping

- Emergency Situation & Evacuation

- Toilets, Tea, Coffee & Lunch

- Badges:
  - West Lancs CCG: Blue
  - Jigsaw pieces: colour of indicates your table for the afternoon

- Suggestion Boxes:
  - Thoughts / views
  - Specific questions

- Consent
WELCOME

John Caine
Chairman
Introduction and Welcome

What is the purpose of today?
• Continuing our journey - the next phase in delivering a new model of care
• We are here to listen to you

What shape will today be?
• Morning – context and background:
  – How have we got to where we are?
  – What is our vision for a new model of care and how can it be achieved?
  – Your thoughts: Q&A session
• Afternoon – workshops and discussion time
  - Outcomes: what would we all expect to see?
  - Networking: opportunities, jigsaw pieces, CCG members
BACKGROUND TO PROCURING COMMUNITY SERVICES

Mike Maguire
Accountable Officer
West Lancashire CCG

Start of our journey

– Established in 2012
– 5 year strategic plan
– Better Care Fund
What’s happening in West Lancashire?

• JSNA
• Growing Ageing population
• Areas of deprivation and inequalities
• There are differences across West Lancs which we could impact

• Growing hospitalisation rates
• Patients with multiple long term conditions increasing
• Survivors living longer

If we are to live within the available resources we have to
• Reduce unnecessary non-electives admissions to hospital
• find alternative places for patients to receive the most appropriate care
Facing the Future Together

Public Engagement

You said, we did - patient insight report on public listening events in 2015

Stakeholder Engagement

You said, we did - patient insight report on public listening events in 2015
Pressures on the NHS in West Lancashire

- Pressures in secondary care
- Inequalities
- Lack of system intelligence
- CQC registration
- Workforce pressures
- Ageing Population
- Rising prevalence of chronic conditions
- Rising patient expectations
- Increase in co-morbidities
- Constrained funding growth

Pressures

- Rising prevalence of chronic conditions
- Workforce pressures
- Inequalities
- Lack of system intelligence
- CQC registration
- Rising patient expectations
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- Constrained funding growth
Real life Scenario 1

92 year old res home resident recent discharge post fall. CT scan of the head – result ok. Went on to develop dense right hemi. Decision made to nurse at home by OOH - sensible - all EOL drugs prescribed. Staff told nil by mouth however worried re oral intake.

I asked staff to phone Speak & Language Therapy (SALT) team as I had another visit. When got back to surgery, message was SALT team refused to do "urgent" visit. I phoned hospital SALT team they said phone community. They were on smartphone answerphone. Left message. Phoned hospital team back. On answer phone. By4:50 no one had got back to me phoned community matrons. On answer phone. Got through to CERT team. They would liaise with DNs. No communication back to me but she took sips over the weekend so presumably something sorted. Message to surgery she died 5 days later at home.
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Who was managing this care post discharge?
Facing the Future Together

Public Engagement

Stakeholder Engagement

Working with partners

Testing the market
Step 1 on our Procurement Journey

• Today is just the first step
• To date we have not defined our:
  1. Procurement route
  2. Contract model

• Today is about listening to you:
  – What do you think about our strategy?
  – How would you like to see it develop?
  – What can we learn from your experiences?
Future Steps

From today
- update our strategy,
- firm up our thinking on the procurement and contracting model

Then we are aiming to get documents out to you:

PQQ Oct / Nov 2015
ITT Jan 2016

With (all approximate at the present time):

Preferred Bidder appointed September 2016
Mobilisation through next 6months
Full Service Commencement April 2017
Understanding our population and our inequalities

Lucinda McArthur
October 2015
Overview

• A recap on health inequalities
• The focus on Skelmersdale
• Prevention
• The approach
• Well North
• Our learning to date – differences between neighbourhoods
• What are we doing with the learning?
• Key messages
What are health inequalities?

