A photograph of three healthcare professionals in a meeting. On the left, a woman in blue scrubs is seen in profile, looking towards the center. In the middle, a woman in a light blue lab coat is smiling and looking down at a document. On the right, a man in a white lab coat with a stethoscope around his neck is smiling and looking down at the same document. They appear to be in a bright, clinical setting.

Northamptonshire's Sustainability and Transformation Plan (STP) for the Health and Social Care system through to March 2021

Northamptonshire STP details

Northamptonshire STP Details

Name of footprint and no: **Northamptonshire - 20**

Region: **NHS England Midlands and East (Central Midlands)**

Nominated lead of the footprint including organisation/function:
John Wardell, Accountable Officer, Nene CCG

Contact details (email and phone): **James Murray, james.murray@neneccg.nhs.uk, 01604 651409**

System Chief Executives:



John Wardell
 Accountable Officer
 NHS Nene Clinical
 Commissioning Group



Carole Dehghani
 Chief Executive
 NHS Corby Clinical
 Commissioning Group



Sonia Swart
 Chief Executive
 Northampton General
 Hospital NHS Trust



Clare Culpin
 Acting Chief Executive
 Kettering General Hospital
 NHS Foundation Trust



Angela Hillery
 Chief Executive
 Northamptonshire
 Healthcare NHS
 Foundation Trust



Paul Blantern
 Chief Executive
 Northamptonshire County
 Council



Daniel Kane
 Chief Executive Officer
 General Practice Alliance
 Ltd



Jane Carr
 Chief Executive
 Voluntary Impact
 Northamptonshire



Andrew Elphick
 Chief Executive Officer
 PML – Principal Medical



Nicki Price
 Director
 3Sixty



Prof. Robert Harris
 Chief Executive Officer
 Lakeside Healthcare Group

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Executive summary

Introduction

All CCGs, NHS Trusts, GP practices working together across 3 federations, 1 super practice, local government and the voluntary sector across our health and care system are committed to deliver reduced health inequalities and improve the health and wellbeing of the population of Northamptonshire. Our *Sustainability and Transformation Plan* (STP) reaffirms a commitment amongst all partners to provide an integrated county wide service.

What have we done?

We have previous experience of working together through the Healthier Northamptonshire programme and have built on this to ensure full engagement from a wide range of stakeholders. An STP Board that brings together system partners has been created and this is supported by a developing network delivery structure.

Our plan has been developed with significant commitment from all parts of the system and has generated a high level of engagement and momentum. A draft plan was submitted in June with a top down analysis of key issues and finances. Work since June has been focused on developing the detail to closing the health, wellbeing and finance gap. There remains work to be done to refine and strengthen these assumptions and how they support, in particular, the achievement of financial sustainability.

What are we trying to solve?

In 2015 the NHS published the Five Year Forward View which identified three clear challenges that the NHS needs to close:

- The Health and Wellbeing gap;
- The Care and Quality gap;
- The Funding and Efficiency gap.

While the challenges identified nationally are common, the nature of those challenges locally are

- Lifestyle and wellbeing issues which drive people into the health system particularly due to respiratory conditions, circulation issues, cancer and mental health as identified through Right Care;
- We need to ensure that people are enabled to access the right health services in the most appropriate way;
- Pressure and lack of investment in out of hospital services that mean that people end up in hospital based services by default;
- The need to ensure sustainability of General Practice and primary care services;
- The need to ensure that acute hospitals services are supported, transformed and optimised to best serve the needs of our population;
- Workforce shortages across the service which drive cost and hamper the ability to provide high quality services;

- The need to improve integration of services across the system to improve efficiency and reduce duplication;
- Ensure the system meets national quality standard including Cancer, and NICE guidelines and addresses CQC issues raised locally.

All of this has led to a system which is very reliant on patients being cared for in a hospital setting, fails to provide the appropriate type of care for a number of patients, is expensive and is becoming increasingly unsustainable.

What will be the impact of our plan?

The Health and Social Care system is a complex system costing over £1bn. Changing a system of this size will require significant focus and sustained work. Successful implementation will result in a very different model of service across Northamptonshire .

Our aim is to provide a more person centred model of care which focuses on individuals health and wellbeing first and then supports their needs when required with fast access and appropriate intervention. People can expect to receive timely, appropriate, holistic care with physical and mental health needs assessed and addressed in a consistent and co-produced manner.

We will deliver this through a health and wellbeing programme to support people to maintain their health and social independence as long as is appropriate supported by an integrated prevention programme developed in conjunction with Public Health.

Where required the health and social care system will look to engage with its community, and the third and voluntary sector, in a way that simplifies access into services. It will provide a more holistic out of hospital support, deliver a high quality acute service when required supported by a system whereby people are able to move back to home care as soon as possible.

Our STP will address the challenges articulated in the GP5YFV and will invest in the suggested solutions and integrated new care models (MCP) work models to enable local general practice and the wider primary care systems to be sustainable and able to take on the wider workload implications of the transformation model.

Out of hospitals services will evolve into 4 community-based MCP models which will provide holistic health and social care for individuals within their communities. They will have clear integrated links into the acute sector for urgent and scheduled care and will move some of their staff around the system to widen knowledge, experience and ownership.

Executive summary

Our provider system will develop integrated Northamptonshire services that work across the existing two acute trusts and also on an integrated basis with primary and community care across the patient pathways. It is envisaged that there will be an impact on the trend of increasing work going into the acute sector which will begin to slow and that significant elements of urgent and complex care work will be delivered through community-based integrated systems. Links between health and social care will be strengthened, supported by the voluntary sector, and enable the transfer of patients in a seamless way.

Key supporting strategies are in development that will support transformation including

- Development of a new flexible workforce building on our current well established workforce supported by Health Education England;
- Development and implementation of Information technology strategies to support integration (LDR);
- Development of a countywide estates plan

Whilst it is challenging, we believe that by delivering this model of care, we will resolve the three gaps with robust and structured transitional change.

Balancing the Finances

We have agreed a strategic direction which will deliver significant health and quality benefits and in doing so will support the delivery of a financially sustainable system. This will require a shift in investment towards out of hospital services that will need to be managed while maintaining financial stability. This transition will be challenging but we believe it will help achieve financial balance through a systematic combination of

- Reducing flows into secondary care through development of alternative care packages and provision outside of hospital;
- Increased productivity of provider services to reduce costs and raise efficiency;
- Developing service integration and synergies to drive out costs through working at scale and avoiding service duplication;
- Continued delivery of national savings targets.

We expect the following programmes to deliver savings as follows;

- Improvements to the urgent care system (£12m net);
- Developing complex care alternative packages (£27m net);
- More efficient delivery of scheduled care (£11m net);
- Developing health and wellbeing and prevention strategies (£5m net);
- Integration of services across the system to improve efficiency and reduce duplication (£33m net).

Communicating the Plan

The system has undertaken engagement with stakeholders in development of the work streams including primary care, Local Authorities and the voluntary sector. We are developing a full communications and engagement strategy which is outlined within this document. This will involve a single line of communication for the system encompassing

- Publication of the STP to the public by January 2017;
- Engagement with all staff across the Northamptonshire health and care system;
- Community and client communication to support the prevention and wellbeing agenda;
- Synchronisation between the STP and the Health and Wellbeing Strategy.

This plan will be led by a single communications lead co-ordinating activities across all key stakeholder organisations.

Implementing the Plan

The system has developed a clear system governance and delivery framework. This is establishing leadership, different behaviours and staff capability and capacity to move us towards a system delivery approach. The system needs to be proactive in its approach to change encompassing and adopting an external facing view of other health and social care sector developments and achievements such as vanguards,

It is vital that we are able to implement whole system change in a way and at a scale that we have not achieved before and it is recognised that a cultural change is required to achieve this

The STP Board provide the forum for bringing the system together and will have an agreed Memorandum of Understanding to manage processes and system/organisational conflicts. This will be supported by the Health and Wellbeing Board to provide democratic overview.

The STP Board will work with regulators (NHSE and NHSI) to ensure that there is a consistent approach across all parties to the delivery and impact of the STP and organisations are supported through the transformation process.

Key to supporting this programme will be

- Implementation of the workforce strategy
- Implementation of the strategy to deliver IM&T interoperability;
- Development of a 10 year system wide estates strategy

In order to deliver the STP, the local system will need to work in a different way. Our workforce will need to evolve to being a part of the Northamptonshire system and not just members of their own organisation. This new way of working will benefit staff through better co-ordination and also move organisations away from a transactional focus towards an outcome focus and transformative mind-set. We will support this with a clear engagement and organisational development process.

Executive summary

Shaping our services

Northamptonshire recognises that as it implements its plan it will need to consider how its commissioner and provider organisations are structured to support the delivery of new models of care and deliver an integrated offer to the population of Northamptonshire. Organisations have started to move towards this process with the development of Provider Memoranda of Understanding to work together and Commissioner reviews of integrated function and joint posts. There is agreement on the key drivers and pressures that will be reviewed to drive the decision making process and it is agreed that form will follow function. The STP Board will review the situation on a rolling 6 monthly basis.

Summary

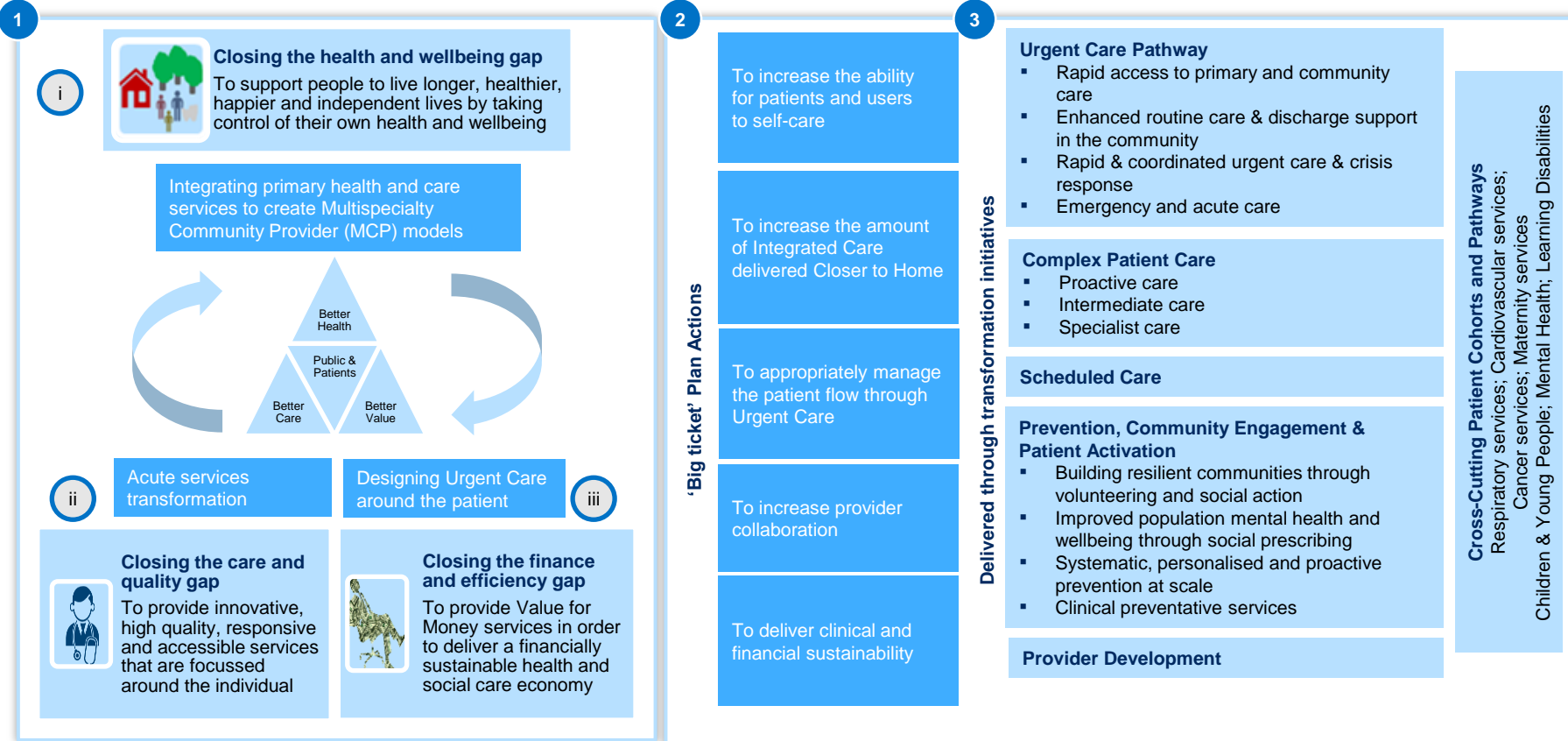
The Northamptonshire system has agreed a clear line of travel for developing and transforming services via the STP process.

Work on developing plans to support the detail of the implementation plan is proceeding and further work is required, the system is well placed to move into the detailed planning and operational phase. Early areas for delivery will focus on improving the urgent care system and reducing pressures on A&E, the development of complex care services and provider productivity.

The system recognises the need to change in the context of the significant challenges to deliver improvements in the first two years of the plan while maintaining operational and financial stability.

Northamptonshire's Sustainability and Transformation 'plan on a page'

Our vision is to improve the health and wellbeing of all people in Northamptonshire and reduce health inequalities by enabling people to help themselves (Supporting Northamptonshire to Flourish: Health & Wellbeing Strategy 2016-2020)



- 5**
- Success Criteria**
- Better lives for the people of Northamptonshire with improved health outcomes and experience of care and a focus on prevention and self-care
 - Reduced health inequalities and an enhanced quality of life for people living with long term conditions
 - Parity of esteem between mental and physical health
 - Providing care in the most appropriate setting and in line with best practice
 - Sustainable, integrated and self-improving system of care that is accessible, cost effective and best value for money

- 4**
- Vision Commitments**
- iv** We will maintain **transparency and openness** in relation to the challenges we face and the decisions we have to make and facilitate better and more appropriate use by the public of prevailing services
 - v** We will **engage, involve and consult with our stakeholders**, including the public, in our planning for improvement and radical changes to the system of health and care provided
 - vi** We will **work across sectors and across regional boundaries** to ensure the best range of integrated services is available to our population
 - vii** We will **ensure improved and equitable access** to high quality health and social care services
 - viii** We will ensure that a key measure of success going forward will be the **elimination of unacceptable health inequalities** across Northamptonshire
 - ix** We will **provide safe care in the most appropriate setting** and in line with best practice
 - x** We will deliver fundamentally different **new models and pathways of care** and ways of working that seek to enhance staff satisfaction throughout our health and care services

We have engaged with our community, providers, commissioners and wider Northamptonshire health social care and VCS bodies in developing this plan

	Description	Key events	Key partners/groups	Future plan
Community engagement	<ul style="list-style-type: none"> ▪ Presentation and discussion at Healthwatch listening and learning event and presentation at Board ▪ Public Engagement Event, over 70 members of the public attend on 26th May & 23rd June 2016 ▪ Presentations and discussions at HWB development days and attendance at a number of meetings with HWF ▪ Presentations to Health & Wellbeing Board, including a focussed STP Board on 13th Oct and Overview & Scrutiny ▪ Joint work with Voluntary Impact Northamptonshire ▪ Newsletters, weekly updates and FAQs ▪ Partner organisations have highlighted STP at their AGMs 	<ul style="list-style-type: none"> ▪ Public events ▪ 'Make Your Voice Count' joint questionnaire with Healthwatch ▪ Patient Congress ▪ Healthwatch listening & learning event ▪ Health & Wellbeing development days & Forum 	<ul style="list-style-type: none"> ▪ General Public ▪ Patient Congress ▪ HealthWatch ▪ Health & Wellbeing Board & Forum ▪ Voluntary Impact Northamptonshire 	<ul style="list-style-type: none"> ▪ Public Engagement around the county including the use of a 'Health Bus' ▪ Health & Wellbeing development days ▪ Health & Wellbeing Board & Forum engagement ▪ Healthwatch public views and soundings
Provider development	<ul style="list-style-type: none"> ▪ New Models of Care (NMC) have had 18 workshops (2 joint federation alignment sessions workshops, and 4 individual working groups with each federation) ▪ Alignment sessions between the different workstreams have begun and are ongoing (Acute, NMC, Urgent Care and Prevention) ▪ Acute providers have built on the existing stakeholder engagement programme formed in the Clinical Collaboration programme 	<ul style="list-style-type: none"> ▪ A workshop with each federation every week at the formative stage ▪ LMC facilitated sessions between federations/super practice and NHFT ▪ Engagement sessions between acute & primary care clinicians and commissioners ▪ Patient engagement 	<ul style="list-style-type: none"> ▪ 3 federations, super practice, NHFT, CCGs ▪ LMC, NHFT, Acute Trusts, Federations/super practice, Urgent Care, Local Authorities, VCS ▪ 2 Acutes, GP federations/super practice, CCGs, service users 	<ul style="list-style-type: none"> ▪ Work with the member GPs to begin executing the plan ▪ Continued provider-to-provider meetings to support execution ▪ Greater involvement of social care and private sector to take place ▪ Continued engagement meetings with all stakeholders
Involving the wider network of stakeholders	<ul style="list-style-type: none"> ▪ STP board and SRO delivery groups meet to review progress of the STP and gain alignment from a wider group of stakeholders ▪ 'working groups' set up to bring together key personnel from the different stakeholders and to focus on the role of key enablers ▪ Finance group bringing together the finance leads to help drive the financial savings analysis ▪ Clinical oversight group challenging and advising input into the developing models of care ▪ Discussions have been held with NHS Specialised Services and they have been incorporated within the overall development process 	<ul style="list-style-type: none"> ▪ Monthly and fortnightly meetings respectively ▪ Collective feedback meetings and 1-2-1 working meeting every week 	<ul style="list-style-type: none"> ▪ CEOs from the trusts, NHFT, CCGs, NCC, NED and public health ▪ Working groups: activity & capacity, LDR, Communications & Engagement and workforce ▪ Finance leads from providers and commissioners ▪ Medical Directors from Providers and commissioners 	<ul style="list-style-type: none"> ▪ Groups partly carried over into the new gov. structure for execution ▪ Converted into the new governance and execute-on structure ▪ Leads accountable for hitting the F&E milestones ▪ Group providing clinical oversight

Our Challenges

i We have identified our health and wellbeing challenge at 2016/17

The local vision for health & wellbeing, as articulated in the Northamptonshire Joint Health & Wellbeing Strategy 2016-2020 (JH&WBS), is to 'improve the health & wellbeing of all people in Northamptonshire & reduce health inequalities by enabling people to help themselves'. This will be achieved by:

- Working in partnership
- Reducing inequalities
- Working toward long term impact/change.

