The Strategy Unit.

Welcome and thank you for attending our first Network Event

17th July 2017

NHS
Midlands and Lancashire
Commissioning Support Unit

The Strategy Unit.

Today is about listening, sharing, meeting people and having fun!

Principles of the day

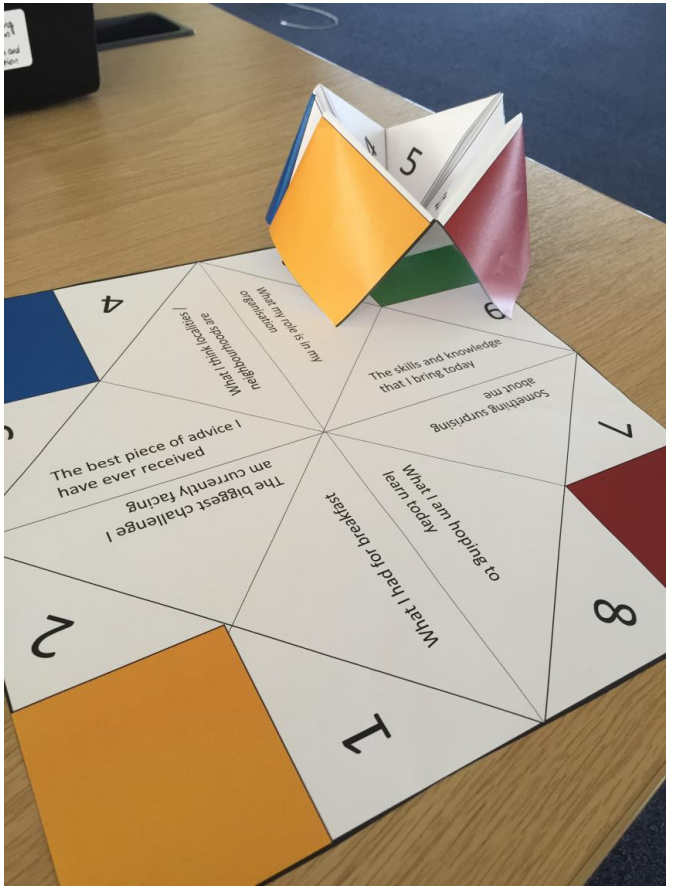
- This could be the start of a network, you have the choice to opt in or opt out. Our offer is to facilitate and present interesting or helpful information
- Invited the speakers as they have experience of ‘doing’; we are sharing all your experiences using the case studies
- Presentations are short to give you time to consider and ask questions
- Opportunity to share without judgement; Tell it as it is
- We aren’t asserting any views of what is right or wrong

High tech and low tech

#SUnetwork

sli.do

#localitynetwork



In your blue folder

- Todays Agenda and Sli.do instructions
- List of all the attendees and their contact details (if email addresses are corporate)
- SU fold out chart
- Evaluation sheet

Meet the Strategy Unit Team

Abe

Shiona

Anam

Simon

Fraser

Alison

Peter

Mahmoda

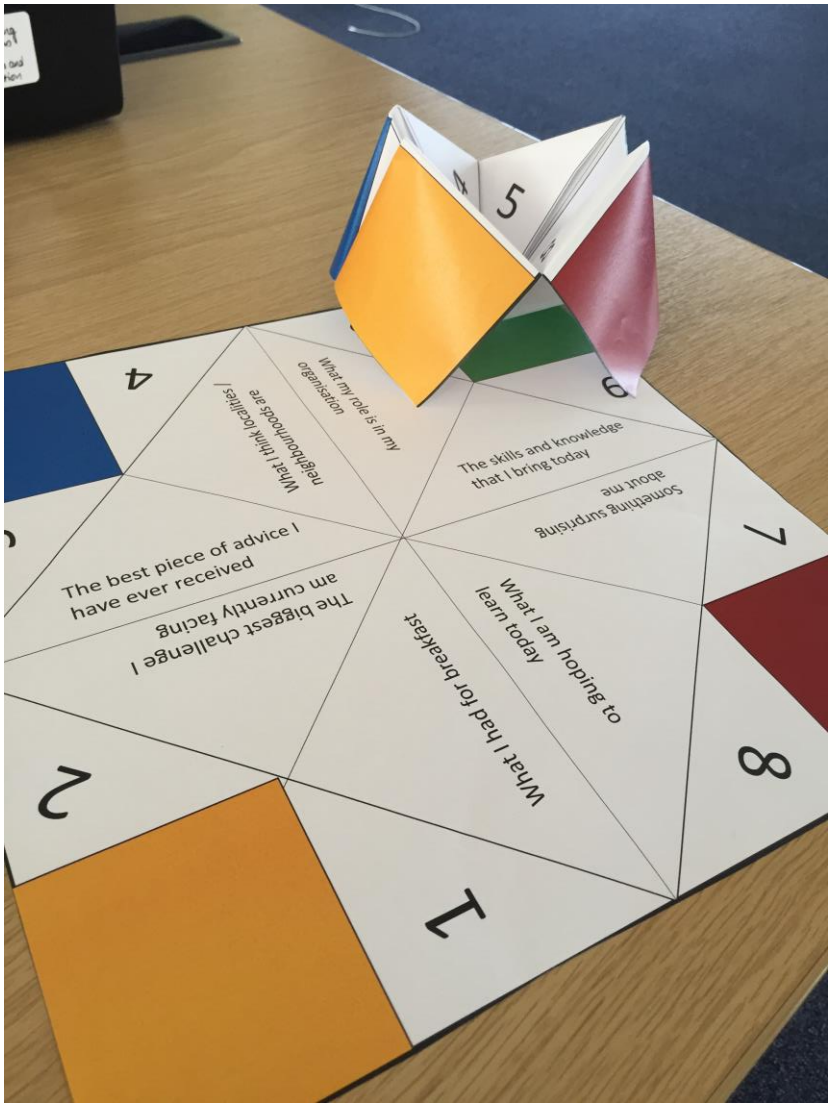
Lucy

Sharon

Karen

David

Get to know each other better



sli.do

#localitynetwork

What type of organisation are you representing today?

What's in a name?

Having reviewed the research and grey publications its evident that local health economies have responded to national policy by developing their own approach to 'locality' working

Integrated Community Team
Integrated Locality Team
Place-Based Care
Primary Care Hubs
Health and Social Care Hubs
Neighbourhood Team
Multi Disciplinary Team
Integrated Neighbourhood Team
Integrated Care Hub
Integrated Local Care Team
Practice Integrated Care Team
Enhanced Primary Care
Community Hub Operating Centre
Community Integrated Team
Primary Care Neighbourhood Model
Primary Care Network

'Localities' go by many names, these are just some of them.

Regardless of their name, they share some common features.

- There is alignment of frontline health and social care teams such as community nursing, mental health professionals, around a general practice and their registered population.
- Team members have a shared set of skills, some have more specialist knowledge,
- There is a culture of inter-professional working allowing members to spend their time where they add most value.
- Teams work with patients as active participants rather than passive recipients of care

What's in a name?

Integrated Community Team
Integrated Locality Team
Place-Based Care
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Health and Social Care Hubs
Neighbourhood Team
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Enhanced Primary Care
Community Hub Operating Centre
Community Integrated Team
Primary Care Neighbourhood Model
Primary Care Network

sli.do

#localitynetwork

What should our network be called?

Locality, neighbourhood…

The Strategy Unit.

Why (and how) does the Strategy Unit want to support neighbourhood working?

Fraser Battye

17th July 2018

NHS
Midlands and Lancashire
Commissioning Support Unit

This presentation has one fundamental message

We see great potential in neighbourhood* working

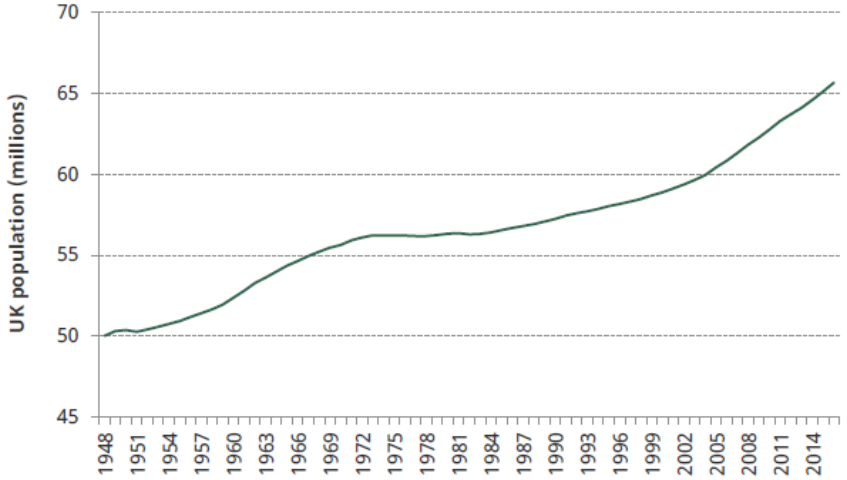
But we think real discipline is needed for this potential to be realised

We want to help by setting up a learning network: we need your advice and participation to make this fly!

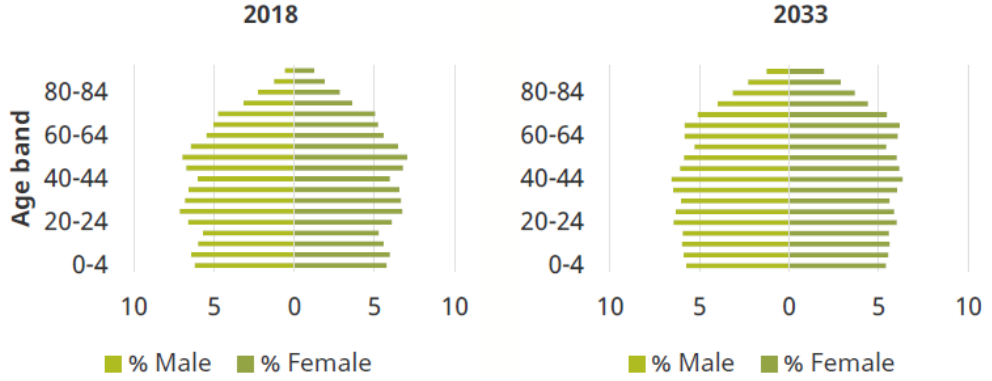
* To be defined….

There is a growing gap between population needs and service resources

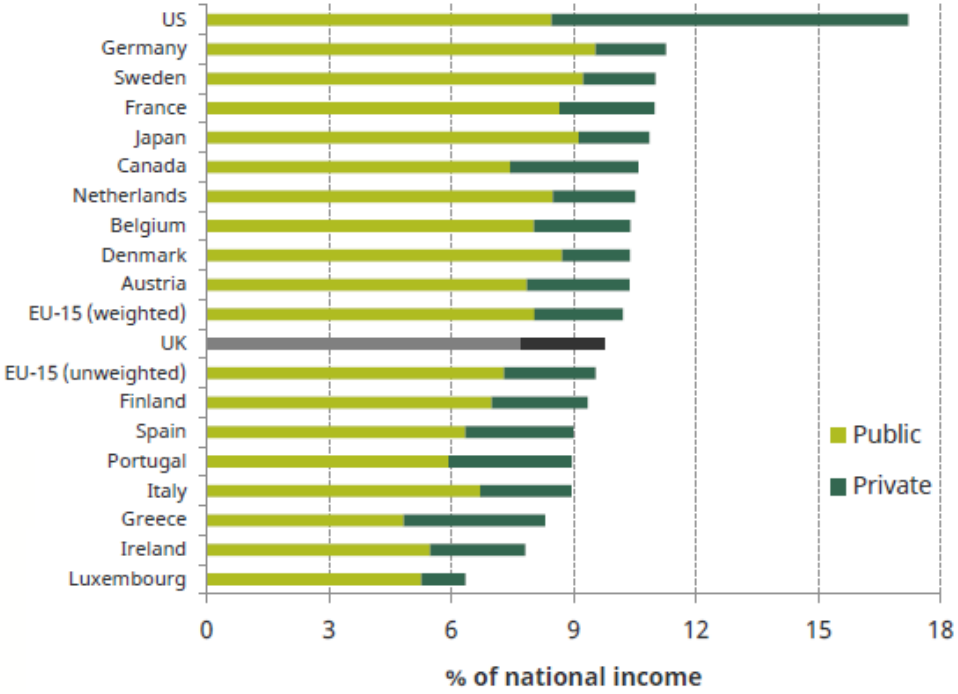
1: There will be more of us



2: We're getting older (so more expensive)



3: We invest less than comparable nations



IFS and Health Foundation (2018) *Securing the future: funding health and social care to the 2030s*

Policy has been emphasising ‘integration’ as a means of bridging this gap for decades

“Often what there is could achieve more if it were better co-ordinated with other services in and out of hospital.”

NHS Reorganisation white paper (1972)

But there has been chronic implementation failure (and recent legislative disaster)

Figure 2.8. Changes in size of different NHS staff groups per population, 1996 to 2016

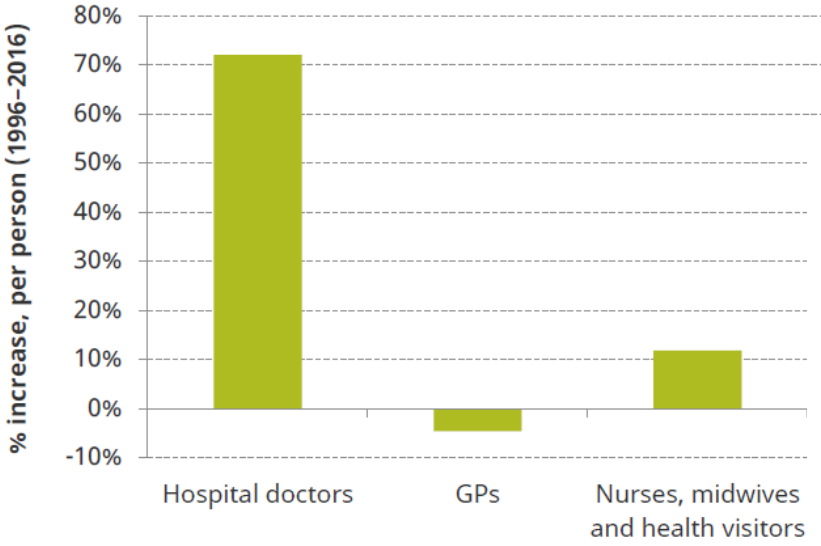
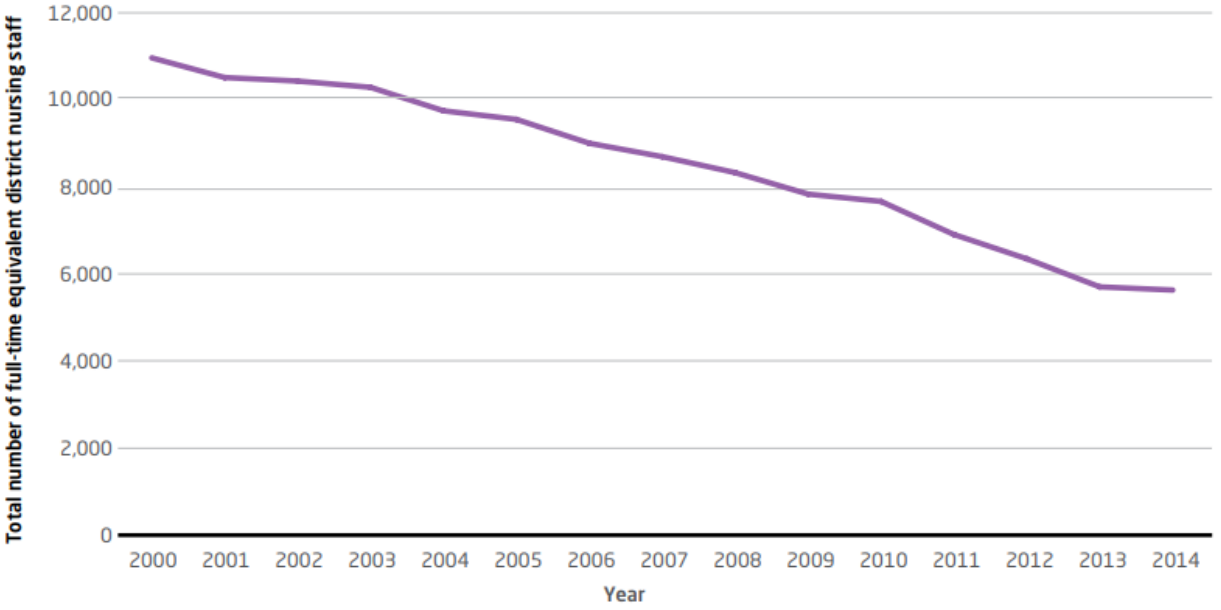
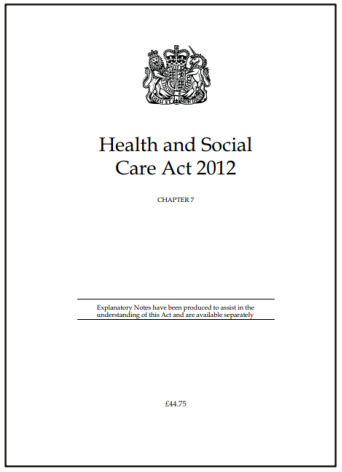


Figure 2 Number of full-time equivalent qualified 'district nurses' by year





Health and Social Care Act 2012

CHAPTER 7

Explanatory Notes have been produced to assist in the understanding of this Act and are available separately

£44.75

~80 references to 'competition'

'Integration'?

The latest NHS developments focus on partnerships, planning and places

Level	Pop. Size	Purpose
Neighbourhood	**~50k**	• Strengthen primary care • Network practices • Proactive & integrated models for defined population
Place	**~250-500k**	• Typically borough/council level • Integrate hospital, council & primary care teams / services • Hold GP networks to account
System	**1+m**	• System strategy & planning • Hold places to account • Implement strategic change • Manage performance and £
Region	**5-10m**	• Agree system 'mandate' • Hold systems to account • System development • Intervention and improvement

Within these developments, we see particular potential at the neighbourhood level

- Integration can be made real – close to people / patients
- Integration wider than just health and social care
- Staff relationships / team culture can be nurtured
- Local knowledge and community assets can be brought in
- Greater resilience to national policy change?

This way of working has caught hold…see:

Primary Care Home

Multi-speciality Community Provider

Primary and Acute Care Systems

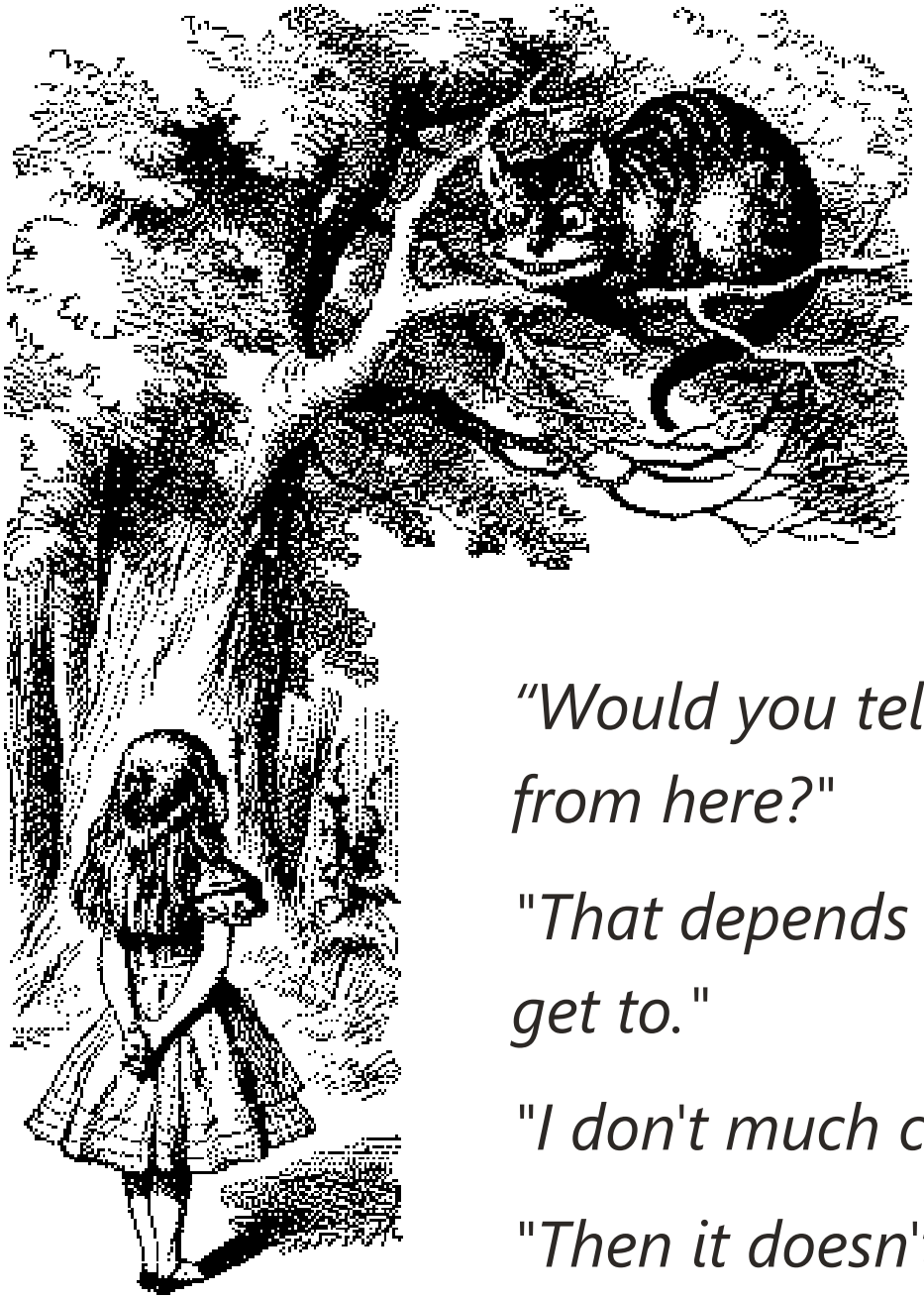
Primary Care Networks

Every Sustainability & Transformation Partnership plan

(Etc)

But, to realise this potential, many questions must be addressed. For example, on:

Function	Form	Theory	Development
Reduce emergency admissions?	Primary care led?	Local knowledge = tailored services?	The right OD given the theory?
Resilient primary care?	Community services led?	Staff relationships = integrated care?	Skills for self-improvement?
Better LTC care?	Local Authority led?	Space and licence = local innovation?	The right tools?
Prevention / public health?	CCG led?	New unit of performance management = greater 'grip'?	Data and information flows?
Better use of all public services?	Role of voluntary sector?		Leadership and culture?
	Community mental health?		