- **Health inequalities** are preventable and unfair differences in health status between different population groups.
- They exist because of unequal distributions of social, economic and environmental conditions within societies.
- These conditions determine the risk of people getting ill, preventing ill health or opportunities to have access to the right treatments.
- These are known as the “social determinants of health”.
- People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.
- Important to consider the place of “proportionate universalism” and the need to have the right interventions, at the right scale, in the right place, at the right time, for the right people.
How do we see equality and our community?

Green reflects a *sense of place* be it our home, our estate, our street. It is the anchor to the whole image.

Coming out of the green are two individuals – *place is made by individuals*. They are loosely connected, looking out for and supporting each other. They have an informal structure, being made up of gifts and skills of different people, not a formal one. *It’s people that make the difference*, not formal bodies or services.

Purple features heavily. It’s a colour of change. It reflects the fact that communities and people are always facing change.

Underneath the figures are many rings of different sizes. Some are solid, some more temporary to reflect the many *different and changing circles of support*. This support comes in the form of family, friends, schools, church, community centres, pubs, clubs and associations.

There is other detail of value reflected too. The *environment*, nature, transport, work, food, mental health, spirituality.
Types of inequalities

- Socio-economic and environmental factors
- Lifestyle and health related behaviours
- Access to services
- Health outcomes
- Inequalities by characteristic;
  - Geography
  - Deprivation
  - Socio-economic group
  - Ethnicity
  - Disability
  - Gender
  - …..and more
“Clinicians have a responsibility to the population they service, as well as to the individual patients who happen to have been referred to them”

J.A. Muir Gray
Getting serious about prevention

Primary Prevention
- Prevention of Ill Health
- Protection of Good Health

Secondary Prevention
- Early Detection of Disease
- Service Improvement
- Effective Treatment and Care to Maximise Outcomes

Tertiary Prevention
- Enhancing quality of life in end of life care

Self Care
- Smoking
- Harmful drinking alcohol
- Diet
- Physical activity
- Wellbeing

Tertiary Prevention
- Cancer
- Respiratory
- Cardiovascular diseases
- Mental health and dementia
- Children and young people’s health and wellbeing
Background to the focus on Skelmersdale

- The CCG duty on health inequalities
- Revision to CCG strategic objectives
- Key questions to be addressed through this work are;
  - What are the key health and wellbeing challenges in Skelmersdale?
  - What are the drivers for health related behaviours in Skelmersdale?
  - What role do key agencies and the local population themselves have for improving health outcomes?
  - What are the interventions that should be prioritised to realise the greatest health gain?
  - Are there opportunities for utilising community assets for alternative health and care service delivery?
Why Skelmersdale?

[Bar chart showing age distribution and gender comparison between Skelmersdale and other areas]
The gap in life expectancy

Travelling east from Westminster, every two tube stops represent over one year of life expectancy lost - Data revised to 2004-08

Source: Analysis by London Health Observatory of ONS and GLA data for 2004-08. Diagram produced by Department of Health.
The approach

• Seven wards, 34,540 people
• Six “rallying points”, 8,970 people
• Understanding not assessing
• Half full not half empty
• Working with people with lived experience
• Understanding demand in human terms to better facilitate and enable self help
• System leadership through local institutions committed to addressing health inequalities
• Identifying and working through “familiar strangers”
• Learning together for cultural change through development of a “neighbourhood learning network” model
• Numerous community buildings and assets
• An infinite number of local associations, local organisations and individual capacities
Well North

• A programme that acknowledges that currently, too many services:
  – Assess rather than understand
  – Transact rather than build relationships
  – “Refer on” rather than take responsibility
  – Prescribe packages of activity rather than taking time to understand what improves a life

• Well North objectives are to;
  – Address inequality by improving the health of the poorest, fastest
  – Increase resilience at individual, household and community levels
  – Reduce levels of worklessness, a cause and effect of poor health

