Greater Manchester, Lancashire and South Cumbria
Clinical Senate

Report of the Greater Manchester, Lancashire & South Cumbria Clinical Senate and Better Care Together Programme

Deep Dive Workshop

Date: 1st September 2015

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Greater Manchester, Lancashire & South Cumbria Clinical Senate

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1. Introduction

1.1 The Clinical Senate and Lancaster North CCG's transformation programme, Better Care Together (BCT), agreed to work together to host a workshop that aimed to examine to explore in depth how the health and care services in Morecambe Bay could move at pace toward the development of an accountable care system that was focussed on population health.

1.2 The purpose of the day was to use the collective wisdom of the clinicians and managers in the room, and to develop practical objectives and recommendations that the programme leaders could use to progress the work. The objective of the workshop was to consider 'How all health and care providers can take a population health approach?'

The Better Care Together **approach to population health is based on the following 'equation':**	The workshop focussed on **following <u>key themes</u>:**
Integrated health and care providers practising population medicine **+** **Populations mobilised at scale for health and wellbeing** **+** **The right drivers in the system to make this happen – an accountable care system with a capitated budget for the 365,000 people across Morecambe Bay**	• Integrated health and care providers, *what do we mean by this*? • *How* do we mobilise communities at scale for health and wellbeing? What is the role of our 12 integrated core teams (place based approaches)? • Changing the drivers in the system – what is the role of capitated budgets, what about other drivers e.g. around primary care and community services? • Evaluating our approach, what do we *measure*?

Amongst the questions asked at the workshop was 'what should the programme leaders do in the next 6-12 months to make it worth the investment of your time today?
This report contains the recommendations from the workshop in response to that question.

2. Methodology

2.1 On the 1st September 28 senior health and care professionals from the Clinical Senate and Better Care Together attended an afternoon workshop to give their advice and expertise (Appendix I). Attendees represented a wider range of clinical expertise, third sector, commissioning and local authority.

2.2 The workshop was designed using a three step approach that allowed attendees to consider key questions in relation to each of the four themes. Initially presentations were given that set the scene and current context of the health and care system in Morecambe Bay; including challenges faced and a review of accountable care organisations.

2.3 The second part of the agenda was given over to an interactive workshop where attendees considered questions relating to the main themes on their own. This was followed by group discussions of the individual responses and finally a wider open discussion with the whole room to capture the main learning points and top three objectives from each theme that emerged.

2.4 Qualitative data from flipcharts, notes and tape recordings of discussions were collected and analysed to produce the final recommendations.

3. Results - Summary table of recommendations made for each theme

3.1 The workshop produced a large amount of qualitative data[1] from which the final recommendations were drawn. The table below provides a summary of the final recommendations each working group made in relation to each theme. Further contextual information is available within the body of the report.

No.	Recommendation – integrated health and care providers	Date
1	Develop a single definition and narrative for population health and integrated care, publish and share widely.	
2	Develop a population profile for each of the twelve localities that can be used to design interventions that are bespoke to each area.	
3	Develop an engagement plan for each of the twelve localities to include practical and cultural aspects of communication.	
4	Provide opportunities for meaningful discussion and debate with local people, to engender ownership of health and care issues.	
	Recommendation – mobilising communities at scale	**Date**
5	Each locality engages with community and presents information relating to the current picture of health and care in the area and are tasked to set priorities for action.	
6	Assess leadership commitment for a) understanding of this approach, and b) what they need to do to deliver it, developing communication and training as required.	
7	Each locality works to develop its approach, and sets mission and value statement that supports their stated ambition so that it can be communicated widely.	
	Recommendation – changing drivers in the system	**Date**
8	Map out all current drivers within the system, making an assessment in relation to outcome produced by the driver and its value in the new system	

[1] For full supporting information and transcripts of detailed outputs of the workshops contact Rachel Ball, PDO Administrator, Better Care Together Clinical Strategy Programme, Rachel.ball@mbht.nhs.uk

9	Fully engage and consult with local professionals and public in the development of a set of new drivers	
10	Reframe visions of health and wellbeing to a single aspiration that encompasses all players in the system, i.e. 'no child misses school due to asthma'	
11	Develop a set of drivers that focus on prevention, not how quickly patients are treated and discharged	
12	Identify quick wins and show results	
13	Adopt a quality improvement methodology to test and measure improvement consistently, i.e. breakthrough collaborative	
	Recommendation – evaluation and measurement	**Date**
14	Engage local public and professionals in the development of a set of quality improvement measures that are meaningful to them	
15	Each measure describes how it improves quality between organisations	
16	Publish quality performance measures and provide opportunities for debate and translation of meaning with professionals and the public	
17	Describe how each measure drives quality improvement	
18	Use quality improvement methodologies, i.e. run charts and SPC to present data for improvement	

