

Health and Wellbeing Board

Date of Meeting: 27th November 2013
Report of: Chief Officer, Eastern Cheshire Clinical
 Commissioning Group
Subject/Title: Caring Together Programme

1.0 Report Summary

- 1.1 The attached document is a summary of the work to date to develop the Caring Together Programme across Eastern Cheshire. It is presented to supply the Health and Wellbeing Board members with background information to support their understanding of the development of the programme through collaborative working with multiple partners and its objectives and the current activities and plans.
- 1.2 The Caring Together Programme is a large scale transformational change programme that is aimed at finding and implementing solutions to complex issues which cannot be resolved by individual organisations working alone. As opposed to normal scale change projects and programmes which all organisations are continually engaged in to ensure on-going improvements to their own business delivery.
- 1.3 The paper sets out the Caring Together vision, the case for making a change, and explains the proposition as a context for the current phase of work. This has been in the main taken from a number of sources, *The Framework Document* (circulated in April/May through Caring Together Executive Board members) and *The Strategic Outline Case* (circulated through Caring Together Executive Board members in August 2013).
- 1.4 The current phase of work is to clearly identify the areas for change and to co-design the possible solutions to these issues with clinicians, professionals and the public. These are focussed across the entire health and social care experience from prevention, and living well through community based services wrapped around the needs of the individual patient, through to hospital and specialist services.
- 1.5 It is anticipated that the proposed changes will necessitate a formal public consultation in June 2014.
- 1.6 The Caring Together Programme has secured additional experience and capability through working with external management consultancy McKinsey and Company and Carnall Farrar LLP. These are market leaders in supporting health and social care economies in developing system solutions and bring with them recent NHS experience of undertaking transformational change.

2.0 Recommendations

- 2.1 The Health and Wellbeing Board is asked to note the information within the attached report as a summary of the work of the Caring Together Programme in Eastern Cheshire as a programme of work to ensure safe, sustainable care services for the population of Eastern Cheshire now and for the future.
- 2.2 At the meeting of the Health and Wellbeing Board Jerry Hawker, Chief Officer, Eastern Cheshire Clinical Commissioning Group will present a short animation on the Caring Together Vision and principles and present the key elements from the Strategic Outline Case.

3.0 Reasons for Recommendations

- 3.1 The Caring Together Programme has sought to engage key stakeholders in its development throughout the last 18 months and this report forms part of the continuous process to ensure a wide range of stakeholders are informed and engaged.

The background papers relating to this report can be inspected by contacting the report writer:

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Integrating Care in Eastern Cheshire

A briefing paper for the Cheshire East Health and Wellbeing Board presented for information on 26th November 2013 on the Caring Together Programme in Eastern Cheshire.

Author: Samantha Nicol, Caring Together Director
November 2013

Foreword

There is much to be proud of in Eastern Cheshire. In general, the education, living standards and health and wellbeing of the residents of Cheshire East are good. Our General Practices, hospital, community and mental health services are well regarded and life expectancy across the local population is amongst the best in the country. All health and social partners have a strong and successful track record of working together and a shared commitment to integrated care and improving the health and wellbeing of our shared population.

The local health and social care economy has responded year on year to its financial challenges by achieving increasing higher levels of efficiency whilst trying to maintain its commitment to high standards of care. Published benchmark data reflects these efforts showing Eastern Cheshire as one of the most efficient economies in England, while service innovation can be seen ranging from the Christie at Macclesfield model, to our award winning integrated respiratory service and end of life care.

While much has been done to improve efficiency this has often been done in isolation without an understanding of the wider system impact. We have yet to address the fact that our current system is fragmented, decision-making is disjointed and care for patients is often undermined by organisational complexity, communications undone by poor infrastructure and a failure of IT systems to enable access to single patient records.

As a consequence there remains a serious underlying financial challenge estimated across the wider health and social care to be more than £66 million over the next three years.

There are still significant challenges in sustainably delivering high standards of care; too often patients do not receive the right care, in the right place at the right time.

The scale of the challenge is not just in meeting current demand, but in addressing future demand knowing that the population served by Cheshire East Council and NHS Eastern Cheshire Clinical Commissioning Group is older than the England average. There is a lower proportion of people aged 15 years or under and a higher than average percentage of people aged over 65 years than England as a whole (20% compared to 16%).¹ The overall population of Eastern Cheshire is forecast to increase by about 28,000 by 2035 and the CCG has the fastest growing over 65 and over 85 populations in the North West.