The H&WB initiatives for Northamptonshire will be aligned with the four JH&WBS priority areas:

- Giving every child the best start
- Taking responsibility & making informed choices
- Promoting independence & quality of life in older adults
- Creating an environment for all people to flourish

The H&WB gap, and therefore impact of Initiatives, has been articulated using both clinical & wider determinant measures.

20 key health & wellbeing indicators*	Do nothing	Target	National
Tobacco smoke	18.90% (e.g. adult smoking prevalence)	15.0%	18.0%
High blood pressure	59.4% (e.g. av. % hypertensives diagnosed)	75%	55.8%
High body mass index	67.7% (e.g. % excess weight)	<50%	64.6%
Poor diet	51% (e.g. % '5 a day')	>65%	52.3%
High total cholesterol	0%	100%	SystemOne baseline tbc
Low physical activity	27.6% (e.g. % inactive adults)	<20%	27.7%
High fasting blood glucose	Prev Prog data tbc	Prev Prog data tbc	Prev Prog data tbc
Air quality	5.5 (e.g. mortality PAF)	<5	5.3
Alcohol & drug misuse	687.6	<500	827/474 (e.g. adm. rate M/F)
Poor mental wellbeing	3.8% (e.g. % low satisfaction)	<1.5%	4.8%
Vaccination coverage	40.9% (e.g. flu vacc)	>75%	50.3%
Screening success	22.8% (e.g. % receive HealthCheck)	>50%	18.6%
Patient Activation Measure	Local collection tbc	Local collection tbc	Local collection tbc
Inequalities in healthy life expectancy	63.5 (M) 64.8 (F) (e.g. HLE at birth)	>70 (M) >70 (F)	63.3 (M) 63.9 (F)
School readiness & attainment	64.6% (e.g. reception development)	>75%	66.3%
Neighbourhood safety	63.6 per 1,000 (crime against person)	56.05 (comparator forces)	55.57
Neighbourhood belonging	27,756 (Households)	<25,000 (Households)	N/A
Personal support system	84.1%	Data from NCC tbc	>90%
Accommodation satisfaction	9.3	<6	N/A
Volunteered 1+ times in last yr	136,000	142,000	N/A

* Taken from ONS, PHE, NHS England, DH.
Please note further measures will exist under each indicator

ii We have identified our care and quality challenge at 2016/17

Overview of the C&Q gap

- We are committed to ensuring that all performance standards are achieved or exceeded as detailed in the NHS Constitution and NHS planning guidance.
- The inclusion of agreed trajectories for performance against the key care and quality standards will form the basis for performance managing implementation of this plan. Trajectories will show clear and sustained improvement against targets, enable deficits to be mapped and remedial action to be taken where performance is not as planned.
- We aspire to have all providers rated as at least Good by the CQC. Should any Provider fail to reach this standard, we have robust systems in place to support them to improve as quickly as possible and to ensure continuous improvement and hence patient experience.

<u>National Measures and Standards</u>	<u>Northamptonshire Baseline</u>	<u>Northamptonshire 2021 Target</u>
We will reduce the potential years of life lost (PYLL*) per 100,000 population from causes considered amenable to healthcare	1,976 (2014) – Nene CCG 2,503 (2014) - Corby CCG	1,778 (2021) – Nene CCG 2,252 (2021) - Corby CCG
We will increase the average EQ-5D** score for people reported as having one or more long-term condition	0.744 (2015/16)	0.762 (2021/22)
We will reduce emergency admissions for Chronic Ambulatory Care Sensitive Conditions per 100,000 population	822.4 (2014/15)	740.2 (2021/22)
We will reduce the average number of DTOC beddays per day per 100,000 population	31.(2015/16)	7 (2021/22)
We will improve cancer patients one-year survival for all cancers combined	69.15% (2013)	75.0% (2021)
We will roll out seven-day services to our population so that patients receive the same standards of care, seven days a week	Baseline against 4 standards completed (2015/16)	100% (2021/22)
We will improve and sustain the % of people experiencing first episode of psychosis to access treatment within two weeks and % of people with relevant conditions access to talking therapies in 6 weeks	100% (August 16/17) 2 week access to psychosis treatment 72.2% (June 2016) 6 week access to IAPT	50% 2 week access to psychosis treatment 75% 6 week access to IAPT

iii We have identified our financial gap if we stay as we are

The organisations across the health and social care system have drawn together a single system gap statement using 2016/17 underlying financial start point as the baseline and taking into account anticipated future pressures and allocations. This is shown in chart as a total gap of £m.

For 2016/17 the NHS system has identified an underlying deficit of circa £41m as identified in the table on the right.

Work has been undertaken to assess the size of the challenge going into 2020/21 from 2016/17 and this is estimated at £230m.

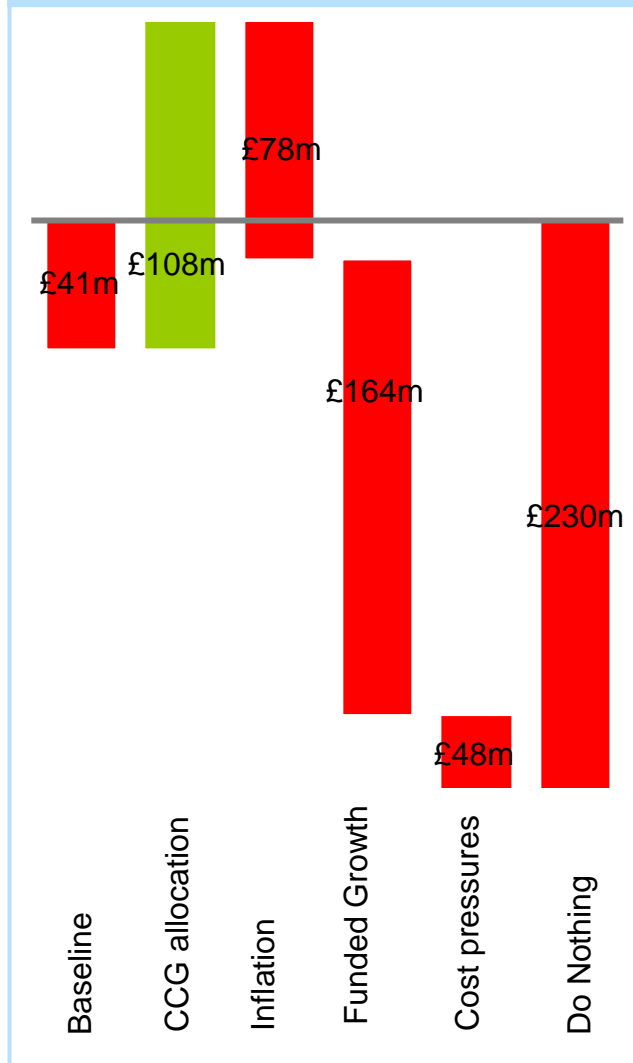
This has made the following key assumptions:

- Application of the key inflation assumptions published by Monitor and NHS TDA on 23rd March 2016;
- Specialist services gap as notified by NHSE;
- Estimate of unfunded pressures on delegated primary care commissioning;
- Application of demographic pressures 1.5% across Nene and Corby CCGs respectively;
- Application of non demographic pressures between 1% and 3% and additional pressures on CHC and prescribing;
- Urgent care pressures have been which has been a significant activity and cost driver in the local system and is currently running at 4% to 5% per annum;
- System cost pressures of 0.5% per annum

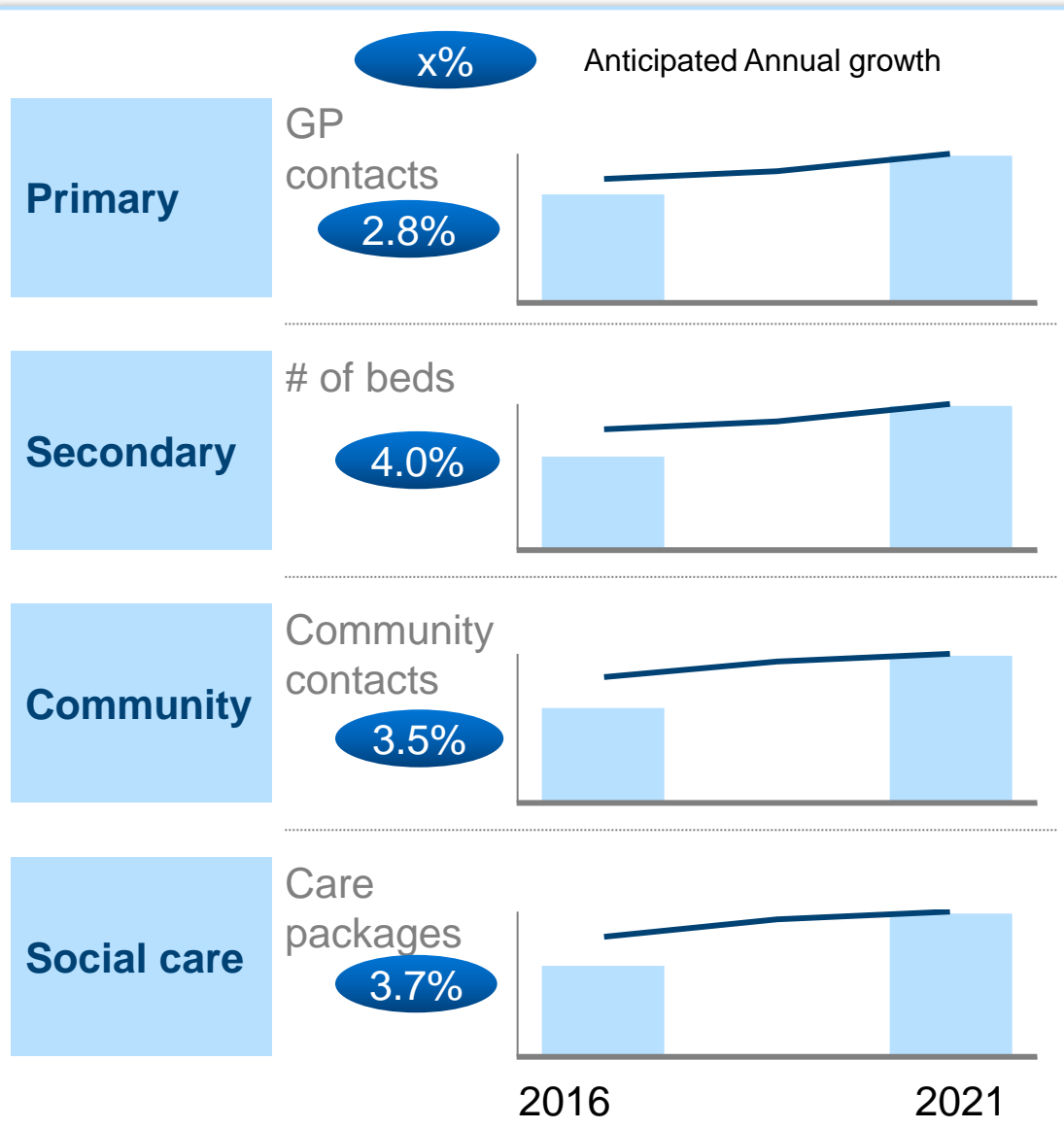
These increases in costs have been offset by the CCG allocations notified for the next four years. Beyond 2016/17 no CIP/efficiency savings or QIPP savings have been factored into the projections and therefore the gap identified is the gross gap.

Local Authority savings relating to Adults Social Care in 2017-18 is £10.4m and this rises to £31.3m. The additional impact of this on health services will be reviewed as plans become developed and is focused into future system planning cycles.

Projected 2017 - 2021 NHS deficit (£m)



Population growth and an increase in complexity of care will lead to a large increase in demand in 2021 under a “do nothing” scenario²



Service impact in 2021 under a “do nothing” scenario

- 150 new GP’s needed by 2021 (according to RCGP)
 - 578,830 new GP Contacts
-
- 283 new hospital beds (@90% occupancy¹)
 - 22,648 more non-elective admissions
-
- 190,439 more community contacts
 - 29 community beds (@90% occupancy)
-
- 2,452 new social care requests
 - 1,756 more ongoing social care packages

¹ 90% occupancy was assumed as a workable figure between current occupancy and national guidance

² Detailed list of assumptions included in the appendix

Quality is central to our plan

Vision for Quality in 2021

Vision:

To reduce variation in the quality and safety of care through a systematic and integrated approach to ensure high quality care and clinical outcomes for local residents.

Quality Assurance and Improvement Objectives:

- Population Wide Quality Outcome Improvement
- Parity of access to safe, high quality healthcare services
- Improved quality outcomes for people with long term conditions
- Improved quality outcomes for people with a learning disability and/or autism
- Increase the number of people having a positive experience of health care
- Increase harm free, effective quality care across all areas of health and social care
- Increase the practice of continual quality improvement through learning from our past mistakes

Key Aims

Description

Plans

Quality Outcomes

Meaningful quality outcome measures will enable us to gauge how well we have achieved our ambition and enable us to refocus our intentions in the future on those with the greatest need.

Local CQUIN monies will be used to drive an STP quality improvement. Soft Intelligence development – clinical and patient soft intelligence development to enhance the quality and richness of information received to enable “you said, we listened, we did” in line with the Francis Report.

Quality Governance

Robust quality governance is essential to achieve our desired outcomes for success through the structure, process, values and behaviours that enable us to provide the assurance that care is safe and of high quality.

Continued development of our quality governance processes to ensure that our commissioning is bound by best practice guidance and this is extended to our members within primary care. Quality Strategy and Assurance Framework will be refreshed to form a strategic alignment with the five year plan.

Quality Surveillance and Assurance

Proactive monitoring, management and evaluation of services to ensure high quality, harm free care; including higher level scrutiny with partners such as NHSE, neighbouring CCGs, CQC, NHSI. Where harm is identified and/or care deemed unsafe the necessary processes are put in place to support and resolve mitigation.

Building a proactive collaborative quality surveillance, assurance and improvement system. Our contingency plan will enable the ad hoc escalation of risk should it arise above a given threshold and be supported by mandated risk registers for identified populations (e.g. Learning Disability)
A focus on proactive safeguarding for children, young people and adults deemed as vulnerable.

Quality Improvement

Quality improvement is the basis for which we continuously challenge quality assumptions, learning from past mistakes and adapting our approach to health care in order to achieve a better focus on improved quality outcomes.

Safeguarding is intrinsically linked to deliver high quality care, working together with partners to drive improvement.

Collaborative working with our providers to further reduce harm and promote a 'lessons learnt' approach to quality and safety improvement. This will include improvement in areas such as pressure ulcer care, falls and performance (RTT/Diagnostics/ Cancer waits), people with a learning disability and/or autism.
Monitor commissioning plans in relation to quality effectiveness change in relation to National guidance and policy.
Continued development of triangulated surveillance and intelligence systems extending to our members within primary care to include quality improvement support.

Our Transformation Initiatives

Our Integrated model of care will be deliver through 5 key areas outlined below and underpinned by a number of enablers



Key Enablers



We will ensure we have appropriate Information Technology links across the county

We will deliver care in the appropriate care setting



We will develop our workforce to support the new delivery models of care

There will be a number of other enablers to support the delivery

Contracting and commissioning

Organisational development

Governance

The patient experience and positive outcomes are at the centre of our Health and Social Care system

Patient Story – Madeline is 54 and has COPD, she is overweight and has previously had multiple admissions to hospital. Madeline also drinks heavily to help her cope. She has recently lost her part-time job and has become withdrawn and isolated.....

Through our transformed system Madeline will receive coordinated support as described below

Urgent care:

Madeline has an agreed Crisis Plan that she holds. She has tried all of her self management techniques but her condition is exacerbating. The co-ordination hub is automatically alerted and work with the ambulance crew to consider available options to manage the escalation. This could be additional intensive support at home, admission to a local health step-up bed for 72 hours to stabilise. On this occasion because there are additional symptoms needing exploration Madeline is admitted to the local acute hospital. Madeline is admitted directly. On arrival Acute colleagues can see her care plan, are aware of her normal ranges and all medication she is currently on avoiding Madeline having to repeatedly relay this information. Her CCT are alerted by text message of her admission. 24 hours later Acute colleagues liaise with the GP and CCT to prepare for her discharge. In the meantime her CCT have organised someone to care for her pet and will provide a volunteer to take her home from hospital and ensure her home is ready, (warm, food, drink etc.). They will also then work alongside the integrated intermediate care team for the first week home.

Complex patient care:

Madeline has been identified as being at risk of becoming increasingly dependent on statutory services. Her GP engages her with her local Collaborative Care Team who undertake a holistic assessment and identify current Patient Activation level. She is allocated a befriender to do regular visits during next few months to act as an advocate and supported by Peer Workers to join the local COPD community asset clinic. This is co-produced by people with respiratory conditions and provides social engagement, education and access to professional advice in an informal setting. The group also has its own psychosocial therapist. Gaining confidence in self management through the group and coaching provided Madeline also joins the Breathe Easy Choir which helps maintain lung function and further build friends / support network. Madeline has telehealth monitoring equipment at home which provides early alert to the coordination hub should any of her readings begin to move out of range.

Scheduled care:

Madeline has suffered with moderate eczema since she was a child, a condition which may start any age but is most common in children, affecting 1 in every 5 children in the UK at some stage. As an adult, Madeline's eczema is self-managed with the support of her GP; unfortunately from time to time her condition is exacerbated. As this results in being extremely irritable, sore and with a risk of dehydration and infection, Madeline is immediately referred by her GP to an Intermediate Dermatology Clinic.

