

Cheshire Pioneer Programme – Profile

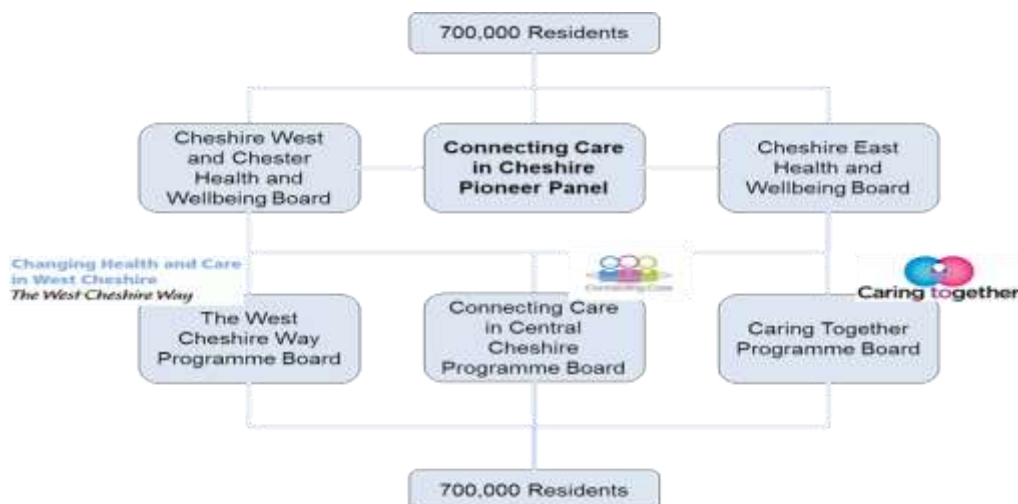
1.1 What is your area like?

Cheshire covers a geographical area of 800 square miles with a population of 700,000 residents. It has a rich diversity of urban centres, market towns and large rural areas. Across the area there are large variations in deprivation and affluence, and large differences in levels of health. The population of people over 65 and over 85 is growing swiftly across Cheshire, leading to a financial growth pressure of around £19m in the west over the coming five years and £36m in the east in the next three years.

1.2 What are you aiming to achieve?

Connecting Care in Cheshire brings together two councils and four clinical commissioning groups (CCGs) in three localities, with a combined budget of £1.3bn, working through two health and wellbeing boards, Cheshire East and Cheshire West and Chester, and with a range of providers from all sectors. The Cheshire pioneer programme is an ambitious one and covers the integration plans of the three localities namely:

- Cheshire East – Caring Together Programme
- Central Cheshire – Connecting Care in Central Cheshire Programme
- West Cheshire – The West Cheshire Way Programme

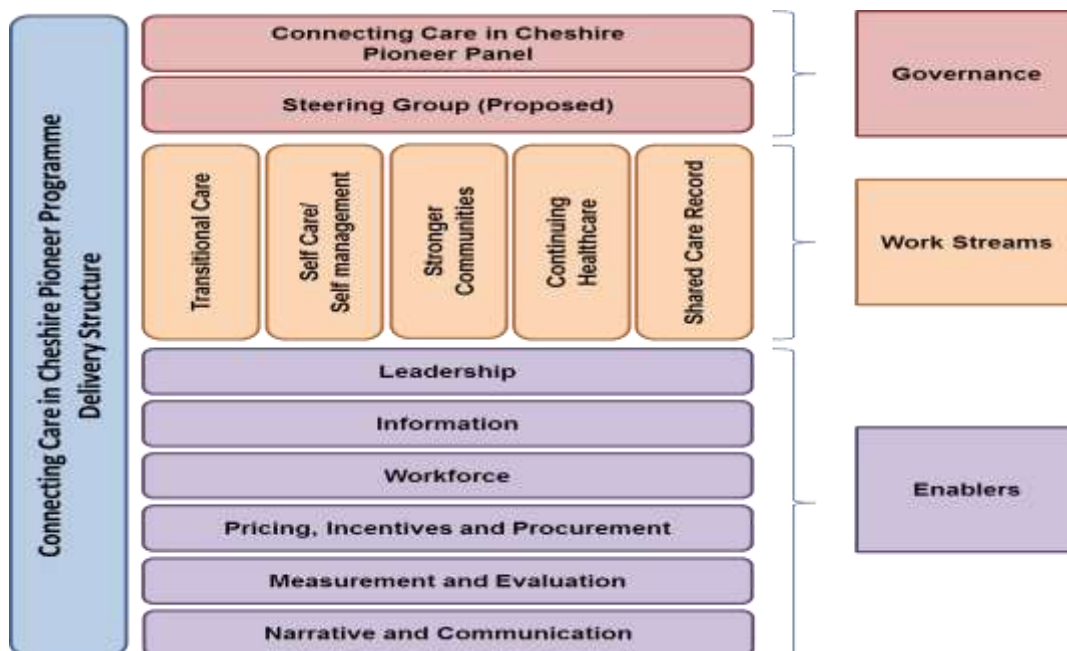


Pioneer partners across Cheshire are committed to a model of collaborative leadership, through which shared visions and outcomes will allow organisations to establish a common direction of travel and to provide a platform for making joint decisions. A Pioneer Panel, which comprises leaders from all key partner organisations, has been established to help coordinate integration activity across the Cheshire pioneer area where appropriate.