• Well North aims to;
  – Help people and communities to help themselves
  – Give unconditional relentless kindness and show it in all that we do
  – Carry risk, be forgiving and never give up on individuals or communities
  – Make the invisible health and emotional economies visible
  – De-medicalise wider determinant presentations
  – De-professionalise the solutions
  – Solve instead of manage the wicked problems presenting
  – Provide evidence of the effectiveness of the programme by evaluating it from the community's point of view
Our learning to date… quantitative analysis

• Out of 52 health indicators available on PHE’s local health tool, Skelmersdale wards are significantly worse than the England average against a number of them
  – Ashurst: 6 indicators
  – Skelmersdale North: 24 indicators
  – Digmoor & Tanhouse: 28 indicators each
  – Moorside & Skelmersdale South: 29 indicators each
  – Birch Green: 32 indicators

• All seven wards were found to have significantly worse rates than the England average for the following indicators:
  – Income deprivation (%)
  – Older people in deprivation (%)
  – Emergency hospital admissions for all causes (SAR)
  – Emergency hospital admissions for COPD (SAR)
  – Hospital stays for alcohol related harm (SAR)
**MOSAIC**

**“Family Basics”**

Families with limited resources who have to budget to make ends meet:
- Families with children
- Aged 15 to 40
- Limited resources
- Some own low cost homes
- Some rent from social landlords
- Squeezed budgets

**“Municipal Challenge”**

Urban renters of social housing facing an array of challenges:
- Social renters
- Low cost housing
- Challenged neighbourhoods
- Few employment options
- Low income

Birch Green
Digmoor
Moorside
Skem North
Tanhouse
Figure **: Income Deprivation (%) - The percentage of the population living in low income families reliant on means tested benefits, IMD2010

The percentage of the population living in low income families reliant on means tested benefits, IMD2010

- **Indicator Value**
- **England**
- **Lancashire-14 average**
- **Significantly above**
- **England average**
- **Significantly below**

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Figure ##: Emergency hospital admissions for all causes (SAR) 2008-13

Emergency Admissions, All Causes 2008-13

- Indicator Value
- England
- Lancashire-14 average
- Significantly above England average
- Significantly below England average

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Figure ##: Hospital stays for alcohol related harm (SAR) 2008-13

Hospital Admissions for Alcohol Attributable Harm 2008-13

- Indicator Value
- England
- Lancashire-14

Significantly above
England average
Significantly below
England average

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With you. For you.
Figure #: Premature mortality from circulatory disease 2008-12

Standardised mortality ratio for deaths from all circulatory diseases, aged under 75

- Indicator Value
- England
- Lancashire-14 average
- Significantly above England average
- Significantly below England average

SMR per 100

- Tanhouse: 193.5
- Birch Green: 188.2
- Digmoor: 154.0
- Moorhouse East: 147.1
- Burscough West: 130.3
- Burscough South: 129.6
- Skelmersdale South: 126.3
- Skelmersdale North: 124.9
- Ashurst: 109.1
- North Meols: 92.4
- Tarleton: 84.3
- Halsall: 81.4
- Knowsley: 79.4
- Aughton Park: 75.9
- Up Holland: 75.4
- Derby: 74.5
- Rufford: 66.8
- Hesketh-with-Becconsall: 66.1
- Newburgh: 65.8
- Aughton and Downhall: 62.7
- Scarisbrick: 61.0
- Parbold: 60.7
- Bickerstaffe: 43.4
Our learning to date… qualitative work
Our learning to date… at LSOA level
LSOA ref E01025482 – Birch Green ward
Feedback from Ketso facilitator

“The work that West Lancashire CCG and partners are undertaking in Skelmersdale demonstrates one of the more thorough approaches to endeavouring to understand the conditions in a local area I have come across in my community development work. I am very impressed with the genuine interest to engage meaningfully with the hardest to reach in the population and to learn more about the underlying causes of ill health and lack of wellbeing, as well as to come up with integrated solutions to these problems.”