The evidence cannot be ignored, with the national financial outlook unlikely to improve, and funding into Eastern Cheshire equally unlikely to change, the current health and social care system is neither viable nor sustainable.

¹ http://www.ec3health.co.uk/uploaded_files/files/ECCCG_Annual_Plan_2012-13_-_Final_High_res.pdf

Small scale changes are not sufficient; a radical and innovative approach is needed, built on partnership with our staff, clinicians, patients and our communities. Founded on a new way of providing care and underpinned with an honest and transparent approach to what is affordable. There is a recognition that integrated care is a 'complex intervention' where management and organisational processes to support integrated care occur at many levels simultaneously.

All partners in Eastern Cheshire have signed a Memorandum of Understanding that has committed them to work together to develop a new model of care; embracing and integrating services within General Practice, community care, mental health services, hospital care and social care designed around our population, driving up standards, while addressing and resolving the long term financial challenges.

1. Eastern Cheshire's vision

The vision of an integrated care system in Eastern Cheshire has existed for some time. The understanding that radical change must be made to the care system to ensure that the provision of care is sustainable was further informed through international experience and evidence that is being used to inform a new approach to health and social care system and service design. This has included visits to Kaiser Permanente, USA and Jönköping, Sweden.

Overall vision:

'Caring together': Joining up local care for all our wellbeing.

This incorporates the following values:

- Encourages collaborative working between health and social care workers and all other elements of health and social care and other colleagues in the statutory, private, independent,
- voluntary and community faith sector to meet the needs of people, and respecting the needs of staff to achieve this
- Promoting self-care and management, health promotion, education and individual responsibility where appropriate and for professionals and patients and carers to work together with access to the required support facilities to enable this
- Valuing, respecting and enabling the resources we have to deliver this, including infrastructure
- Promoting innovation, and encouraging new ideas from patient, carers and staff
- Development of a community based asset approach.

This can be best achieved by a new integrated care system that is professionally led and publically accountable, driven by quality, collaborative working and empowering patients and staff.

We are taking what we have learnt from the UK and American and European examples; so that we design a system that redistributes health and social care resource away from hospital and residential care to prevention, earlier diagnosis, care planning and case management, thus reducing reliance on costly hospital or residential care beds and providing a wider net of care to support people who need it more efficiently and effectively.

We intend to do this by integrating our health and social care system so that we bring together funding with supply, acute, community and primary care service and with aligned IT systems.

The next stage of development was aimed at establishing a framework for the design of the way services are delivered based on the agreed vision and principles. This has emerged as the four pillars of care.

The *Caring Together Framework* set out aspirations for a new integrated health and social care system, underpinned by four pillars of care



Caring Together shifts care from a reactive and acute¹ to proactive community based

¹ Includes hospital-based, social and mental health acute care
Full explanation of the pillars refer to Caring Together Framework document



Integrating Care in Eastern Cheshire

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Eastern Cheshire's new model of care:

The new system will bring about a shift in care from a reactive hospital based setting to a proactive community based setting, with increased activity in health screening, health improvement and care at home.

It intends to be patient centred and use primary care as the foundation of the new model of care, creating a common view of patients, to drive health improvements by identifying those most at risk and most vulnerable. This will be supported by a care co-ordination service to provide a central point of contact for patient information, co-ordinate a faster and more effective referral process and manage the use of new technologies to monitor some health conditions remotely.

This model enables traditionally hospital based specialists to work more closely with GPs and community services. This will also support health and social care panels to review cases of specific medical conditions and take the lead in the strategic management and design of care services to ensure smooth transitions and effective management of organisational interfaces.

This will enable reduced waiting times for patients by streamlining referral pathways and making consultant opinion more available so that primary care is more confident in managing patients who do not need significant consultant opinion. In turn this will release consultant time so that the patients who need consultant opinion have greater and more frequent access.

This model is based on a locality team approach, these neighbourhood nursing, allied health professional, social work and mental health professional teams will have the skills, knowledge and facilities to deliver community care services that meet population demand, will deliver the majority of support to primary care to deliver local effective care.

An integrated health system that is built from GP lists combined with public health knowledge and hospital and social care information will provide a rich source of data that is very specific to the local neighbourhood – with the potential for profiling by town, postcode and street name. By using this data appropriately to identify prevalence of certain diseases or high risk patients, health and social care services can be tailored to meet local demand or targeted at the most vulnerable groups to reduce inequalities and meet national and local targets.

