Presentation to Lancaster City Council OSC 11 June 2014

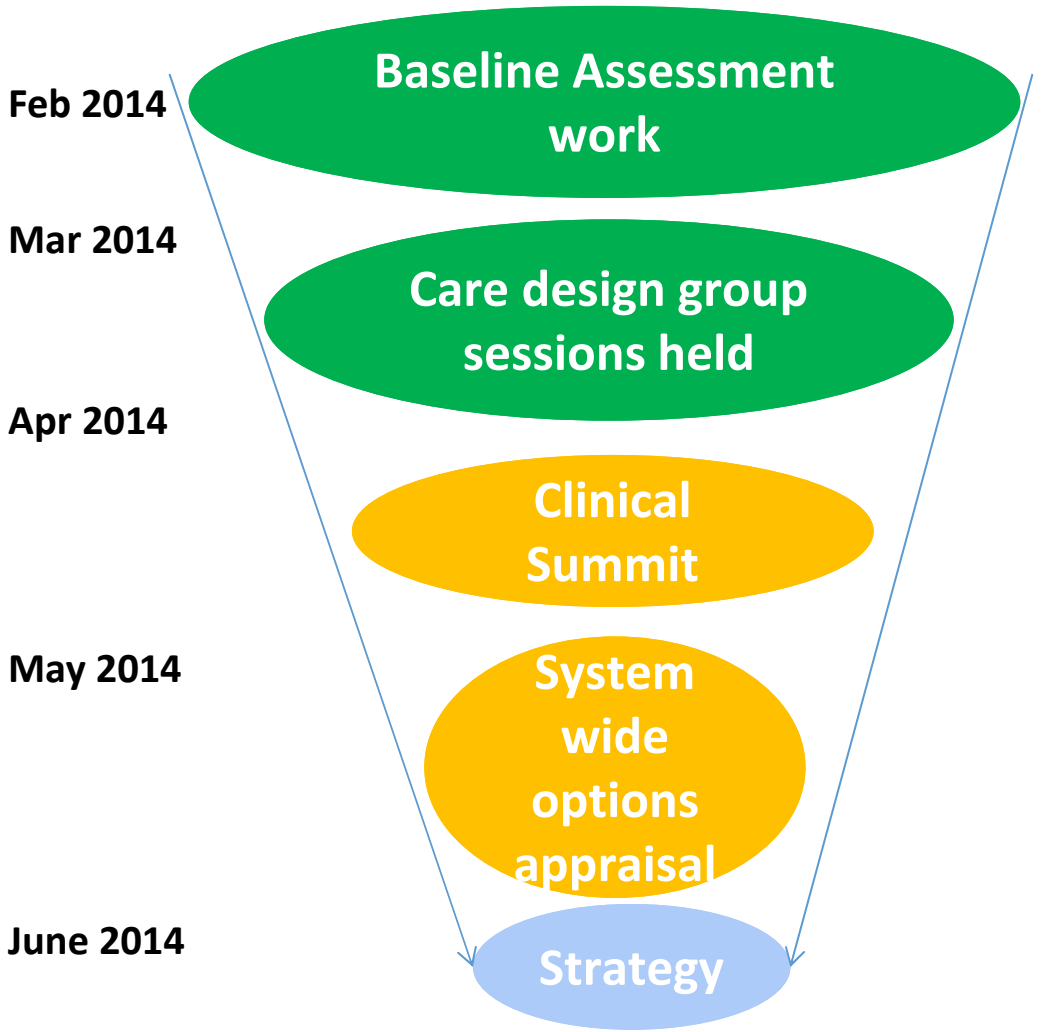
Update on the Clinical Strategy for Health Services in Morecambe Bay:

Better Care Together

Since we last saw you:

- Further development of service models – in and out of hospital
- Testing the feasibility of the options in relation to e.g.
  - Estate facility feasibility and potential capital requirements
  - Workforce re-profiling e.g. skilling for out of hospital work
  - Impact on patient flows
  - Financial cost modelling
- Acting on feedback from our engagement activity

Where we are in the process



Recent engagement – March 2014

- 5 drop in events for staff at each of our three hospital sites, and community based sites

- 12 public 'drop-in' style events across different localities within Morecambe Bay which were advertised via full page newspaper adverts, our networks and via the use of an "ad-bike". Attendees were invited to complete a number of activities to give us feedback, however this was completely voluntary. Some people simply wanted more information and the opportunity to speak with clinicians. There were also opportunities to complete comment cards; to take the activities away and complete at home; to complete the activities online; and to participate in a Q&A session. Numbers of attendees were modest, but the events were well represented by clinicians, better care together team members and external support team members.