Dr. Joanne Tippett
Lecturer in Spatial Development
School of Environment, Education and Development, The University of Manchester
Differences between neighbourhoods

• 5 indicative localities

• Variations between neighbourhoods

• Locality one has smallest population \((n=13,322)\) as compared to locality three \((n=29,595)\)

• Locality three has highest number of those over 75 years of age
What are we doing with the learning?

• Using it to inform the direction of travel of our clinical strategy
• Focusing on securing Skelmersdale as a Well North site
• Taking the approach to the individual level – identifying those with lived experience, familiar strangers and more
• Demonstrating the positive benefits of the approach, particularly for defined groups and those experiencing extreme exclusion
• Continuing to use the learning to inform commissioning, service redesign and workforce development
Key messages

- Systematic delivery of services at scale balanced against individual needs, assets and opportunities
- Design and deliver services relevant to the needs of different groups of our West Lancashire population
- Ensuring equitable access to healthcare and equity in opportunity of meeting outcomes
- The importance of genuine collaboration with a range of agencies for holistic, wrap around support to individuals
- Listening to, understanding the needs and solutions of and co-producing with local people including those with lived experience
- Invest in and prioritise human capital
The difference between Wellness and Illness?

[Smiley face]

wellness  illness

We  I

Source: Julie A Swanson
ANY QUESTIONS?
BUILDING FOR THE FUTURE
A NEW VISION FOR ADULT COMMUNITY HEALTH SERVICES

Claire Heneghan – Chief Nurse
West Lancashire CCG
MAHATMA GANDHI ONCE SAID

THE FUTURE DEPENDS ON WHAT WE DO IN THE PRESENT
Guiding Principles

- TOTAL PLACE
- OUTCOMES FOR PEOPLE
- PLANNED COORDINATED CARE
- CARE IN A CRISIS
- COLLECTIVE ACCOUNTABILITY
- TELLING MY STORY ONCE
- WHOLE SYSTEM ENABLERS
- NEIGHBOURHOOD /POPULATION BASED INTEGRATION
The West Lancashire Health Profile

- Significant localised health inequalities
- Ageing population significant frailty & long term conditions
- Acute focus dominated
- Desire to investment in community and primary care services
- Coterminous with West Lancashire Borough Council
- Finite resources
- High elective referrals
- Focus on reduction in non elective admission
- Desire to integrate services and transform the whole system at scale and pace
Neighbourhood/population based integration

- Multidisciplinary teams wrapped around General Practice
- Access to consultant opinion and diagnostics
- Data and information sharing
- Collective accountability for care and outcomes
- Community asset based approach
- Integration for populations
- Case management determined by risk
- Urgent response
- Targeted early intervention and enablement
- Care Coordination
Common GP complaints

- We don’t know the people to whom we are referring patients or who to refer to, or on what form.
- Complaints about the information you send with a referral and then passed from pillar to post.
- We don’t know who is being seen for what.
- Patients phone for prescriptions/visits and we don’t know why.
- No alternative but to send to A&E.
- A referral doesn’t answer your question.
- Tests you have already performed are repeated.
- We are unaware that a patient was seen in the A&E.
- We were unaware that a patient was admitted/discharged.
The vision for the West Lancashire system 2020

Extensive GP, patient and carer engagement...

- “More services are available closer to my own home”
- “I’ve had fewer admissions to hospital over the last year”
- “I know when my condition is worsening and who I should contact”
- “I know the team who support me and they know me”
- “The people who support me work as a team”
- “I didn’t have to wait long to get out of hospital”
Joined up Coordinated Care = the H in the HELIX’…

The reality 2015:
We have been working towards integration and service transformation for more than four years now. We are starting to see some benefits of new ways of working, but progress is not at scale or at pace.

The vision 2020:
To work with all partners to develop integrated care services in West Lancashire, providing the best possible care and value for money now & in the future.

