REGISTRATION OF INTEREST- Fylde Coast New Models of Care

Q1. Who is making the application?

(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)

Applicant: Fylde Coast Local Health Economy which includes the following statutory organisations:

Blackpool CCG
Blackpool Teaching Hospitals NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Fylde and Wyre CCG
Lancashire County Council
Blackpool Council

Additionally, we would wish the panel to note that, although our application does not specify individual organisations, our programme also encompasses provision by voluntary & 3rd sectors.

Contact: Andy Roach, Director of Transformation and Integration Blackpool CCG and Programme Director - Fylde Coast New Models of Care Programme. (andy.roach@blackpool.nhs.uk or telephone 01253 956653)

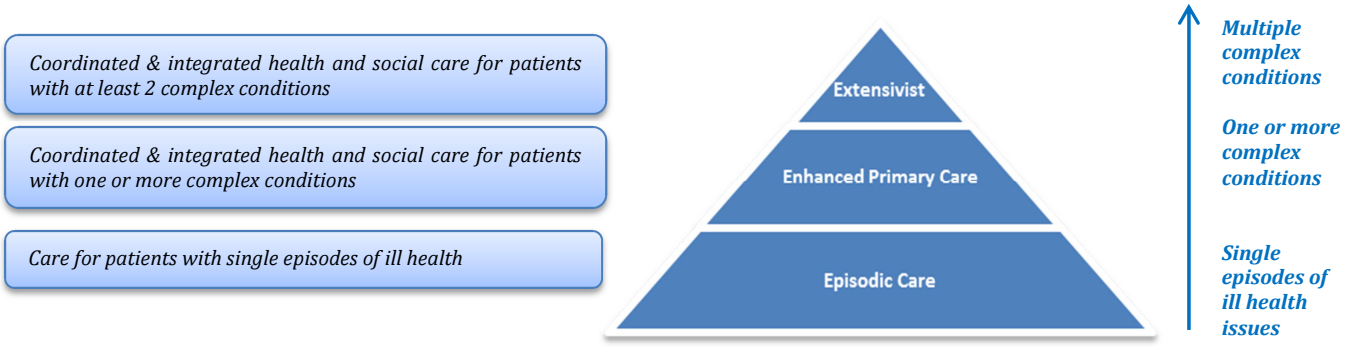
Q2. What are you trying to do?

(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

The vision for the Fylde Coast is to; create new models of care, wrapped around local populations, spanning across health and social care, to improve jointly the health and wellbeing of the Fylde Coast population, whilst maintaining financial stability. Our initial analysis (2014) of the Fylde Coast population shows that a substantial proportion of the healthcare resources are spent on a few patients only, notably those with multiple long term conditions. The evidence and examination of successful international models have shown an opportunity to deliver different models of care.

Our principle changes are to integrate community services and social care with primary care. This will reduce hand-offs, enable effective sharing of information and reduce the reliance on unplanned, reactive care currently delivered in a fragmented way.

In addition to this we are establishing a number of Extensive Care Services focused on elderly/frail populations which will free up capacity in general practice.



Enhanced Primary Care – we will provide primary care at scale by integrating all community services and primary care teams. Providing care to neighbourhood registered populations, patients will have a single point of access for all out of hospital care needs. Integrated Neighbourhood Teams will be using shared records and coordinate their workload to target patient needs effectively. They will ensure there are no gaps in service for patients to fall through.

Extensive Care – Our analysis demonstrates that 3% of our population uses 48% – 55% of our secondary care expenditure. Extensive Care teams with a range of clinical and non-clinical roles will provide proactive care with the explicit aim of reducing the proportion of income supporting this cohort of patients. The team will intensively manage long term conditions along evidence based pathways and coordinate care, with a single point of access to reduce the need for these patients to seek unplanned care.

Our community will have a care system which is orientated around their needs; care will be coordinated and integrated so that the system is simplified. Our care will overcome organisational divides so that provision across health and social care becomes seamless. There will be a beneficial impact on families and carers so that improvements in health and wellbeing are more widespread.

Our staff will be empowered to work across the traditional demarcations between health and social care. They will be connected to the community within which they work and navigate the system to coordinate care. Hand-offs will reduce and silos will be removed. Our plans include the development of new clinical and non-clinical roles, including training and development. There will be a Single Point of Access with a shared health record so that all clinicians will have access to the whole care history.