- 3 stakeholder workshops in Lancaster, Barrow and Kendal which were facilitated by TNS

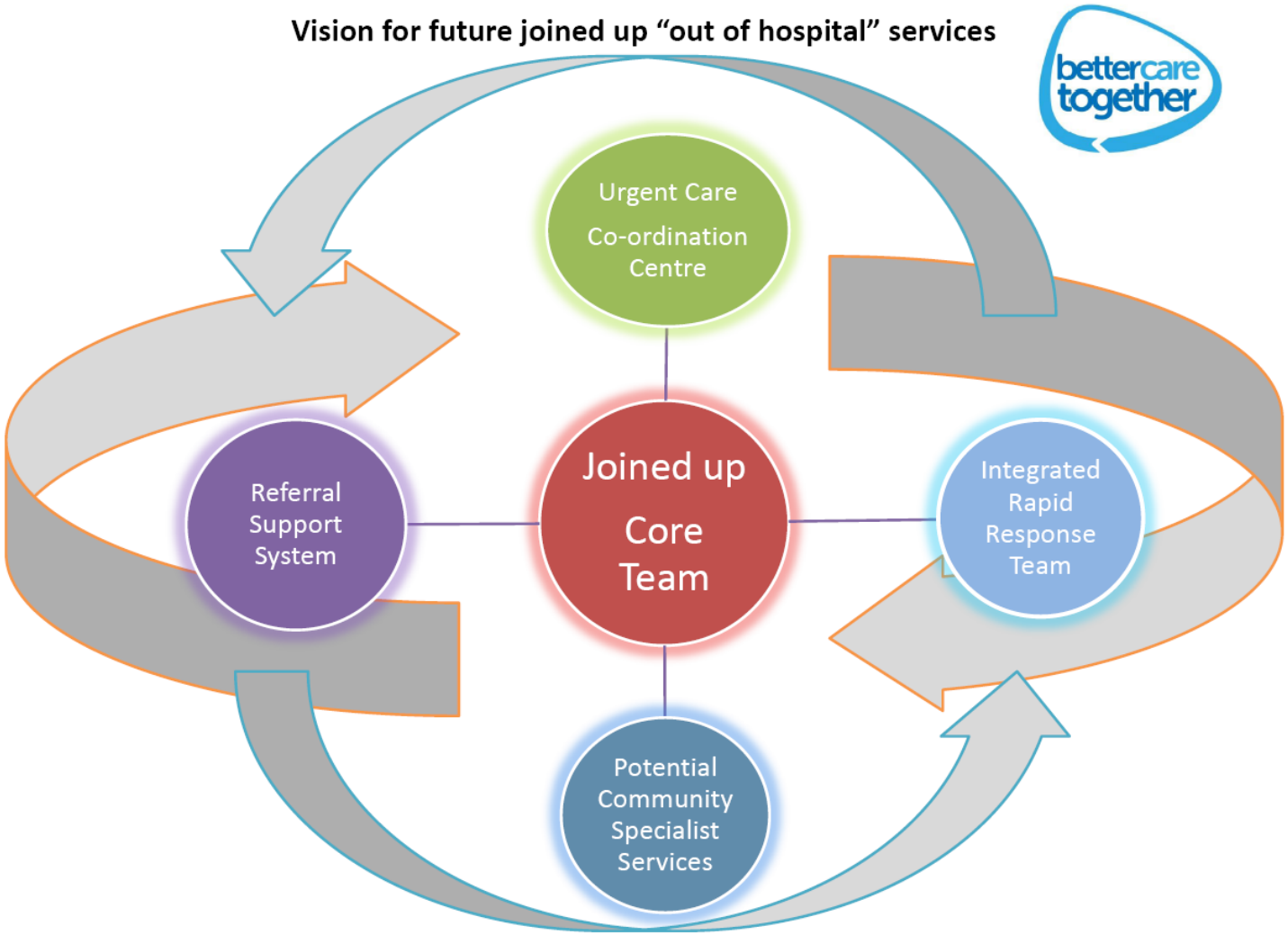
- Lancashire North CCG held a voluntary sector event in March and participants were asked to take part in the activities described above.

There were over 250 attendees across all the events and these included Council and OSC representatives ; local media; 3rd sector representatives; members of public; and a broad spectrum of colleagues.

For a summary of the engagement to date you can read our report by visiting: www.bettercaretogether.co.uk "Our engagement to date"

Engagement activities

The vision of out of hospital services emerging from Care Design Groups were shared with the public and stakeholders who were asked for their comments on each element of the proposed whole system model. This was then fed back to the Clinical Summit



Out of Hospital care scenarios

Vision for future joined up "out of hospital" services

Joined up service scenario no. 3

Integrated (joined up) Rapid Response Team

This service could see you being treated by a specialist multi disciplinary team of skilled health and social care professionals whose role is to get you home safely. In many instances this team will help you to get home as soon as possible, with the right support, often within 48 hours. This sees
together the right package of care for you.