The Northamptonshire Dermatology Service provides Intermediate Clinics delivered by a Multi-Disciplinary Team that is in a convenient community location only a few miles from Madeline's home and on a serviced public transport route, which means that she can attend appointments inexpensively and with minimum disruption to her life. Upon referral, Madeline is triaged and seen by either a Specialist Nurse, GP with a Special Interest in Dermatology or her Consultant, to provide the most appropriate and consistent care for her condition.

Madeline could also have her trips to the clinic organised through the Non-Emergency Patient Transport Service, if she was eligible or alternatively she would be signposted to her local Voluntary Car Scheme.

Prevention & Wellbeing:

Through social prescribing Madeline can access six counselling sessions to help avoid depression/anxiety developing. She will also have three sessions with the local CAB to deal with mounting debt due to loss of employment.

Addressing the debt worries will allow Madeline to attend a prescribed 6 week support group with the local community drug and alcohol support centre to deal with increasing dependency on alcohol as a coping mechanism, then following on appointment fixed with local volunteer centre to start some supported volunteering to increase employability skills.

Urgent Care Pathway

Urgent care:

Madeline has an agreed Crisis Plan that she holds. She has tried all of her self management techniques but her condition is exacerbating. The co-ordination hub is automatically alerted and work with the ambulance crew to consider available options to manage the escalation. This could be additional intensive support at home, admission to a local health step-up bed for 72 hours to stabilise. On this occasion because there are additional symptoms needing exploration Madeline is admitted to the local acute hospital. Madeline is admitted directly. On arrival Acute colleagues can see her care plan, are aware of her normal ranges and all medication she is currently on avoiding Madeline having to repeatedly relay this information. Her CCT are alerted by text message of her admission. 24 hours later Acute colleagues liaise with the GP and CCT to prepare for her discharge. In the meantime her CCT have organised someone to care for her pet and will provide a volunteer to take her home from hospital and ensure her home is ready, (warm, food, drink etc.). They will also then work alongside the integrated intermediate care team for the first week home.

We will transform our urgent and emergency care system with four key interventions

Vision for Urgent care in 2021

- For those people with urgent but non-life threatening physical or mental health or social care needs we will provide highly responsive, effective and personalised services, outside of hospital, or delivered as close to peoples homes as possible, thus minimising disruption and inconvenience for patients, their carers and families.
- For those with more serious or life threatening emergency physical or mental health needs we will ensure they are treated in centres with the very best expertise, delivering high quality and safe services in order to optimise patient outcomes and enable as many people as possible to safely return to their own homes.
- Ensure delivery of the greatest value from every NHS and Social Care pound invested.

Key initiatives

Rapid access to Primary and community care

- Collaborative, multi-disciplinary approach to managing same day demand for primary and community care through shared, integrated resource
- Aligned / integrated 24/7 service
- Enhanced primary care mental health pathways
- Focussed support to care homes
- Community initiated IV therapy

Enhanced routine care and discharge support in the community

- MDT approach to assessing , coordinating and meeting complex patient needs in the community
- Optimising Telehealth and Telecare
- Timely access to community based services for key patient groups e.g. those with eating disorders, mental health and alcohol issues and children & young people with complex needs.
- Single point of access to discharge, reablement and rehab services to significantly reduce discharge delays – ‘home first’

Rapid and coordinated urgent care and crisis response

- 24/7 SPA via 111 for rapid assessment and advice which has access to the full range of services available to treat and support people in their home, local community or non acute setting (intermediate care)
- 24/7 mental health crisis response and intensive home treatment service/ crisis house
- Enhanced hear/ see and treat approach
- Rapid access community based services for key patient groups e.g. frail older people and children, LD access teams

Emergency and acute care

- Effective streaming and redirection of patients on arrival at A&E
- GP & EMAS direct access to advice, assessment and treatment services to avoid A&E attendance
- Optimised use of ambulatory Care Services
- Achievement of the 7 day service clinical standards
- Adoption of new medical models of acute care
- Optimised patient flow improved via internal patient care and review process/systems
- All age mental health liaison services available 24/7
- Configuration of services to optimise outcomes and efficiency.

Key Impact areas

- Reduction in A&E attendances and emergency admissions for physical and mental health reasons
- Release GP time to re-invest in complex and scheduled care
- Timely intervention to prevent unnecessary escalation and admission
- Improved patient satisfaction
- Reduction in acute occupied bed days and community admissions and occupied bed days.
- Increasing proportion of patients discharged to place of usual residence
- Reduced re-admission rates
- Improved quality of care and care delivered in the right setting
- Improved quality of life
- Right care, right place, right time
- Reduce acute demand
- Streamlining access
- Reduction in conveyances
- Consistent high quality services 24/7
- Right access first time
- Improved mortality and morbidity
- Reduce proportion of commissioning resource spent on acute care
- Delivery of national standards
- Better management of Mental Health needs in acute hospital settings

Total financial impact

£12m net

Rapid Access to Primary and Community Care

Baseline

Target driver

- Same day access to primary care - Reducing A&E attendance

Transformation Objectives

For those people with urgent but non- life threatening physical, mental health or social care needs we must provide highly responsive, effective and personalised services outside of hospital, delivered in, or as close to, peoples homes as possible, thus minimising disruption and inconvenience for patients, their carers and family.

Progress

Delivery through the Primary Care pathway.
Federation models emerging
detailed planning yet to be undertaken.

Project(s) Description

- Same day access to an appropriate health or social care professional via a GP led multi-disciplinary service model which includes therapists, pharmacists, community physical and mental health nurses and social workers. Delivery will be through a network of practices and/or hubs within each Federation, with services available from early morning into the evening, 7 days a week.
- Out of Hours services will be either aligned or integrated with the daytime same day access service.
- Enhanced support to care homes to enable them to confidently and safely respond to a range of routine and urgent care health and wellbeing needs, thereby reducing A&E attendances and acute admissions for these residents.
- New models of care to ensure consistent, effective, compassionate primary care mental health services.
- Community Initiated IV therapy

Impact

Activity and capacity

- Reduction in A&E attendances for physical and mental health reasons
- Reduction in acute and mental health admissions
- Release GP time to re-invest in complex and scheduled care

Health and wellbeing

- Earlier resolution or management of health and social care concerns
- Increased self management
- Improved access to local support and advice.

Care and quality

- Timely access to treatment and support from the most appropriate health or social care professional within local communities.
- Improved patient satisfaction
- Acute providers more able to focus on patients who genuinely require their expertise.

Enhanced Routine Care and Discharge Support

Baseline

Target Driver

- Admission avoidance
- Reduced A&E attendance
- Reducing LOS

Transformation Objectives

The care of patients living with long term and complex conditions will be integrated and personalised with multidisciplinary community health, social and voluntary services teams delivering joint assessment, care planning, care coordination and self care support to ensure that;

- Patients are better equipped to self manage their condition and are fully involved in developing their care plan which is reviewed with them regularly.
- Routine monitoring and support and care coordination enables wherever possible risks and signs of deterioration to be appropriately managed at home or in the community.
- All partners have access to key information about a patient's condition and their care plan (with consent) ensuring their response is personalised to their needs.

The first and preferred option for all inpatients will be discharge home, where support is required to achieve discharge this will be coordinated via a single access point and available promptly.

Project(s) Description

- Extensive Care, very high and high risk patients (5% of the population) as detailed in the complex patient care section.
- Collaborative care, medium and low risk patients (5-20% of population) as described in the complex patient care section.
- In reach to acute and discharge interface by primary/community staff as detailed in the complex patient care section.
- Use of Telehealth and Telecare solutions will be optimised to support maintaining patients in their own homes.
- Services for inpatients who require support in order to be discharged will be accessed via a single contact point. The focus will be on maximising the number of people who are able to return to their own homes and to significantly reduce discharge delays.
- Timely access to community based services for key patient groups e.g. those with eating disorders, mental health and alcohol issues, learning disabilities and children and young people with complex needs.

Progress

Delivery through the complex care pathway - detailed planning to be completed.

Impact

Activity and capacity

- Reduction in A&E attendances
- Reduction in acute admissions
- Reduction in acute occupied bed days
- Reduction in re-admission rates
- Reduction in admissions to community beds and bed days occupied in the community.

Health and wellbeing

- Improvement in the health and wellbeing of patients with complex and long term conditions
- Increased self management

Care and quality

- Improved quality of care
- Patient involved in care planning, delivery and review
- Increased patient satisfaction
- Greater patient empowerment and confidence
- Improved outcomes and quality of life
- Streamlined and coordinated access to services
- Care delivered in the right setting
- Increased proportion of patients discharged to their usual residence

Rapid and Coordinated Urgent Care and Crisis Response

Baseline

Target Driver

- Increased 111 transfers to clinical advisor
- A&E avoidance
- Increasing EMAS non-conveyance

Transformation Objectives

24/7 single point of access for the public, via 111, to rapid initial assessment and advice on their urgent and emergency care needs and support to access the full range of services available to support their requirements, with the intention of ensuring that where clinically appropriate their needs are addressed within their local community and where necessary they have rapid access to the appropriate specialist acute services.

Progress

Initial actions are being pursued through 16/17 delivery plan

Project(s) Description

- 24/7 single point of access service, via 111, which delivers rapid assessment and advice via a clinical decision hub and which can access a range of primary care and urgent and intermediate community physical and mental health services, social services and voluntary support, as well as an emergency response from the ambulance service, to ensure an appropriate response to meeting peoples' needs.
- A 24/7 community mental health crisis response and intensive home treatment service
- Rapid access to community based ambulatory assessment and treatment services for key patient groups e.g. Frail older people and children, which can also support the management and treatment of certain medical conditions, with the overall intention of avoiding the need for acute care.
- EMAS provided hear and see and treat services to avoid the need to convey certain patients to hospital.
- Learning disability intensive support services.

Impact

Activity and capacity

- Reduction in A&E attendances of physical and mental health reasons
- Reduction in acute and mental health admissions
- Reduction in conveyances to hospital

Health and wellbeing

- Improved rapid access to local treatment and support
- Increased self management

Care and quality

- Streamlined rapid response to handling peoples' urgent and emergency health and social care concerns to deliver the right care, right time in the right setting.
- Improved coordination and support to access the appropriate service and support locally
- Improved patient satisfaction
- Acute providers more able to focus on patients who genuinely require their expertise

Emergency & Acute Care

Baseline

Target Driver

- Compliance with 7 day standards
- GP rapid access to advice, assessment and diagnostics
- Reducing LOS

Transformation Objectives

Patients with serious or life threatening emergency physical or mental health needs will be treated in centres with the very best clinical expertise, delivering high quality and safe services in order to optimise patient outcomes and enable as many people as possible to return to their own homes.

Progress

Actions are being pursued through 16/17 delivery plan

Project(s) Description

- Effective streaming and redirection of patient on arrival at A&E
- Delivery of compliance with the national 7 day service clinical standards for the 10 key specialties identified.
- Configuration of services to optimise service outcomes and efficiency
- Hospital internal patient care and review processes and systems will be improved to optimise patient flow and support timely discharge e.g implementation of SAFER principles,
- thereby contributing to a significant reduction in bed days lost to Delayed Transfers of Care.
- The use of Ambulatory Care Services to avoid inpatient admission will be optimised.
- GPs & EMAS will have direct access to outpatient, ambulatory, diagnostic and assessment services to avoid the need to refer patients to A&E services.
- All age mental health liaison services will be available in acute trusts 24/7

Impact

Activity and capacity

- Reduction in A&E attendances
- Reduction in inpatient admissions
- Reduction in acute provider bed occupancy and bed requirements
- Increase in use of Ambulatory Care pathways

Health and wellbeing

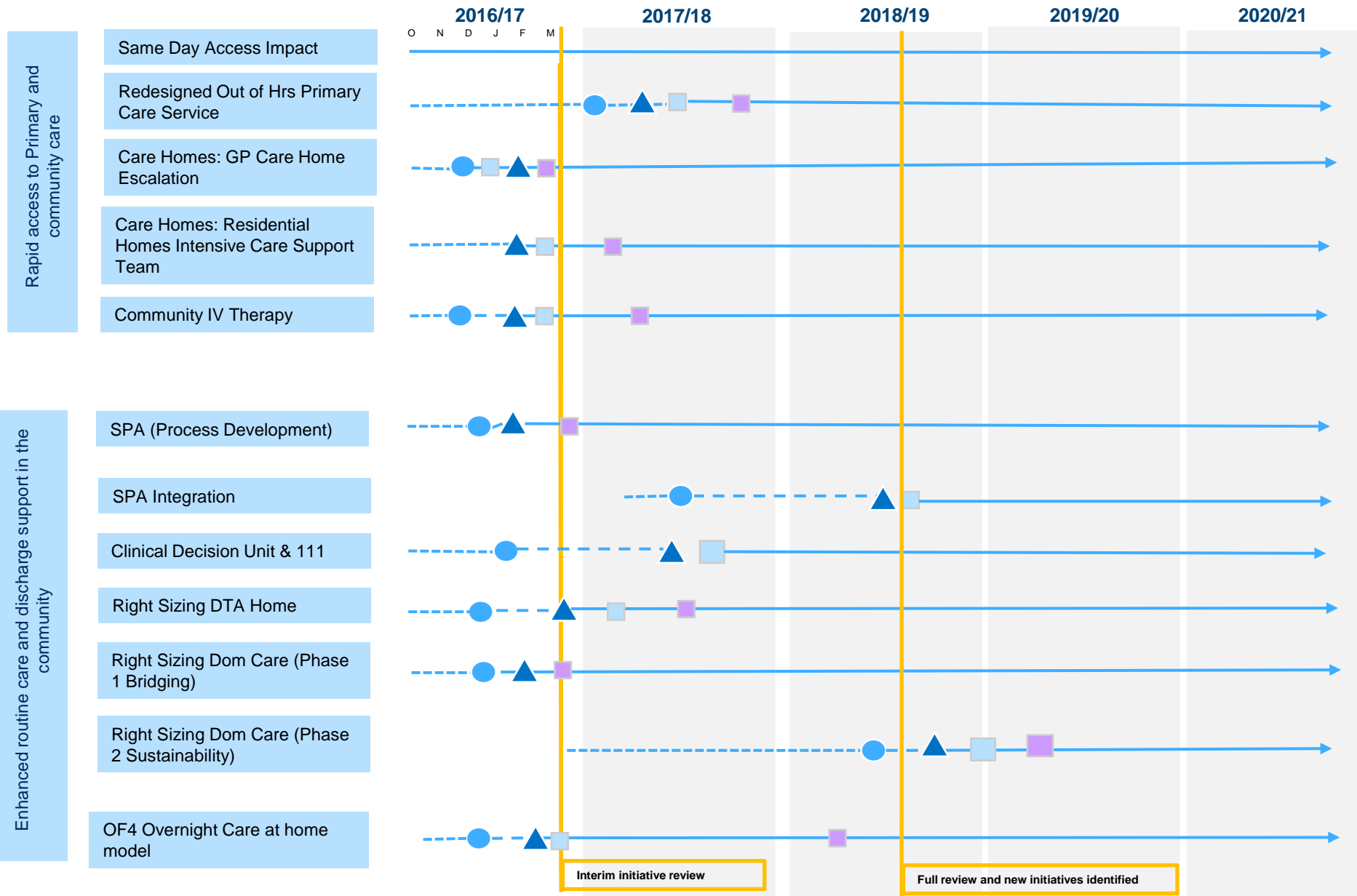
- Improved mortality and morbidity
- Improved patient experience/satisfaction
- Risk of elderly patients decompensating whilst in hospital significantly reduced improving their ability to continue to live within their own home.

Care and quality

- Assessment and treatment provided by the right person, at the right time in the right setting.
- Delivery of high quality services consistently across the week.
- Delayed Transfers of Care reduced to within the national 3% target and timely discharge of all patients improved.
- Improved ambulance handover times to meet national standards.