Our vision for the Connecting Care in Cheshire programme is that within three years the residents of Cheshire will enjoy a better standard of health and wellbeing. We anticipate that this approach will place less demand on more costly public services through the implementation of ground-breaking models of care. As every community in Cheshire is different, local solutions will reflect local challenges but our actions are united around four shared commitments namely:

- Integrated communities
- Integrated case management
- Integrated commissioning
- Integrated enablers

We identified five key workstreams that were common areas of work to each of the transformation programmes and agreed to deliver these in partnership across the Cheshire footprint. These areas of work are supported by six enablers as highlighted within the diagram below:



1.3 What have been the highlights of your first year?

- Submission of joint bid to Tech Fund 2 to develop a digital shared care record across Cheshire
- Joint planning to integrate continuing healthcare
- Joint work and shared learning on intermediate care and personal commissioning

1.4 Details of the year

1.4.1 Developing the Connecting Care in Cheshire programme – joint workstreams

1.4.1.1 Transitional care

We currently have two programmes of work to develop integrated, personalised intermediate care services – the STAIRRS project and the Care Category framework. We are sharing learning as these services develop and, while localities may have different systems, these will be linked to shared principles and outcomes, so that people across Cheshire receive the same high standards of service. See case study: [Developing transitional care models](#).

1.4.1.2 Self-care/stronger communities

We are scoping a self-empowered work programme to commence in 2015 led by the two directors of public health across Cheshire. Through a successful application to the Integrated Personal Commissioning Initiative we will focus on introducing personal health budgets for people with learning disabilities.

1.4.1.3 Continuing healthcare

We are planning to implement a new operating model to drive a change in the provision of continuing healthcare commissioning support services. The intended outcome of this programme is to ensure that the services that are commissioned are safe for service users and that service users and their families are fully involved in decision making.

1.4.1.4 Shared care record

We have recognised the need to establish an infrastructure that enables the flow of high-quality, comprehensive and up-to-date information between care professionals across Cheshire. In 2013/14 the West Cheshire programme developed a digital patient record, supported by NHS England Tech Fund 1, and is piloting this in A&E and GP practices. Building on this, in September 2014 a joint bid was submitted to Tech 2 which will roll out this initiative across remaining partners in Cheshire. See case study: [Setting up a pan-Cheshire integrated digital care record](#).

1.4.2 Joint enablers

1.4.2.1 Leadership

Supported by the national pioneer programme, we had a joint ‘disruption event’ with Cornwall pioneer where we learned more about the Energy for Change model and how we can lead change in the system. We have agreed to continue to work on shared leadership through an ongoing series of events that give space and time to share and progress ideas.

1.4.2.2 Workforce

We have recognised that delivery of our three ambitious integrated health and care transformation programmes will hinge on the availability of an effective, engaged workforce that feel supported by strong leadership; have opportunities to create strong and active relationships across organisations; and have access to appropriate education and training opportunities. We are working with national support partners

to scope the size and complexity of the workforce challenge and to deliver a five-year Integrated Workforce Strategy.

1.4.3 Locality integration programmes – highlights of the first year

1.4.3.1 Caring Together – East Cheshire

In the Caring Together Programme commissioners and providers have been working to co-design a new integrated system of care, with an emphasis on outcomes-based specifications and innovation. This includes:

- Scoping the introduction of five caring together community teams
- Developing a new care co-ordination hub, supporting case management
- Introducing supported self-management techniques
- Commitment to delivering the three million lives project (assistive technologies)
- Piloting specialist community in-reach services

1.4.3.2 Connecting Care in Central Cheshire

Partners in Central Cheshire have been preparing the landscape for change to support the move to increasing levels of collaboration and integration. This includes:

- Established shared vision, leadership and governance arrangements to support whole-system working and delivery of integration outcomes
- Baseline mapping of all integrated work in progress or planned
- Increased pooled resources
- Agreed delivery model for integrated care
- Testing new contracting approaches such as a collaborative provider 'alliance' contract