Appended is a slide describing how patients will experience care differently.

Continuous improvement:

These plans are aimed at ensuring the best environment to support and encourage the development and implementation of innovative service integration plans at an operational level. We will be ensuring a change in culture and an underpinning continuous improvement methodology. We are keen to ensure an appropriate service improvement methodology linked to the large scale change model and ensuring the alignment of values and relationships are at the heart of what we do, with good measurements and the ability to make the information available to all as a means of supporting on-going improvement and motivation.

How have we reached these views

Following a visit to Kaiser Permanente in 2010 by Dr Paul Bowen, ECCCG Chairman and Dr Rob Stead, Medical Director East Cheshire NHS Trust with the North West Leadership Academy and the Place Based Leadership Programme facilitated by Deloitte plc there has been a programme of work including engagement with key stakeholders to develop the vision, values, principles and desired outcomes of a new health and social care system.

There has been continued and strengthened collaborative working through the development of the Caring Together Programme and the Caring Together Board and a number of work streams that have highlighted the required actions and resources to ensure the development of robust plans for a new health and social care system.

This has included:

- NHS Eastern Cheshire Clinical Commissioning Group
- Cheshire East Council
- East Cheshire NHS Trust
- Crescent Community Interest Company
- Vernova Community Interest Company
- Cheshire and Wirral Partnership NHS Foundation Trust

We have adopted the Large Scale Change Model to underpin our organisational development approach and have secured an external company Participate UK Ltd to design and implement our campaign strategy, using social mobilisation techniques to frame and reframe our change proposals and to harness every small cycle of change to ensure continued and increasing engagement with professionals and the public in this new model of care.

We have also been active participants in the AQuA Integrated Care Community Development Programme and incorporated the learning from this into the programme of work. This has enabled us to establish a number of projects around integrating the work force, linked to the development of the neighbourhood teams. It has also given us access to expertise from the King's Fund which has enabled some tailored support to focus on work force development, our governance approach, financial/contract models.

We have also utilised other colleagues in academic and think tank organisations including Keele University and the Nuffield Trust.

We have continued to be supported by the North West Leadership Academy with a multi organisational team visiting Jonkoping in Sweden in May 2013 and with a further visit to Kaiser in June 2013 by the Medical and Nursing Directors of East Cheshire NHS Trust.

2. The Strategic Outline Case

In April 2013 it was agreed by the Eastern Cheshire Partnership Board that it would take on the responsibility for the delivery of the Caring Together Programme and it agreed to reform as the Caring Together Executive Board.

At this point the partners acknowledged that the financial situation across the health and social care economy and the growing burden of need associated with a rapidly increasing elderly population provided an opportunity for radical change.

To move forward at scale and pace it was agreed that a credible strategic plan for the partner organisations in Eastern Cheshire, NTDA and NHS England was required. To include the case for change, progress to date, successful programmes completed. To describe the strategic focus on integration across the health and social care system, the methodology for development and implementation with early case studies illustrating the approach, and a robust project plan to develop the detail for implementation. This plan was to include foundation principles, and modelling of the options, considering the financial impact, patient flow impact and workforce impact.

NHS England provided the funding to procure necessary external expertise of McKinsey and Company and Carnall Farrar LLP. McKinsey and Company are an international management consultancy with extensive experience of working with health and social care providers and commissioners both nationally and internationally supporting their integration programmes and Carnall Farrar LLP bring recent NHS leadership experience of a large scale change programme across London.

The SOC was targeted at the leadership of local commissioners and providers in Eastern Cheshire and national partner organisations and set out:

- The clinical and financial case for change in Eastern Cheshire
- How care needs to change to improve outcomes and experience for the residents of Eastern Cheshire
- The financial implications of these changes for commissioners and providers

The SOC equates to 66 slides and has a further 100 slides as appendices. In this document I have copied elements of the SOC to illustrate its main points.

The SOC stated that doing nothing was not an option because of the impact of current and future financial constraints of all health and social care organisations in Eastern Cheshire and the increasing demand for care services.

The Caring Together Programme will deliver benefits in four areas:

- Patient experience and care outcomes
- Staff experience
- Service utilisation

- Financial resources

Again a slide explaining these in more detail is appended.