"Would you tell me, please, which way I ought to go from here?"

"That depends a good deal on where you want to get to."

"I don't much care where..."

"Then it doesn't matter which way you go."

We want our learning network to help improve neighbourhood working

We hope today is an enjoyable first step

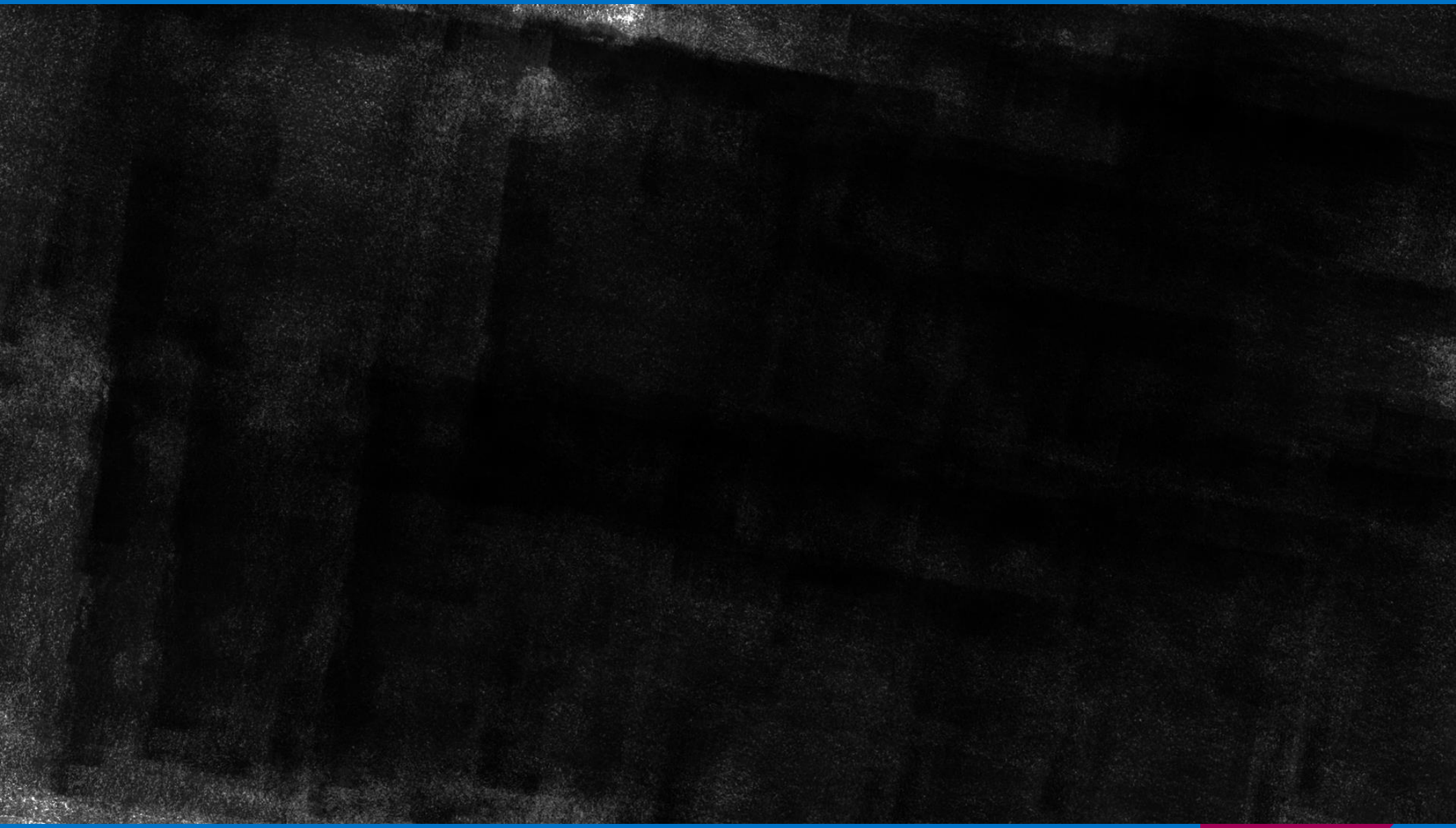
We need your support and advice to shape our future direction

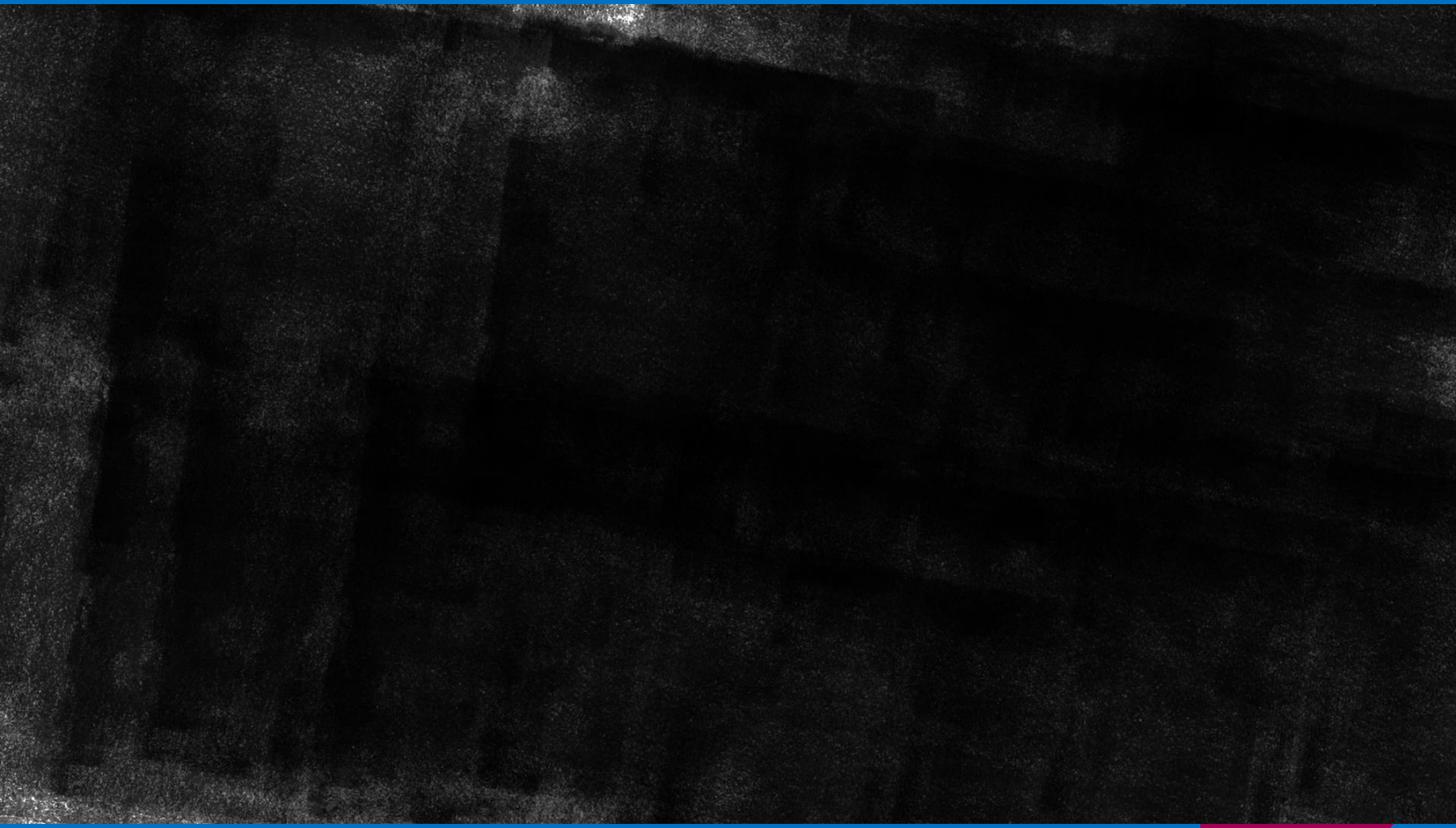
Sharing learning from the National ICS Primary Care Development Programme

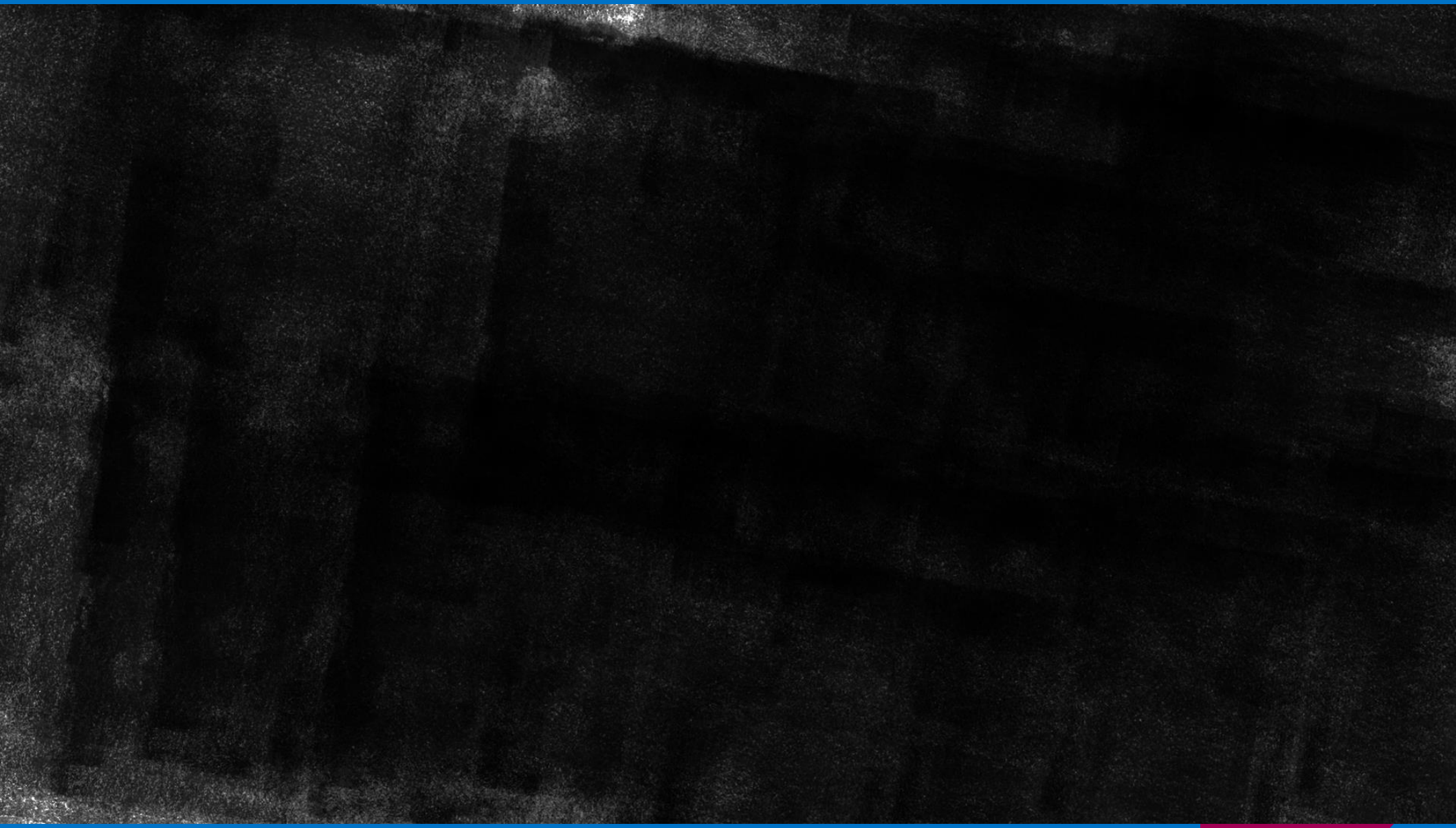
Professor Nick Harding OBE
Senior Medical Advisor to Primary Care /Right care
Aston Medical School

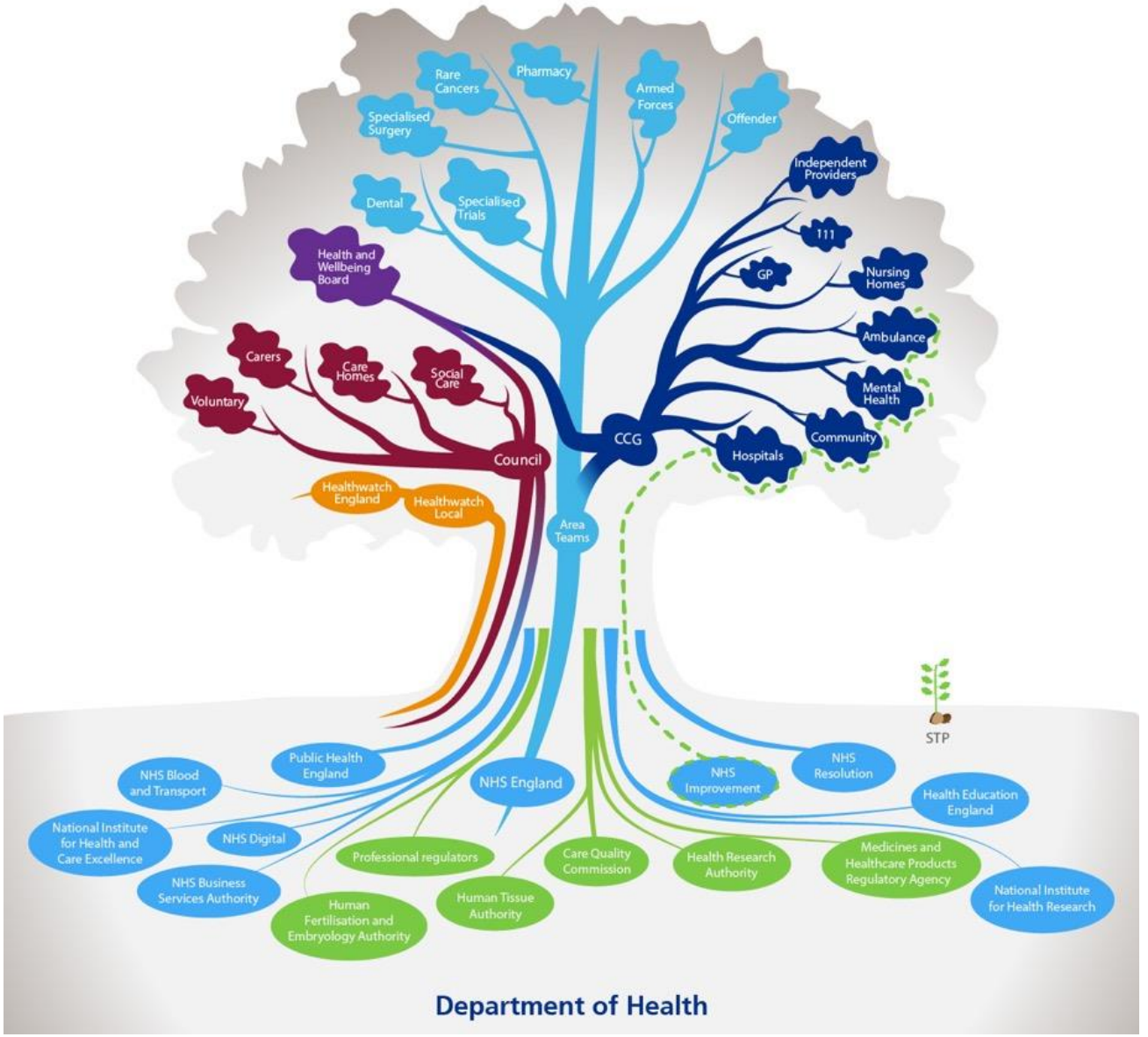
17th July 2018


CARD TRICK



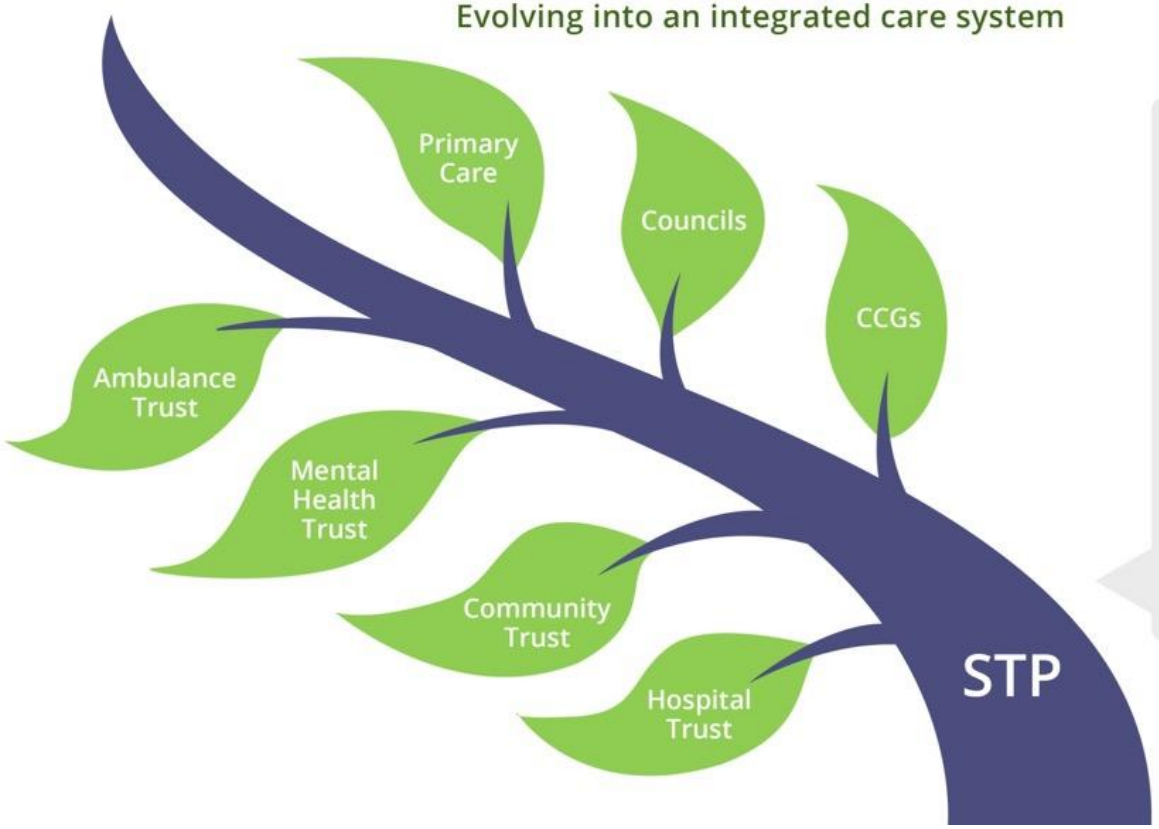





Rare Cancers
Pharmacy
Armed Forces
Offender
Specialised Surgery
Independent Providers
Dental
Specialised Trials
111
Health and Wellbeing Board
GP
Nursing Homes
Carers
Care Homes
Social Care
Ambulance
Voluntary
Mental Health
Council
CCG
Community
Hospitals
Healthwatch England
Healthwatch Local
Area Teams
STP
Public Health England
NHS Blood and Transport
NHS England
NHS Improvement
NHS Resolution
Health Education England
National Institute for Health and Care Excellence
NHS Digital
Professional regulators
Care Quality Commission
Health Research Authority
Medicines and Healthcare Products Regulatory Agency
NHS Business Services Authority
Human Tissue Authority
National Institute for Health Research
Human Fertilisation and Embryology Authority
Department of Health

Sustainability and Transformation Partnership

Evolving into an integrated care system



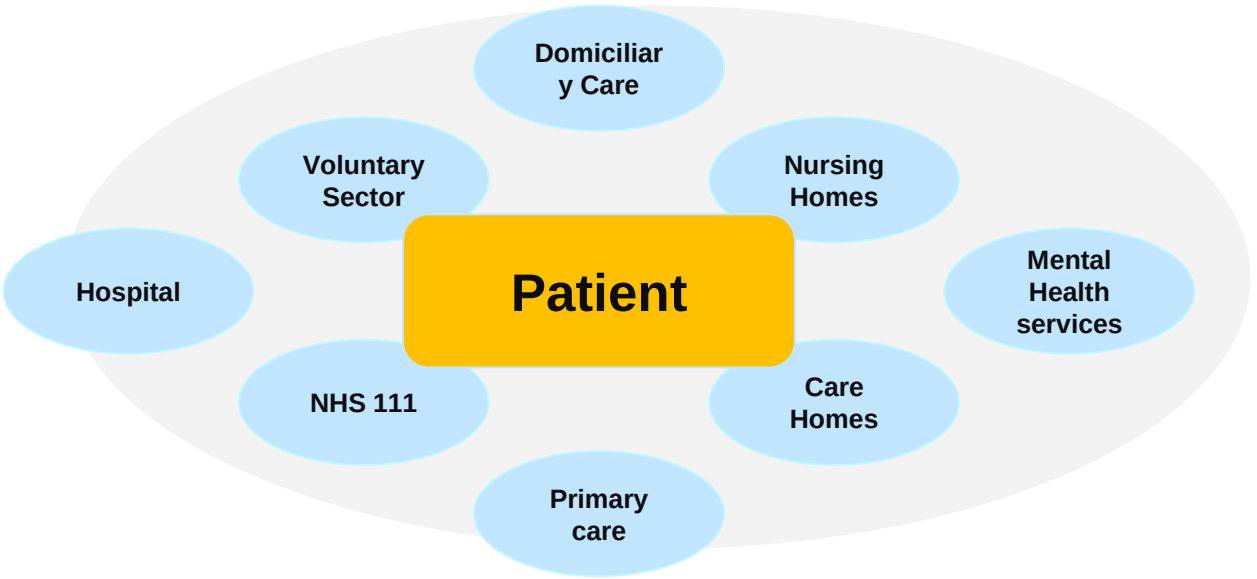
- Transformation
- Financial balance
- Improve health and care services centred around the population's needs
- Integration between health and social care
- Infrastructure
  - Workforce/ IT
- System resilience

The health needs of the population are changing…

The changing health needs of the population are putting pressure on the health and social care system in England.