Transforming the way we work:
- Create whole system approach & collective accountability
- Redesign pathways and supporting infrastructure
- Drive tactical efficiency and ask everyone to help
- Improve our operating model
- Harness technology
The elements that will help us to progress

• Creating time and space to develop understanding of new ways of working

• Building integrated care from the bottom up as well as the top down with shared objectives and sense of purpose.

• Use the workforce effectively to be open to innovations in skill mix, self care and use of community assets
Delivering services across organisational and professional boundaries

Three Core Functions

- **First contact** / acute assessment, diagnosis, care, treatment and referral
- **Continuing care** rehabilitation, frailty, long term condition management, end of life care
- **Public health** / health protection and promotion programmes that promote self care, improve health and reduce inequalities
Maintaining a focus on what the vision means for community services....

- Avoid inappropriate admissions
- People staying in their own homes for as long as possible
- Urgent and anticipatory response “know the population”
- Relieve bed pressures and speed up discharge
- Address fragmented service provision and silo working
- Limit multiple patient assessment with better coordinate service planning
- Freeing up resources for investment in preventative care
- Advanced, practice and developed generalist skills
Making the vision relevant and evidence based

- Reviewing length of stay, and admission data
- Practice specific disease profiling
- Agreeing model to deliver a 17% shift in activity

Overall net saving 3.4 million over 5 years
Tapping into frontline views on opportunities

- ‘Better understanding of roles’
- ‘Roles to be more holistic’
- ‘This will give us ability to avoid getting to crisis point’
- ‘This will provide knowledge of how to better manage risk’
- ‘This will improve links with voluntary sector and signposting to other services’
- We can do so much more with technology

- ‘A care coordination service could make it easier to manage patients and their families, targeted early intervention’,
- ‘Advantage of immediate access to colleagues’
- ‘It is right to build services around the patient not the organisation’
- ‘It provides a drive to keep people living independently’
- ‘I can see patient information at a glance, making care safer’
Recognising the key challenges…

• Understanding and respecting one another’s roles and responsibilities
• Navigating through one another’s systems
• Aligning differing cultures and values
• Identifying and maximising opportunities for sharing expertise
• Maintaining peer support networks and professional leadership when part of multi-disciplinary teams
• Securing staff feedback and input in taking forward
• Accommodation and IT
• Ensuring business continuity in change
Turning the Vision into Reality
Three Integrated Care Management Groups Incorporating Community Assets and Coproduction

- Community Assets
- Transitional Care Group
- Long Term Care Group
- Ambulatory Care Group
Adapting teams to support the population

COPD Non-elective Admissions 2013/14 £644,000 slipping into 4th quartile so problem growing on average £2,500 per admission

Ranked 158 out of 211 CCGs (NHS Better Care Better Value Indicators)

Do we have the appropriately skilled workforce to deal with this growing demand across the system?

Are we managing COPD across the population appropriately?

Do we make every contact count?

Do we know and understand the population?
The challenge of care coordination

- Multiple entry points to adult community services
- Variation in systems and processes
  - Reducing duplication and ‘hand-offs’
  - Making every contact count
- Targeted planned and urgent intervention
- Moving from paper based systems
- Managing expectations
- Maintaining safe referral systems
- Technology to support care coordination
Care coordination in the future …

- Full Care Co-ordination is a clinical system not an administration function
- Patient/client needs will be assessed professionally by a case manager
- Assigning care via care pathway delivery and assessing progress over time
- Professional staff working in a different environment
- Our services targeted to where they are most needed
- Real time patient information at the finger tip
Connecting the thinking

The Care Co-ordination Model

- Patient Care Co-ordination Hub
  - Clinically Led
  - Patient Support/Urgent Response/System Tracking