The SOC set out the financial position of each partner organisation and tested the proposed system changes against international evidence best practice and in summary concluded that:

- There is a strong case to radically change how we deliver care to our 200,000+ residents in Eastern Cheshire. Failure to act will result in declining care quality, growing dissatisfaction with the system and rising financial deficits across commissioners and providers of health and care services
- The Caring Together Programme is an ambitious solution required to address these challenges in Eastern Cheshire. The programme provides opportunities across three areas: integrated care, acute services redesign and productivity improvements within all organisations
- The proposed framework for a new care model will shift care from reactive acute to proactive care closer to home and will have a dramatic impact on patient experience, quality outcomes, staff satisfaction and financial sustainability
- While the financial challenge is significant the evidence in the SOC indicates that Caring Together could significantly reduce the financial pressure on commissioners and providers in Eastern Cheshire. However, this impact will only be achievable if investment is shifted from acute care into care in home and the community.

During August and September 2013 each of the partner organisations discussed the SOC with their own boards, governing bodies and cabinets and the Caring Together Executive Board agreed that this provided sufficient evidence to support the move to undertake a programme of work to develop a business case that would set out clearly the options for service changes and their impact on ensuring good patient experience and care outcomes, improved staff experience of providing that care, a shift in where and how the care is provided and the financial consequence of these changes.

3. Mobilising the Caring Together Programme

In order to develop a business case and particularly one that is likely to present a number of options for service changes that will require a formal public consultation process there needs to be a formal programme management approach applied.

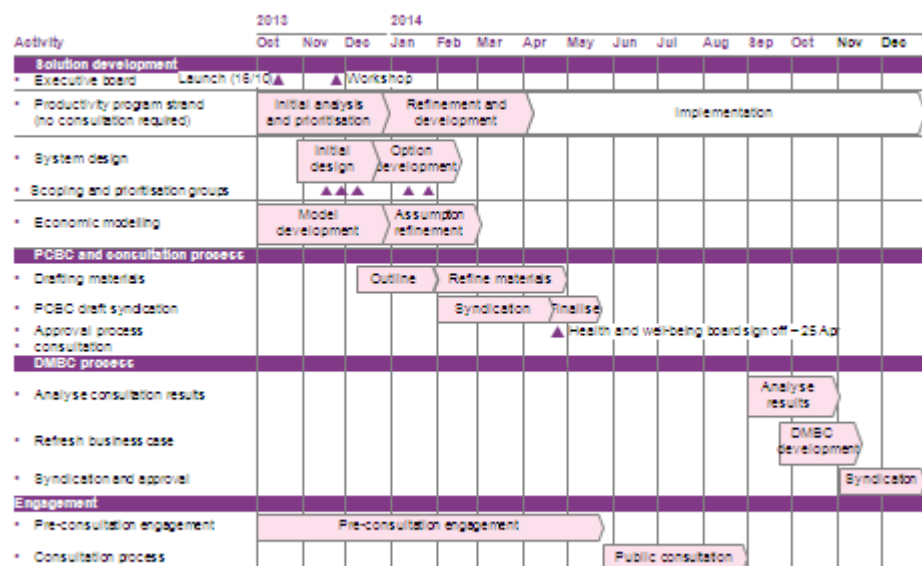
This approach will ensure that there is appropriate engagement in the design of the care services, that the needs of the local population are fully considered in this design process and that proposed changes are based on evidence best practice and fully tested and reviewed by clinicians, professionals and the public.

There is a recognised programme of work, and required governance structures and processes that the Caring Together Executive Board initiated following a Board Summit on 16th October 2013.

The outline programme timeline is set out below showing indicative milestones and activities, but a more detailed plan has been developed along with a structured decision making process, this has yet to be reviewed and signed off by the Executive Board (meeting to be held on 25th November 2013).

Caring Together programme plan (through consultation)

PRELIMINARY



At the moment the work is focussing on developing the productivity plan, to maximise the opportunities for improved efficiency and productivity across all the organisations, developing a detailed baseline of costs, expenditure, activity, workforce and estates.

Key to this is the agreement of the service changes led by clinicians, professionals and patients and this work has just commenced with multi organisational/professional groups meeting every two weeks this will give the business case a clear picture of care services across Eastern Cheshire and how they will be different.

All of this work will need to be completed to allow time for the business case to be taken through appropriate bodies prior to a proposed formal public consultation in June 2014.