3.2 Results – Integrated health and care providers

3.2.1 It was recognised that there is a current lack of awareness, and variance of understanding, of population health approach and integrated care varies across the health and care system. This was evident from discussions and from the pre-workshop survey and from the workshop.
The terminology used can be confusing to the lay person and as a result, there is a risk that localities, teams and individuals will interpret what it means differently. Therefore, we need a common understanding and shared narrative of what it is developed and communicated widely. This is so that everyone can speak the same language when discussing it in the various contexts that it needs to be communicated in.

a) It is vital that we recognise that not one size fits all, and the development of an engagement plan for each of the twelve localities is developed, and properly resourced that includes addressing any competencies gaps and cultural change issues so that it can be done respectfully.
b) Financial drivers to support this was identified as crucial in promoting integrated care but it was difficult to crystalize an objective in relation to this during the time in the workshop. This is something that requires a focus as getting the rewards within the system will be essential.

c) In order to understand the diversity and tailor approaches accordingly, it will be necessary for each of the twelve localities to develop a population profile that will describe the characteristics of each area so that provision can be tailored to suit the needs of each area.

d) In terms of practicalities, and learning from other areas, the following should be considered:
   - Programme Management Office approach to development
   - Developing a social movement
   - Identifying and communicating what, for each locality, is the common issue that the community can get behind to build momentum for change.

No	Recommendation – integrated health and care providers	Date
1	Develop a shared narrative for population health and integrated care, publish and share widely.	
2	Develop a population profile for each of the twelve localities that can be used to tailor interventions.	
3	Develop an engagement plan for each of the twelve localities to include practical and cultural aspects of communication.	
4	Providing opportunities for meaningful discussion and debate with the local people, to engender ownership of health and care issues.	

3.3 Results – Mobilising communities at scale

3.3.1 In mobilising communities it is important that the communities themselves are involved in defining priorities. Therefore, communities need to be identified, engaged and provided with up to date information that gives a real time picture of outcomes and any variation so that they can be included in deciding what is important, and involved in deciding what to do about it. In essence, there needs to be a cultural shift that ensures that local people are seen as assets and mobilised to support and help in setting priorities. In setting objectives for this area, the workshop concluded that:

a) Leadership and commitment to mobilising communities' needs to be demonstrated at all levels, everyone has to understand what this is about.

b) Community engagement is important in delivering this but we need to understand what we mean by this, and how it is defined.

c) It is important to be aspirational in this, essentially designing a social movement, and so ask the question 'how brave do we want to be?

No	Recommendation – mobilising communities at scale	Date
5	Each locality engages with community and provides information relating to the current picture of health and care in the area and tasked to set priorities for action.	

6	Assess leadership commitment for a) understanding of this approach, and b) what they need to do to deliver it, developing communication and training for each area as required
7	Each locality works to develop its approach, and sets mission and value statement that supports their stated ambition so that it can be communicated widely.

3.4 Results – Changing drivers in the system

3.4.1 From the discussions and information gathered there were a lot of comments about existing drivers that people wanted to move away from, and not so many new drivers. There were some drivers that it was felt should be removed, i.e. the four hour target for A&E. However even with the flexibilities of being a vanguard it was recognised that this indicator is unlikely to change and we will still have to meet certain core national standards.

Following discussions, the following principles emerged from the workshop:

a) Understand all current drivers within the system, both good and bad
b) It is important that there is local engagement in the development of any new drivers in order to engender ownership of them.
c) It will be necessary to make changes to how services are commissioned and purchased; working around prevention and not how quickly you can get patients treated and out.
d) Any drivers developed should make everyone across the system interested.
e) It will be necessary to reframe our drivers, so that all players in the health, social care, education and local authority systems are interested. For example, drivers follow aspirations and visions that can be set and owned across systems, such as: 'no child misses school due to asthma'
f) In terms of practicalities, the following should be considered:

- Identify all existing drivers in the system, both good and bad.
- Be prepared to challenge existing targets that are not helpful.
- Reframe visions of health and wellbeing to a single aspiration that encompasses all players in the system, e.g. 'no child misses school due to asthma'
- Identify quick wins to promote engagement, showing how drivers can be changed and ideas implemented.
- Engage with staff and public in each of the localities across the patch, demonstrated by green shoots of social movement in every locality across the area. If there is no evidence of this after six months ask why not?
- Adopt existing improvement methodology, i.e. breakthrough projects, PDSA as a model improvement for projects and to test changes.