Benefits Realisation plans make explicit expectations that there will be reductions in unplanned admissions, out of hours contacts, A&E attendances and Outpatient referrals. We expect that more effective use of resource will generate capacity to improve access. Overall, we intend to shift the equivalent of £18m from secondary care expenditure to out of hospital services. Investment plans are in place to pump-prime developments 2015/16 with savings being realised and reinvested from 2016/17 onwards.

Q3. Which model(s) are you pursuing? (of the four described)

Multispecialty Community Provider - during 2014/15 the Fylde Coast Programme has taken a clinically led approach to the development of new models of care. Progress so far has focussed entirely upon models of care rather than organisational form but we anticipate that changes in form will follow implementation.

Q4. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

During 2014/15 we have progressed as follows in the following areas:

Planning

- All partners (commissioning, providers, health and social care) are committed to the implementation of New Models of Care
- Established a New Models of Care Programme Board with executive representation from all partners
- Established our governance structures and assurance processes
- Identified investment which is included in our 5 year planning assumptions
- Translated international models into clear implementation plans
- Invested in a Programme Management Office headed by a Programme Director
- Commenced the implementation of shared access so all patients records in EMIS web are available to view by clinicians in A&E, AMU, medical wards, urgent care and out of hours GP services.
- Developed an evaluation methodology (with support from NHSE) to establish evidence base through the early implementer sites for Extensive Care Services

Enhanced Primary Care

- Neighbourhoods of GP practices are developed.
- Multi-disciplinary teams integrate the practice team with community nursing

Extensive Care

- Funded significant protected time for senior clinicians to develop service models
- Developed a Clinical Blueprint for Extensive Care Service for our frail/elderly population
- Defined patient cohorts using risk stratification to analyse patient numbers across the new models of care
- Have identified sites
- Started recruitment
- Have confirmed go-live dates for two Extensive Care Services for April 2015)

Care Records

- A new care record system is being implemented across our community services meaning that a system for

shared records across community and GP provision will be implemented by April 2015

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

(Please describe the changes, realistically, that could be achieved by then.)

Enhanced Primary Care in April 2016 will be:

- Fully implemented throughout all of our neighbourhoods so that our integrated teams comprise of:
  - Community Nursing
  - Allied Health Professionals
  - Social Care
  - Mental Health
  - 3rd Sector

Extensive Care in April 2016 will be:

- Caring for 1000 people within our two Extensive Care Service early adopter sites.
- Have developed learning from our implementation and evaluation methodology to develop the model and create an evidence base
- Have finalised the Extensive Care model for the whole of the Fylde Coast, based on risk stratification & patient numbers
- Begun rollout of Extensive Care in remaining neighbourhoods across the Fylde Coast

Care Records

- Fylde Coast is part of the EMIS pathfinder initiative to develop systems specifically designed for MCPs. This will deliver a system to provide a single care record for teams which will be integrated with wider health and social care partners.

Q6. What do you want from a structured national programme?
(Aside from potential investment and recognition: i.e. what other specific support is sought?)

Consistent with the needs we have already discussed as part of the New Models of Care Network, partners in the Fylde Coast would seek support in the following areas:

- Support to further the organisational development of out of hospital providers
- Provide a structured programme of independent support for providers (including small, medium and voluntary sector) to think innovatively about:
  - How they respond to the development of New Models of Care
  - Considering the future market place, both threats and opportunities
  - Considering the future contracting models, organisational models, operating models, service offers and strategic partnerships
- Support with information governance with Social Care to enhance the sharing of information.
- Support for IT providers for specific issues we encounter in developing single care records
- Support to develop and implement our Evaluation Methodology to develop the evidence base from the implementation on the Fylde Coast.
- Connection to other sites in the national programme to develop our models of care and create shared learning.
- Organisational development support for the development of the necessary skills in our workforce
- Support for whole systems change and integration to optimise the benefits of our plans
- Support to navigate competition rules which may put barriers in our way when developing MCPs.
- Facilitation of new contractual arrangements and associated financial frameworks
- Non-recurrent funding would significantly accelerate our implementation plan and achieve change at scale and pace