Ageing population	Between 2017 and 2027, there will be 2 million more people aged over 75.
Chronic conditions	The NHS' predominant task has changed from treating individual episodes of illness, to helping people manage long-term conditions.
New Treatments	The steady expansion of new treatments gives rise to demand for an increasing range of services.

… and the system has not changed enough to meet these needs



- Service provision is fragmented in multiple different types of organisations
- Too often, these services don't communicate effectively with each other
- The totality of patients' needs are not always understood by those serving them
- Care is not always delivered in a person-centred way

My first week

80

Ian,
sick child

18

Christine,
diabetic

2

Stephen,
dementia

Hand-me-down healthcare

- We were using an outdated model
- 10 years later, we had twice as many patients
- The hand-me-down model was no longer sustainable – something had to change

Healthcare fitted to personal need

contact hub

training

focused packaged of care

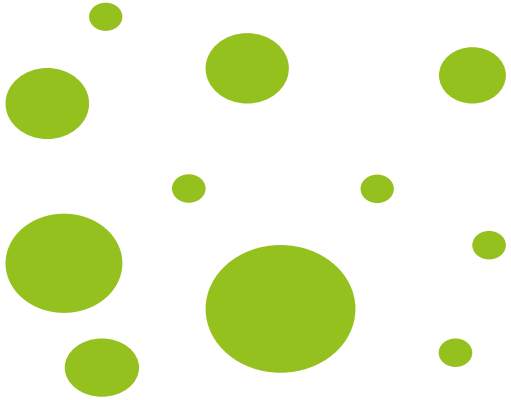
complex conditions become our challenge to deal with

Business Forms: Just a Means to an End

Scatter — Collaboration — Full Merger

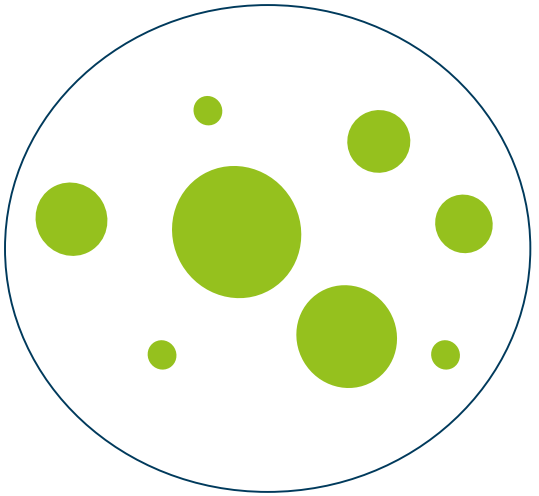
Traditional Practice Model

(Sole trader, multi-partners)



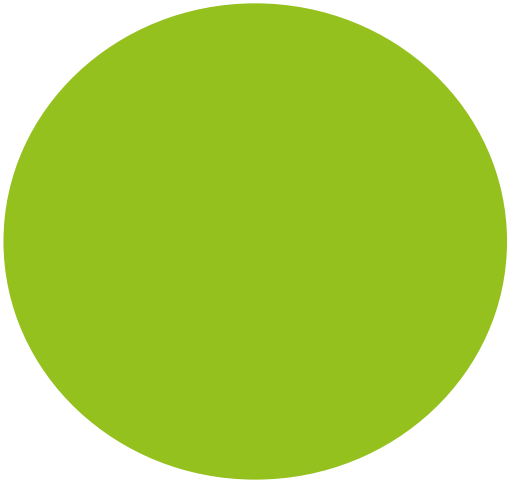
2k – 15k patients

Federations



50k – 500k patients

‘Super Partnerships’

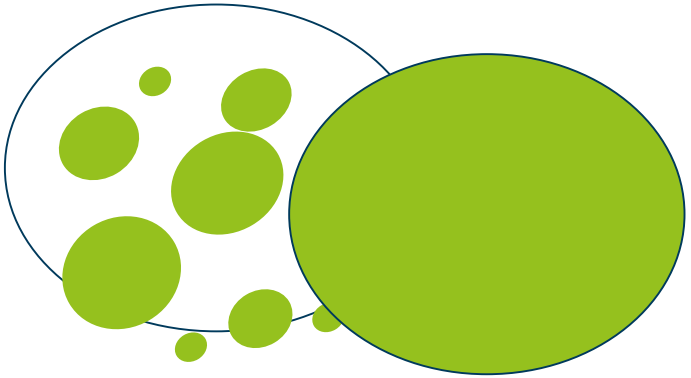


50k + patients

Business Form: Size Matters

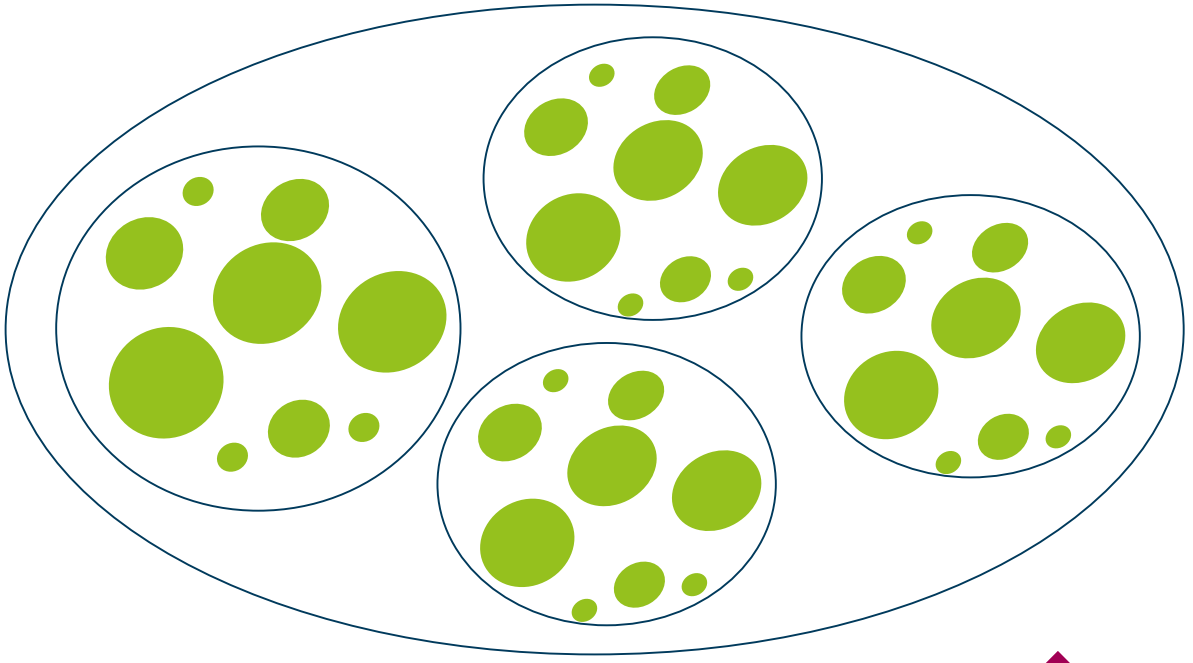
New Generation Mix / Collaboration Models

Federation Plus SP



100k – 500k patients

Super Federation



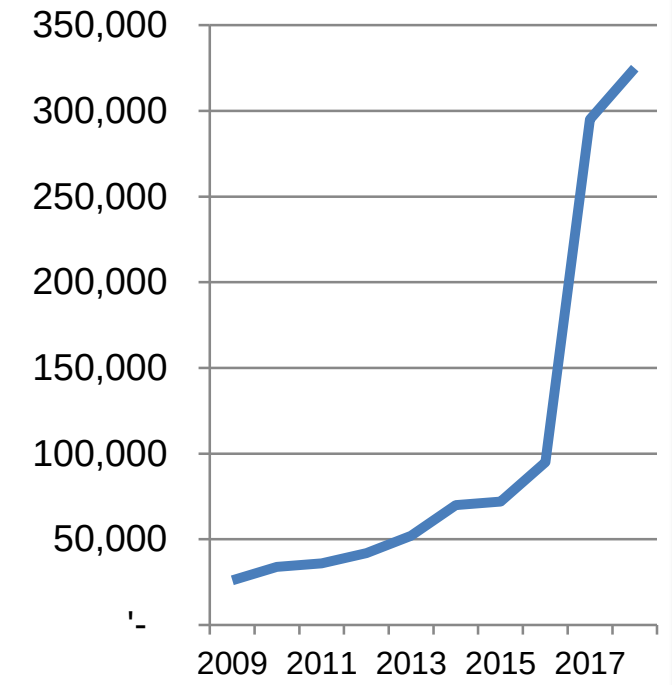
500k – 1m+ patients

An example

At a Glance

- Over 325K patients across 7 regions: Sandwell, Birmingham, Walsall, Wokingham, Hull, Airedale, Wharfedale & Craven, and East Surrery
- NHS Ethos / Single Partnership
- Primary and Outpatients Care Services
- Currently 120 Partners, >35 sites, ~1,000 staff
- Executive Boards at National and Regional levels with centralised Back Office
- Track record of being first movers with new care models and use of technology
- Leading role in facilitating joint working with CCG, Acute, Community, Mental Health and other system players to shape and improve care delivery

Registered Population



Primary Care Working Together

NHS England

Clinical Contact HUB	Practice Level	Back Office Support
The Platform		
• Website Optimisation • Patient Apps • NHS symptom checker • Re-routed NHS 111 • Video consultations • Twitter/Facebook • Digital NHS F&F Test • E consulting • Care Navigation • Call/Recall	• Standardised clinical templates • Patient Interaction Initiatives • Extended Access • Enhanced Services • Specialist Services Delivery • Enhanced Primary care teams • Physio/pharmacy/ANP/PA/EP • MDTs with community	• HR • Governance • Finance /Payroll • IT Support • Group Purchasing • Training

Change Management

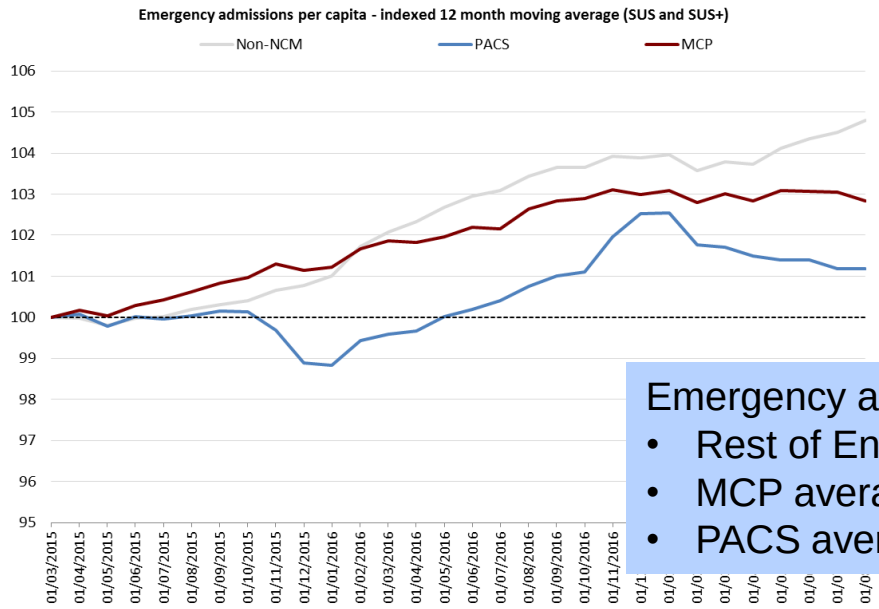
Continual Improvement

The vanguards have started to demonstrate how integrating services improves services for patients…

East London Utilising the power of voluntary and community services	• In **Tower Hamlets**, care co-ordinators in primary care can refer patients to 1500 local voluntary sector organisations that support residents to manage their health and wellbeing • Patients have been supported to engage in arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.
Yorkshire Integrating care teams across organisational boundaries	• In **Wakefield**, multi-disciplinary teams have been formed between care homes and primary care to manage the needs of residents in 27 care homes and 6 supported living facilities • Local analysis showed that ambulance call outs have been reduced by 9% and bed days have reduced by 26% from the 2015/16 baseline.
Lancashire Providing flexible access to specialist support	• University Hospitals of **Morecambe Bay** NHS Foundation Trust has been working with local out-of-hospital providers, to implement electronic advice and guidance across 16 specialities • The service has enabled patients to seek specialist support without being referred to secondary care, saving around 1700 referrals.

…as well as making the system more effective and efficient

PACS and MCP Vanguards have seen slower growth in emergency admissions…



…and Care Home Vanguards *reduced* admissions

Emergency admissions growth from care home residents[2]:

- Rest of England: +6.7%
- EHCH Vanguards: -1.4%

Emergency admissions growth[1]:

- Rest of England: +4.9%
- MCP average: +2.6%
- PACS average: +1.2%

1. For the 12 months to Q2 2017/18, compared to the base-line year 2014/15.
2. For the 12 months to Q2 2017-18, compared to a baseline period of Q3 2014-15 to Q2 2015-16.

The task now is to spread this learning to systems across England

We launched 44 Sustainability and Transformation Partnerships (STPs) to enhance joint working between NHS commissioners and providers, and local government, in every health and social care system across England.

STPs will provide the opportunity for…

1. A cultural shift towards systems leadership
2. Create the right environment and incentives to support the integration of services
3. Develop sustainable and autonomous systems, that can make the decisions required to improve care in their area within their share of the budget

In time, mature local systems will…

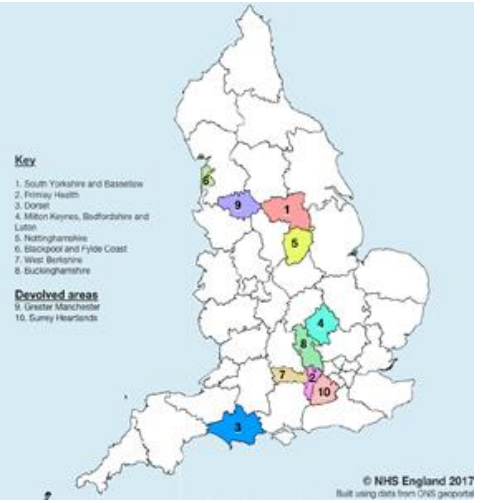
1. Work together to address systemic challenges
2. Collaboratively develop a care model that more proactively manages need and gets upstream to prevent illness
3. Makes the necessary decisions to improve services in their area, within their share of the budget

The most advanced will become Integrated Care Systems, and receive support to go further faster…

- Integrated care systems will:
  - Make more **robust cross-organisational arrangements** to tackle systemic challenges
  - **Integrate services to support those at risk** of developing acute illness and hospitalisation
  - Take **collective responsibility** for financial and operational performance, as well as health outcomes

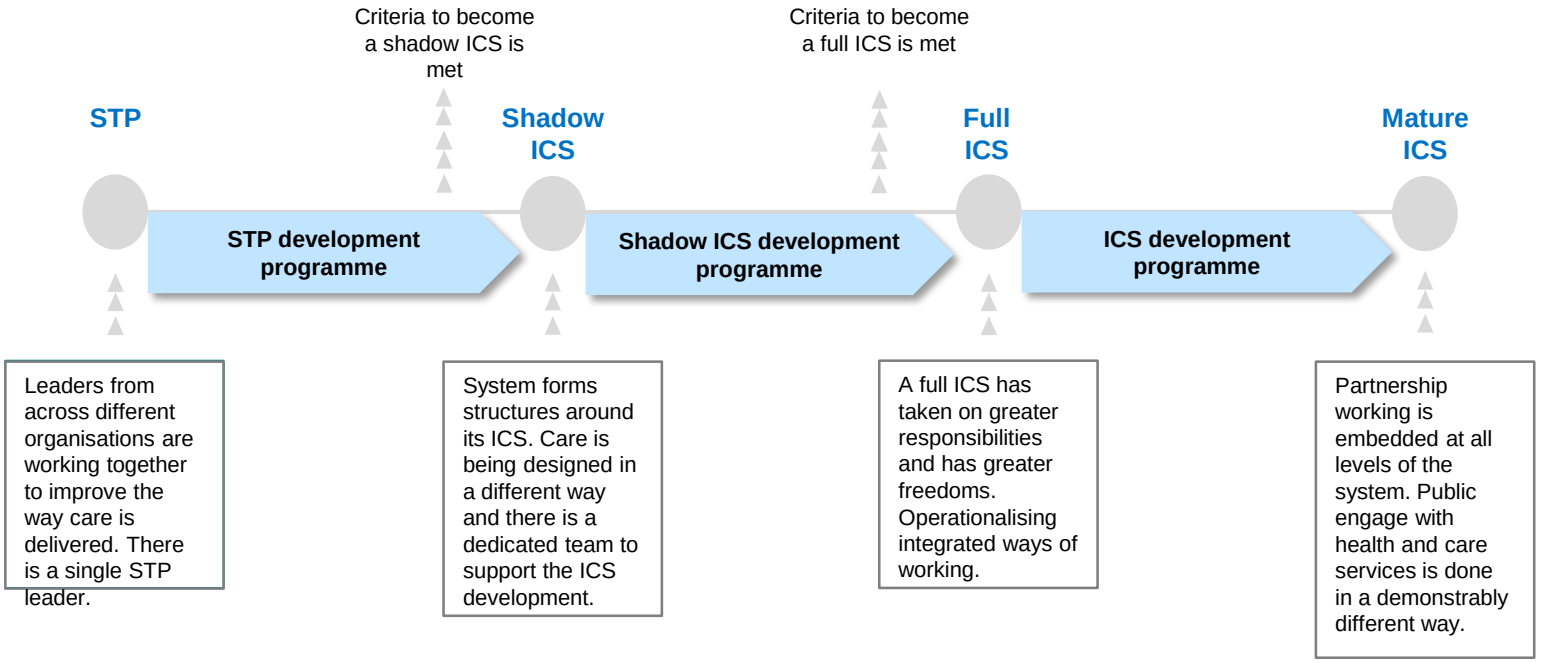
- For 2018-19, Integrated Care Systems will:
  - Prepare a **single system operating plan and narrative**, that aligns commissioner and provider assumptions, and delivers to a single system control total
  - In some cases, adopt a **system-based approach** to the provider and commissioner sustainability funds, whereby no payment will be made unless the system as a whole has delivered against its system control total, in exchange for a more autonomous regulatory relationship

Wave 1 ICSs care for around nine million people

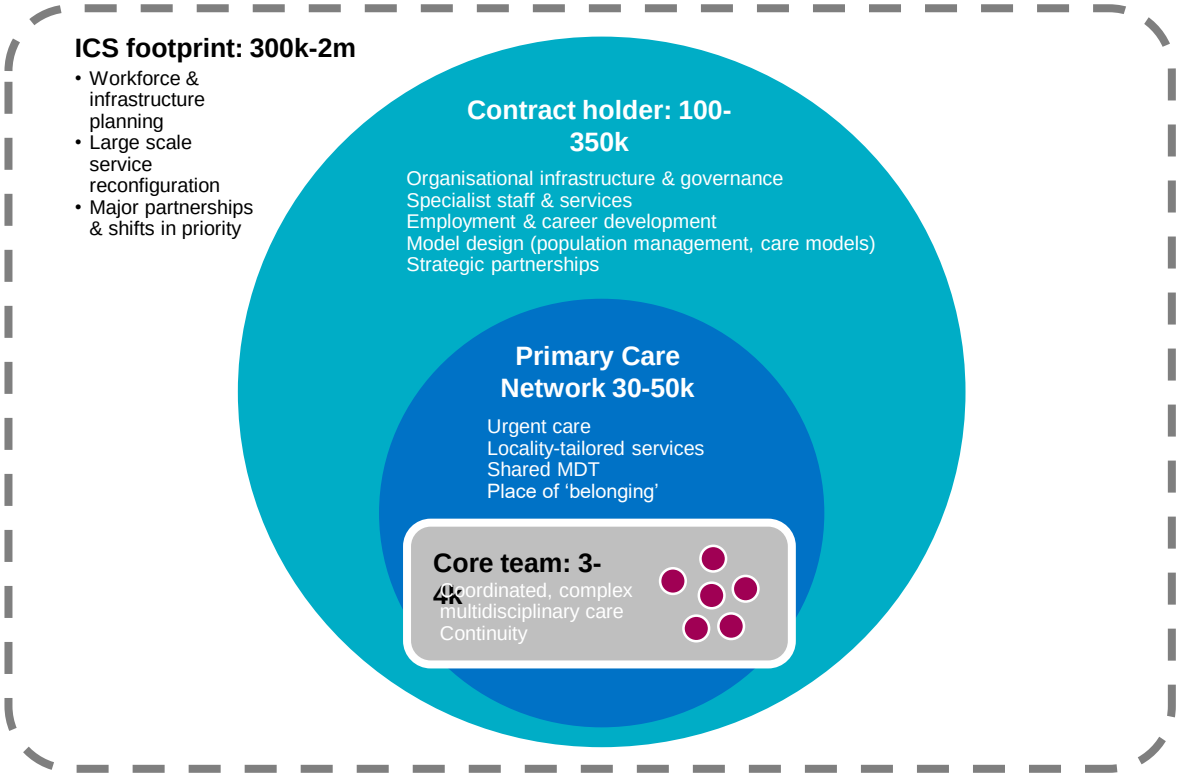


We are supporting all STPs to develop into ICSs over several stages…

The diagram below illustrates the roadmap to become an ICS, including the two "gateways" to become a "shadow" and "full" ICS.