Relationships & Agreements Connectivity

- Community Services
- Hospitals
- Social Care
- GP Practices

Real time information at a glance

West Lancashire CCG Executive/Membership Council

Neighbourhood Clinical Council

Neighbourhood Practice Teams

MDT
What the experience is like for staff and patients…

Community geriatrician working with community services to address family anxieties and prevent admission:

- Patient under care of community matron, known to community geriatrician
- Pneumonia – care package, medication and observation
- Concerned visiting family drop in, take her to A&E as concerned, community matron informed
- Community matron alerts community geriatrician, who meets family and patient at A&E
- Reiteration that hospital intervention would not change patient outcome and community matron to reinstate care
- Community matron accesses geriatrician notes on EPR and reassures family of joined up services
What the experience is like for staff and patients…

Long term care group and urgent care team prevent frequent hospital admissions:

- Patient known to local services admitted x5 in a year for IV infusion UTI/ Cellulitis
- Admission stressful and protracted, due to complications from previous stroke
- Patient proactively identified by multidisciplinary transfer of care team
- Pattern of admissions reviewed, plan implemented to check proactively by neighbourhood team
- Home IV transfusion arranged under the care of the IV team and neighbourhood team when needed
- Patient less anxious about fear of regular admission – maintained at home with coordinated care and linking into wider community support
Proposed shift in care

To enable investment
- Investment in community & primary care services to ‘fill the gaps’

Estimated savings
- The % of non elective spells relating to patients with conditions that can potentially be managed by the proposed service model based on Better Care, Better Value indicators.
  - Achieving 50th percentile overall performance would potentially save £416,642 per quarter
  - Achieving 25th percentile overall performance would potentially save £636,121 per quarter
  - Achieving 10th percentile overall performance would potentially save £826,028 per quarter
  - COPD represents a potential saving of around £110,000 per quarter

- IV Therapy savings alone could be achieved if:
  - 50% reduction in ALL admissions = £913,309
  - 50% reduction in Non Elective Admissions = £861,120
What we expect…

• Formalising closer engagement with GPs as partners, providers and commissioners
• Maximising links to mental health services to support long term conditions and frailty
• Managing relationships with acute partners … collaboration not competition, gain/risk share
• Maximising use of technology to enable care coordination
• Cross system standardisation reducing variance in care
• Evidenced based approach to service transformation
• Social care, care homes and local community's as partners
WE ALL AGREE!!

"THE FUTURE DEPENDS ON WHAT WE DO IN THE PRESENT"

CARPE DIEM
OUR DIGITAL JOURNEY
Enabling better care and transformation

Chris Russ
IT Advisor

Bapi Biswas
GP Executive
Our starting point

• Low levels of IM&T investment
• Worst position out of all CCGs in Lancashire
• Lots of variation in the way systems are used
• Limited sharing of patient data
1st Step – Address the Basics

- CCG IM&T Strategy (Chapter 1)
  - Investment in infrastructure
    - COIN connections
    - System consolidation (All practices EMIS Web)
    - IP Telephony and Unified Communications
  - Creating the ability to access EMIS on the go using tablet devices
1st Step – Address the Basics

- CCG IM&T Strategy (Chapter 1)
  - Delivering against National Requirements (all completed)
    - Summary Care Record
    - Patient access
      - Booking/cancelling appointments
      - Ordering repeat prescriptions
      - Access to summary record
    - Electronic Prescription services
      - West Lancashire is the highest user of the service in Lancashire
1\textsuperscript{st} Step – Address the Basics

- CCG IM&T Strategy (Chapter 1)
  - Reduced our operating costs
    - Improved our BI Offer from our Clinical Support Unit and re-negotiated the costs.
    - Introduced a single device strategy to reduce waste and cost for the CCG team.
    - Stepped down from using a referral management centre for 1\textsuperscript{st} Outpatient appointments and support to GPwSI services.
  - Managed the impact of reduced funding levels for GP IM&T enabling us to have a balanced budget
1st Step – Address the Basics