No	Recommendation – changing drivers in the system	Date
8	Map out all current drivers within the system, making an assessment in relation to outcome produced by the driver and its value in a new system	
9	Fully engage and consult with local professionals and public in the development of a set of new drivers	
10	Reframe visions of health and wellbeing to a single aspiration that encompasses all players in the system, i.e. 'no child misses school due to asthma'	
11	Develop a set of drivers that focus on prevention, not how quickly patients are treated and discharged	
12	Identify quick wins and show results (green shoots of social movement in each locality)	
13	Adopt a quality improvement methodology to test changes and measure change	

3.5 Results – Evaluation and measurement

3.5.1 Over the course of the afternoon, a recurring theme of engagement has emerged and as a result the findings of the workshop include:

a) Each community is given the opportunity to identify outcomes and measures that are relevant to the places themselves. This means that each locality is given the opportunity to input into the design the measures and outcomes and ensure that they are included in any final portfolio of measures and standards.

b) Measures chosen must support the quality improvement of care and experience between organisations, and not just within one organisation.

c) It is important that we share and learn from the measures collected; therefore we should publish performance and quality measures with the population. In addition to publishing measures, opportunities for translation and discussion with the public and professionals in relation to the measures are created.

d) The measures collected should drive improvement and designed so that they do this. There are different types of measures that are typically used in health and care systems, these include I) quality improvement, II) research and III) assurance; each are presented in a different way for a variety of reasons. Typically, measures for improvement are demonstrated in statistical process control charts, run charts to show and control variation in performance of the systems.

No	Recommendation – evaluation and measurement	Date
14	Engage local public and professionals in the development of a set of quality improvement measures that are meaningful to them	
15	Each measure describes how it improves quality between organisations	
16	Publish quality performance measures and provide opportunities for debate and translation of meaning with professionals and the public	
17	Describe how each measure drives quality improvement	
18	Use quality improvement methodologies, i.e. run charts and SPC to present data for improvement	

4. Summary and conclusion

The Clinical Senate and Better Care Together hosted workshop that was attended by 28 health and care professionals who gave their expertise and time to consider questions relating to how Morecambe Bay move toward an accountable care system focussed on population health. A large amount of energy and enthusiasm was generated in the room that produced a lot of debate which was distilled down to 18 recommendations contained within this document for the Better Care Together leaders to consider.

Appendix 1 – Attendance list

BETTER CARE TOGETHER - MORECAMBE BAY
Deep Dive Workshop – Population Health
1st September 2015

Name	Title
Donal O'Donoghue	GMLSC Senate Council Chair; Consultant Renal Physician and Professor of Renal Medicine, **Salford Royal NHS Foundation Trust**
Juliette Kumar	Senate Manager & OD Lead, Workshop facilitator **GMLSC Senate Council**
Nicola Cook	Regional Manager **Macmillan Cancer Support**
Ian Donaldson	Consultant Critical Care/Anaesthesia, **Lancashire Teaching Hospitals Foundation Trust**
Graham Spratt	Consultant Clinical Psychologist **5 Boroughs Partnership NHS Foundation Trust**
Vats Patel	Pharmacist **Senate Council**
Angela Douglas	Scientific Director, Cheshire and Merseyside Genetics Service **Liverpool Women's Hospital**
Angela Manning	Assistant Medical Director, Medical Directorate **NHS England (Lancashire & Greater Manchester)**
Helen Hurst	RGN BA Msc PhD Advanced Nurse Practitioner, CAPD unit **Manchester Royal Infirmary**
Sakthi Karunanithi	Director of Health Protection and Policy **Lancashire Local Authority**
Dr Shyam Mariguddi	Consultant Paediatrician with Epilepsy Interest **Senate Assembly**
Andrew Wardley	Consultant Medical Oncologist Clinical Director of The Christie NIHR/CRUK Clinical Research Facility **The Christie NHS Foundation Trust**
John Patterson	General Practitioner **NHS Oldham CCG**
Carole Gavin	Consultant in Emergency Medicine and a Forensic Physician **Salford Royal Foundation Trust & St Mary's Hospital**

John Howarth	Deputy CEO, Director of Service Improvement CPFT, Better Care Together, Chair of the workshop **Cumbria Partnership NHS Foundation Trust**
Andrew Bennett	Chief Officer **Lancashire North CCG**
Claire Morris	Community Specialist Paramedic **North West Ambulance Service**
Hilary Fordham	Head of Commissioning **Lancashire North CCG**
Emma Foster	Network Director **Lancashire Care**
Jacqui Thompson	Senior Manager, Planning **Lancashire North CCG**
John Miles	General Practitioner **Lancashire North CCG**
Lauren Butler	Manager **Lancashire North GP Federation**
Lisa Moorhouse	Network Director **Lancashire Care**
Marie Bowler	South Cumbria Primary Care Collaborative Business Manager **GP Federation**
Nick Harper	Deputy Medical Director **Blackpool Teaching Hospitals**
Sue Moore	Chief Operating Officer **Lancashire Care**
Amanda Boardman	Clinical General Practitioner Lead **Cumbria CCG**
Anthony Gardner	Director (South Cumbria) **Cumbria CCG**
Colin Cox	Director of Public Health **Cumbria County Council**