Scales of operation



… with different functions carried out at different levels within a system

Integrated Care System Care at the system level	Integrated providers Care in a place	Locality networks Enhanced primary care

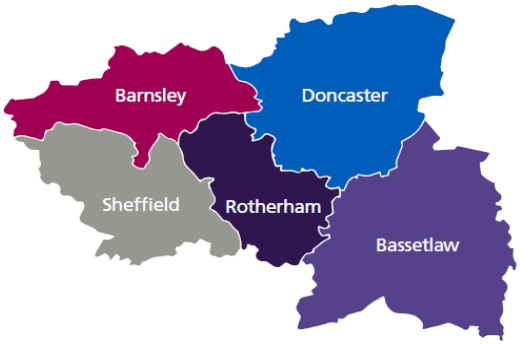
• **+1million population**
 	
• Providers and commissioners collaborating to:
  ○ Hold a **system control total**.
  ○ Implement **strategic change**.
  ○ Take on responsibility for **operational and financial performance.**
  ○ **Population health management**.
	• **~100-500k population**
	
	• Providers collaboratively:
	  ○ **Integrate** primary care, mental health, social care and hospital services.
	  ○ Work **preventatively** to stop people becoming acutely unwell.
	• Care models to redesign care.
		• **~30-50k population**
		
		• Link GP practices together to:
		  ○ Enhance **access.**
		  ○ Give additional **resilience**.
		  ○ Share **workforce**.
		  ○ Provide **proactive** services.

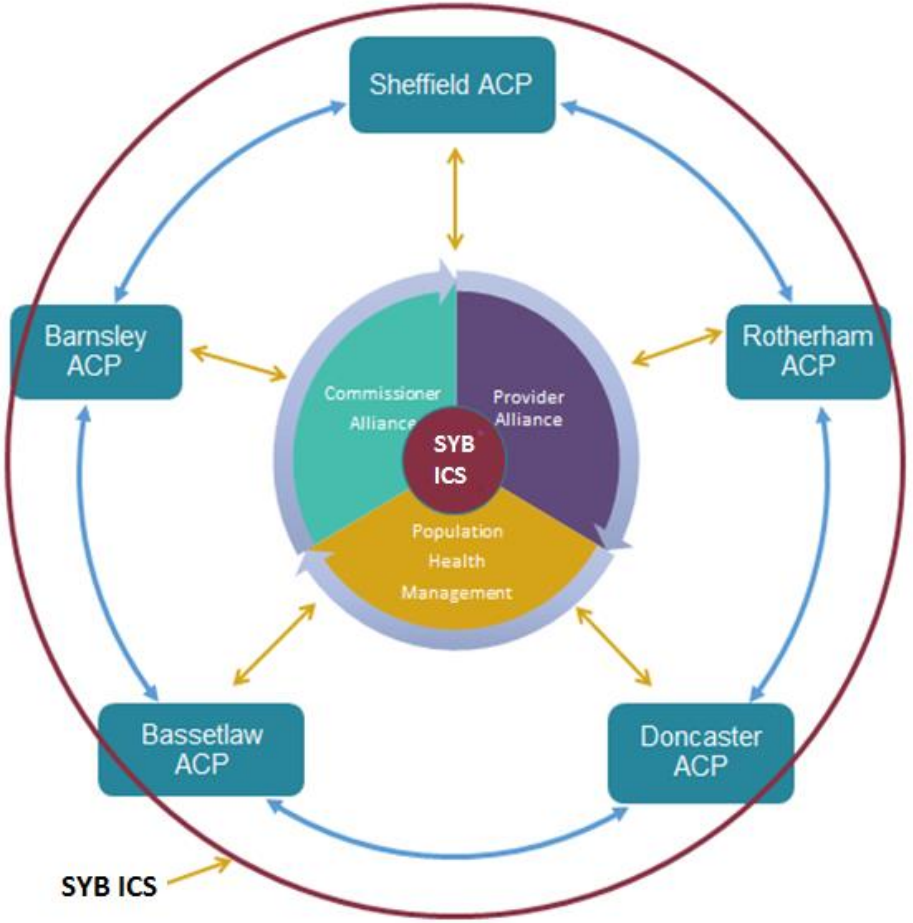
A working definition.

- Primary care networks will enable the provision of proactive, accessible, coordinated and more integrated primary and community care improving outcomes for patients. They are likely to be formed around natural communities based on GP registered lists, often serving populations of around 30,000 to 50,000. Networks will be small enough to still provide the personal care valued by both patients and GPs, but large enough to have impact through deeper collaboration between practices and others in the local health (community and primary care) and social care system. They will provide a platform for providers of care being sustainable into the longer term.

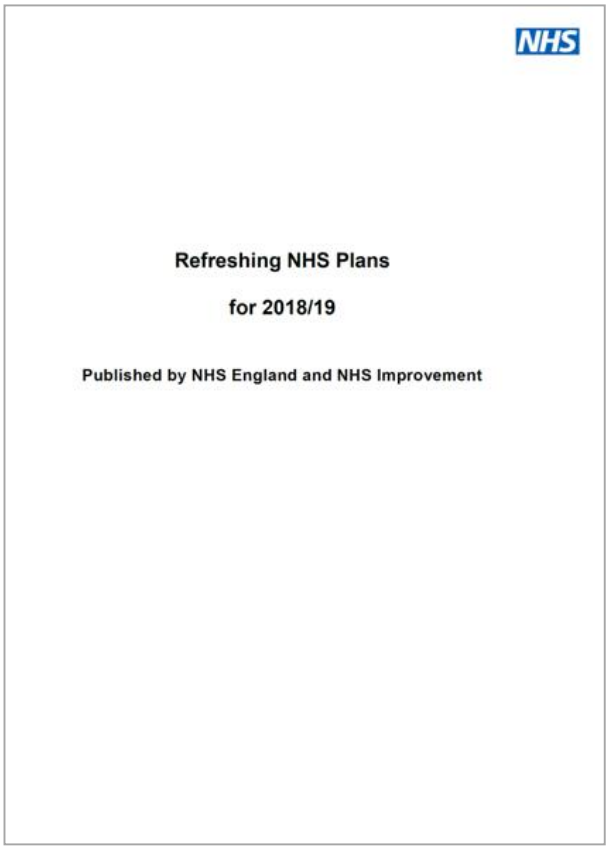
South Yorkshire and Bassetlaw are putting this model into practice

- £3.9b health and care budget
- 1.5 million population
- 72k health and care staff
- 208 GP practices
- 6 acute and community trusts
- 5 local authorities
- 5 CCGs
- 4 mental health trusts





Planning Guidance



- Published 2nd February 2018
- Overall Goal for primary care in 2017-2019 to stabilise general practice today and support the transformation of primary care and for tomorrow, by delivering General Practice Forward View and Next Steps on the NHS Five Year Forward View.
- Actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000.

Building on the GP Forward View, the ICS Primary Care Development Programme aims to achieve three things

A new model of primary care for the future

- A new way of delivering primary care for today and into the future
- GPs and other staff have a manageable and appropriate workload, and teams are resilient to fluctuations in demand
- Primary care can attract and retain the staff it needs

Improved population health

- People receive new models of primary care, targeted to their specific needs, including improved prevention and self care.
- People can access care from an appropriate service when they need it

Better use of the health system's resources

- Systems are able to move investment from acute to out of hospital care
- Primary care deploys its resources effectively to achieve the best possible outcomes for patients

Five themes are emerging from the work to date with the Wave One Integrated Care Systems:

1. **Right scale.** Primary care working as networks with other system partners; and with sharing of information and expanded capabilities.

2. **Integrated working, across all of primary care.** including general practice, community services, social care and the third sector.

3. **Understanding population needs, targeting care.** Data driven population segmentation to understand people's health and care needs. Increased focus on high quality preventative and proactive care.

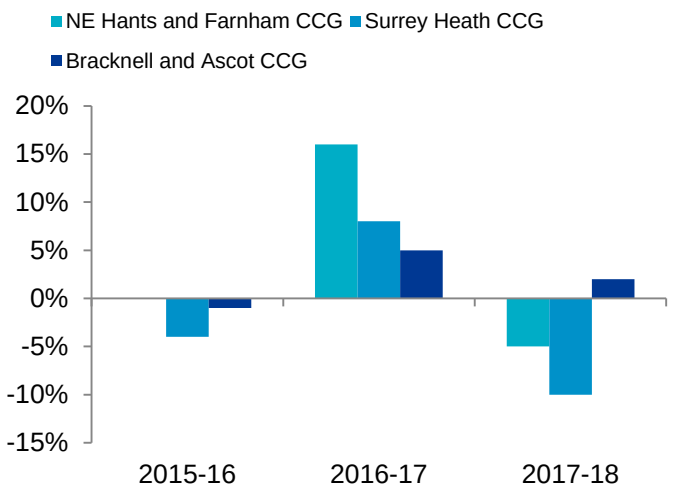
4. **Managing resources and reducing variation**.

5. **Empowered primary care.** Including equal partnerships across health and social care in system-level decision making.

The model is starting to bear fruit… In Frimley, activity is falling

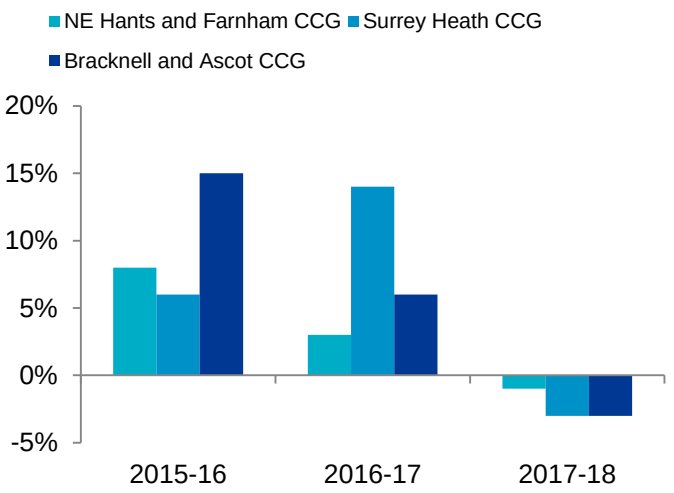
Referrals

Relative percentage changes 2015-16 to 2017-18 YTD



Emergency Admissions

Relative percentage changes 2015-16 to 2017-18 YTD



Each ICS will need to go on a journey of development

	***Foundations for** transformation*	***Step 1***	***Step 2***	***Step 3***
Right scale	**Plan:** Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level.	**Practices identify PCN partners** and develop shared plan for realisation.	PCNs have **defined future business model** and have early components in place.	**PCN business model** fully operational.
Targeting care	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Analysis on variation** in outcomes and resource use between practices is readily available and acted upon.	Functioning i**nteroperability within networks,** including read/write access to records, sharing of some staff and estate.	**Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed.
Integrated working	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Basic population segmentation** is in place, with understanding of needs of key groups and their resource use.	All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for intervention, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.	**Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation.	**Integrated teams**, which may not yet include social care, are working in parts of the system.	Early elements of **new models of care** in place for most population segments, with **integrated teams** throughout system, including social care, the voluntary sector and easy access to secondary care expertise. Routine peer review.	**New models of care** in place for all population segments, across system. Evaluation of impact of early-implementers used to guide roll out.
Primary care provider voice		Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them.	**Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding.** Data being used in clinical interactions to make best use of resources.
		Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices.	Primary care plays an **active role in system tactical and operational decision-making,** for example on UEC	**Primary care providers** full decision making member of ICS leadership.
		Primary care has a **seat at the table** for system strategic decision-making.		

BLMK proposed primary care incentive scheme mapped to NHSE ICS development path

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale **Integrated working** **Targeting care** **Managing resources** **Empowered Primary Care**	**Plan:** There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level **Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there. ✓ **Time:** Primary care, in particular general practice, has the headroom to make change. **Transformation resource:** There are people available with the right skills to make change happen.	**Practices** identify partners for network-level working and develop shared plan for realisation. **Integrated teams**, which may not yet include social care, are working in parts of the system. **Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. **Prototypes** in place for highest risk groups. Steps taken to ensure **operational efficiency** of primary care delivery. **Primary care** has a seat at the table for all system-level decision ma ✓	**Practices** have defined future business model and have early components in place. Functioning **interoperability between practices,** including read/write access to records. Data sharing agreements in place. **Integrated teams** formalised to include social care, the voluntary sector and easy access to secondary care expertise. The system can **track data in real time,** including visibility of patient movement across the system and between segments, and information on variability. **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system. Evidence of active sign posting to community assets. **Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	**PCH Characteristics** • Cluster/network agreement/MoU in place with clinical leader identified • Network development plan using NAPC or ICS maturity matrix • Sharing infrastructure eg premises, back office • Evidence of MDT working • Data (1) using variation at network and practice level with action plans • Data (2) Looking at data to identify patient risk population* • Data (3) Information Sharing Agreement in place • Actively recruited, recruiting or commitment to recruit to new roles eg clinical pharmacists, navigators • **Incentive payments for evidence of (for example) 6 out of 8 characteristics (* = mandatory)** • Primary care network full decision making member of ACS leadership

Clinical Performance Dashboard

QoF @ Feb 17	Target	Ann Jones		Bellevue		CRS		Crompton Road		Enki		Hillcrest		LPHC		MAG	
		Jan-17	Feb 17	Jan-17	Feb 17	Jan-17	Feb 17	Jan-17	Feb 17	Jan-17	Feb 17	Jan-17	Feb 17	Jan-17	Feb 17	Jan-17	Feb 17
CON003 (Contraceptive) End of Year	90%	100%	100%	100%	100%	100%	100%	100%	100%	91%	96%	100%	100%	100%	100%	100%	100%
DEP003 (Depression) End of Year	80%	100%	100%	77%	93%	77%	91%	17%	29%	88%	83%	78%	93%	94%	96%	84%	85%
CAN003 (Cancer) End of Year	90%	100%	100%	86%	88%	100%	100%	0%	100%	83%	100%	82%	100%	94%	94%	100%	100%
DEM005 (Dementia) End of Year	80%	NA	100%	64%	70%	NA	NA	100%	100%	100%	100%	88%	83%	100%	100%	NA	100%
DM014 (Diabetes) End of Year	90%	100%	100%	96%	96%	100%	100%	100%	100%	94%	94%	100%	100%	88%	91%	100%	100%
CS002 (Cytology) How Am I Driving	80%	77%	77%	72%	73%	83%	82%	88%	88%	85%	85%	87%	86%	81%	82%	78%	75%
DM009 (Diabetes) How Am I Driving	92%	93%	92%	82%	81%	79%	80%	76%	74%	86%	88%	92%	93%	87%	89%	89%	86%
Exception Diabetes From 1416	Xpts	8	8%	6	12%	0	12%	0	0%	19	3%	3	12%	7	12%	0	0%
Max Tolerated Therapy - Diabetes	Xpts	0	0%	1	13%	1	12%	0	0%	2	13%	1	13%	15	33%	0	0%
End of year prediction	545		510.18		367.21		472.56		352.26		456.53		474.75		456.00		483.0

Influenza @ Feb 17	Target	Ann Jones		Bellevue		CRS		Crompton Road		Enki		Hillcrest		LPHC		MAG	
		Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17
Flu Vacs given : Over 65's yrs inc declined	75%	73%	76%	64%	75%	66%	76%	69%	78%	65%	66%	78%	78%	64%	67%	78%	81%
Over 65's who have declined flu vaccination		15%	15%	4%	5%	11%	12%	10%	11%	22%	23%	11%	13%	13%	17%	11%	13%

Vacs & Imms @ Feb 17	Target	Ann Jones		Bellevue		CRS		Crompton Road		Enki		Hillcrest		LPHC		MAG	
		Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17
Pneumococcal Over 65's vaccinated (inc. declined)		80%	82%	64%	64%	73%	73%	76%	76%	77%	77%	71%	71%	69%	69%	85%	85%
Pneumococcal Over 65's declined (last 12m)		2%	4%	1%	2%	3%	4%	4%	4%	3%	2%	3%	4%	5%	5%	1%	1%

Medicine Management @ Feb 17	Target	Ann Jones		Bellevue		CRS		Crompton Road		Enki		Hillcrest		LPHC		MAG	
		Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16	Aug 16- Oct 16	Sept 16- Nov 16
Antibacterials ADQSTAR PU - Indicator (ADQSTAR PU)	<0.74	0.253	0.304	0.472	0.513	0.749	0.697	0.52	0.601	0.586	0.583	0.799	0.804	0.572	0.591	0.491	0.554
Oral NSAIDs ADQSTAR PU	<1.336	0.161	0.173	1.481	1.408	2.059	1.285	0.235	0.261	1.124	1.038	0.914	0.825	1.155	1.089	0.455	0.533
Inhouse Meds Man Searches		Jan-17	Feb-17	Jan-17	Feb-17	Jan-17	Feb-17	Jan-17	Feb-17	Jan-17	Feb-17	Jan-17	Feb-17	Jan-17	Feb-17	Jan-17	Feb-17
Number of pts prescribed Benzo/Hypnotics on repeat over the last month		1	1	95	96	7	7	4	4	76	74	18	18	51	53	16	16
Number of pts issued 'never events' drugs in the last month		0	0	23	14	21	60	2	3	4	9	6	3	4	4	3	2
Number of pts on ACE/ARB medication with potassium overdue	0%	2%	2%	28%	28%	6%	5%	14%	9%	28%	7%	13%	12%	9%	8%	9%	7%
Patients on Lithium. Lithium levels overdue	0%	0%	0%	44%	22%	0%	0%	0%	0%	40%	0%	55%	100%	33%	67%	0%	0%
Patients on Methotrexate FBCs overdue	0%	0%	0%	44%	27%	0%	0%	0%	0%	0%	29%	100%	27%	67%	27%	100%	33%

Practice Data @ Feb 17	Target	Ann Jones	Bellevue	CRS	Crompton Road	Enki	Hillcrest	LPHC	MAG
List Size	Feb-16	2044	8188	2676	2387	7725	5518	12816	2968
List size	Feb-17	2033	8131	2673	2349	7521	6836	13338	2945

NHS Choices Feb 17	Target	Ann Jones		Bellevue		CRS		Crompton Road		Enki		Hillcrest		LPHC		MAG	
		Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17	Dec-16	Jan-17
Overall practice rating	5	2.5	2.5	3	3	2	1.5	4.5	3.5	2.5	3	2.5	2.5	2	2.5	3.5	3
Number of positive comments in the last month		0	0	0	1	0	1	1	0	3	2	0	0	2	3	0	1

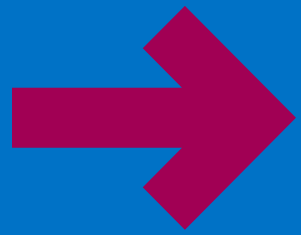
2% DES as of April 2016	Target	Ann Jones	Bellevue	CRS	Crompton Road	Enki	Hillcrest	LPHC	MAG
List size of over 18's as of 1/10/2016		1450	6209	1819	1815	5927	4280	9457	2463

Modality View February 2017 | CON003 | DEP003 | CAN003 | DEM003 | DM009 | DM014 | CS002 | Flu Uptake Over 65's inc decl | Flu Uptake | Benzo Hypnotics | Never Event ...

Changing face of NHS leadership

Old style leadership	New-style leadership
It's all about the **money**	It's about **balance**
Payment by results	**Value** – NHS is a good investment
Focus on secondary care – **hospitals** are all that matter	Focus on primary care and a **community-based** NHS
Improvement is a '**specialist**' issue	Quality improvement is **everyone's role**
Providing services to patients – a **one-way relationship**	**Involving patients** in their care – developing healthcare with patients
Command and control	**Collegiate** approach
Managed from the **centre**	Local decision-making to meet **local needs**
Rule-bound and cumbersome	**Flexible** and fleet of foot

Thank you



Telford & Wrekin Neighbourhoods

Anna Hammond & Louise Mills

Team Telford

Telford & Wrekin Neighbourhood Programme

A single programme of work across Telford and Wrekin. Incorporates all community approaches from peer led support to delivery of services traditionally delivered in acute settings.