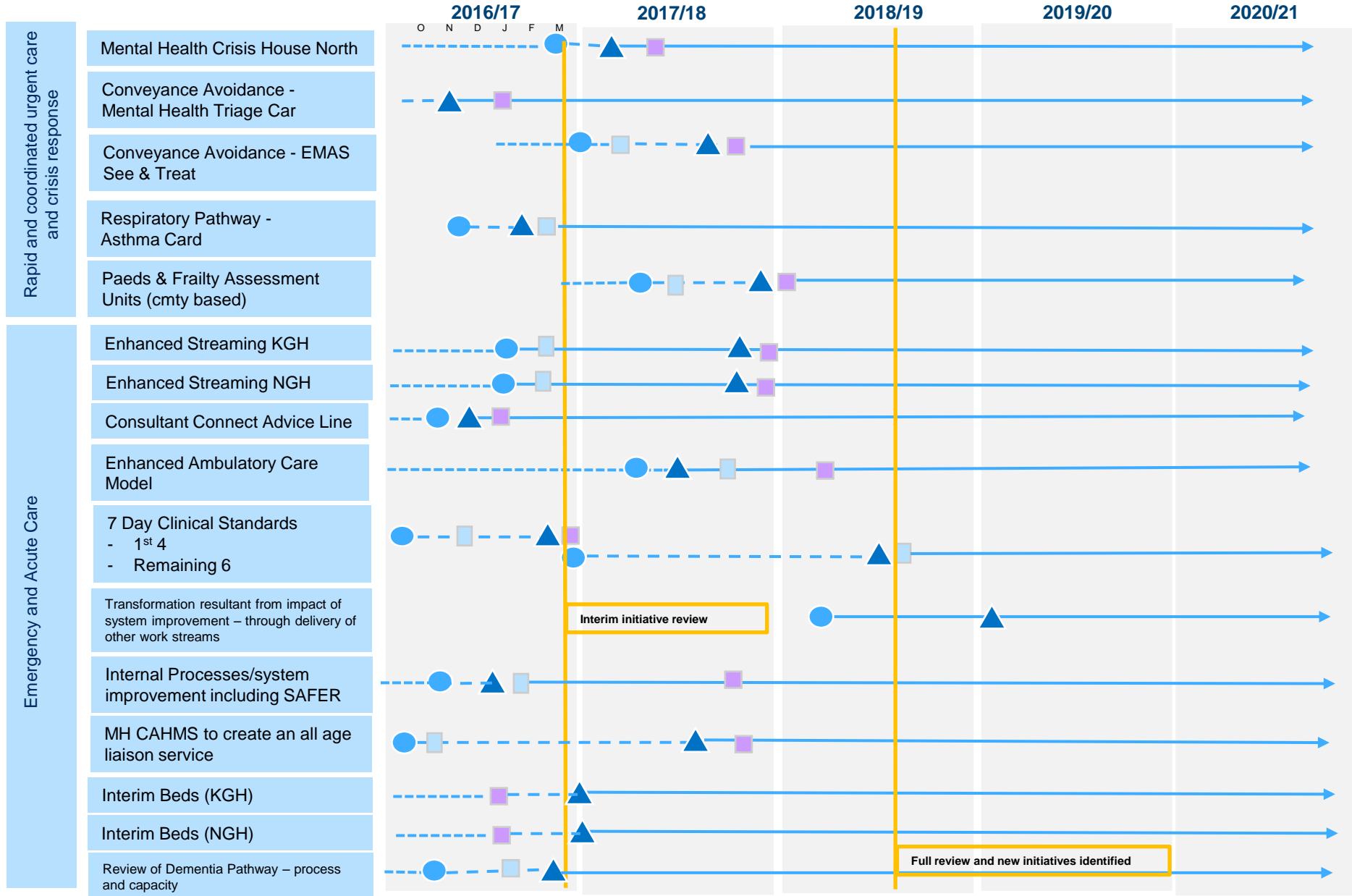
Key milestones for delivering the urgent and emergency care system

- Planning/ mobilisation
- Roll-out started
- Ramp up
- ▲ Fully rolled out
- Ongoing delivery
- Impact begin/maximise (indicative)
- Impact begin/maximise (indicative)



Key milestones for delivering the urgent and emergency care system

- Planning/ mobilisation
- Roll-out started
- Ramp up
- ▲ Fully rolled out
- Ongoing delivery
- Impact begin/maximise (indicative)



Complex Patient Care

Complex patient care:

Madeline has been identified as being at risk of becoming increasingly dependent on statutory services. Her GP engages her with her local Collaborative Care Team who undertake a holistic assessment and identify current Patient Activation level. She is allocated a befriender to do regular visits during next few months to act as an advocate and supported by Peer Workers to join the local COPD community asset clinic. This is co-produced by people with respiratory conditions and provides social engagement, education and access to professional advice in an informal setting. The group also has its own psychosocial therapist. Gaining confidence in self management through the group and coaching provided Madeline also joins the Breathe Easy Choir which helps maintain lung function and further build friends / support network. Madeline has telehealth monitoring equipment at home which provides early alert to the coordination hub should any of her readings begin to move out of range.

Our complex patient care programmes are...

Total financial impact

£27m net

Vision for care for people with complex needs in 2021

- Patient-centred approach to care (through population segmentation) where needs are identified and met, no matter if they are physical, mental or social (e.g., respiratory, circulatory, mental health, learning disabilities)
- Proactive support for people at higher risk of an adverse effect of their condition incl. the right coordinated care and support to reduce the risk of undesirable events
- Seamless intervention to ensure the effect of an individual's condition on their quality of life, function and longevity is softened
- Empowerment of people, carers and families so they can manage their health and make decisions about their care
- Agreement between the individual (together with their carers and family as appropriate) and the care professional to help manage their day-to-day care
 - This agreement, or care plan, will be continually updated to ensure it captures the whole needs of the individual (incl. personal goals, physical and mental health, social care needs)
 - It will be available to the individual and the people involved in their care
- A workforce empowered to deliver across traditional boundaries, working at the top of its skill level and promoting independence and responsibilities for individuals.
- Maximisation of remote monitoring and information technologies to support self-care and seamless care across all parts of health and social care

Key initiatives

Description

Key Impact areas

Proactive Care (top 20% of population)

Coordinated care from a MDT of health and social care professionals for those with complex needs living in the community to support each patient to achieve his/her health and wellbeing goals, to improve the management of exacerbations and empower people to manage their health and wellbeing. Each person will have a comprehensive assessment, personalised care plan, a dedicated care coordinator and support from an MDT. Those at the highest risk will have their care coordinated by an extensivist doctor and receive the most intensive support.

- Improved quality of care including continuity of care, seamless delivery for patients with clear care plan, reduced crises
- Better quality of life, e.g., people supported to stay independent
- Reduced managerial cost, e.g., through less duplication
- Reduced acute demand
- Treatment in appropriate setting
- Knowledge sharing between providers

Intermediate care (top 20% of population)

Our new intermediate care service will operate as one but will not necessarily be a single team or organisation. It will provide the four types of intermediate care set out in national guidance – crisis response, home-based rehabilitation, bed-based rehabilitation and reablement. Patients experiencing a crisis or recovering from a spell in hospital will be able to access the intermediate care service for a period of up to six weeks. At the end of their episode, patients will ideally return to their previous home environment (with adaptations where required) or the most suitable alternative.

- Reduced avoidable non-elective admissions to acute care
- Improved safety and speed of discharge from hospital
- Improved access to rehabilitation and reablement at home
- Improved long-term outcomes following rehabilitation
- Integrated approach between health and social care

Specialist care (top 20% of population)

Transform specialist care to meet the needs of people with complex physical and mental health co-morbidities including frailty. Deliver services that provide adequate access to specialist input, minimise harms and ward moves and provide care that is compassionate and person-centred.

- Consistent approach to specialist care countywide
- Optimised inpatient pathways performing to best practice length of stay and readmissions
- Reduced cost through increased throughput

Enablers

Our three complex care programmes will be supported by linked datasets, an effective risk stratification model, an outcomes framework, capitated budgets and a new (MCP) contract.

- Ability to target the right patients with the right care
- Improved measurement of impact
- Shared incentives/risks

Proactive care

Baseline

Target Driver

- “Reduce cost of care”
- “Reduce demand growth”

Transformation Objectives

- Segment the population and deliver a suite of targeted interventions to proactively manage the health and wellbeing of the whole population.
- Implement optimised disease pathways for individual long-term conditions.
- Introduce new measures to promote self-management.
- Strengthen and expand the case management approach by developing integrated, multi-disciplinary teams in the community to assess, plan and coordinate care in partnership with individual patients.
- Build resilience in care homes through a suite of targeted interventions.
- Deliver the improvements for people with LD, as described in the transforming care programme

Progress

- Programme team in place
- Delivery plans for 17-19 in place

Project(s) Description

- **Disease management** – optimise care packages for certain long-term conditions – diabetes, heart failure, atrial fibrillation and COPD.
- **Self-management** – patient activation and empowerment to manage their own long-term conditions via education programmes, health coaching, telehealth and other approaches.
- **Case management** – introduce coordinated and proactive care from a MDT of health and social care professionals for those with complex needs living in the community to support each patient to achieve his/her health and wellbeing goals, to improve the management of exacerbations and empower people to manage their health and wellbeing. Each person will have a comprehensive assessment, personalised care plan, a dedicated care coordinator and support from an MDT. Those at the highest risk will have their care coordinated by an extensivist doctor and receive the most intensive support.
- **Care homes** – build resilience in care homes through a tailored learning and development programme, an improved interface with and support from primary care, access to proactive and intermediate care.
- **Learning Disabilities** - Transform care for people with learning disabilities in Northants by: increasing choice for patients/families via personal budgets, providing more care in the community, increasing early intervention and support, and strengthening care and treatment reviews.

Impact

Health and wellbeing

- Improved performance against the ‘20 health and wellbeing indicators’ (see HWB challenge slide for details)
- Improved personal wellbeing of patients, as they receive more personalised and integrated care

Care and quality

- This is expected to have a significant impact on the EQ-5D for LTC score as integrated complex care follows the patient not the organisation
- This should also reduce emergency admissions for ACS conditions and improve life expectancy from an improvement in all-round integrated care

Intermediate care

Baseline

Target Driver

- Deliver a quality sustainable service
- “Reduce long term care packages”
- “Effectively manage demand growth”

Transformation Objectives

- Integrate and consolidate current intermediate care services across health and social care to provide up to 28 days home- and bed-based rehabilitation, crisis response and reablement countywide based on a single, comprehensive assessment and accessed via a single point of access.
- Reduce the number of intermediate care beds and increase the number of home-based rehabilitation/re-ablement services and telecare.
- Develop a pro-active in-reach service with secondary care to increase the impact of intermediate care on avoidable non-elective admissions and facilitated early discharges
- Embed the ‘Home First’ principle across the Health and Care economy partners through OD development and training

Project(s) Description

- **Single Point of Access** – a hub for the county provides telephone and e-referral access to the four intermediate care pathways, optimizing access and capacity
- **Comprehensive assessment** – a single, comprehensive assessment process is used across health and social care and the intermediate care service to identify need and develop an appropriate care plan.
- **Reablement** – effective reablement support for people for up to up to 28 days at home from an integrated intermediate care service with upper quartile benchmark performance and sufficient capacity to meet demand.
- **Home-based rehabilitation** – personalised rehabilitation programme of care delivered by a skill-mixed and integrated team of health and social care professionals with upper quartile benchmark performance and sufficient capacity to meet demand.,
- **Bed-based rehabilitation** – effective bed-based rehabilitation programmes delivered from a right-sized bed base across the county achieving upper quartile performance.
- **Crisis response** – rapid response within 2 hours from a skill-mixed team of health and social care professionals to avoid unnecessary admission to hospital/care.
- **Telecare**- Optimisation of telehealth and telecare, to improve self –management and reduce dependancy.

Impact

Health and wellbeing

- Improved performance against the ‘20 health and wellbeing indicators’ (see HWB challenge slide for details)
- Improved personal wellbeing of patients, as they receive more personalised and integrated care
- Improve independence scores avoiding or delaying the need for long term care

Care and quality

- This is expected to have a significant impact on the EQ-5D for LTC score as integrated complex care follows the patient not the organisation
- This should also reduce emergency admissions for ACS conditions and improve life expectancy from an improvement in all-round integrated care
- Improve LTC , and Dementia Public Health and ASCOF outcomes ratings

Specialist care

Baseline

Target Driver

- “Reduce cost of care”
- “Effectively manage demand growth”

Transformation Objectives

- Transform specialist care to meet the needs of people with complex physical and mental health co-morbidities including frailty.
- Deliver services that provide adequate access to specialist input, minimise harms and ward moves and provide care that is compassionate and person-centred:
- Address sustainability issues in identified specialties through collaborative working countywide

Progress

- Interdependencies with urgent care identified and modelled
- Electronic templates for comprehensive assessment being piloted
- Discussions underway with acute providers on specialty outreach into the proactive care model

Project(s) Description

- **Comprehensive Interdisciplinary Assessment** embedded within the hospitals and informed by community team
- Collaborate with the Urgent and Emergency Care Team in extending the rollout of the **SAFER bundle** to ensure patients receive:
 - Senior review from a consultant every day before midday
 - Treatment on the right ward with reduced chance of ward moves
 - An Expected Discharge Date agreed with him/her and family/carer
 - Early discharge before midday with the aftercare in place (as required)
 - Follow-up in the community as required (proactive care)
- Effective **front-door frailty model** at both hospitals to avoid unnecessary admission and provide early advice from a specialist to inform the inpatient care plan.
- **Right-sized acute bed capacity** countywide
- **Specialty staff outreach** to participate in multi-disciplinary teams in the community delivering proactive care
- Improving pathways of care in physical health inpatient services for people with co-morbid functional and/or organic mental health conditions (e.g. delirium, dementia, depression, anxiety and chronic mental health problems).

Impact

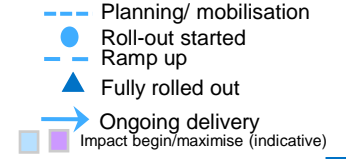
Health and wellbeing

- Improved performance against the ‘20 health and wellbeing indicators’ (see HWB challenge slide for details)
- Improved personal wellbeing of patients, as they receive more personalised and integrated care

Care and quality

- Reduced emergency admissions for ambulatory care sensitive conditions
- Reduced delayed transfers of care per 1,000 population
- Improved performance against 7 day service standards

Key milestones for delivering the Complex Patient Care Programme



Scheduled Care

Scheduled care:

Madeline has suffered with moderate eczema since she was a child, a condition which may start any age but is most common in children, affecting 1 in every 5 children in the UK at some stage. As an adult, Madeline's eczema is self-managed with the support of her GP; unfortunately from time to time her condition is exacerbated. As this results in being extremely irritable, sore and with a risk of dehydration and infection, Madeline is immediately referred by her GP to an Intermediate Dermatology Clinic.

The Northamptonshire Dermatology Service provides Intermediate Clinics delivered by a Multi-Disciplinary Team that is in a convenient community location only a few miles from Madeline's home and on a serviced public transport route, which means that she can attend appointments inexpensively and with minimum disruption to her life. Upon referral, Madeline is triaged and seen by either a Specialist Nurse, GP with a Special Interest in Dermatology or her Consultant, to provide the most appropriate and consistent care for her condition.

Madeline could also have her trips to the clinic organised through the Non-Emergency Patient Transport Service, if she was eligible or alternatively she would be signposted to her local Voluntary Car Scheme.

Our plans for Scheduled Care Services are...

Vision for Scheduled Care in 2021

- Co-created new service delivery models for specialties e.g. Dermatology and Rheumatology will predominantly be delivered in the community through effective partnership working.
- Musculo-Skeletal and Orthopaedic services will have community based clinics ensuring that patients are appropriately assessed and navigated through clear, LEAN pathways. Those that need procedures and surgical interventions will be delivered in an acute care setting.
- The seven other specialties are: Pathology, Radiology, Urology, ENT, Ophthalmology, Gynaecology and Cardiology
- Shared back office functions where efficiencies can be unlocked without compromising care delivery

Key initiatives

Description and Scope

Key Impact areas

Scheduled Care

Right sizing of acute care provision to support delivery of high quality care that meets elective demand in the 10 specialities under review. This will include ongoing work with our hospital and community based health and social care partners to integrate services to reduce avoidable hospital admissions and lengths of stay

Review and redesign of clinical services across the Trusts to eliminate variation, establish and deliver opportunities for collaboration that unlock efficiencies and deliver best value from our combined resources. We will consider all options for 10 specialties initially; from shared pathways and standards to a single site for each speciality. In doing so we will engage fully with patient, carers and stakeholders, building on our existing work with these groups.

Work with tertiary partners for specialist services to achieve and exceed minimum clinical standards.

Seize opportunities presented to exploit the efficiency and productivity opportunities highlighted by the Carter Review and maximise opportunities through collaborative working

- Reduced variation
- Clearer pathways for patients to navigate
- Improved quality of care through joint MDT's for complex cases
- Continuous improvement and learning through increased joint working
- Increased productivity, meeting benchmarked best practice
- Sustainability of clinical expertise through shared caseloads
- Appropriate use of estate and infrastructure through redesign and productivity

Total financial impact

£11m net

Scheduled Care

Baseline

Target driver

- Reduce variation in cost & quality
- Increase productivity
- Ensure accessibility
- Sustainability of services
- Financial savings

Transformation Objectives

- Delivery of the 10 identified specialities for acute collaboration between KGH and NGH. Delivering single service models that are integrated across the county and involving a range of partners pertinent to the redesign of each clinical service.
- Co-created, shared and integrated services providing efficient and productive scheduled patient pathways
- Redesign of provision where possible whilst maintaining accessibility
- Shared workforce and MDT working across patient pathways using clear and productive processes.

Project(s) Description

- Rheumatology – Single county-wide service and single point of referral; Integrated clinical pathways between community and hospital-based care; Multidisciplinary care model with combined clinical and workforce resource
- Dermatology – Single service offering across two acute sites and community locations. Integration of services and standardisation of pathways to reduce variation, provide robust governance and assurance and improve access
- MSK – Single service operating across two acute sites with a single point of access MSK triage service
- Cardiology – Single county-wide service
- Pathology – Single county-wide service
- Ophthalmology, Radiology, ENT, Gynaecology, Urology to be defined once redesigned

Progress

Progress has been maintained in the 3 key specialities that are resourced (Orthopaedics, Rheumatology and Dermatology). We have also seen developments in Cardiology and Pathology with the agreement to deliver single service models across the two hospitals

Legally binding MoU which underpins the federation has been signed in October.

An additional programme manager has started with the team and will work on the cardiology and Pathology programmes initially.