How could this work for Mary?

Mary has had a fall at home and has been tak
than necessary in hospital she will be seen by
across health and social care. They can arrang
home, such as helping to arrange transport h

Vision for future joined up "out of hospital" services

Joined up service scenario no. 2

Urgent Care Co-ordination Centre

This service could see a change in the way you access NHS services and the way health professionals contact each other. This service could see a team, under one telephone number, as a main point of contact who will make the right appointment for you, with the right health professional e.g. a GP or District Nurse. This team will help triage (assess) you,
ry. This will help prevent you going to A&E if you don't
emergency. It will also put health professionals in
ealth, social and voluntary care.

o to call when she feels ill and today she feels very
o call and the centre will make an urgent
ocal area. Mary can now call a single number rather

Vision for future joined up "out of hospital" services

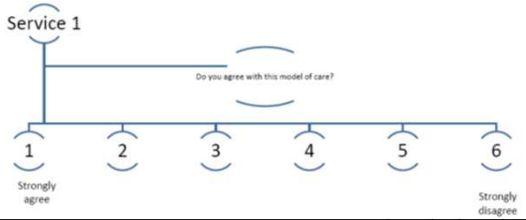
Joined up service scenario no. 1

Integrated (joined up) Core Team

This service could see a team working together in an out of hospital setting. This could be a multi skilled team e.g. GPs, social care, district and mental health nurses working together. Their role is to try and identify vulnerable people to give them a care plan. This way if you are vulnerable they can work to keep you well and prevent urgent care where possible.

How could this work for Mary?

Mary is struggling at home and needs support to stay independent. Mary would be assessed by one person in the integrated core team, (Mary can contact the team via her GP surgery) who would work with other colleagues e.g. a voluntary organisation and social care worker to put together a package of care for Mary. This means Mary no longer has to ring different people in different health and care organisations: it is done for her.



Vision for future joined up "out of hospital" services

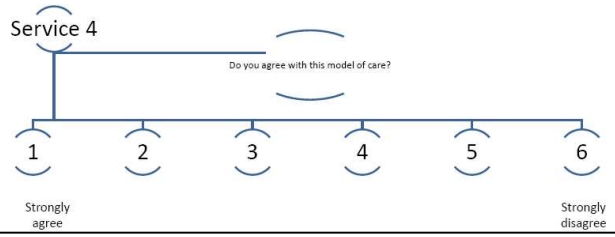
Joined

Potential community specialist services

This service could see the movement of some spe
care and pain management into an out of hospital
health clinic or GP surgery, where you would be se
This would expand on the community services alre

How could this work for Mary?

Mary has diabetes: a long term condition. This me
to see different people for six monthly checks. Ma
manage her condition if she feels ill in-between ch
call if she feels her condition is getting worse. This
appointments she has the benefit of specialist community services to prevent her diabetes escalating.

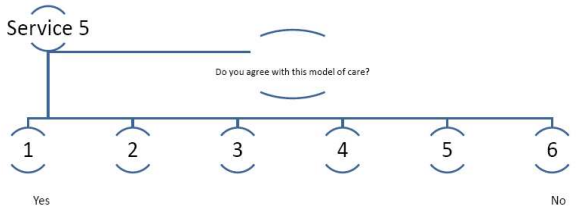


Joined up service scenario no. 5

t Service

l system from one health professional to another
would benefit from an agreed referral system
consistent advice, guidance, and referrals
d out of hospital. This system helps staff to help
gh NHS services.

he but doesn't want to go through the current
g a consultant and then seeing a physiotherapist.
using established referral protocols which determine the best health professional, Mary is referred by her GP straight to the physiotherapist. In this instance it takes one step out of the patient journey meaning she has less travel, and can be seen quicker.



What happens next?

- Strategy is submitted on 30th June to NHS England and Monitor
- NHS England begin an Assurance process - ?2 months
- BCT will continue to share information with colleagues and stakeholders
- We will continue to receive feedback from our stakeholders and continuously update the themes and emerging trends
- We have commissioned an independent report from the Consultation Institute on our engagement to date with a view to seeking recommendations for future activity which will meet national best practice
- We have prepared a summary of engagement to date which is available on the bct website
- We will continue to working closely with yourselves to ensure scrutiny and feedback on the better care together programme

Thank you for listening

Your questions?