Our approach – the start of our journey

Consideration of a joint narrative…….

Being the Change - local authority vision for working with partners and communities

Working as a **Co-operative Council**

- ✓ Bringing more public services together so that people get what they need at the right place and the right time;
- ✓ Involving local people more in planning and running services; and
- ✓ Supporting our communities better and encouraging people to do more to help their communities.

Strong foundation for collaborative working across health and social care

The Story of Self

Leadership roles for Anna & Louise

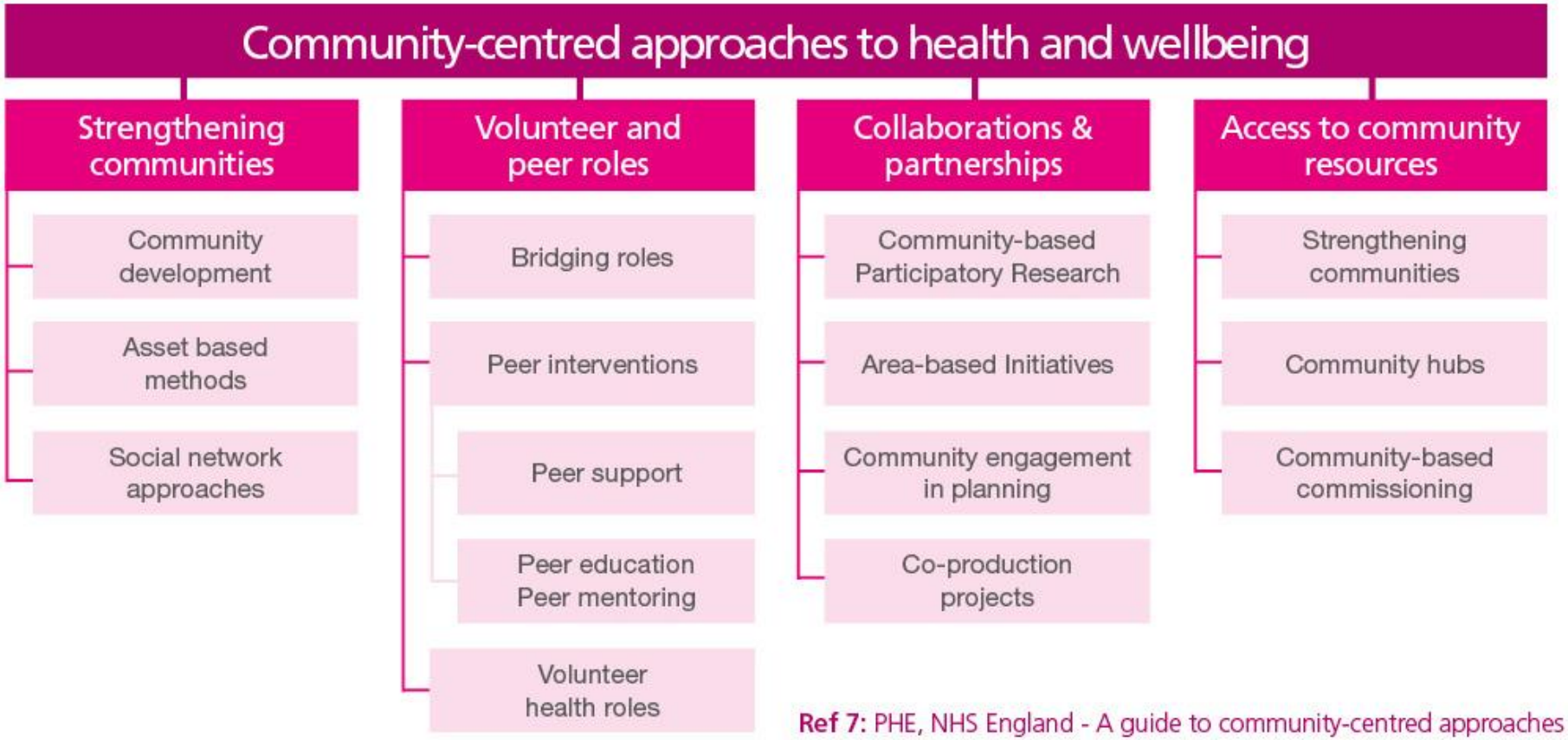
Why I have been called into action?

Why I care?

The Story of Us

Why we care - what brought everyone together?

- ✓ A sense of shared vision and shared community
- ✓ Light touch approach to structures and committees
- ✓ Joint narrative outlining the case for change across health and social care – working with communities
- ✓ Considered the evidence: Community centred approaches to health & wellbeing , TLAP, RCGP on austerity
- ✓ Culminated in the introduction of the neighbourhood approach
- ✓ Ethos grass roots, make change, light touch, just get on with it



Ref 7: PHE, NHS England - A guide to community-centred approaches

The Story of Now

Telling the story of how it is now and the story of how it will be has motivated people into taking action

Challenges along the way

- Dependency on relationships
- Buy in!
- Resources
- Assessing the impact of changes
- Fitting in with the national agenda

Thank you for listening

For more information:

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@HealthyTF

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Break – back at 11:40

Developing Integrated Community Services In Wolverhampton

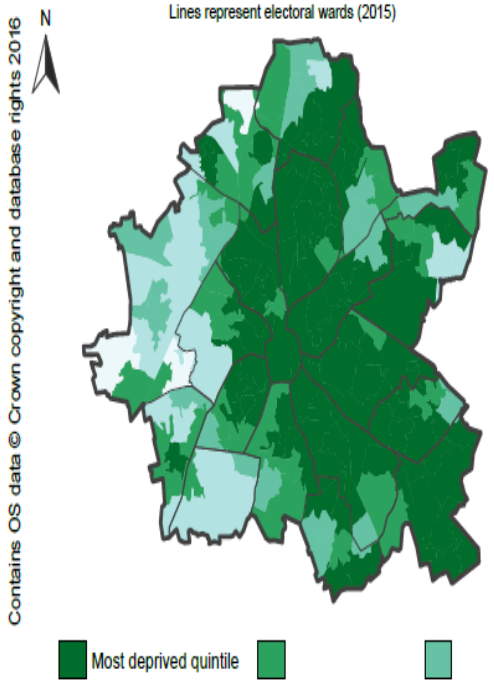
Paul Aldridge, *Project Manager, Wolverhampton CCG*

Tracey Slater, *Advanced Nurse Practitioner Long Term Conditions*, *The Royal Wolverhampton NHS Trust*

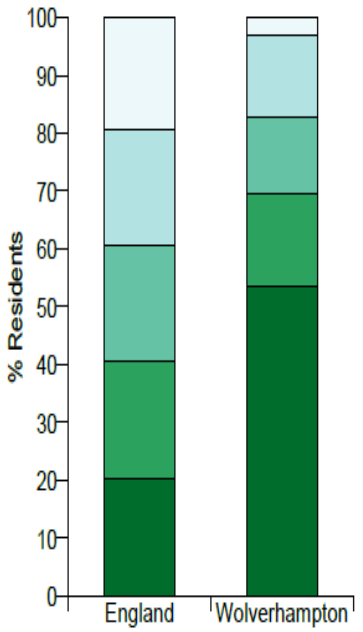
Rachael Berks, *Specialist Lead Nurse Practitioner/ Service Lead Manager for Admission Avoidance Services, The Royal Wolverhampton NHS Trust*

Wolverhampton demographic

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.



- *Over half our population fall amongst the most deprived in the country.*
- *There is a greater than ever life expectancy - but no corresponding increase in healthy life expectancy*
- *Our population can expect to live on average 2 years less than the England average and a life expectancy gap across the City of between 7 and 8 years depending on location*
- *Our Health Summary is statistically amongst England's worst where 31% are currently registered on a chronic condition register and 27.7% have one or more long term conditions*
- *Over 64% of adults 60+ living with frailty*
- *There are significant health inequalities across the city and ethnicities*

BCF Vision Statement

‘Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them to **live longer, healthier and more independent lives no matter where they live in the city.**

Health & Social Care colleagues will work better together, alongside local community organisations to **deliver support closer to where individuals and families live and in line with their needs’**

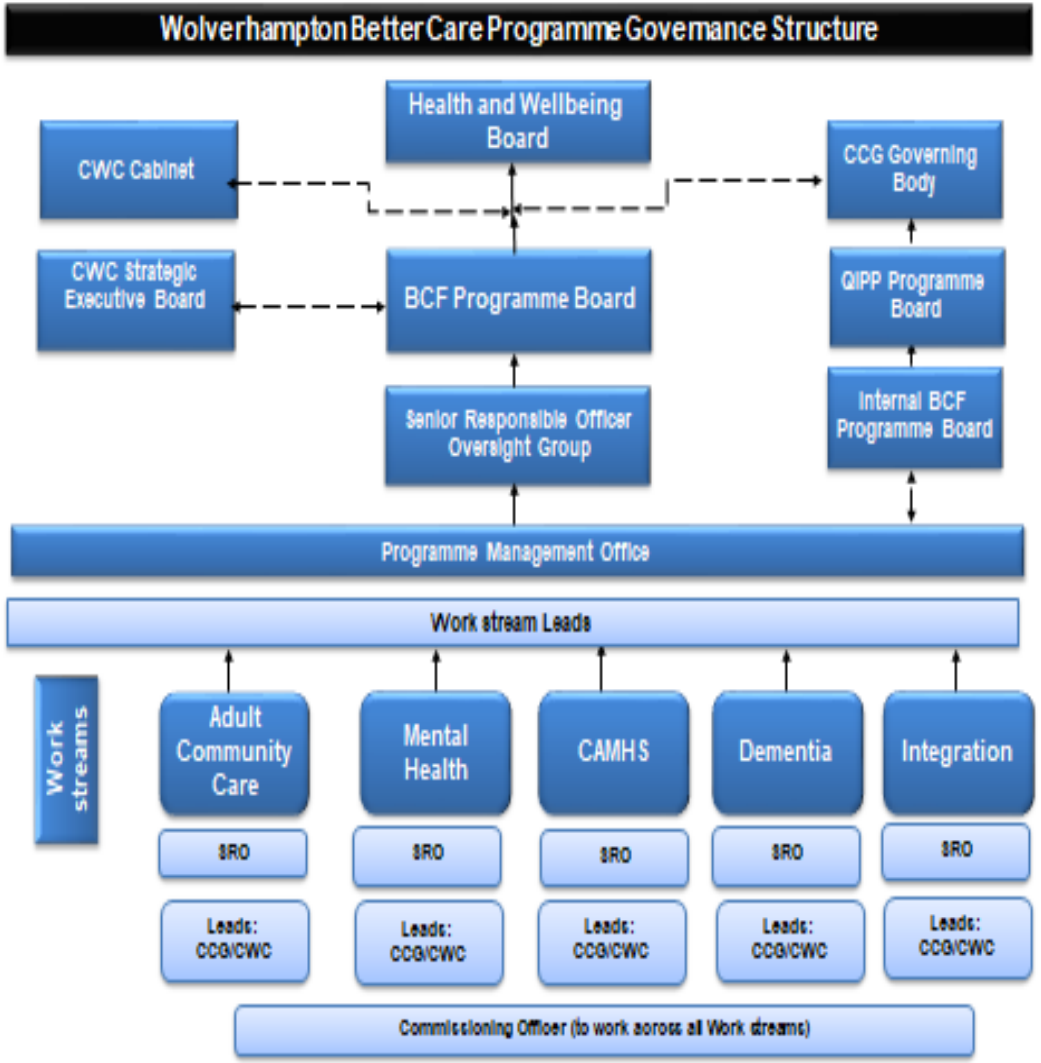
Wolverhampton BCF Programme Board

What this means for our population

- **A fundamental transformation of health and social care** that will have a direct impact on *reducing health inequalities* and *provide a better experience* for the local population
- **Care and support will be delivered closer to home** and focus on *promoting independence and prevention*, whilst *providing a rapid health and social care response where required**.***
- **Services being proactive in meeting population needs and service developments that are evidenced based**. *Empowered people, managing their own care and support* needs by *making use of all assets available to them*, not just those provided by statutory services.

Integrated Community Services in Wolverhampton – delivered through BCF

How are we working towards this?



…and importantly, Project Management Support

How we make things happen

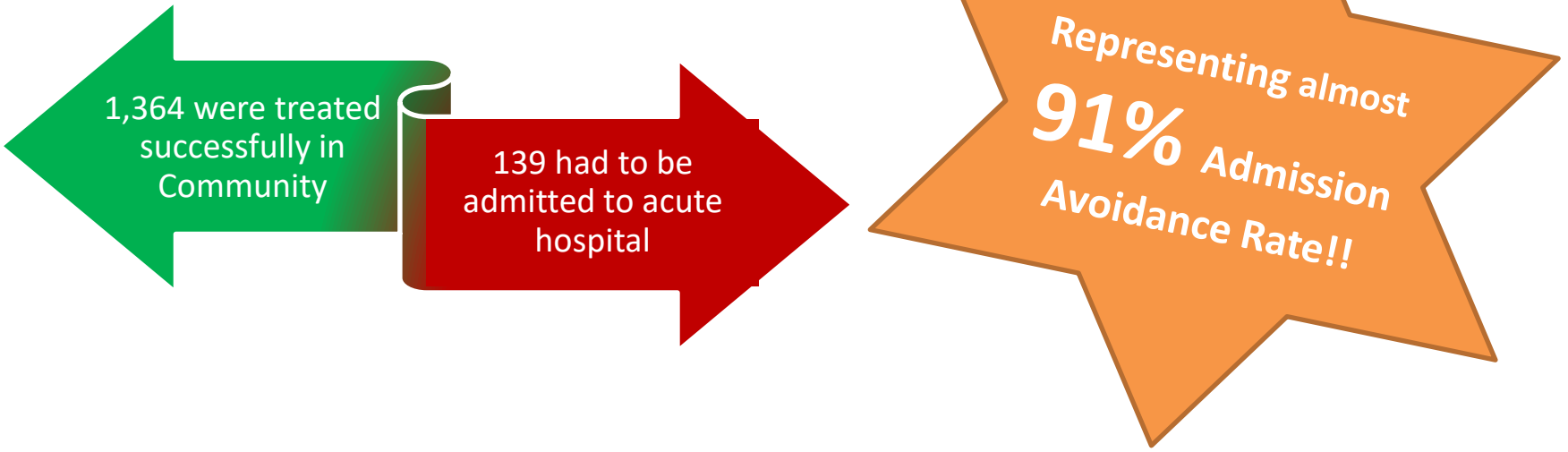
- **Breaking down organisational barriers** by understanding each others worlds and focussing on improving outcomes for individuals at an operational level
- **Adopting a ‘can do’ attitude to making change happen** and taking individual responsibility for taking actions into individual organisations
- **Speaking with an integrated voice to our decision makers** to affect the right change
- **Working to a principle of equal partnership** and respect for each voice in the workstream
- **Being brave and willing to sometimes disrupt conventional practice and thinking** within our individual organisations

Achievements to date

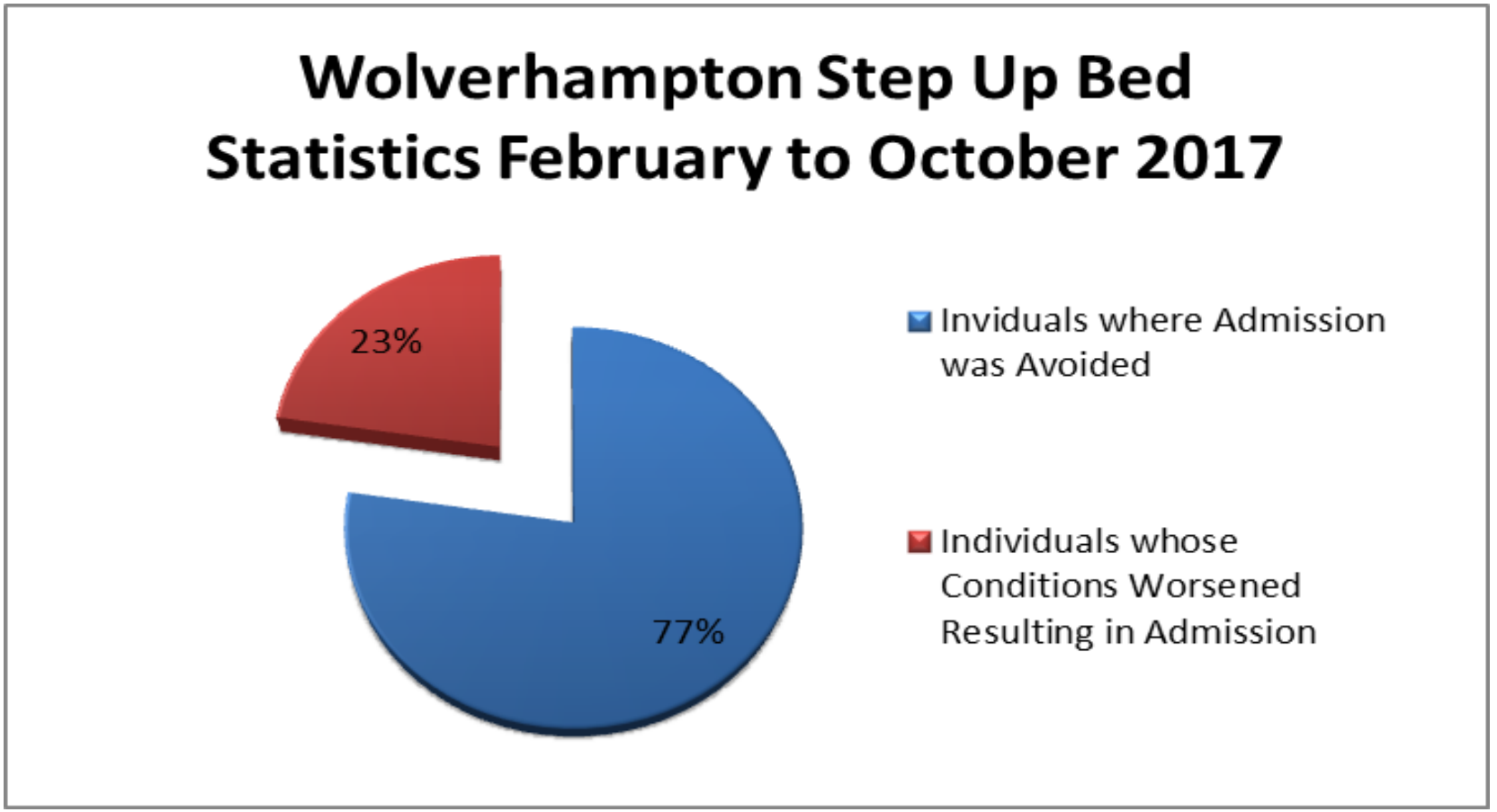
Implementation of a city wide Rapid Intervention Team supported by Medical Consultant (s) to see and treat individuals who are experiencing an exacerbation of certain medical conditions (with rapid access to mental health services and Social care) that would otherwise have resulted in conveyance to A&E.

The impact on our population to date:

Over the quarter ended March 2018 we assessed and treated 1,503 patients:-



Commissioned a ‘Step-Up Bed’ facility



Case Study 1 – Rapid Intervention Team

Rapid Intervention Team – Case Study

The Scenario…

Person taken ill in the night and too unwell to go to GP next morning. Husband went to local practice and the receptionist referred to Rapid Intervention Team (RiTS)…

What we did…

Within the hour a nurse arrived at the house, took her temperature (38.9) and her oxygen level which was very low. The nurse got patient to use her inhaler a few times and ensured she was using it properly, she explained that this was to increase her oxygen levels and open up her airways. She was also advised to open a window, take off the bedcover and sleep with just a sheet at night until her temperature was under control. The RiTS Nurse prescribed antibiotics and took sputum samples. From then on she had daily visits from the nurse from the Community Nursing Team who checked her temperature and oxygen levels. 5 days later a matron arrived who had the results from the tests and patient was diagnosed with Lung disease: Bronchiestis Pseudomonas – Aeruginosa (bacterial infection). Further medication was prescribed by the Rapid Intervention Nurse

The Outcome…

Person received care at home for 2 weeks and was discharged under the care of the community

Person feedback was…

"Very grateful and impressed with the quick response and wonderful service from both agencies, because it takes the worry out of being ill, it was wonderful to be at home in comfort and in the care of her husband and the health teams" Described the nurse as "a ray of sunshine"

Case Study 2 – Rapid Intervention Team

The Scenario…

Individual was a 95 year old lady who lived with her daughter. She was referred to the Rapid Intervention Team by her GP. Their GP had visited her at home twice during the week and commenced her on antibiotic treatment for cellulitis of the lower legs and a chest infection. Her condition had deteriorated and she was becoming increasingly breathless and visibly more unwell lady refused to go into hospital…

What we did…

The Rapid Intervention Team nurse practitioner 'Kate' visited within 2 hours of the referral being made. Kate assessed her and found her to be in acute Heart Failure. After discussing the options available to her, the lady and her family advised that they did not want her to be admitted to hospital as she was petrified of hospitals having only ever been in once in 95 years and she wanted to remain at home with her family present. Kate completed a DNAR and organised for the urgent delivery of a hospital bed to enable the lady to be positioned comfortably in the home with her family. She also prescribed medication to help calm her breathing along with palliative anticipatory medication. A fast track referral was made to district nurses and 'end of life care' was initiated straight away. Other necessary equipment was provided by the intermediate care team and a 24 hour emergency contact number was supplied for the district nursing team.