The remaining services will move towards implementation as resources become available

Impact

Activity and capacity

- A reduction in length of stay and avoidable admissions
- Repatriation of elective activity from other NHS & non-NHS providers
- Reduction in outpatient appointments in acute settings

Health and wellbeing

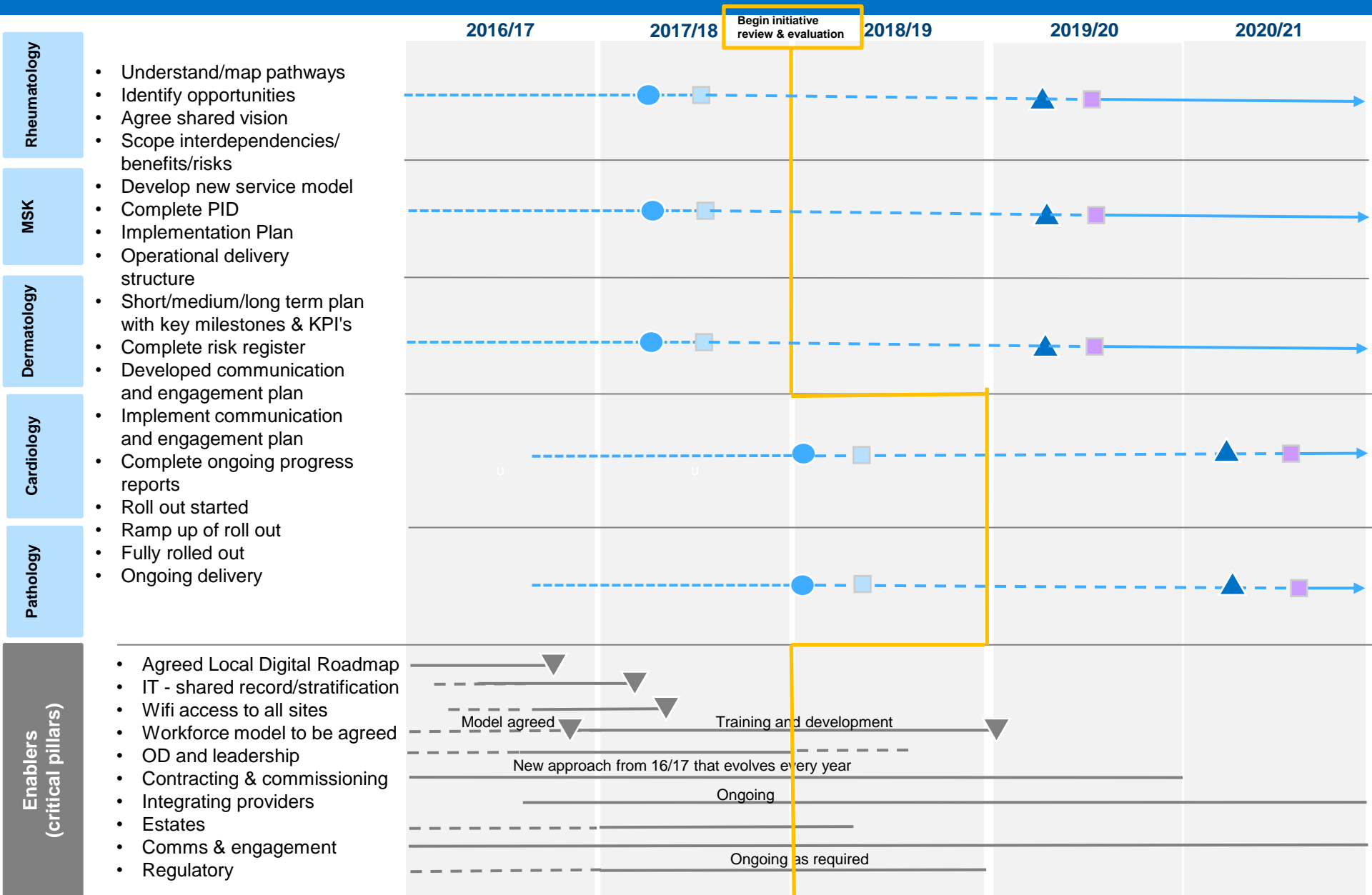
- Support for the prevention agenda through delivery of 'lifestyle' clinics to help patients stop smoking, lose weight and stop drinking.

Care and quality

- Delivery of national access standards for elective and urgent & emergency care
- Elimination of variation in clinical services
- Delivery of 7DS clinical standards for urgent & emergency care

Key milestones for delivering Scheduled Care

- Planning/ mobilisation
- Roll-out started
- Ramp up
- ▲ Fully rolled out
- Ongoing delivery
- Impact begin/maximise (indicative)



Begin initiative review & evaluation

Prevention, Community Engagement and Patient Activation

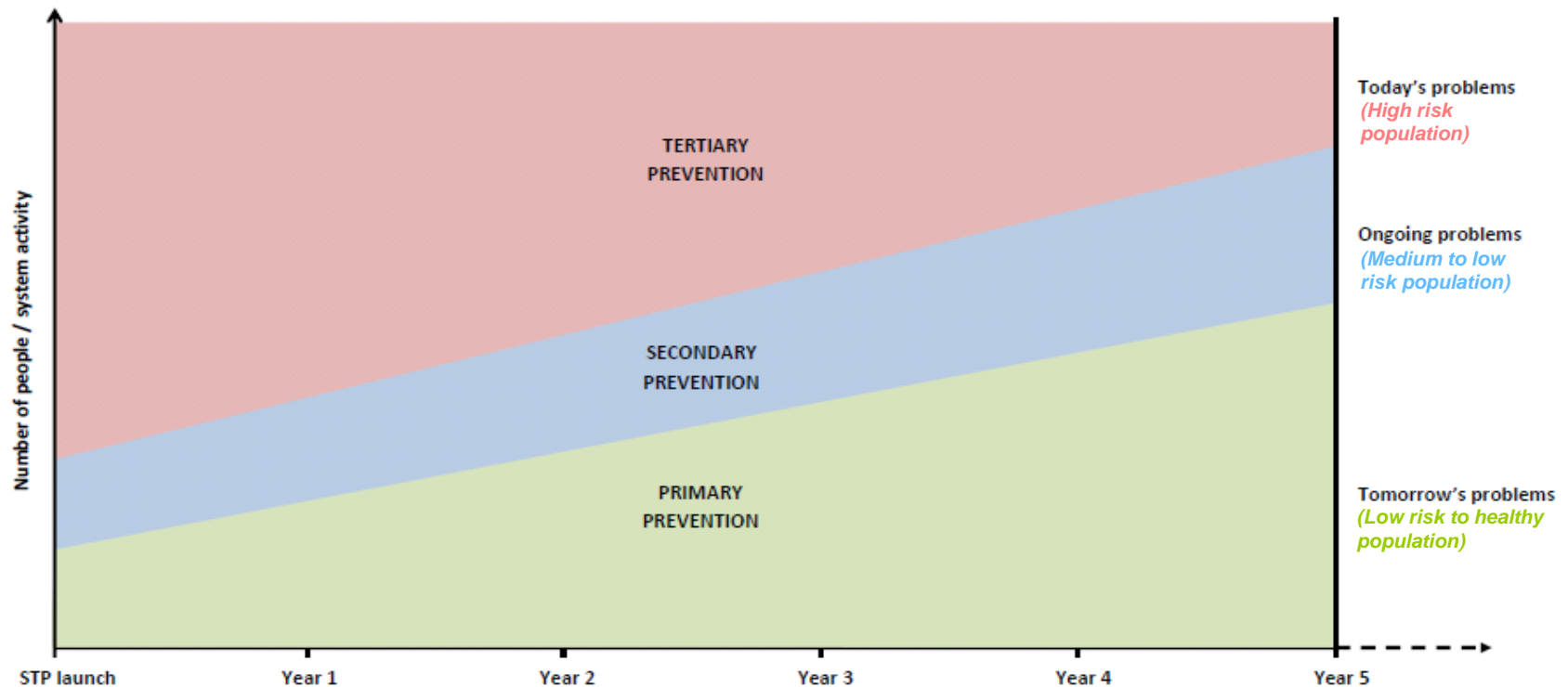
Prevention & Wellbeing:

Through social prescribing Madeline can access six counselling sessions to help avoid depression/anxiety developing. She will also have three sessions with the local CAB to deal with mounting debt due to loss of employment.

Addressing the debt worries will allow Madeline to attend a prescribed 6 week support group with the local community drug and alcohol support centre to deal with increasing dependency on alcohol as a coping mechanism, then following on appointment fixed with local volunteer centre to start some supported volunteering to increase employability skills.

Prevention, community engagement and patient activation transformational initiatives

- Programme is initially focused on helping to stabilise the system by increasing tertiary prevention through social prescribing, reducing clinical variation & optimising care (including social and emotional support and self-care).
- Secondary prevention is enhanced through improved communication and social marketing campaigns and further reductions in clinical variation.
- Primary care becomes the focus of the programme once pressure and funding are released, to ensure demand continues to reduce and the quality of life and life chances of citizens are optimised.



Prevention, community engagement and patient activation transformational initiatives

Vision for Prevention, Community Engagement & Patient Activation in 2021

The vision for prevention, community engagement and patient activation is that commissioners & clinicians use a framework of engagement through networks of VCSE groups and organisations, HealthWatch, Patient Engagement Groups & 1:1s. An informed ongoing commissioning cycle is entrenched with continuous input from current and future service users. All engagement is advance planned & runs in parallel with decision making to allow input, change and feedback from inception. Citizens therefore live & interact in supportive and safe home & community environments. Citizens have a sense of purpose and build social capital through involvement in the VCSE sector. Unhealthy lifestyle risk factors, and the impact of wider determinants of health, are understood and informed, healthy choices are made easier; leading to fewer citizens developing disease whilst activating those that do. Mental health is viewed equally by all, while those with LTCs take responsibility for self-management, feel in control of their care and know how to access services effectively. People live healthier lives and, due to targeted programmes, have equal chance of doing so.

Key initiatives

Description

Key Impact areas

Building resilient communities through volunteering & social action

Existing VCSE community organisations & groups align capacity to enable pathways of care & bring their existing volunteering & social capital to support engagement, communication & provide a framework for change.

↑ social capital through volunteering
 ↑ neighbourhood belonging
 ↑ neighbourhood safety
 ↑ personal support system
 ↑ patient activation
 ↓ poor mental health
 Options and capacity for community care vs acute speeds discharge & reduces risk
 Reduction in acute episodes of between 20-30%

Improving population mental health & wellbeing through social prescribing

Easy access for the whole population to a broad range of sources of support from the community avoiding unnecessary use of healthcare & social care services.

↑ patient activation
 ↑ volunteering locally
 ↓ inequalities in healthy life exp.
 A reduction in A&E admissions through better self-care & information
 A reduction in potential years lost as personal health awareness & monitoring improves

Systematic, personalised & proactive prevention at scale

Prevention is the foundation stone for all care & citizens are actively engaged in lifestyle choices & care management. Care is holistic & considers the impact of wider determinants. It is provided by VCSE agencies alongside NHS & Social Care, & is commissioned with a view to reducing inequalities & increasing quality of life.

Positively impacts all 10 key health indicators
 ↑ population vaccination coverage
 ↑ screening success
 ↑ PAM
 ↑ volunteering capacity locally as NSDU supports VCSE sector
 ↓ inequalities in life expectancy

Clinical Preventative Services

Patients with LTC feel empowered to manage their own health & wellbeing to optimise their quality of life. Patients require fewer contacts with health & care services owing to increased knowledge, networks & support to stay healthy in their own home. Clinical variation is reduced & inequalities are addressed to ensure quality of life improves.

Positively impacts all 10 key health indicators
 ↑ patient activation
 ↑ personal support system
 ↓ poor mental health
 An improvement in EQ-5D for patients with 1+ LTC
 Reduction in A&E admissions as a result of better all-round care
 A reduction in potential lives lost as a result of all-round care

Total financial impact

£5m net

Building resilient communities through volunteering & social action

Baseline

Target driver

Reduce demand & demand growth for health through shift to prevention & community - Right place demand management

Transformation Objectives

Existing VCSE community organisations & groups align capacity & are commissioned to support pathways of care & bring existing volunteering & social capital to support engagement, communication & provide a framework for change.

Progress

Plan to develop community capacity being drawn up using intelligence from JSNA, Joint Health & Wellbeing Strategy, local primary & secondary care demand analysis & community engagement (yet to be completed). Options appraisal of level of adoption of Social Value Act being completed.

Project(s) Description

- Significantly ↑ volunteering to support community-based care & reduce pressure on NHS & ASC
 - Using existing expertise, knowledge & best practice available through VCSE sector
 - Existing volunteering base & structures across all partners are optimised & built on
- Social action is supported to engage communities using Asset Based Community Development (ABCD), particularly in target areas
 - VCSE facilitate community level activity
 - VCSE support new & existing, informal & formal community, groups & organisations
- Capacity of VCSE sector is aligned with health through shared pathways & patient plans
 - Commissioning shift to 'local & VCSE' using Social Value Act
 - Adopt Social Prescribing model
 - Grants to build capacity, address gaps & support small pilot projects
 - Build on current VCSE business & strategic support
- Patient pathways, & associated information & data flows, promote patient choice & self management
 - Align commissioning & engagement process
 - Real time data sharing of joint metrics & data repository (Northamptonshire Analysis)
 - Above framework used to shape & deliver key messages/information to facilitate seamless care & support

Impact

Activity and capacity

- Reduced demand on A&E
- Reduced readmissions
- Reduced unplanned admissions
- Reduced length of stay when admission occurs
- Reduced primary care demand
- Increased self care

Health and wellbeing

- ↑ social capital through volunteering
- ↑ neighbourhood belonging
- ↑ neighbourhood safety
- ↑ personal support system
- ↑ patient activation
- ↓ poor mental health

Care and quality

- Options & capacity for community care vs acute speeds discharge & reduces risk
- Reduction in acute episodes of between 20-30%

Improving population mental health & wellbeing through social prescribing

Baseline

Target driver

“Reduce demand growth”
Right place demand management

Transformation Objectives

Easy access for whole population to broad range of community-based support which empowers citizens to maintain healthy lifestyles, therefore avoiding unnecessary NHS service use.

Progress

Social prescribing response to reduce A&E demand being scoped. Further scoping to be completed on social prescribing to support hospital discharge. Governance & assurance framework being developed to encourage commissioning from VCSE sector & provide a framework for development & evaluation.

Project(s) Description

Access through the SPA & care professionals

- Citizens will be signposted (via web, mobile apps, SPA, care pros) to services, info & support groups that will help them keep healthy
- Solutions available on ‘social prescription’ will align with the key local priorities*:

Every child gets the best start in life

- Programmes to support parents pre & post birth, young parents, challenging behaviour, healthy lifestyle choices, child advocacy, carers, etc

Taking responsibility & making informed choices

- Programmes to support healthy lifestyle choices, low level MH issues, patient activation, community development & cohesion, family support, etc

Promoting independence & quality of life for older adults

- Programmes to support isolated groups, low level MH issues & dementia, community development & cohesion, self-care, end of life choices, carers, etc

Creating an environment for all people to flourish

- Programmes to support education & employment, finance/debt, housing availability & standards, inequalities, service access, crime reduction, environmental issues, etc

Impact

Activity and capacity

- Reduced demand on A&E
- Reduced admissions/readmissions
- Reduced LoS
- Reduced primary care demand
- Increased self care
- Reduced demand on primary care

Health and wellbeing

- Impacts all 10 key health indicators
- ↑ patient activation
- ↑ school readiness & attainment
- ↑ neighbourhood safety/belonging
- ↑ personal support
- ↑ accommodation satisfaction
- ↑ volunteering locally
- ↓ inequalities in healthy life exp.

Care and quality

- A reduction in A&E admissions through better self-care & info
- An reduction in potential years lost as personal health awareness & monitoring improves

Systematic, personalised & proactive prevention at scale

Baseline

Target driver

“Reduce demand growth”
Right place demand management

Transformation Objectives

Prevention is the foundation stone for all care & citizens are actively engaged in lifestyle choices & care management. Care is holistic & considers the impact of wider determinants, is provided by VCSE agencies alongside NHS & is commissioned sustainably with a view to reducing inequalities

Progress

Detailed analysis of risk factor prevalence being completed, which will include ACORN profiling to inform education and engagement approach. 1 x MECC Co-ordinator post being prepared for recruitment. Work of PH dept being aligned with NSDU project - implementation plan being developed.

Project(s) Description

- Deliver a comprehensive county-wide prevention programme with a focus on:
 - 10 key lifestyle risk factors/indicators
 - Changing social norms & behaviours
 - ↑ screening & immis (national & local [HIV])
- Produce local IT solution(s) to support healthier choices & avoid development of disease & /or disability
- Embed MECC & IBA in all settings
- Create a Northamptonshire Sustainable Development Unit (NSDU) to include:
 - Sustainable health & care sector
 - Sustainable health care
 - Sustainable health & wellbeing
- Transformational funding for campaign materials, social media, IT solutions & evaluation
- Impact period expected from year 2 onward

Enablers:

- Single, holistic assessment framework
- Proactive, personalised management plans
- Risk stratification software
- Co-design with citizens & partners (e.g. HW)
- Employ the Patient Activation Measure tool
- Target services to reduce inequalities

Impact

Activity and capacity

- Reduced demand on A&E
- Reduced admissions/readmissions
- Reduced LoS
- Reduced primary care demand
- Increased self care
- Reduced demand on primary care

Health and wellbeing

- Positively impacts all 10 key health indicators
- ↑ population vaccination coverage
- ↑ screening success
- ↑ PAM
- ↑ volunteering capacity locally as NSDU supports VCSE sector
- ↓ inequalities in life expectancy

Care and quality

- ↓ YLL to causes amenable to HC
- ↑ EQ-5D scores in LTCs
- ↓ admissions from ACSCs
- Improve cancer survival through earlier detection

Clinical preventative services

Baseline

Target driver

“Reduce demand growth”
Right place demand management

Transformation Objectives

Patients with LTCs are educated & empowered to manage their health & wellbeing & therefore optimise their quality of life. Patients require fewer contacts with health & care services owing to broad support networks & are able to retain independence & remain in their own home. Patients are supported holistically to ensure associated MH issues do not develop, through to the end of their life.

Progress

Analysis of LTC pathways being completed (RC deep dives) to identify areas of most opportunity. Prevention (1, 2 & 3) being embedded in other programmes of work to ensure self-care optimised. Social prescribing to support complex patients being scoped.