1.4.3.3 West Cheshire Way

The West Cheshire Way is based on designing services around the needs of the whole person. The programme will improve self-care, support people in the community, and ensure services are coordinated. First year highlights include:

- Nine integrated teams are operational, six of which are already co-located
- A shared care record pilot commenced in A&E
- A single access gateway covering mental health, physical healthcare in GP practices and hospitals and social care is being developed
- A centre for healthy ageing hub is being developed
- Frailty clinics have been established with further links planned between community geriatricians, GP practices, integrated care teams and community services
- A team of commissioners and providers visited the Jonkoping health and care system in Sweden to understand their patient centred approach, their leadership, innovativeness, impact on health improvement, and to see how we can use this in our local area

1.5 What has been the most exciting aspect?

Achieving transformational change across a complex but achievable geography without implementing structural change continues to be an exciting aspect of the programme. One of the most crucial aspects in achieving this has been the development of authentic working relationships across the health and care economy between key partners: CCGs, acute trusts, mental health and community trust, primary care and local authorities. This has happened not only at the most senior level between clinical and management leaders but also throughout organisations, and has enabled the transformation vision to be owned by those who are going to be crucial to delivering it.

The implementation of the integrated teams in West Cheshire has been a fundamental aspect in forming the building blocks of the future system. We have learnt that it then takes time for those teams to embed in order to work effectively together including working through the alignment of processes.

1.6 What has been the most challenging aspect?

The rising tide of demand has made it difficult to shift resources into the community away from the acute sector sooner than we were hoping. This is not unique to this health economy, but due to the demographics of our population we believe we are feeling it acutely.

Due to the Cheshire geography, communicating our success and learning across our footprint has been difficult, but, to address this issue, a pioneer website has been developed which will be used as a vehicle of communication and networking. A pioneer network of senior commissioners has also been set up which will ensure joint commissioning opportunities become a reality.

1.7 What are you planning to do next year?

1.7.1 Connecting Care in Cheshire

- The major initiatives that commenced in 2014 (above) will continue to be progressed
- We will deliver a 'challenge session' to tackle hard conversations about finance, and barriers to joint work, such as national tariff, with providers and national pioneer partners including DCLG, NHS England and Monitor
- In 2015/16 we will be working with the national Integrated Personal Commissioning Team to introduce personal health budgets for learning disabilities

1.7.2 Caring Together – East Cheshire

- The further development of a joint commissioning specification for a more integrated health and social care system, focusing on rewarding outcomes and maintaining standards

- The ongoing facilitation of horizontally and vertically integrating our health providers, through transitional arrangements and leadership development
- Work in partnership across the pioneer partners to commission and implement the new integrated digital shared record
- Establish the local infrastructure and investment required for Caring Together integrated community teams, integrated rapid response services and improved capacity and access to primary care
- Working with Cheshire East Council as the lead partner ensure the Caring Together Empowered Individual ambitions and work programme is developed and implemented across the pioneer footprint
- Complete and implement across Cheshire a new improved model of care for patients with continuing healthcare needs

1.7.3 Connecting Care in Central Cheshire

- Build capacity and capability of the workforce to lead improvements, challenge existing practice and systems and to implement and evaluate change
- Utilise the workforce effectively and be open to innovation in skill-mix, staff substitution, new roles, hybrid roles, 7-day working and roles that span organisational boundaries
- Put 'Listening into Action' – to re-engage our workforce to drive and own the changes needed as part of an ethos of continuous improvement
- Create a 'learning network' and 'central Cheshire academy' to support cultural and behavioural changes required to deliver new models of care

1.7.4 West Cheshire Way

- Work with neighbouring localities across Cheshire to implement a new improved model of care for patients with Continuing Healthcare needs
- Develop a comprehensive workforce strategy that both supports front-line clinicians to improve current ways of working as well as developing the skills for the future, cutting across traditional organisational boundaries
- Set out on the road map towards the realisation of an accountable care organisation through further development of the accountable lead provider for intermediate care and the integrated provider hub for mental health and learning disability
- Implement the 'House of Care' model for long term conditions to shift the majority of care to be based around the supported and empowered individual in their own community
- Test and roll out radically different models of general practice to support the transformation of the rest of the health and care system
- Fully implement the new integrated digital shared care record

1.8 What is your advice for areas starting on their own integration journey?

The individual is at the centre of all the work that we do; we need to continually keep bringing ourselves back to this thought.

It is important to create a compelling story which everyone at all levels across the economy can associate with and take themselves back to when they are facing a challenging situation to remind themselves this is why we are on this journey.

Establishing good relationships is fundamental to joint working and should not be underestimated; listening to others, trust, openness all need to be nurtured.

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