- CCG IM&T Strategy (Chapter 1)
  - What else have we done?
    - Given GPs the ability to access diagnostic images.
    - Initiated work to improve the electronic flow of clinical correspondence.
    - Initiated work to implement Electronic Ordering and Results Reporting.
    - Worked alongside our provider to begin to implement EMIS Community to improve data sharing and patient care across Primary and Community Care
    - Approved a business case to implement FLO (Text based Telehealth system – grant successfully obtained
      - First deployment planned for October.
OUR DIGITAL JOURNEY
CHAPTER 2
Chapter 2 – Strategy Refresh

- Approved by CCG Exec in July 15.
- Is designed to underpin the CCGs Five Year strategy and clinical commissioning strategy.
- Is clear that fixing the issues we face can’t be done without innovative IT.
- Recognises that current and emerging generations are becoming intelligent consumers of healthcare and want a far more responsive service.
  - Technology and the way they interact will be a number one priority.
Chapter 2 – Quote from Deloitte

“While most industries have embraced the idea that the customer comes first, healthcare has lagged far behind. No more, the recognition has finally dawned on healthcare providers that meeting the challenges of today rests on their ability to put the customer at the centre of everything they do, changing from a paternalistic approach to a patient-centred approach that will recast the deal between patients providers and payers”

(Sarah Thomas, Director, Deloitte US Center for Health Solutions)
Chapter 2 – Our Focus

- Shared Care Records
- Electronic Referral Management
- Digital Health - FLO and TECS
- Capacity and Demand Management
- GP IT
- Information Sharing
- Digital Inclusion - Improving access to digital health
- Technology to support Programme Delivery
Chapter 2 – Our Focus

- **Empower**
  - Commercial Partnerships
  - Voluntary Sector
  - Social Enterprises
  - Charities
  - Family & Friends

- **Enable**
  - Personal Fitness
  - Assistive Technology
  - Mobile Apps
  - Remote Consultation
  - Remote Monitoring

- **Risk profiling**
- **Planning**
- **Predicative Analytics**
- **Population Health**
- **Big Data**

**Tier 2 Sharing** – Individually owned & shared on request

**Personal (Life-long) Wellbeing Record**

**Shared Records Platform**

**Tier 1 Sharing** – Public Sector, secure, relevant & proportionate

- **Share**
  - Social Services
  - Hospitals
  - GP Practice
  - Ambulance
  - Research

**Digitally**
Chapter 2 – Our Focus

E-Referral Service

Integration and Usability
Referral support
Electronic Communication
Any to Any referrals
Enhanced reporting
Self referrals
Linked appointments
Follow up appointments

Shared Care Records
Electronic Referral Management
Digital Health – FG and FCE
Capacity and Demand Management
GP IT
Information Sharing
Digital Inclusion - Improving access to digital health
Technology to support Programme Delivery
Chapter 2 – Our Focus

- Telehealth
- Telecare
- Telecoaching
- Teledicine
- Teleconsultation

Supporting more efficient care

Selfcare apps
Chapter 2 – Our Focus

- Rally Round
- FLO and TECS
- Social Media
- Improved Capacity Management
- Aligning Intelligence
- Referral Management
- Exploiting what is already enabled
We know there are many challenges

• But…
  – We must work quickly to deliver
  – The NHS can’t continue to survive without adopting capabilities now available.
  – Technology no longer an obstacle for transformation
  – People want to live healthy lives, are better informed and are already using technology to understand future risks to their health and to self monitor.
Video – Digital Health

https://www.youtube.com/watch?v=HSOhdmV8WsY
Our expectation

The future provider of community services will need to …

demonstrate plans to embrace technology to deliver a more convenient, consumer focussed healthcare service, which provides the capability for the individual to take, where appropriate, and with support, better control of their healthcare.
Comments on what we want?