Project(s) Description

Optimising clinical care

- Programme focusing on holistic 2/3 prevention & care optimisation in patients with:
 - CVD
 - BBV
 - MH
 - Resp disease
 - Cancer
 - Frailty

Supporting new diagnoses of LTC

- Develop & deliver patient & carer education programmes for range of LTC, built on DESMOND/DAPHNE programmes
- Educating patients to understand their illness & empower them to manage it independently
- Develop peer support groups, with focus on MH

Enabling patients to self-manage & maintain independence

- Invest in telehealth & similar supportive technology to enable self-management. (e.g. monitoring oxygen saturation, BP, temperature & weight)
- Invest in technology, in partnership with other agencies, to provide equipment to promote independence (e.g. alarm pendants, etc)

Signposting & social prescribing

- Train care professionals to give clear direction to tailored, community-based support, as outlined in Initiative B
- Directory of services, web portal & mobile apps developed to signpost & refer patients through the SPA, including self-referral

Impact

Activity and capacity

- Reduced demand on A&E
- Reduced admissions/readmissions
- Reduced LoS
- Reduced primary care demand
- Increased self care
- Reduced demand on primary care

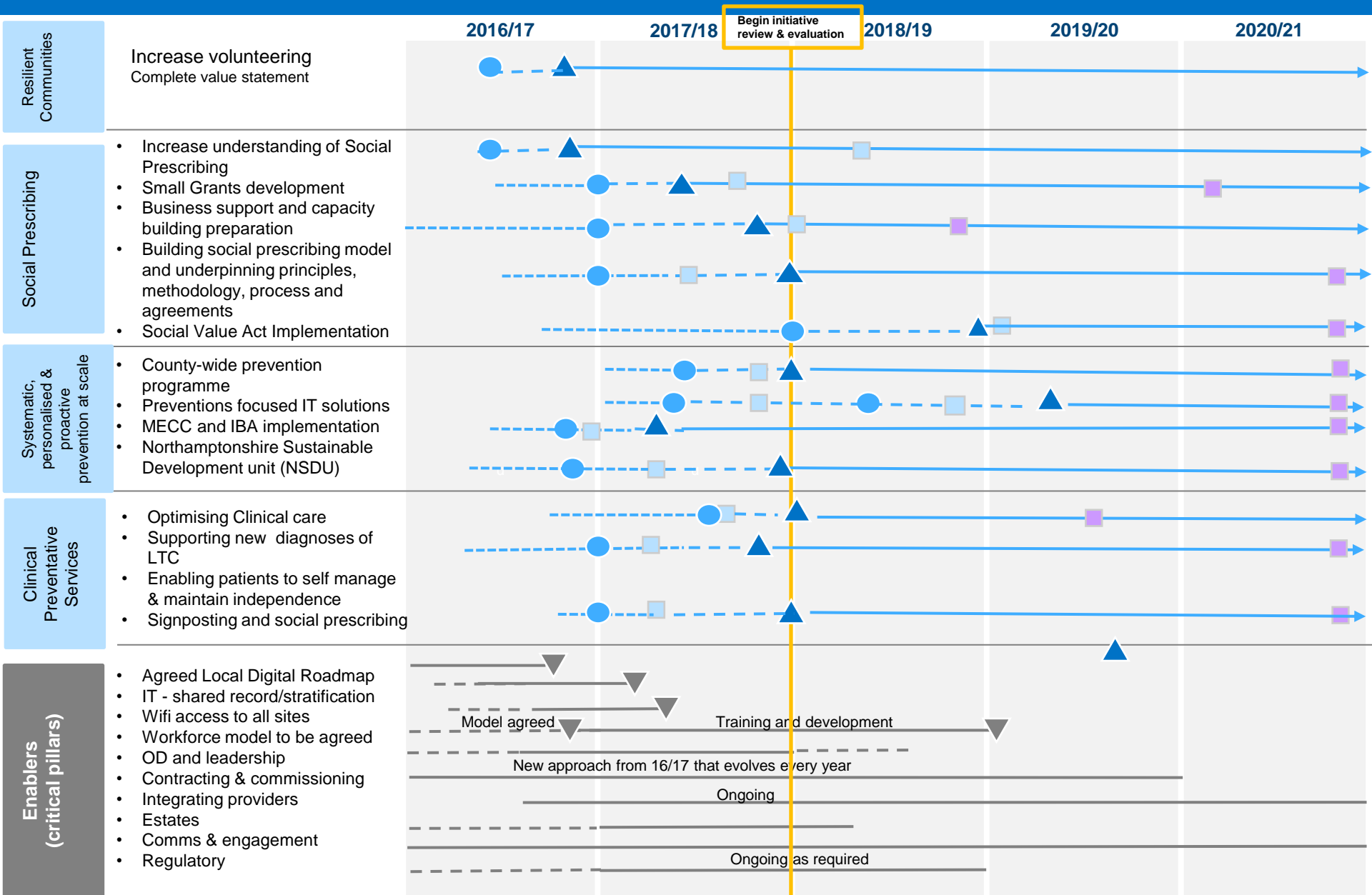
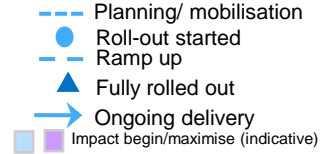
Health and wellbeing

- Positively impacts all 10 key health indicators
- ↑ patient activation
- ↑ personal support system
- ↓ poor mental health

Care and quality

- An improvement in EQ-5D for patients with 1+ LTC
- Reduction in A&E admissions as a result of better all-round care
- A reduction in potential lives lost as a result of all-round care

Key milestones for delivering Prevention, Community Engagement and Patient Activation



Provider Development

Provider Development

Total financial
impact

**£33m net
including
commissioners**

Overview

Implementation of the STP will lead to a different shape to the structure of provider services and lead to a need to review organisational form. It will be essential that the system as a whole reviews the impact of the developing STP on organisational functions and how they need to adapt to deliver. This will provide the ideal opportunity over the next few years to ensure that the organisational forms of providers support effective and efficient delivery of healthcare to Northamptonshire residents.

The system will need to gain confidence in development of early plans to support this process.

Key issues driving this will be

- Service redesign to such an extent that it make little sense to continue with separate organisational processes
- Service failure (including regulatory involvement)
- Failure to deliver system-wide urgent care services/standards
- National drivers including change in minimum clinical standards meaning urgent service change is required to divest/consolidate
- Financial failure of one or more partners
- Development of GP federations/super practice and sustainability of primary care
- Delivery of integrated primary and community care through new care models

Critical support to this process to consider will be

- Culture and ethos
- Capital and physical capacity requirements
- Clinical, operational and financial sustainability
- Workforce availability and sustainability

In addition, we need to recognize the role the wider provider market incorporating both the voluntary sector and the private sector and work through how best to ensure that they play a part in an integrated system. Intrinsic to this will be market management.

The three key providers and evolving GP federations/super practice are working actively across the work streams identified within to ensure that the system can support them to deliver significant improvements in each of these areas and develop a single service offer across Northamptonshire. At the end of this, we expect to see a single service working with integrated out of hospital services, sustainable primary care and in the medium term will be looking to develop new estate options across the county to provide a true 21st Century service.

Critical to the shape and sizing of services will be

- Assessing the impact of a growing population
- Development of an adaptable and sustainable workforce
- Implementation of prevention and wellbeing and other clinical work streams to reduce population dependency on interventional health services

- Improved productivity of services through the system
- Implementation of integrated information systems through the LDR
- The scale and timing to access additional capital funds to support a fundamental review of estates over a 3 -15 year period.

Next Steps

It is clear that how certain aspects of the STP develop and the impact they will have will set a timetable and process for future organizational review. Specifically critical to this will be

- The move towards developing a single model of acute care across Northamptonshire for acute services
 - The initial 10 specialties within the scheduled care project
 - Review of the rest of the specialties within the acute sector.
- The successful development of GP Federations/super practice through the local assurance process and their ability to develop services at scale that will
 - Secure sustainable primary care services across all parts of Northamptonshire;
 - Deliver further services out of hospital where it is beneficial for the patient
 - Support development of MCPs
- Development of integrated out of hospital service model that will see closer integration between the four main areas, acute, NHFT, GP federations/super practice and social care and a closer working arrangement to the common goals laid out within the STP;
- Develop links with the voluntary and third sector to support communities and services;
- The implementation of a successful health and wellbeing strategy supported by the prevention and wellbeing agenda and other workstreams laid out within this STP that will begin to increase social and health independence and moderate demands on health and social services supported by capacity aligned to patient and population needs.
- Review opportunities to share back-office functions

Options and Timescales

The STP runs until 2020/21 but it is clear that the ambitions of the STP extend well beyond that timescale. However, at this stage no firm decisions are needed or indeed desirable on organisational form. It is clear that the system needs to develop the functionality of the STP across a range of areas and then at key decision points decide whether a review of organisational form would support delivery the next phase of the STP and its ambitions. The STP Board will facilitate this review on a 6 monthly basis and will take into account.

- Progress against delivery of the key components of the STP
- Clinical Sustainability of key services across the system
- Development and sustainability of managerial functionality across organisations.

Commissioner Development

Commissioner Development

Overview

It is clear that through the development of STPs commissioning organisations will need to evolve. Consideration to both function and form will be taken into account so that process towards strategic commissioning can be achieved.

Critical to any decision framework will be:

- Development of integrated structures across CCGs
- A bottom up population health and wellbeing needs focus, maintaining a coherent and integrated STP and Health and Wellbeing strategy.
- Full delegation of primary care commissioning
- Anticipated delegation of specialist services commissioning
- Development of a single contracting and strategic commissioning framework across both CCGs
- Accelerated development and assurance of new care models working across a range of services at scale
- Integration of social and health services into single models of provision requiring new processes and governance around joint commissioning
- Development of a single contracting framework across local providers
- Movement towards capitated budgets and outcome based commissioning
- Development of national views, and consideration on the future of CCGs
- Ability of CCGs to transfer and delegate key statutory obligations such as safeguarding etc
- Shape and structure of the provider network
- Impact of Competition law and the need to maintain a clear, transparent and strong commissioning process.

Key immediate issue are

- An immediate need to ensure there are joint commissioning processes and practices going into the two-year operational plan
- Integration of CCGs and our commissioning support partner to establish committees and structures where possible
- Development of a single contracting framework across providers
- Development of robust independent organisations capable of delivering the full scope of new care models
- Review and identification of opportunities to integrate back office services
- Seek areas for joint commissioning functions across NCC and CCGs.

2018/19 and Beyond

The key decisions going forward will depend on:

- Organisations delivering new care models
- Less transactional and more sophisticated forms of contract based on outcomes
- Integration of health and social care provision
- Existing functions across CCGs that would more logically fall into the developing landscape including transfer of any corresponding statutory functions
- Size and sustainability of CCGs and a move towards fewer commissioning organisations across Northamptonshire and potentially across wider geographical boundaries

Potential longer term going forward

In the longer terms the move towards a strategic commissioning functionality could lead to

- A single commissioning organisation across Northamptonshire with a population locality based focus
- A single commissioning organisation across health and social care across Northamptonshire (potential for phased movement with a population locality based focus)
- A single commissioning organisation across a wider geographic area than Northamptonshire but with locality focus.

Shaping Our Services

We will build resilience in communities & the Voluntary, Community & Social Enterprise (VCSE) sector

Current community engagement & vision for 2020/21

The Voluntary, Community & Social Enterprise (VCSE) sector consists of 2,500-3,000 groups & organisations in Northamptonshire, providing a breadth & depth of community penetration to enable prevention activity & local support for patients. The sector also provides a framework for community engagement & has the knowledge (& a proven track record) of practice that supports self help, patient activation & volunteering. Investment in the sector, alongside the redesign of care pathways to include VCSE groups, will create further networks, build VCSE capacity & capability to shift non-clinical & wider determinant activity out of primary & secondary care, and build social capital, supporting and reinforcing the elements that lead to, and embed, behavioural change; thereby increasing community & patient choice & control and maximising the system's return on investment.

Northamptonshire's response to the six principles of engagement

1

Care & support is person-centred, coordinated & empowering

- A menu of services that include VCSE to broaden patient, carer & clinician options
- Shared plans for patients that include the patient & align & streamline processes

2

Services are created in partnership with citizens & communities

- Network of VCSE organisations is utilised to engage & stay engaged
- VCSE & HealthWatch create, enable & support a network for individuals to be represented
- Real time information flows

3

Focus on equality & narrowing inequalities

- Use & develop VCSE network to reach & target specific communities
- Community & housing groups identify & support those in poverty
- HealthWatch & equality groups are used as critical friends

4

Carers are supported & involved

- 16,000 known carers are engaged through the Carers Partnership
- Build capacity to reach the 60,000 estimated carers, particularly younger carers (c.6,000 - one of the country's highest) who are more likely to develop health issues

5

VCSE & housing sectors involved as key partners & enablers

- Identified VCSE leads
- Investment strategy that uses Social Value Act & Social Prescribing
- Use VCSE capability & capacity to build community resilience
- Data sharing of joint metrics

6

Volunteering & social action are recognised as enablers of change

- Use VCSE to lead on social action & volunteering programmes
- Social action using ABCD- Asset Based Community Development
- VCSE as a network & route to engage & disseminate information and support behavioural change

Keys areas for monitoring and sustaining primary care in 2021 are as follows

Vision for Primary Care in 2021

Robust, sustainable, consistent high quality general practice services working in partnership with community and other services to provide comprehensive, population based out of hospital care.

Care will be adapted to a persons needs not “one size fits all” and underpinned by technology capable of supporting people at home as well as in care facilities.

A primary care workforce and skill mix used to meet the needs of people in the right place at the right time.

Key Aims	Description	Plans
A Workforce	Sufficient recruitment and workforce expansion is required to stabilise the future of general practice and deliver the GP forward view. There are underlying recruitment and retention issues across many areas, changes to how practices work together and the development of new clinical roles are key to stabilising general practice workforce.	<ul style="list-style-type: none"> Working together with Federations/super practice to improve resilience, shared workforce for specialist skills, competency based training & development at scale Joint working with the LMC and HEE to increase GP training capacity and increase recruitment New ways of working including the recruitment of Primary Care Physician Associates and Clinical Pharmacist roles MDT Community based provision for the local population. Support programmes at scale for struggling and vulnerable practices
B Care Redesign and Enabling Self Care	Enabling people to be partners in their own care, giving them the knowledge, skills and confidence to take more responsibility for their health and be more in control of their outcomes Better use of and development of a wider workforce and working at scale across practices to provide extended access collectively.	<ul style="list-style-type: none"> Contracting to enable integrated care delivery Same day care commissioned at scale to ensure good access for all Greater focus on health promotion and disease prevention Greater use of digital technology to connect people to their practices and professionals with each other. Online self-support & signposting to other services Better access to wider services in the community Development of a wider integrated workforce i.e. ANPs, therapists, pharmacists and care navigators
C Improving Quality	The GP Forward View and the development of new models of care offer an opportunity to increase sustainability and resilience. Review and improve quality within general practice. Working with the CQC and NHS England a shared framework will be developed to understand and report on quality, whilst also improving and simplifying the transparency of information about general practice.	<ul style="list-style-type: none"> Embed the use of the Quality Dashboard to identify variation and prioritise support for practices Development of a successor to the Quality and Outcomes Framework To promote and generate a safety culture in which practices are comfortable to report incidents of harm and potential harm to patients Supporting practices to achieve regulatory compliance Federations/super practice lead on professional development, clinical governance and service improvement
D New models of Care and infrastructure	The vision for primary care will need to have a strong infrastructure to support sustainability and the development of new models of care.	<ul style="list-style-type: none"> Development of hubs for shared GP Federation/super practice and MDT out of hospital service delivery. Localities within those to support primary care sustainability and development; Implementation of the Local Digital Roadmap; Development and integration of the health and social care estate in the county.

We will introduce a progressive model of care in the community

Model design

- Integrated health and care services outside the hospital via new care models.
- Will comprise primary, community, acute and voluntary services and deliver services across the four STP clinical pathways .
- Will serve geographical areas and populations mapped to the established federations / superpractice.
- Will be commissioned based on payment for outcomes and risk/gain share agreement within a capitated budget
- 5 year local assurance process is underway to determine stages of development and readiness to take on capitated budgets
- Investment is required which reflects a very different workforce to deliver new care models.

Implementation by population

Population served by

Overview

DocMed

- Serves the needs of the c174k people in the predominantly rural south of the county
- Includes some of the best performance across the county in NEL admissions, but lags others in EL admissions and OP attendances
- Priorities complex and scheduled care

3Sixty

- Serves a population of c270k people in north Northants.
- Includes some of the county's best performance in OP attendances, but lags others in NEL admissions
- Immediate priority is same day care.

GPA

- Serves a predominantly urban population of c213k people in Northampton
- Includes some of the best EL admissions performance, but lags on NEL and A&E attendances
- Immediate priority is same day care.

Lakeside

- Serves c60k people in Northants (with additional patients in Leics and Lincs)
- Includes some of the county's best performance in both EL and NEL admissions.
- Priorities are to create an extensivist hub and to improve the urgent care offer.

Projected impact

Activity and capacity

- Workforce productivity up 10-15%
- 25-30% reduction in NEL admissions for 'very high' and 'high risk' patients'

Health and wellbeing

- Reduction in risk factors as a result of better management of long-term conditions / clinical prevention

Care and quality

- Improved EQ-5D scores
- Reduced NEL adm. for ACS conditions
- Reduced DTOC
- Improved access to talking therapies

Finance and efficiency

- Reduce the flow into acute hospitals over the 5 years of the plan
- Improved productivity of primary and community services staff
- Better utilisation of hospital bed base

Key themes

- **MH** - Improved mental HWB via strengthened community offer
- **Children** - Reduced NEL admissions, improved physical/ mental HWB
- **Respiratory and Circulatory** – improved outcomes for COPD, asthma, cardiovascular disease and diabetes
- **Cancer** – earlier diagnosis, proactive care and reduced NEL admissions

A financial strategy has been developed to resolve the finance and efficiency gap

The overall financial NHS gap has been addressed through three key methodologies

- Alternative management of demand
- Productivity
- Cost reduction.

The savings attached show the net saving required from each area net of potential investments and each area is detailed within the STP and supporting financial templates. At this stage, timing of schemes will require significant acceleration to arrive at the delivery of control totals in the early years of the plan.

It is anticipated that all CCGs and Trusts will deliver their nationally mandated 2% CIP and QiPPs and that a programme of decommissioning will be developed for 2017/18. This is aimed to cover £82m and will include delivery of back office rationalisation, as highlighted within the Lord Carter review.

Key local savings plans have been identified on

- Urgent care
- Complex care
- Scheduled care
- Prevention and wellbeing

Significant work has now been undertaken in developing these areas in more detail and the scope of this is detailed within the STP.

The provider and commissioning transformation work stream has now mapped out a clear path of work to develop supporting plans and strategies that will ensure the provider network is working in the most productive form to deliver financial efficiencies and deliver the vision within the STP.