The Outcome…

Lady passed away peacefully at home as per her and her family's wishes, rather than in an acute hospital setting

Son said…

"The whole team were fantastic, Mom was able to spend her last hours peacefully and comfortably in familiar surroundings with her loved one's thanks to their efforts. The service shows the NHS at its finest."

Community Multi Disciplinary Team Meetings

Development of 3 locality based integrated Community MDTs underpinned by software (Fibonacci) enabling health and social care to share appropriate data by NHS Number. The MDTs also utilise the Risk Stratification Tool.

- **Attendees**
  - Locality Nurse Manager
  - Band 7 Senior Sister or Deputy
  - Community Matron
  - Diabetes Specialist Nurse
  - Social Workers
  - Dietetics
  - Advanced Nurse Practitioner LTC
  - Compton Hospice
  - Others by invitation include, for example Mental Health Services
- **Since January 17 there have been:**
  - 30 MDT's held across the city, (one per month in each of the localities).
  - on average 8 patients discussed at each meeting in each locality
  - Total number of patients discussed at MDT across all 3 localities is approx. 240
  - Average length of time for discussion is 10 minutes approx.

Impact of the MDTs

- MDT meetings have enabled some excellent examples of joint working resulting in positive outcomes for patients/clients. These are a mix of qualitative and quantitative
- Buy-in from all agencies with excellent attendance and a robust IT system (Fibonacci) to collate actions and leads.
- It provides an opportunity to understand the role of others with shared learning and positive feedback from staff
- It promotes a culture of team working bringing together staff and sharing knowledge, skills and experience
- It has established the foundation for greater integration and further steps towards the Community Neighbourhood Team model

Challenges have included

- Expanding Primary Care and Mental Health
- Developing the Fibonacci software solution and the underpinning Information sharing Agreement
- Demonstrating the impact and value of the MDT

Fibonacci – Our Integrated Health and Social Care Record

- In order to achieve effective integration of services, Wolverhampton recognises the importance of having a user friendly, accurate and timely system that allows individuals involved in a person's direct care access to key information from across partners
- Underpinned by a robust Information Sharing Agreement, Fibonacci is a software solution that enables key data to be pulled from multiple systems across partners to form a single view of the person
- Our current record incorporates data using the NHS Number from our Acute Trust, Adult Social Care data from the Local Authority and Mental Health data from our local provider, with plans in place to feed Housing data in the future.
- Fibonacci has provided the information platform that has formed the basis of integrated care plans for complex patients in Wolverhampton that require cross organisational planning and intervention to help people manage their conditions and care within the community.
- The shared care record ultimately has enabled a safer, more holistic approach to be applied to a person's care – our evidence for this has been captured in the form of case studies and also by the reducing risk stratification scores for those patients involved.

Case Study 3 – Integrated Community MDTs

Integrated Community MDTs

The Scenario…

Brian lives in the North of the city with his son and worked as a milkman for many years, he sustained a stroke at the age of 58 years. He has been housebound for a number of years and only leaves the house to attend medical appointments. There has been a long-standing history of self-neglect and this seems to be the way the family lived when his wife was alive. Brian's health deteriorated following a second stroke , he is now very dependant on his son with all tasks to maintain his wellbeing. He has reduced mobility and mobilises with a frame. He has limited use of his right arm and reports to feel a lot of pain in the arm. Brian acknowledges that he is struggling with maintaining his personal care and general maintenance of his home. Challenges To overcome included, reluctance to engage with carers/ professionals, main carer (Son), not coping with caring role and reluctance to accept support. The son also appeared to be experiencing some mental health difficulties, not aware of the consequences of the quality of his care having on his Father. There were also environment, financial and safeguarding challenges.

What we did…

Work alongside District Nurses was crucial in ensuring the main carer had some understanding why his father needed support. He wanted total control over the situation but joint working was successful in that he could sit down and ask questions and obtain explanations as to why services were going in to the home. Safeguarding was also discussed with Brian and he has always voiced that he wished to remain at home. After spending time with both men it was obvious that they are very close and any neglect issues are non-intentional. Various things were discussed to make carer aware what the aims and objectives were. It was obvious that son had some mental health problems and this triggered the referral to the GP and a joint visit was requested. SW contacted GP to voice concerns regarding son's mental wellbeing and a joint visit was completed, however as son was reluctant to engage with the GP no referral to MHCT was made. Using a person-centred approach was important to reduce the risk of disengaging again, SW visited a number of times both solely and jointly with District Nurse building up a trusting relationship and this made a difference to how Brian and his son have adapted well to the support.

The Outcome…

District nurses have a better understanding of the situation with son and are able to manage the situation much better. Brian and son continue to work with an independent provider to clean up the home environment and arrange for the finances to be sorted out.

Other initiatives

- Integration of the Wolverhampton Housing Offer into Community services and acute hospital to work alongside health and social care colleagues to maintain individuals in their homes and improve discharge planning
- The inclusion of housing in the work stream has facilitated a number of positive outcomes for staff and residents
- We have facilitated linking housing to a wide range of services accessed by our local population
- Both Health & Social Care professionals now have access to a range of housing solutions to support residents to be safer in their own home
- We plan to begin more proactive work around falls with the housing team early this year

Case Study – Housing

Housing

The Scenario…

Mrs X is a vulnerable client who was unable to be discharged from hospital due to her home conditions despite being medically fit. The issue was that the staircase was spiral. The client requires four people to carry her up and down which poses risks to both her safety as well as that of the ambulance crew as each step is wide at one end, very narrow the other, without adequate room to stand and when bringing her into hospital one of the crew did slip fortunately no-one was injured). The client is end of life care, bowel cancer, chronic back pain, curvature of the spine, depression and anxiety, vertigo, bilateral cataracts, spinal abscess, lymphoma and pressure sores. The extended stay was affecting her mental wellbeing which in turn affects her physically.

What we did…

Wolverhampton Home Improvement Service (WHIS) investigated altering the staircase, which the family refused as they would lose the downstairs toilet facilities. The final solution was to install a reconditioned through floor lift from the bedroom into the dining room.

The Outcome…

Client was able to return home within 2 weeks of our involvement and is now for the first time in years able to join her family downstairs at will with the use of the lift. They are now fully participating in family life.

External Recognition of our Programme

Winner! Rapid Intervention Team, *Who Cares Wins Category,* 2018

Nursing Times Awards 2018

Shortlisted! for October 2018 Awards, *Technology in Nursing.* Fibonacci - Technology Innovation Enabling Integrated Direct Patient Care in Wolverhampton

Home Improvement Agencies
Making Homes Warm, Safe & Secure

Shortlisted ! for July 2018 Collaboration Award

The Better Care Fund

Wolverhampton hosted National Team Learning Visit July 2018 *"We found the visit very informative, it was good to visit Wolverhampton and hear from everyone involved in developing and running the great examples of integration happening on the ground. It was helpful to meet all the staff that gave their time on the day, and to see first hand how much you all operate as an integrated team with a shared focus on improving outcomes and health for your local people. It is clear that these initiatives are already showing enormous benefits for local people"*

Challenges

- Developing services that have the flexibility and information to understand and adapt to differing needs across localities/communities
- Ongoing financial challenges and individual organisational priorities (can unintentionally make money the focus rather than doing the right thing)
- Shifting engrained cultures and management thinking that have developed across organisations over many years
- Understanding and managing the inter-dependencies (and change fatigue!) between other transformational programmes across the health and social care economy including:-
    - STP
    - GP New Models of Care
    - Development of an Integrated Care Alliance/systems
    - Adult Social Care Transformation Programme – aligning with the 3 conversations model
- Further integration of data and information sharing on a wider scale
- Measuring success (demonstrating impact) and KPIs. Some transformation work in this area cannot always be measured in volumetrics – and outcomes will take time to shift – requiring patience from leaders
- Integrating Mental Health services
- Physical space in Wolverhampton for co-location of more integrated teams/hubs
- Focus and measurement of Urgent care, DTOC and LOS nationally can deflect spotlight away from the admission avoidance and prevention agenda
- Shaping the market for care in the community

Next Steps

- 1st health & social care teams to co locate this year (including housing and voluntary sector)
- Further investment in Community services
- Redesign of MDT's
- 'Three Conversations' roll out
- Evaluate D2A to ensure sustainability
- Continue roll out of Fibonacci
- Explore opportunities to further integrate housing including the DFG

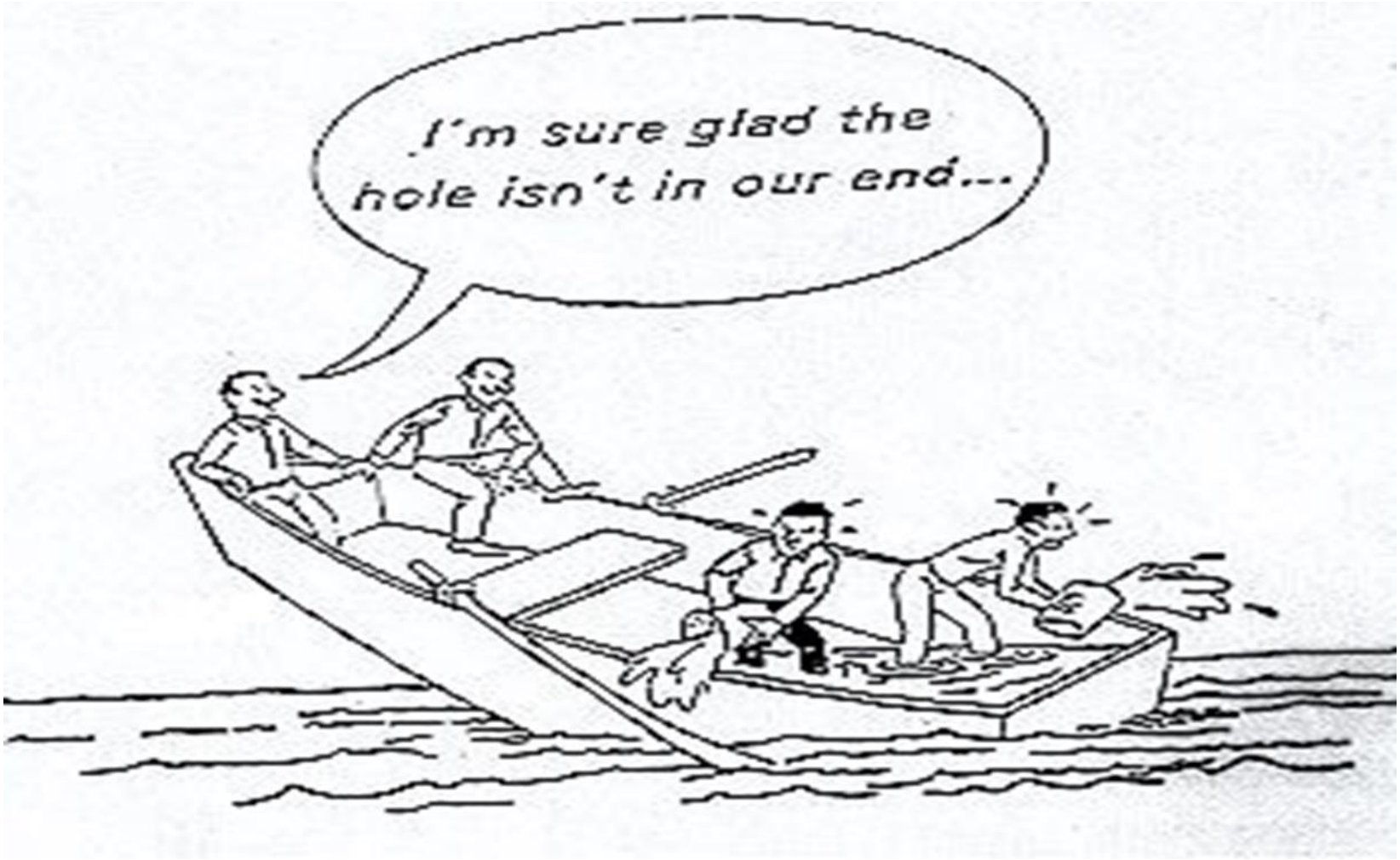
Worcestershire Neighbourhood Teams

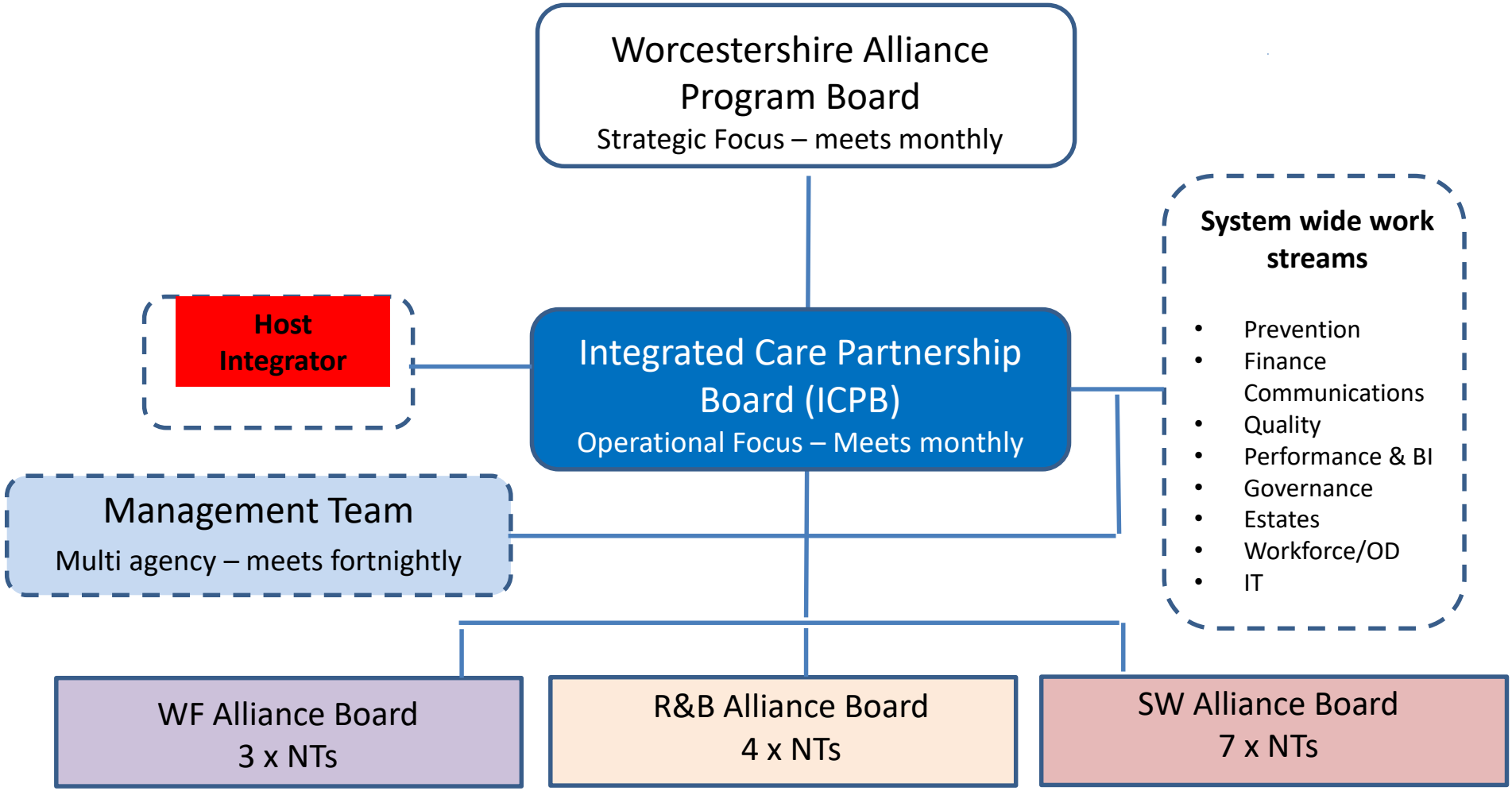
Impossible to Inevitable at the speed of trust

17th July 2018

Herefordshire and Worcestershire Safe and effective health and care services

Worcestershire Integrated Care Partnership


I'm sure glad the hole isn't in our end...


Worcestershire Alliance Program Board
Strategic Focus – meets monthly
Host Integrator
Integrated Care Partnership Board (ICPB)
Operational Focus – Meets monthly
System wide work streams
Prevention
Finance
Communications
Quality
Performance & BI
Governance
Estates
Workforce/OD
IT
Management Team
Multi agency – meets fortnightly
WF Alliance Board
3 x NTs
R&B Alliance Board
4 x NTs
SW Alliance Board
7 x NTs

Host Integrator

- COPD pilot
- Diabetic Treatment Targets
- Development fund
- It takes a bit of thinking though, income up control down.
- Competency led not team defined

Neighbourhood Teams Outcomes

For staff:

- A more satisfying work environment for staff
- More time to spend on patient as there should be less duplication

For the people we support

- Promote & sustain independence, and support to self-manage
- Increased focus on proactive care, avoiding crisis where possible
- More choice to stay at home
- Improved patient journey with better care co-ordination

For the system

- Reduced reliance on secondary care, including a reduction in emergency admissions
- To reduce inpatient stays and help facilitate discharge
- To live within our budget
- Single number to contact Neighbourhood Team's

So, what does all that mean?

Herefordshire and Worcestershire Safe and effective health and care services

Worcestershire Integrated Care Partnership

What helped us

- Find some like minded folk and get to know them well.
- If your going to be patient centred make sure you all have a shared understanding of that.
- Alliance charter – not voting but agreeing, bring a packed lunch.
- Staff, patients and carers told us to get on with it.
- Don’t get stuck with things you cant change , find a different route, its interesting.
- You can only move at the speed of trust.

What's Tricky

- Some of the regulation
- money
- Myths in the system
- Redefining what is fair
- Stopping doing things
- Assumed success
- OD specialists or not?


QUESTIONS

Summary of the morning

- Over lunch, please send in your responses to the following question over *Sli.do.*

- **What's been the most interesting thing that you've heard this morning?**

- **Lunch – back at 13:30**

Influencing for Change

Kathryn Perera | @kathrynperera
NHS Horizons | @HorizonsNHS

The HORIZONS TEAM

This is what we do

1 PEOPLE own what they HELP CREATE

We create spaces where people with a diversity of views and experiences can come together and co-create the future so we get...

BETTER, QUICKER OUTCOMES

2 REAL CHANGE takes place in REAL WORK

We support the frontline staff who do the work to share ideas, experience and operational practise to speed up...

LEARNING ACTION & CHANGE

3 The people who do the work do the CHANGE

We help people, staff and patients to build their POWER to make a difference

4 CONNECT the system to more of itself

We connect thousands of people to each other, through social networks, virtual communities and social media

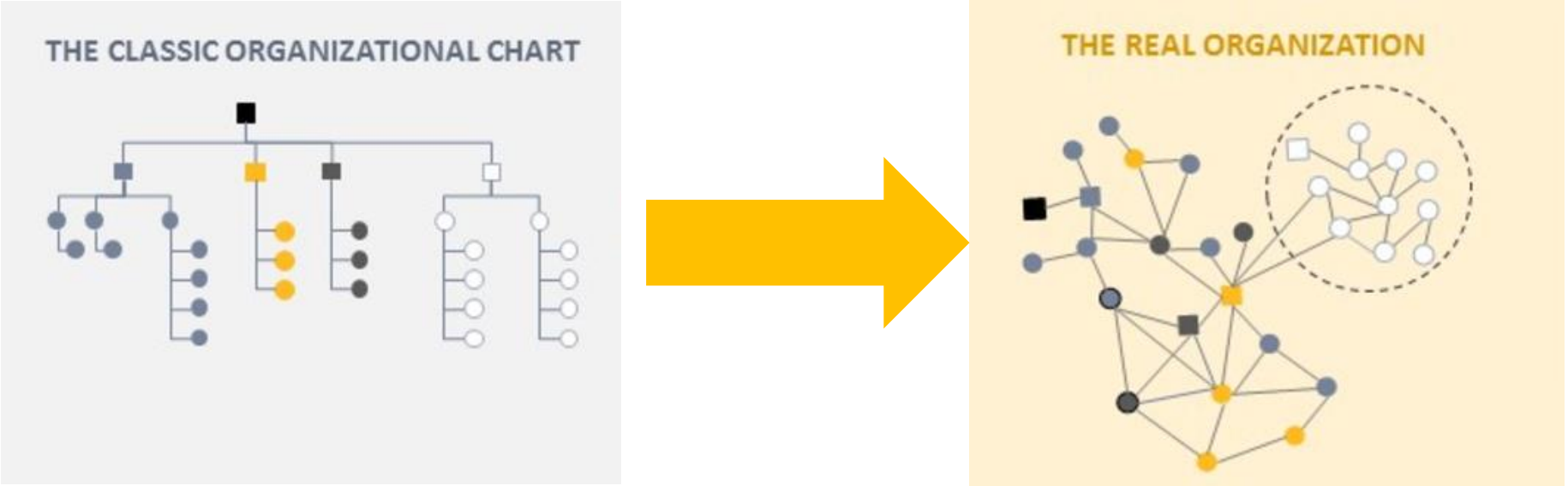
Principles taken from Myron Rogers: "Myron's Maxims

HORIZONS

Power lasts 10 years;
influence not more than 100.