This is what we are looking for…

• Ethos and Enthusiasm for IT running through - the team need to "get it"
• Some expertise
• Start Paperlite - Avoid Fax - move to EPR
• EMIS Web Community or interoperable community system
• Embrace cross organisational tasking
• Data not Diesel
• Start as we mean to go on avoid the temptation to go stepwise - jump in and take the risks.

Can it be delivered?
QUESTIONS & ANSWER SESSION

Paul Kingan
LUNCH AND NETWORKING 1
WELCOME BACK, RE-CAP AND COMMISSIONING FOR OUTCOMES

Jackie Moran
Head of Quality, Performance and Contracting
Figure #: Income Deprivation (%) - The percentage of the population living in low income families reliant on means tested benefits, IMD2010

The percentage of the population living in low income families reliant on means tested benefits, IMD2010

- Indicator Value
- England
- Lancashire-14 average
- Significantly above England average
- Significantly below England average

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<th>Indicator Value</th>
<th>England</th>
<th>Lancashire-14 average</th>
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West Lancashire’s 5 Proposed GP neighbourhoods

1. Tarleton, Hesketh Bank and Banks
2. Burscough and Parbold
3. Ormskirk and Aughton
4. New Skelmersdale and Upholland
5. Old Skelmersdale and Beacon Primary Care
Facing the Future Together

Public Engagement

Stakeholder Engagement

Working with partners

Testing the market
Summary

Person centred coordinated care

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”
Building for the Future
Integrated Care Model Summary

We envisage three concentric care teams, working as one, under a single line management structure in order to prevent barriers to the delivery of seamless care and transition as determined by patient need.

Urgent care has to be integral to and a pivotal part of a one system approach from admission avoidance to attendance at A&E and beyond, in a mutually dependant system of care.
Model of Care

Transitional Care Team

A

B

C

Long-Term Care

Ambulatory Care Team
IT enabled services

- Shared Care Records
- Electronic Referral Management
- Digital Health - FLO and TECs
- Capacity and Demand Management
- GP IT
- Information Sharing
- Digital Inclusion - Improving access to digital health
- Technology to support Programme Delivery
One Vision – the same aims

All aiming to achieve the same things

Collectively accountable for delivering what is required.
SOME OF OUR JIGSAW PIECES

NWAS

EARLY ACTION
Lancashire Constabulary

ADULT SOCIAL SERVICES
Lancashire County Council

Pharmacists

WELLBEING SERVICE
Lancashire County Council

VCFS

GPs

HEALTH INEQUALITIES

CARE HOMES

IT
Measuring Outcomes

We want to measure what’s important not what we can measure
More people feel supported to optimally manage their care, confidently and safely closer to/at home

Measure…

How many people go into hospital in an unplanned way
Particularly for conditions that could have been kept at home
Did anyone go back in within say 30 days of discharge
Reduction in occupied bed days - with LTCs and/or are frail elderly

Ask people…

If they feel more aware of how to self manage or where to access support when required
ANY QUESTIONS?
Today
Listening……..

• Start of our tendering process
  – Shape our requirements
  – Shape our tendering processes
  – Shape our the contract form

• Informing your bid

Talking……..
• Making links
• Start to shape some of the Outcomes
INTRODUCTIONS

Who’s sitting on your table?
We want to know…

What does a good community service look like?
We want to know…

To shape our requirements we want to know

What does a good community service look like?

Talk on your table about

– your experiences of community services or
– the scenarios on the table and

Answer

– how we might improve the system?
– how could we use technology?
– what should it be like for all parties?
– what should we expect to see?
FEEDBACK

One important thing

What should a good community service look like?

– how we might improve the system?
– how could we use technology?
– what should it be like for all parties?
– what should we expect to see?
COFFEE & NETWORKING 2
INFORMAL NETWORKING

Coffee

Informal networking

- Jigsaw pieces in the Lathom Suite
- CCG Executives in the Adlington Suite
ROUND UP AND CLOSE

Mike Maguire
Accountable Officer