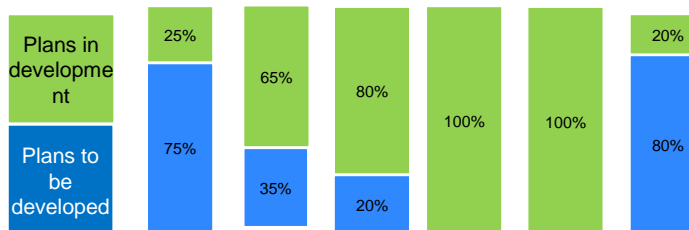
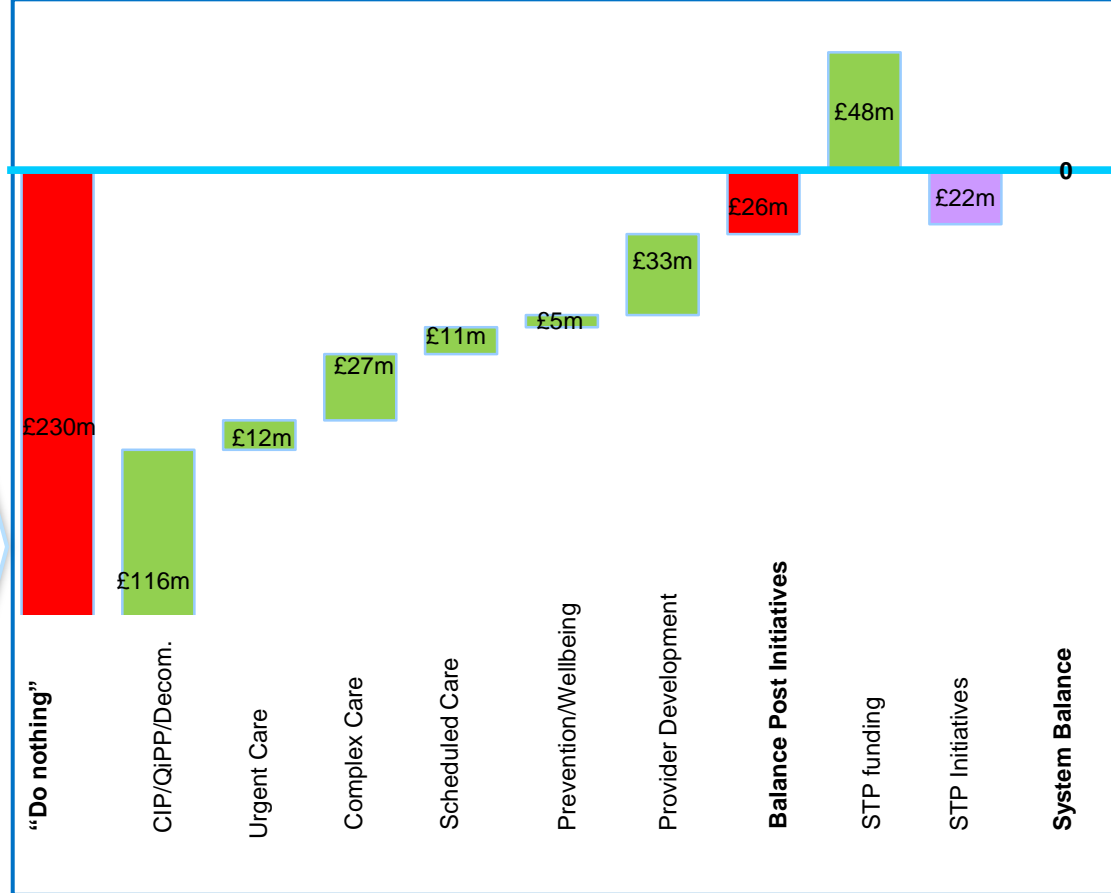
Immediate key investments areas will be

- Development of out of hospital services;
- Double running and programme costs;
- IM&T to support new ways of working and integration;
- Implementation of national programmes including 7 day working, mental health and GP FYFV;
- Sustainability of all service providers through transition.

Work is now underway to secure the first year of the STP in the local organisational operational plans for 2017/18 and 2018/19 within the control totals currently notified.

In the medium term, a system estates plan is to be developed to support organisational shape and new contracting methodologies will be explored to ensure they are able to support system change

Financial bridge targets (£m)



**Our response to
Rightcare and key
patient cohort needs**

Right Care has identified the following key areas...

Respiratory

(see also Complex Care programme)

- Federation/MCP model providing more out of hospital care across Northamptonshire and spread across STP areas and populations.
- Federation/MCP to take responsibility for whole population/budget/care pathway.

Key Aims

To commission a set of Long Term Condition care packages at a Federation/MCP level. The focus will be self-care, prevention, optimisation and integrated management in primary care, avoiding the need to be admitted to hospital.

Respiratory care package scoping has identified the following areas to make biggest impact in reducing unnecessary hospital admissions primarily due to COPD, which will inform further development of an asthma care package.

- Case finding; Vaccination; Smoking cessation; Pulmonary rehabilitation; Emergency pack of steroids + antibiotics; Post exacerbation review, anticipatory care plan

The adjacencies to the urgent care system are a clear focus in reducing unnecessary non – elective admissions to improve patient outcomes. This supports a more sustainable urgent care system where only those patients that require hospital based care have access to timely, safe, high quality specialised treatment.

Cardiovascular

(see also Complex Care programme)

- Federation/MCP model providing more out of hospital care across Northamptonshire and spread across STP areas and populations.
- Federation/MCP to take responsibility for whole population/budget/care pathway

Key Aims

To commission a set of Long Term Condition care packages at a Federation/MCP level. The focus is integrated management in primary care avoiding the need to be admitted to hospital. Cardiovascular (CVD) care package scoping has identified the following areas to make biggest impact in reducing unnecessary hospital admissions primarily due to **CVD and Diabetes**.

- Heart Failure; Atrial Fibrillation; Stroke; Coronary Artery Disease; Venous thromboembolism; Peripheral arterial disease; Valve Disease; Diabetes.

The adjacencies to the urgent care system are a clear focus in reducing unnecessary non – elective admissions to improve patient outcomes. This supports a more sustainable urgent care system where only those patients that require hospital based care have access to timely, safe, high quality specialised treatment.

Cancer

- Definitive diagnosis within 28 days of GP referral
- Investment in imaging and endoscopy capacity to enable quicker diagnosis
- Development of workforce to deliver new models of care

Key Aims

- Prevention
 - Lifestyle risk factor awareness; Screening – improving uptake particularly in vulnerable groups; Cancer early signs and symptoms awareness
- Early diagnosis
 - GP Practice profiles; Cancer decision tools; NICE referral guidelines (GP 2ww); GP education and information; Cancer lead in every GP practice (GP Quality contract)
- Prompt high quality treatment
 - Streamlining pathways; Seamless and timely transfer of patients; Better transition to specialist oncology for patients diagnosed in secondary care; Improving capacity to meet demand in diagnostics and endoscopy; New models of care; Risk stratified care pathways; Pro-active care; Telephone follow ups
- Survivorship
 - Recovery package

Cancer aligned to the CCGs' end of life strategy particularly around avoiding inappropriate admission to hospital where the patient's preferred place of care is home.

Running through the initiatives we have identified illustrations of clinical patient cohorts... (1/4)

Maternity

An NHS England National Maternity Review, led by Baroness Cumberlege published in Feb 2016 found that maternity services are safer than ever and satisfactions is rising . However, the vision for the future of maternity services includes a series of recommendations to further improve care. A Maternity Transformation Board has been established ensure the delivery of “ Better Births” and the 7 themes identified in the review.:

- Personalised Care
- Continuity of Carer
- Safer Care
- Better postnatal & Perinatal mental health care
- Multi professional working
- Working across boundaries
- Fairer payment systems

Other national initiatives and guidance are included in this work programme and which also provides the governance for “ Saving Babies Lives “ – Care Bundles (2016), and the findings from the MBRACE report

Key Aims

- In order to develop a strategy we will start by developing a countywide approach to progressing the implementation of the 7 themes for “Better Births”. A local gap analysis has been undertaken across Northamptonshire including the two providers of hospital based maternity care, of the current position. Agreed action plans against key delivery milestones are in place.
- To deliver the Care Bundle for “ Saving Babies Lives – Reducing Stillbirths” across the county and ensure county-wide delivery of required elements to establish the recommended pathway of care to lead to a 20% reduction in stillbirths. This includes the smoking cessation in pregnancy pathway and foetal growth restriction; movement; monitoring in labour. Agreed action plans are being developed with providers;
- To deliver MBRACE (Saving Lives Improving Mothers’ care)
- To develop a perinatal mental health service development (awaiting outcome of funding bid)
- To ensure monitoring of delivery against a local KPI maternity dashboard is to be reviewed quarterly by commissioners & quality teams
- A Maternity Led Unit (MLU) has been established in Northampton General Hospital (NGH); plans are being considered to develop a MLU in Kettering General Hospital; There will be system-wide consideration of Obstetrics and Neonatal Services in line with national guidance and the learning from the scheduled care workstream of the STP

Running through the initiatives we have identified illustrations of clinical patient cohorts... (2/4)⁵⁴

Children and Young People (C&YP) Services

C&YP services have a prevention and development focus. The key components of our programme include:

- When issues arise, C&YP are able to access urgent care out of hospital as well as receiving care by the right person, at the right time, in the right place, ideally closer to home.
- Hospital discharge for C&YP with complex conditions is safe, holistic & supported.
- “Future in Mind” is implemented locally & care is delivered via an integrated model & includes universal health services, maternity & LA.
- All C&YP with SEND will have an Education Health and Care Plan by September 2017

Key Aims

- To transformation outcomes for our children and young people we will:
- Establish a fully integrated service model for specialist community services for C&YP and their families with a single model of care across Northamptonshire that prevents unnecessary hospital admissions and provides high quality care within the community.
- Implement the ‘Future In Mind’ programme, including:
 - A new prevention, early intervention & post crisis support programme; Self referral mechanisms with no ‘wrong door’; De-medicalised pathways (where appropriate); Additional support for vulnerable groups
 - A bespoke community and same day Eating Disorder service for CYP
- Develop a Children’s Complex Care Scheme (bespoke nurse-led MDT to support safe discharge of C&YP with complex needs)
- Develop “On-the-day Demand” hubs in collaboration with GP federations
- Ensure the improvement of C&YPs choice and care through increased use of personal health budgets
- Embed the Children & Families Act into service planning & delivery e.g. EHCP agenda
- Deliver closer & more effective work with Safeguarding
- Develop a universal education programme to promote healthy lifestyles, behaviours and relationships to empower children, with a particular focus on vulnerable groups
- Work with Providers to deliver the ‘Better Births’ recommendations by 2020.

Running through the initiatives we have identified illustrations of two clinical patient cohorts... (3/4)

Mental Health is everybody's business

Mental health services will seek to empower people to live meaningful lives. People accessing services can expect interventions supported by evidence to improve emotional wellbeing outcomes.

People should expect, and receive, timely, appropriate, holistic care with physical and mental health needs assessed and provided in a consistent manner. We wish to decrease stigma and increase psychological literacy and social engagement across the whole-age life path.

At all levels of service – early intervention, scheduled support, in-patient or crisis; services will promote independence, resilience and recovery utilising a strengths based, solutions focused approach.

The services will be designed and coproduced through equal and reciprocal arrangements in partnership with service users, carers and professionals.

Integrated services will work together enable people to improve their lives.

The Children and Young People's Local Transformation Plan and the Mental Health Transformation Board will ensure that mental health is everybody's business.

Key Aims

Access and availability

- More young people accessing high quality mental health care
- Community based Perinatal mental health services
- Increasing access to psychological therapies to meet the new national 25% access target integrated with physical health pathways
- Maximise use of technology to improve self management and emotional literacy
- Increase in individual placement support
- Adults requiring non specialist in-patient support can expect to receive care close to home
- Parity of esteem in waiting times will be implemented by 2021
- Increasing personalisation and choice through implementation of Personal Health Budgets for Mental Health
- Increase in mechanisms for self-referral ensuring there is "no wrong door" to accessing services

Community services

- 24/7 all ages crisis pathway to support more people in the community and utilise least restrictive treatment options.
- Community Services that proactively offer support and treatment to improve and maintain good mental health
- Collaborative care teams- holistic care for people with complex needs
- New models of care to maximise consistent, effective compassionate primary care services
- Working in partnership with other agencies to improve holist outcomes to further the wellbeing of people e.g. housing, employment etc.

Prevention & Self Care

- Developing a Prevention Concordat
- Wellbeing Education Network maximising peer support and community assets
- Targeted interventions for people with SMI to address smoking , alcohol and weight
- Making every contact count to include emotional health check
- Provide a resource to signpost people to useful information, advice and guidance including local interventions, services and resources available in the area
- Promote anti-stigma messages to encourage people to seek help at the right place and time to meet their needs without further prejudice.

Running through the initiatives we have identified illustrations of clinical patient cohorts... (4/4)

Transforming Care for people with a learning disability (see also Complex Care programme)

The Northamptonshire Transforming Care Plan includes people of all ages and has been produced by the local Health and Social Care Partnership who share the vision that:

“Everybody has the right to be supported to live in their own home in their local community in the least restrictive environment possible. Partners will work together to ensure services are right for people and people have been involved in deciding what is right for them. It is important that services work for people and are responsive to individuality and changing need. Everyone has a right to live independently; independence means different things to different people.”

Learning Disability Services will provide care and support that is:

- ✓ Closer to home
- ✓ In line with best models of care
- ✓ Co-ordinated and person centred
- ✓ Personalised and therefore responsive to needs over time
- ✓ Based on the individual's and their family's wishes
- ✓ Outcome focussed and value for money

Key Aims : ‘Services are designed around me’

Support to live in my own community

- Ordinary living as the default position and the aspiration for individuals stepping out of secure hospital arrangements
- Outcomes based contracts with selected provider/s
- Prime Provider model for appropriate pathways of care
- A workforce with increased skills in autism and positive behaviour support
- A more varied and responsive range of skilled bed based provision including short term step up and step down provision
- An increase in supported housing models
- Flexible respite options and new contracted arrangements to support informal carers
- Community connectors and social prescribing
- An increase in the numbers of people benefitting from the use of Personal Budgets

Integrated care and support

- Leadership from a joint Health and Social Care commissioning structure
- Co-located health and social care fieldwork teams
- Joint assessment and review activity
- Joint outcome based individual plans that seek to progress individuals that build on their individual strengths and potential
- New roles for required skills – advance practitioners, assistant practitioners, hybrid roles
- Integrated quality monitoring approaches designed around the needs of individuals
- A singular Pooled Budget to enable behaviour change and focus on outcomes

Specialist Hospital avoidance and using acute hospitals

- Maintaining information on people who are at risk of escalation or deteriorating conditions
- Every individual has a crisis plan and a hospital passport plan
- Early intervention service with direct coaching and a 7 day a week response
- People with complex needs are reviewed very regularly
- People are supported to access mainstream services and primary care services are supported to manage their population well
- People receive community Care and Treatment Reviews at the right time
- Where admission has been required; a discharge plan is agreed within 7 days of admission and professionals are focussed on enabling discharge
- Where an individual is admitted to an acute hospital there is immediate discharge planning and everyone knows the plan

Key Enablers

- *Re-purposing of four-bedded assessment and treatment unit for enhanced community provision and revised bed based services from December 2016*
- *Joint commissioning structure December 2016*
- *Workforce training December 2016 to February 2017*
- *Pooled budget operational from April 1st 2017*

Our Governance and Enablers

STP Governance (1/2)

In reviewing the the governance arrangements for the delivery of the STP the system has reviewed the work of the HN programme and the development of the STP alongside new guidance on operational and system wide plans. It is recognised that the system will need to develop new working relationships and adapt both organisational focus and emphasis while maintaining clear control of organisational targets and operational plans. An OD programme is being implemented to support this cultural change across the system starting at CEO level.

The focus for the delivery of the STP will be the STP Board supported by a Memorandum of Understanding signed by all organisations and will work with the Health and Wellbeing Board to ensure alignment for strategies and support democratic engagement with the STP. The STP will operate within a clear system control total which will have a collective responsibility to support delivery of their plans based on the plans agreed through the STP.