Korean proverb

HORIZONS



Source: Innovisor

HORIZONS

Old power

Currency

Held by a few

Pushed down

Commanded

Closed

Transaction

New power

Current

Made by many

Pulled in

Shared

Open

Relationship

HORIZONS

Jeremy Heimens, Henry Timms New Power: How it's changing the 21st Century and why you need to know (2018)

How are you approaching change…?

http://www.unterstein.net/su/docs/CathBaz.pdf

HORIZONS

As a change agent, my
centrality in the informal network
is more important than my
position in the formal hierarchy

The Network Secrets of Great Change Agents

Julie Battilana &Tiziana Casciaro

HORIZONS

An influencing model for spread…

ACTIONABLE: The idea is designed to make you do something. It might start wit sharing but it's a call to action

CONNECTED: The idea promotes a closer connection with people you care about or share values with. It makes you feel part of a community and the network effect creates further spread

EXTENSIBLE: The idea can be easily customised, remixed, reshaped by people taking part. It's structured with a common stem that encourages communities to alter and extend it

Jeremy Heimens, Henry Timms New Power: How it's changing the 21st Century and why you need to know (2018)


HORIZONS


HORIZONS


Chris Kennedy
@ckgolfsrq
Follow
Thanks @JonBullas. You're up next @KevinAylwin, Jeanette Senerchia and @mattdodson7 #IceBucketChallenge youtu.be/WpJCWjs6kYA
2:49 PM - 15 Jul 2014
CK ice bucket challenge
YouTube @YouTube
9 RETWEETS 14 FAVORITES

HORIZONS


© Youtube
HORIZONS

Model for Large Scale Change

https://www.england.nhs.uk/publication/leading-large-scale-change/

HORIZONS

Kathryn Perera | @kathrynperera
NHS Horizons | @HorizonsNHS

Establishing self-improving systems in the NHS

West Midlands Quality Review Service
Tim Cooper - Director
July 2018

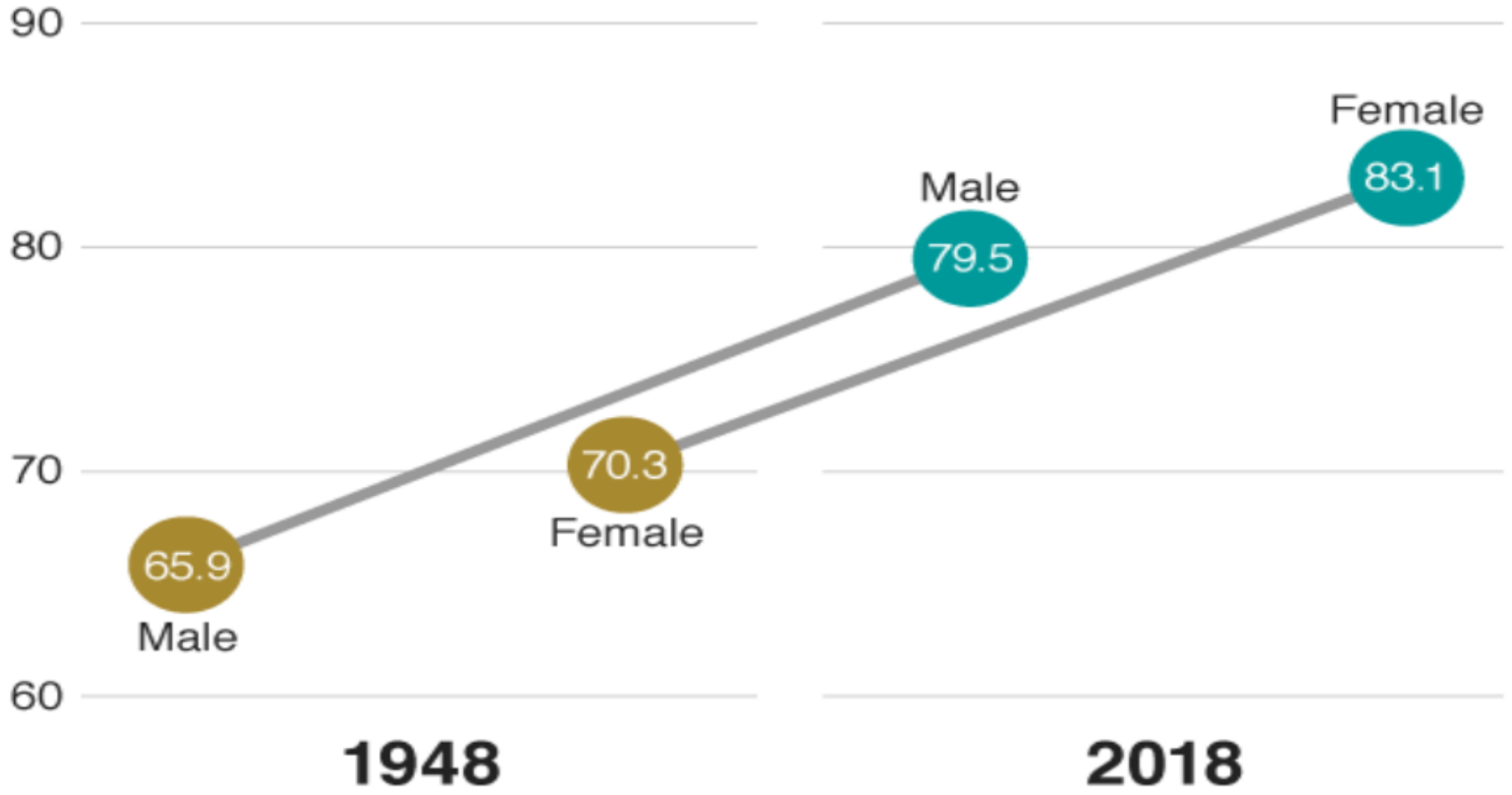
WHAT IS WMQRS

- Part of the NHS available Nationally.
- Supporting organisations to improve quality.
- A range of bespoke approaches driven by local need.
- Peer to Peer process with strong clinical and patient engagement.
- Undertaken by Clinicians and patient/service users
- Provides high levels of assurance and governance for provider and system.
- Design informed by Providers & Commissioners – you chose what's important.
- Evidence Based - Uses clinically developed published standards.
  (WMQRS have over 30 standards & self assessments published)
- Looks at Patient Pathway – not location.
- Exchange of good practice, shared learning and CPD for all involved.
- Published reports with enough detail to drive improvement.
- UKAS accredited (8831) Only NHS healthcare peer review accredited organisation

DRIVERS

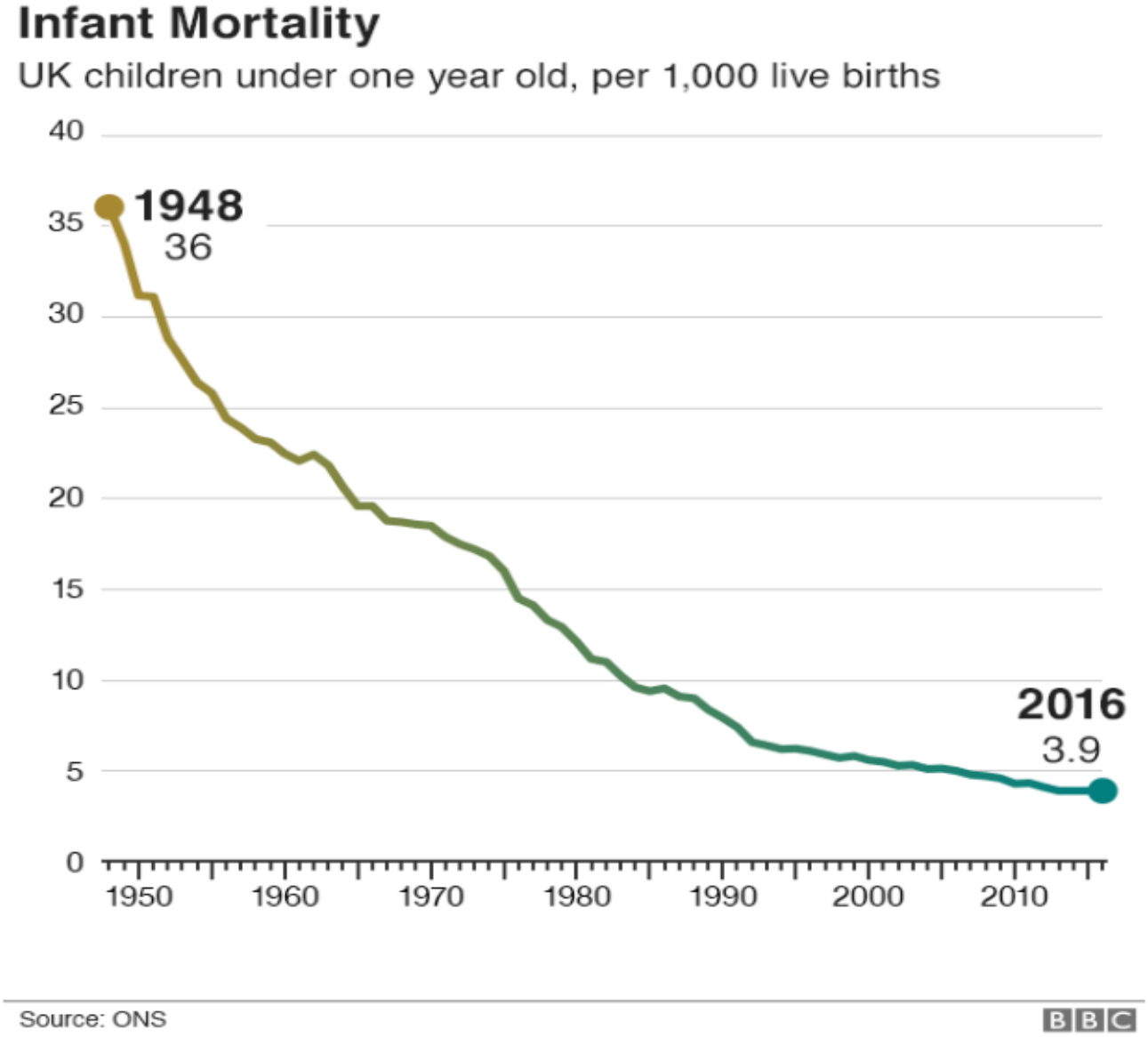
- Continuous improvement is required to sustain the NHS.
- In the NHS, experience is not always shared systematically or effectively, and therefore some people continue to do what has always been done.
- "… the unintended consequence of the current system of assurance is that it creates a culture of compliance and risk aversion which limits innovation within provider organisations" (Ham, 2014).
- To establish a culture of continual improvement staff, need to be empowered, given the time to learn, and the skills to improve and innovate as well as the freedom to do so and trust of those in leadership positions. (The Kings Fund, 2012)

Life expectancy



Source: ONS

BBC


Infant Mortality
UK children under one year old, per 1,000 live births
40
35
30
25
20
15
10
5
0
1948
36
2016
3.9
1950
1960
1970
1980
1990
2000
2010
Source: ONS
BBC

DRIVERS

- Continuous improvement is required to sustain the NHS.
- In the NHS, experience is not always shared systematically or effectively, and therefore some people continue to do what has always been done.
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LEARNING AND IMPROVEMENT

- “the most important single change in the NHS…would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.” (Berwick Report, 2013, p5)

- Prof Sir Mike Richards (Care Quality Commission, 2017) suggested a move away from insular approaches towards an active sharing of learning between organisations as a vital way to drive improvement. He advocated peer review and transparency as a way of inspiring and encouraging others as well as sharing best practice and supporting others to adapt processes to their own needs.

CQC review of the state of care in acute NHS Hospitals 2017

THE BUURTZORG MODEL

Founded by Jos De Blok, the central mandates of the Buurtzorg philosophy are:

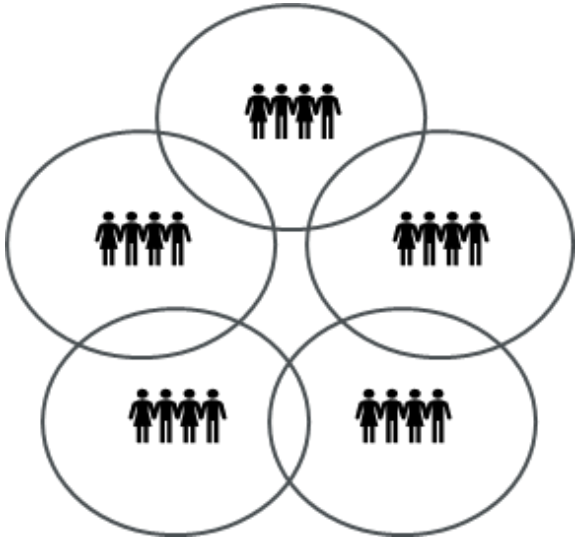
- A focus on community resources and on community capacity building
- Trust on the individual practitioner's craftsmanship, focusing on the needs of the client in a holistic rather than a task orientated manner
- Shared responsibility between employees
- The importance of team working, reflection and dialogue
- Trust in the motives of front-line staff and their desire to improve care for patients

SELF IMPROVING SYSTEM CHARACTERISTICS

- Greater autonomy to resolve problems and constraints. A greater emphasis on professionalism and trust.
- Those in the system will maximise their own experience and those of colleagues.
- Strong networks that allow short-life working bonds to find solutions.
- Those receiving services will be a partner in care – not just a recipient.
- There will be a focus on holistic approach rather than task based. Much of their time will be spent on the task, and less time spent measuring the process.
- Share their learning with others. Less concerned with credit and glory and more concerned with achieving a good outcome (who ever does it).

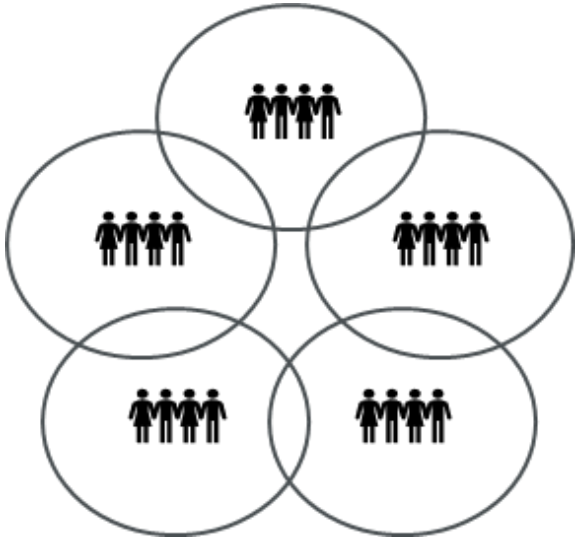
SELF IMPROVING SYSTEM CHARACTERISTICS

- Learning from poor outcomes, but also learning from good outcomes
- Independent teams with a small core team size (max 12-15 members), with each locality operating around 10-12 teams.
- Internal/external support (coaching) to help people find solutions – NOT to help them do the job.
- Reduced bureaucracy (smaller admin functions).
- Reliance on IT solutions (enter once – use many times) and use of technology.



IMPROVEMENT OPPORTUNITY

- The relationship between teams is the opportunity for shared learning, quality improvement and development.
- Networks are developed with neighbouring teams; and through them to wider networks.
- The point of overlap of teams gives an opportunity for peer review, learning, improvement and development in a developmental setting.



PEER REVIEW

"The creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement"

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary (2013, p.76)

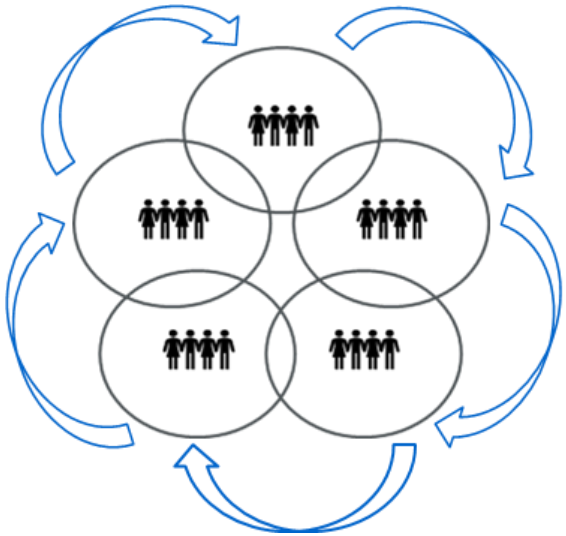
Integrated Community Teams

Demonstration of compliance: BI- Background Report; V - Visit; MP&S- Meeting Patients and Staff; CNR -Case Note Review; Doc- Document

Ref Number	Demo of Compliance	Quality Standards	Notes on Quality Standards	SA Met?	SA Comment
MK-101	Visit MP&S Doc	**Service Information** Each team should offer patients and, if appropriate, their carers written information covering: a. Role of the team b. Staff available d. How to contact the team for help and advice, including out of hours e. How to complain about the team including details of where complaints should be directed	1 Information should be written in clear, plain English and should be available in formats and languages appropriate to the needs of the patients. 2 Information may be in paper or electronic/e-learning formats. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers. 3 Information may be combined with condition-specific information (QS MK-102).		
MK-102	Visit MP&S CNR	**Condition-Specific Information** Patients and, if appropriate, their carers should be offered up to date, written information about their condition and its impact covering: a. Brief description of the condition and its impact b. Possible complications and how to prevent these c. Interventions offered by the team and possible side-effects d. Symptoms and action to take if unwell, including out of hours help and advice e. Sources of further advice and information	1 As QS MK-101 notes 1 and 2. 2 Information may be in the form of national or locally produced booklets and combined with service information (QS MK-101).		
MK-103	Visit MP&S CNR	**Holistic Care** Information and support should be available covering at least: a. Local services available to provide help, support and care b. How to access a directory of local services c. Maintaining a healthy lifestyle and preventing harm: i. Memory loss ii. Nutrition and hydration iii. Maintaining mobility, including exercises iv. Falls prevention v. Preventing and managing incontinence vi. Skin and foot care vii. Managing medication, including reducing polypharmacy d. How to access an advocate e. How to access advice on: i. Mental capacity and Deprivation of Liberty Safeguards ii. Power of Attorney iii. Advance Care Planning iv. End of Life Care f. Support available for carers g. Availability of assistive technology h. Relevant national groups and organisations i. How to give feedback on support and care received	1 As QS MK-101 notes 1 and 2.		

PEER REVIEW – THE QUALITY ASSURANCE APPROACH

- Review and agree standards of care (what does good look like)
- Train individuals and teams to review
- Team A - reviews B - reviews C



- Shared learning
- Peer Review is NOT audit
- Assures high quality practice
- Peer review and shared learning provide assurance of quality
- Teams and individuals that are struggling get supportive help

BENEFITS *RUSHMER ET AL. (2004)* *DRENNAN ET AL. 2017*

- Patients
  - positive feedback personally from patients, GP's and other health professionals ().
- Outcomes
  - GP's and other HCP's in the GSTT trial were positive. GP's able to illustrate significant quantifiable improvements in patient's condition as a result of the nurses' work with them. These had not been achieved by any previous health professional involvement with the patients.
- Staff
  - Staff feedback from the GSTT trial was positive; the nurses took great satisfaction in their direct work with patients and being able to provide "good holistic care".
  - improved morale
  - staff retention
- Service
  - teams more productive /increases flow as blockages caused by waiting for the availability of an individual are reduced as the task can be carried out by another
  - building capacity within the team to make a difference


When the best leader's work is done the people say, 'We did it ourselves.'
– Lao Tzu

The Strategy Unit.

Peter Spilsbury: Director, The Strategy Unit

A pause for thought....

NHS
Midlands and Lancashire
Commissioning Support Unit

“The decision was made to provide individuals, their families, and neighbourhoods with a team of practitioners that would both coordinate medical care and lead health promotion efforts based on evidence gathered about the specific health problems faced by the population in their geographically determined catchment area.

In effect, the principles of public health and clinical medicine were combined into a single professional duo emphasizing prevention and epidemiologic analysis with improvement of individual and population health outcomes as the central purpose.”

1980

NHS

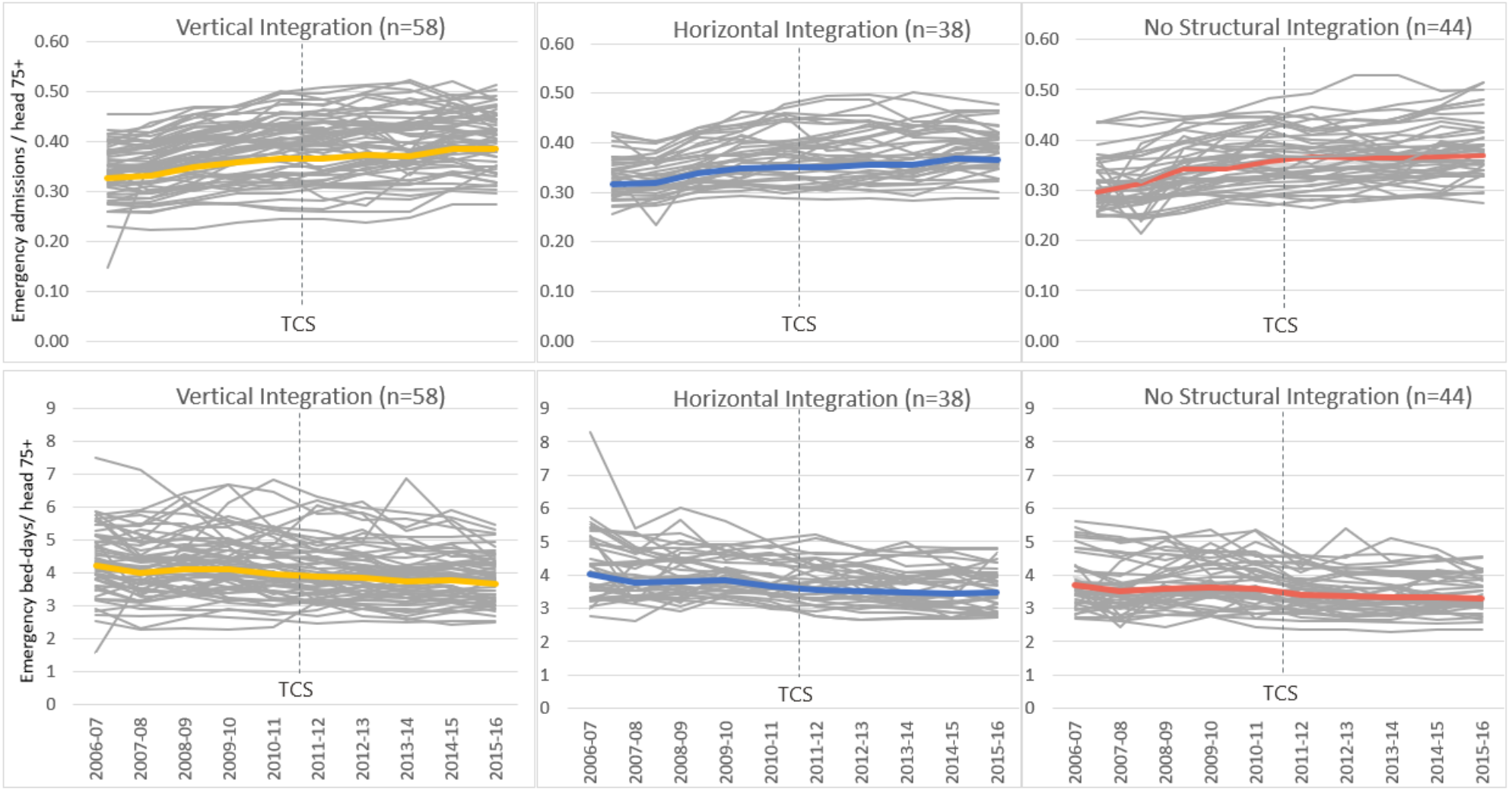
Cuba

(National Health System)

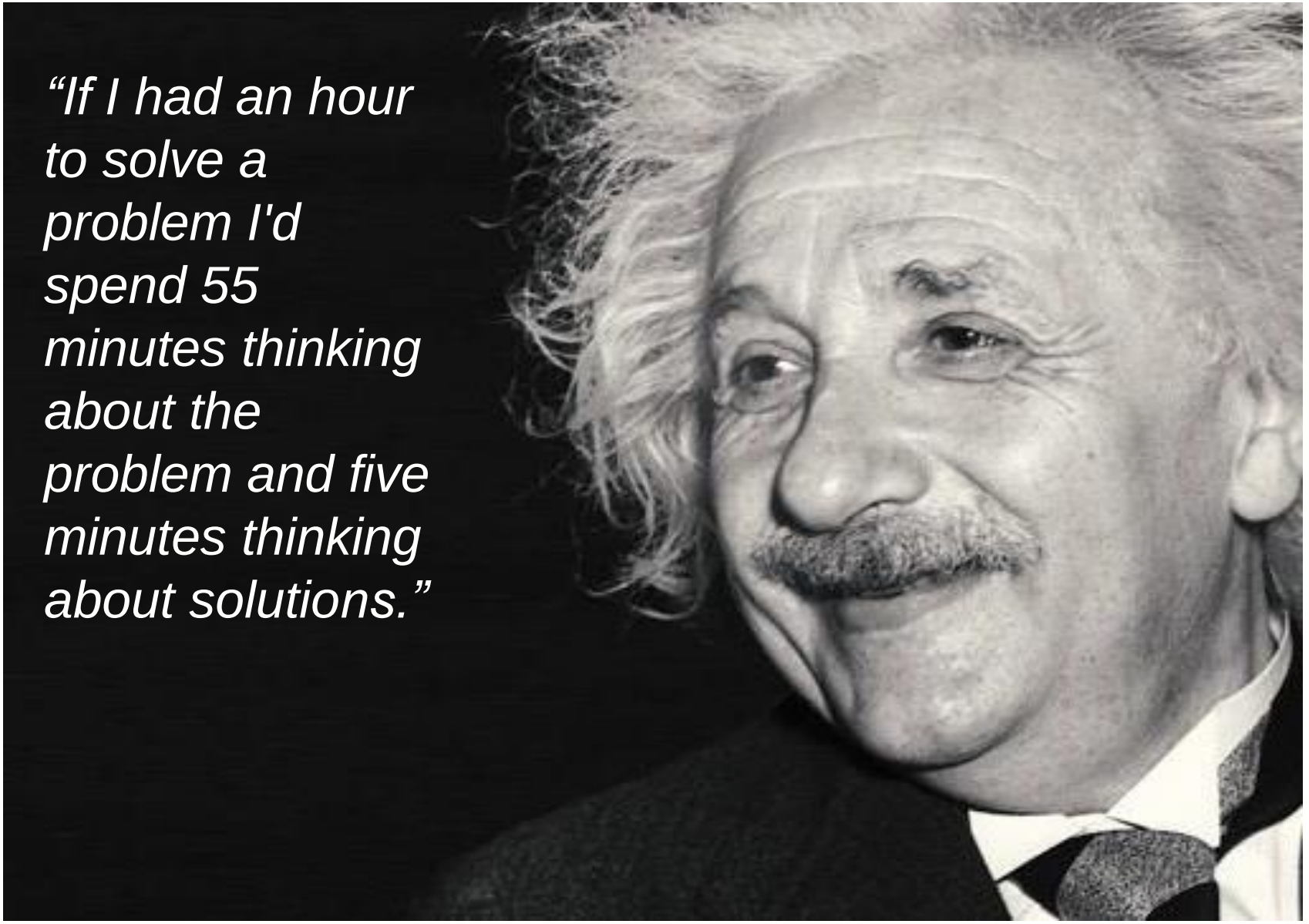
http://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.300822

Trends in Emergency Admissions and Bed-days Rate per Head of Population 75+

(Grey lines represent individual PCTs, coloured lines represent the aggregate rate across the PCTs in each group)



“If I had an hour to solve a problem I'd spend 55 minutes thinking about the problem and five minutes thinking about solutions.”



Locality or 'place based' working is expected to play a critical role in solving many enduring challenges

Reducing demand for urgent care, recognising/addressing interaction of factors beyond 'illness' alone

Reducing the occupancy of hospital beds by people who could be better cared for in a less intensive way;

Removing disruptive hand-offs and duplication

Addressing wider determinants of health/health literacy

Tackling the mental health/physical health divide

Reducing intensive acute utilisation in end of life care

Enabling confident self-management

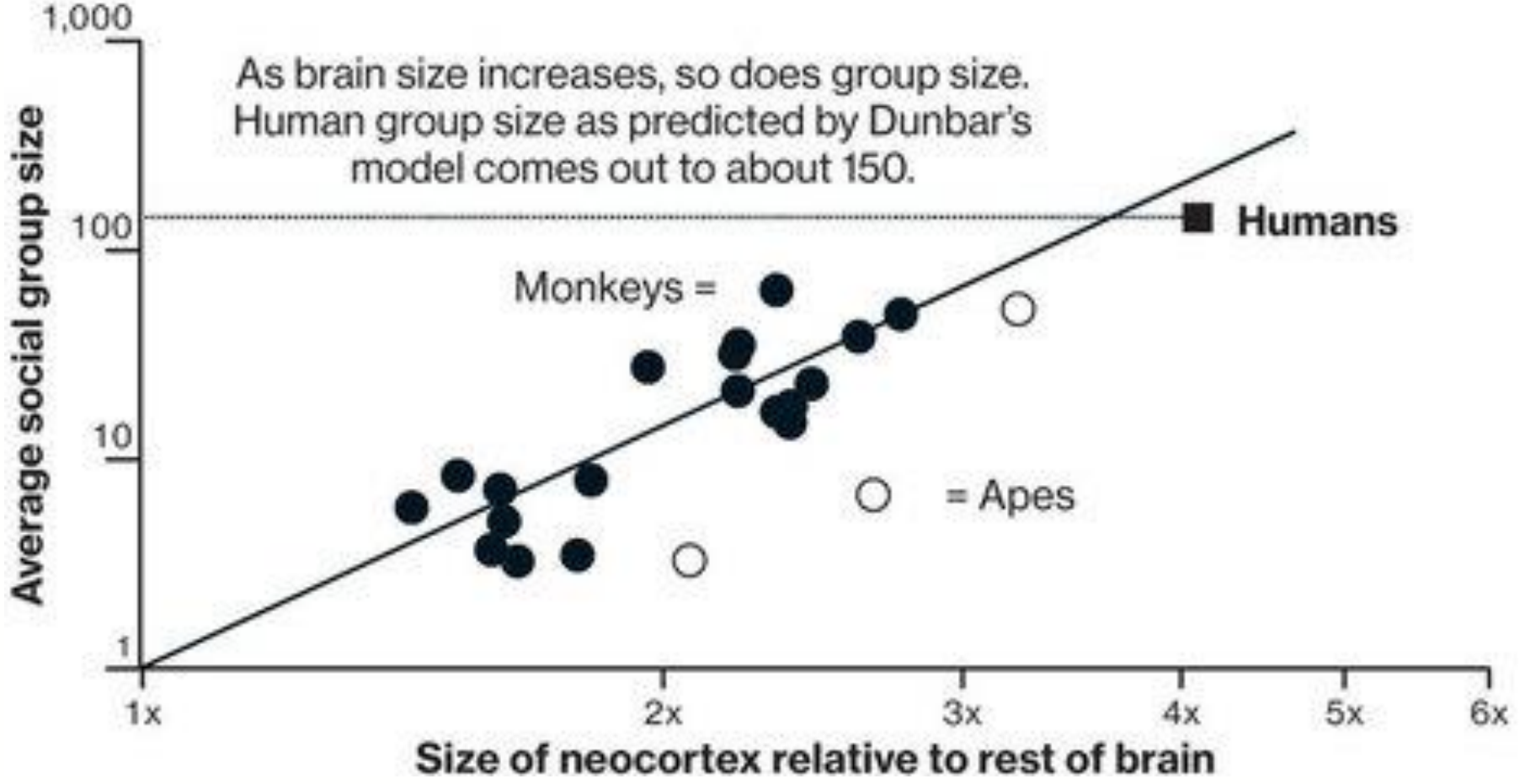
In doing all these, there is a need to improve access to high quality, resilient enhanced primary care.

Why do people think ‘locality’ or ‘place based’ working is important?

In what ways do they think it will allow the problems of today and tomorrow to be more effectively tackled?

No agreement on ‘theory of change’

The Social Cortex




LOCAL
SHOP


THIS IS A LOCAL SHOP
FOR LOCAL PEOPLE THERE'S NOTHING
FOR YOU HERE

Summary findings - strategic

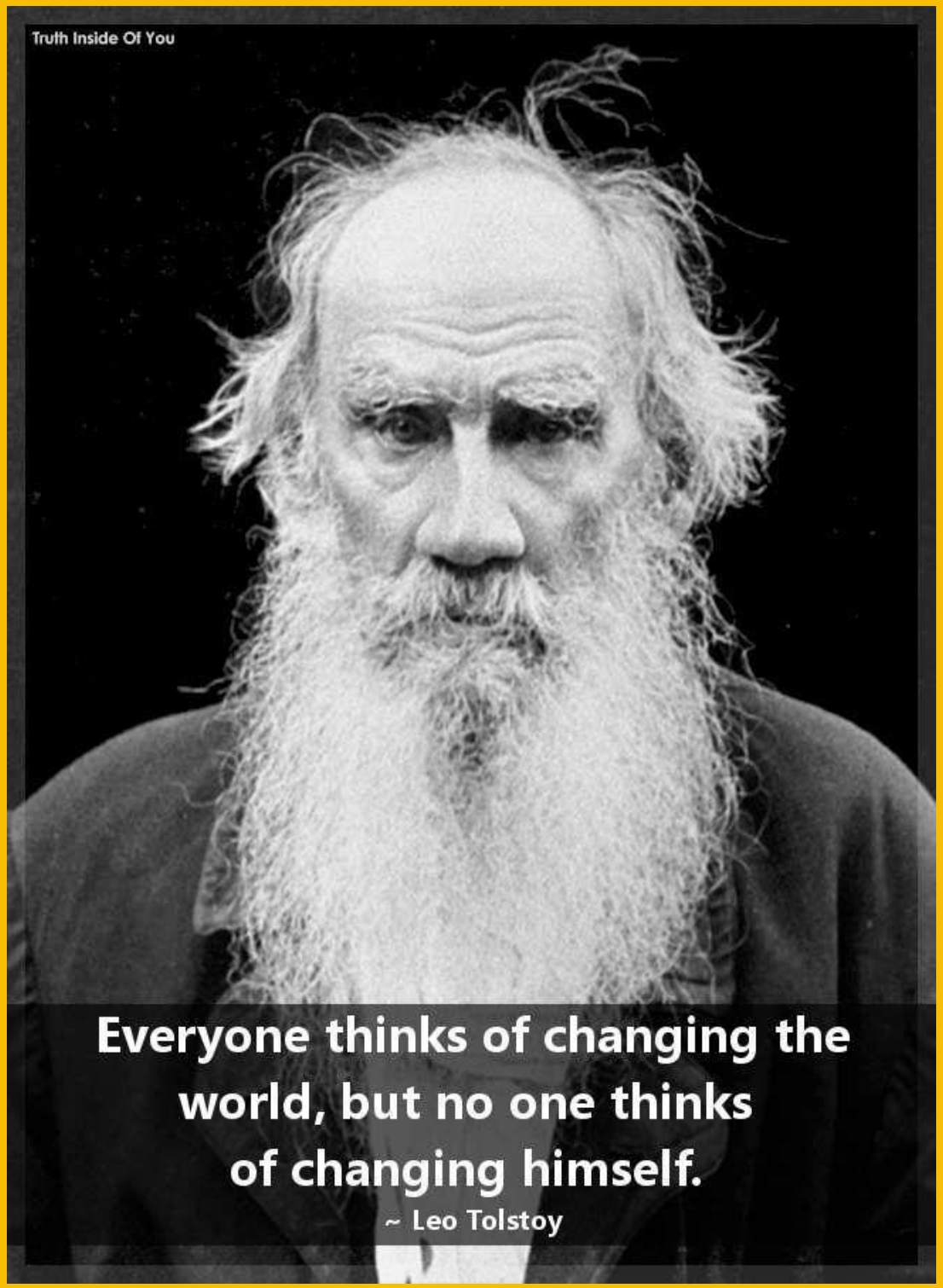
- **No common view amongst leaders or localities on the definition of 'localities' and their role** within the system.
- **Communication between the 'system' and strategic/locality leads was poor** – trust has been damaged as a result.
- **Few system leaders could name localities/knew their leaders/knew what they were trying to achieve and why**.
- **Locality leaders are not sufficiently visible**, typically 'not at the table'

Summary findings - localities

- Localities were **unaware of and don't necessarily 'buy in'** to the strategic direction of travel towards place-based care.
- Locality working is in most places limited to **a monthly primary care meeting**
- **No system level agreement or understanding** on the extent of management resource that is/should be available to drive locality working
- **Little engagement** or understanding from other providers or local government for locality working
- **Third sector are not 'designed in'** in most places – reported being reduced to making 'pitches'
- **Little by way of structured public/patient engagement** in locality working

Conclusions

The most significant gap is the lack of a clear, shared rationale (theory of change) to drive design, development and operational considerations.


Truth Inside Of You
Everyone thinks of changing the world, but no one thinks of changing himself.
~ Leo Tolstoy

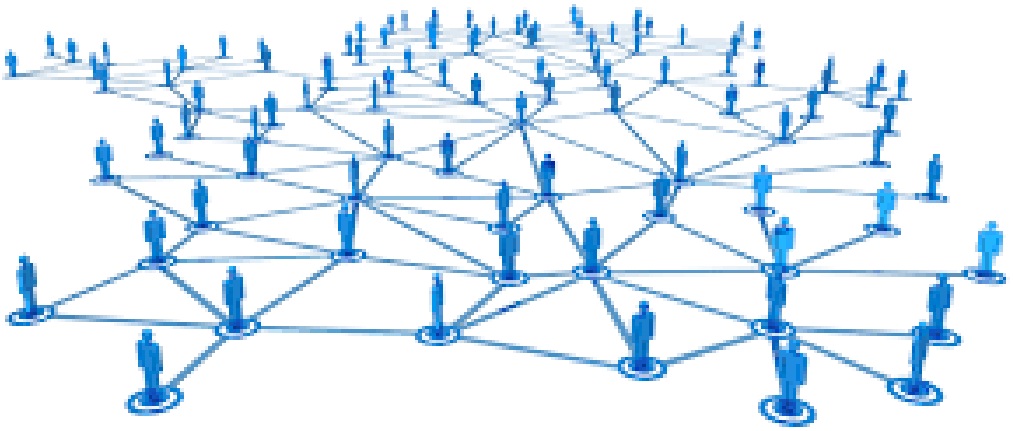
The ‘Un-Conference’

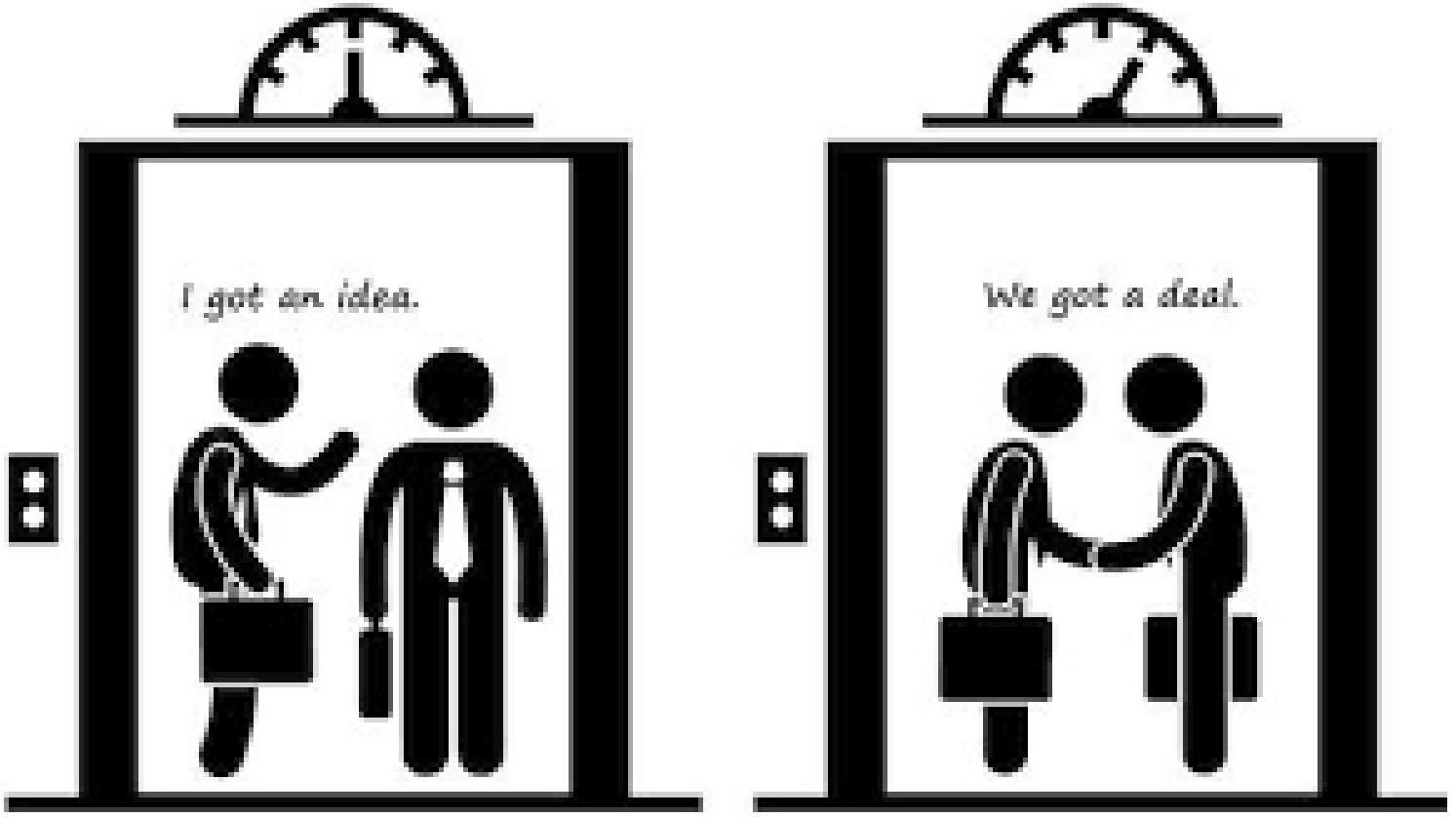
Lucy Hawkins – The Strategy Unit

Process

Given what we've been talking about today what would you like to see next from this network?

You have 5 minutes to discuss on your tables and then each table will make a 30 second pitch for their idea




I got an idea.
We got a deal.

Unconference principles

1) Whoever comes are the best people who could have come
2) Whatever happens is the only thing that could have happened
3) It starts when it starts
4) It's over when it's over

The Law of Two Feet

"If you are not learning or contributing

then find somewhere you can"

Idea:	
Why is it needed:	**What will the benefits be:**
Who is it for:	**How will it happen:**

Reflections on the day

Peter Spilsbury

The Network goes on……..

Next Event – 11 October 2018