The proposed Northamptonshire STP governance structure is made up of 2 layers:

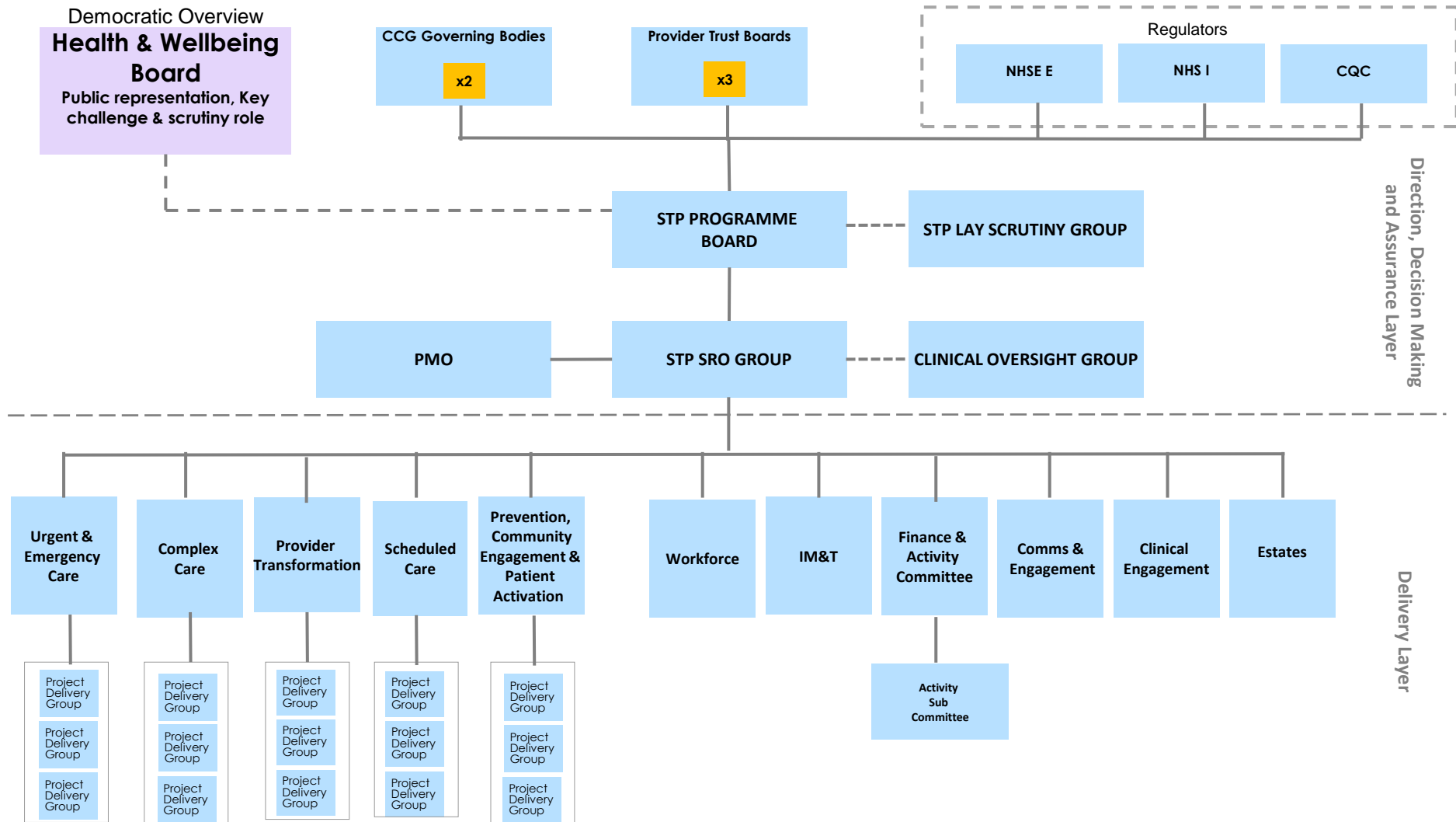
Direction, Decision Making and Assurance Layer

- The central governance body in the direction, decision making and assurance layer is the STP Programme Board;
- This board has overall responsibility and accountability for the delivery of the Northamptonshire STP, directly overseeing the delivery of the Northamptonshire wide programmes and enablers, as well as the BCF Programme Executive;
- The Health and Wellbeing Board will have a key role in providing cross-sector and Northamptonshire-wide challenge and scrutiny of STP implementation and impact
- The statutory bodies (CCGs, Providers and Local Authorities) will work within an agreed MoU for STP related business through the Northamptonshire STP Board;
- The membership of the Northamptonshire STP board would represent all parts of the system, via nominated representatives of the different organisations and groups;
- The system will look to work on a single view of delivery across NHSI and NHSE.

Delivery Layer

- The delivery layer manages the operational implementation of the Northamptonshire STP plans;
- The central governance body in the delivery layer is the STP SRO Group, which provides operational direction and oversight of the delivery of Northamptonshire-wide programmes, and reports to the STP Board (escalating risks and issues as necessary);
- The STP SRO Group consists of the SROs for the different work programmes and enabler leads within the STP;
- The Working Groups (and underlying delivery groups) are responsible for the operational delivery of the different areas of the Northamptonshire programme, and report into the STP SRO Group;
- Our working groups will also liaise directly with our private providers, EMAS and our GP Federations/Super Practice in delivering their programmes
- A central PMO, of a size complementary to the project management resources made available throughout the Northamptonshire system, will act to align, co-ordinate and support the output from Working Groups. A proposal for the ongoing resources has been identified and will be resourced through the two year operational plan process. Interim arrangements for the remainder of this financial year are being put in place;
- Advisory groups and enabling groups also sit within the delivery layer, providing expertise and advice on specific elements of the programme (Finance and Activity, Clinical Engagement, Workforce, IM&T, Comms, Estates).

Proposed Governance Arrangements for the Implementation of the Northamptonshire STP (2/2)



Workforce (1/2)

A Northamptonshire Workforce and Organisational Development Strategy has been drafted and describes our key workforce objectives through to 2021

Our aim will be to recruit where required to traditional staff groups where historically the system has struggled, manage the existing workforce flexibly across the system and develop staff to fit into new accredited roles. Additionally we will need to review how we maximise the use of voluntary services within the system plan and manage the risk and workforce implications of this. In particular,

- Develop a system-wide approach to attraction and retention including place based marketing
- Rotational nursing posts project to develop the ability to move people around the system e.g. through closer alignment of TS&Cs, rotational posts
- Developing the Primary Care workforce
 - Improve recruitment into primary care
 - Identify new capabilities of new staff groups to support primary care
 - Identify roles and competencies that sit outside of primary care that will be required to support the left shift of provision
- Developing the secondary care workforce through the medical workforce group
- Developing Culture, including system leadership capacity, staff engagement and change management
- Developing a combined workforce wellbeing approach building on shared best practice across the system

Draft terms of reference for our Local Workforce Advisory Board (LWAB) have been developed and will be approved at the first meeting to be held in September. The membership includes representation from all local health provider organisations, social care, voluntary sector, CCGs and local universities.

The LWAB will be co-chaired by the STP CEO lead for Workforce with HEE (ME). Locally it has been agreed that LWAB will be supported by 4 advisory groups that reflect the requirements of the 'engine room' on the diagram below.

The terms of reference for each of the four sub-groups have been approved. The focus for each of the sub-groups is as follows;

Education

o Key focus to align and prioritise the timing of future education & training requirements to support the delivery of the new models of care for each of the four STP Programmes

Workforce Transformation

o Key area of focus is to align new models of care with workforce supply - emphasis on defining the skills and competencies required across health, social care and voluntary sector

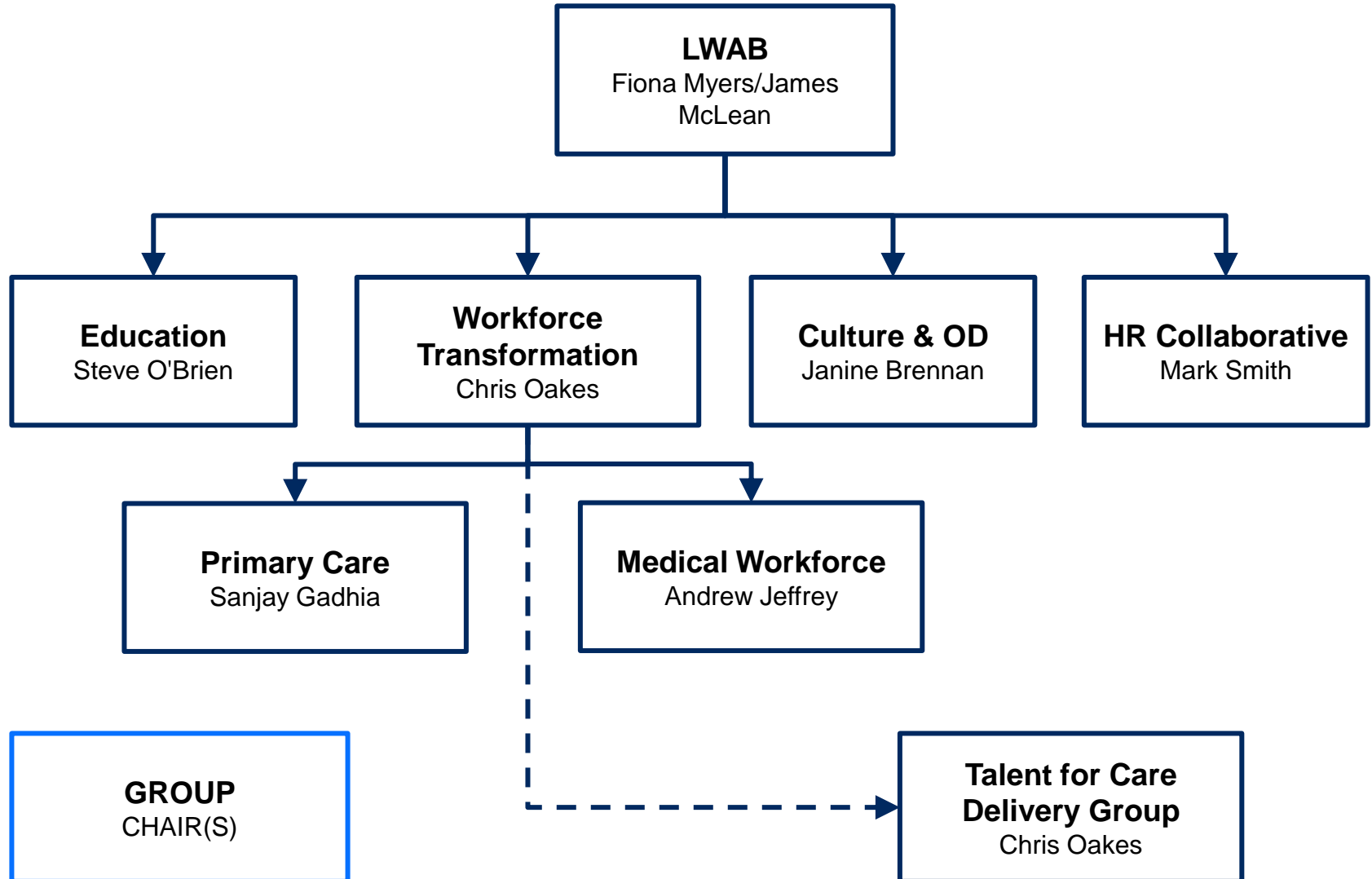
Organisational Development

o Key area of focus is developing culture, leadership and OD support for teams through service transformation across the footprint of the STP.

HR Collaborative

o The areas of focus for this group is to support each of the four STP programmes in providing timely advice and intervention in respect to: Recruitment and Retention strategies; Employee relations; Staff mobility; Terms and conditions for staff across the STP footprint; Legal advice in respect to workforce changes

Workforce (2/2)



Organisational Development (OD), Leadership and Cultural Transformation

The system has learnt the lessons of its previous transformation programme - Healthier Northamptonshire: the need to have clear system and organisational accountability and responsibilities, clear senior sponsorship and ensure programmes are properly resourced. Additionally, it is important that we find, support and develop local leaders and clinical champions who will help drive significant change,

- Invest in organisational development across the system (primary care and more broadly to drive change and increase sustainability e.g. strategic skills, managerial skills, stronger federation management)
- Build a strong cohort of senior clinical, professional, managerial and political leaders to articulate a clear patient-centric vision and case for change, and also empower teams to collaborate
- Ensure role modelling of new ways of working from respected individuals in each professional group and within localities

As part of the STP, we will look to commission support to assist the system to prepare itself for the delivery process through undertaking an organisational capability and structure review.

The OD programme will facilitate the leadership team to identify the vision and develop a binding agreement as to what needs to be done, how it will be achieved and the underlying programme governance framework - for example where and how decisions will be made and how progress will be tracked. This will take into account explicitly the potentially conflicting individual agendas of the leaders and the different regulatory frameworks in which they operate.

The OD programme will support the team in identifying the core capabilities for success of the programmes e.g. Innovation, change agility and agree the modus operandi of the leadership team, including the necessary leadership behaviours:

Adopt an OD approach to driving the programme ; Provide change management expertise; Develop and harness the capabilities of the individual programme teams; Maximise sustainability; Service Improvement

The following principles were agreed by LWAB in September to cover the development and delivery of the STP workforce and OD strategy;

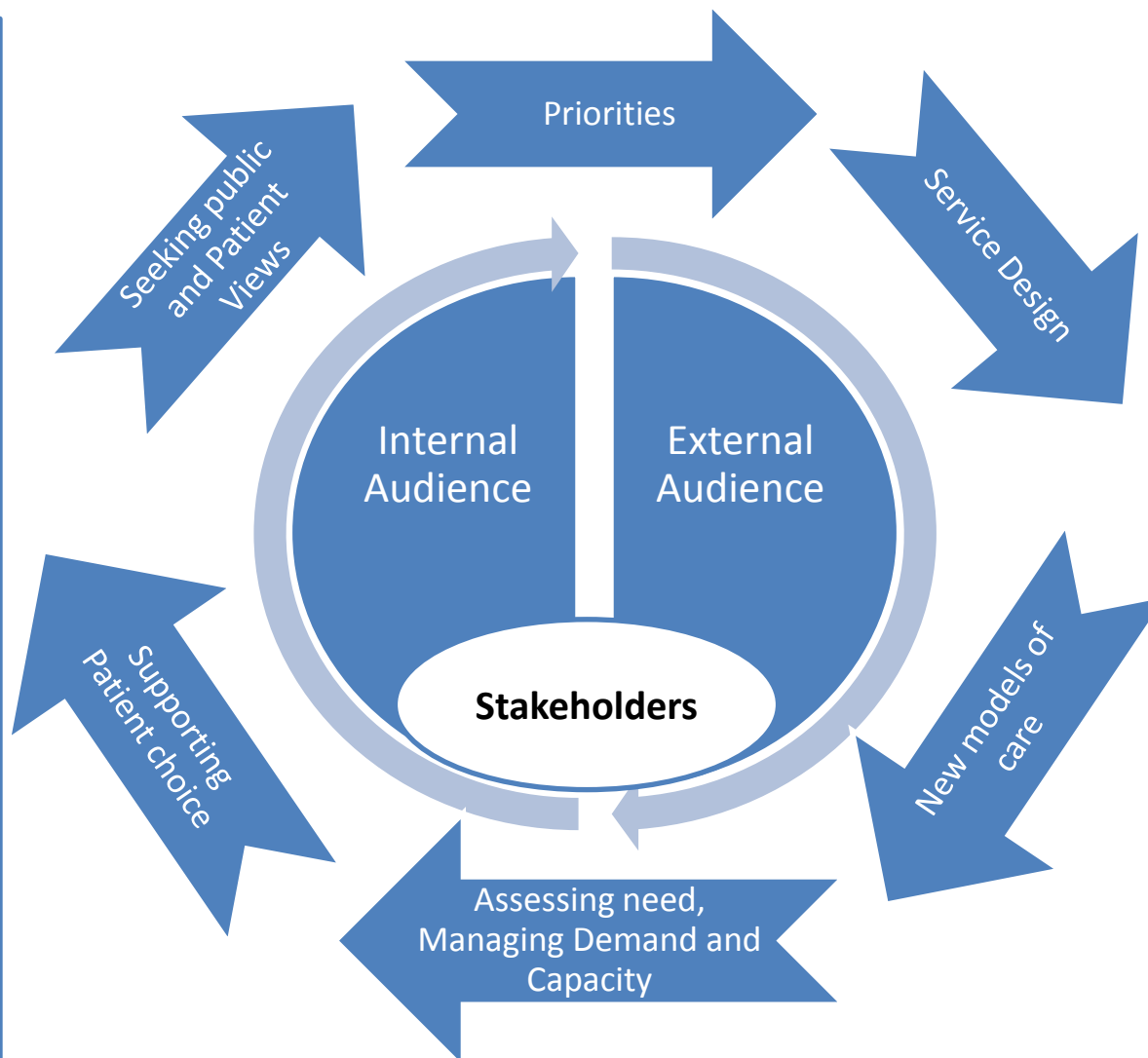
- Clinical outcomes: Improved clinical outcomes for patients across Northamptonshire
- Patient experience: Improved patient experience across Northamptonshire
- Staff experience: Improved staff experience and motivation to change working practices across Northamptonshire
- Equity of care: Aiming for consistency of service provision, variability will be minimised in access to quality and sustainable services;
- Population health needs: Are met across the whole of Northamptonshire;
- Value for money: Cost effective service delivery and maximisation of available resources;
- Strategic fit: Services meet nationally defined standards;
- Sustainable services: Clinical, operational and financially sustainable services.

Communication and Engagement Strategy (1/4)

It is essential that our STP partners have an ongoing dialogue with patients, volunteers, carers, clinicians and other staff, citizens, the local voluntary and community sector, local government officers and local politicians, including those representing health and wellbeing boards and scrutiny committees and MPs. We may also wish to consider how to engage with people who live outside Northamptonshire but access health and care services within it and may therefore be affected by our proposals.

Internal Audience

This term applies to the staff and membership of the footprint organisations. Staff and membership are the local voice of an organisation. It is imperative that an extensive engagement programme is developed which also ensures the delivery of a comprehensive consultation, where needed, so that membership and staff are enabled to be fully informed, engaged and involved as appropriate.



External Audience

This term applies to any and all parties that are external to the footprint organisations who live within or access health and social services within the region (such as patients, carers and their families as well as the wider community) or have an interest in the implementation of the plan (such as MPs, elected representatives, the voluntary sector and the media).

Communication and Engagement Strategy (2/4)

Outline communications approach

Successful implementation of the STP will require patients, service users, carers and the wider public to take greater responsibility for their own health and wellbeing. In order to implement a successful campaign that results in effective engagement and involvement, behavioural change social marketing is required.

A public relations service is required to manage and maintain the messages surrounding the STP and relationships with the media.

To oversee and coordinate the communications strategy, implementation and programme of activities, and public relations, it is recommended that a communications specialist and/or service be retained to fully advise and support this process. In addition to this, a budget will be required to support campaigns and activities.



GPs and staff

Other NHS providers



Public and patients



Voluntary sector

Community groups

Statutory including **healthwatch**
Northamptonshire

Political (MPs & local councillors)



Next steps

In order to deliver the STP communications and engagement strategy effectively, additional resource will need to be identified to support this activity, through:

- Engagement role/service
- Engagement activities and events budget
- Communication and public relations role/service
- Social marketing budget

We are looking to commission a short piece of work with SROs and organisational executive leads to develop the communications and engagement plan.

Our Plan

- 1. Interim programme management resource is now in place for the communications workstream.**
- 2. NHS and LA organisational leads have been identified**
- 3. Inaugural workshop / meeting date has been set for 21st October 2016**

The proposed objectives of the workstream are that it

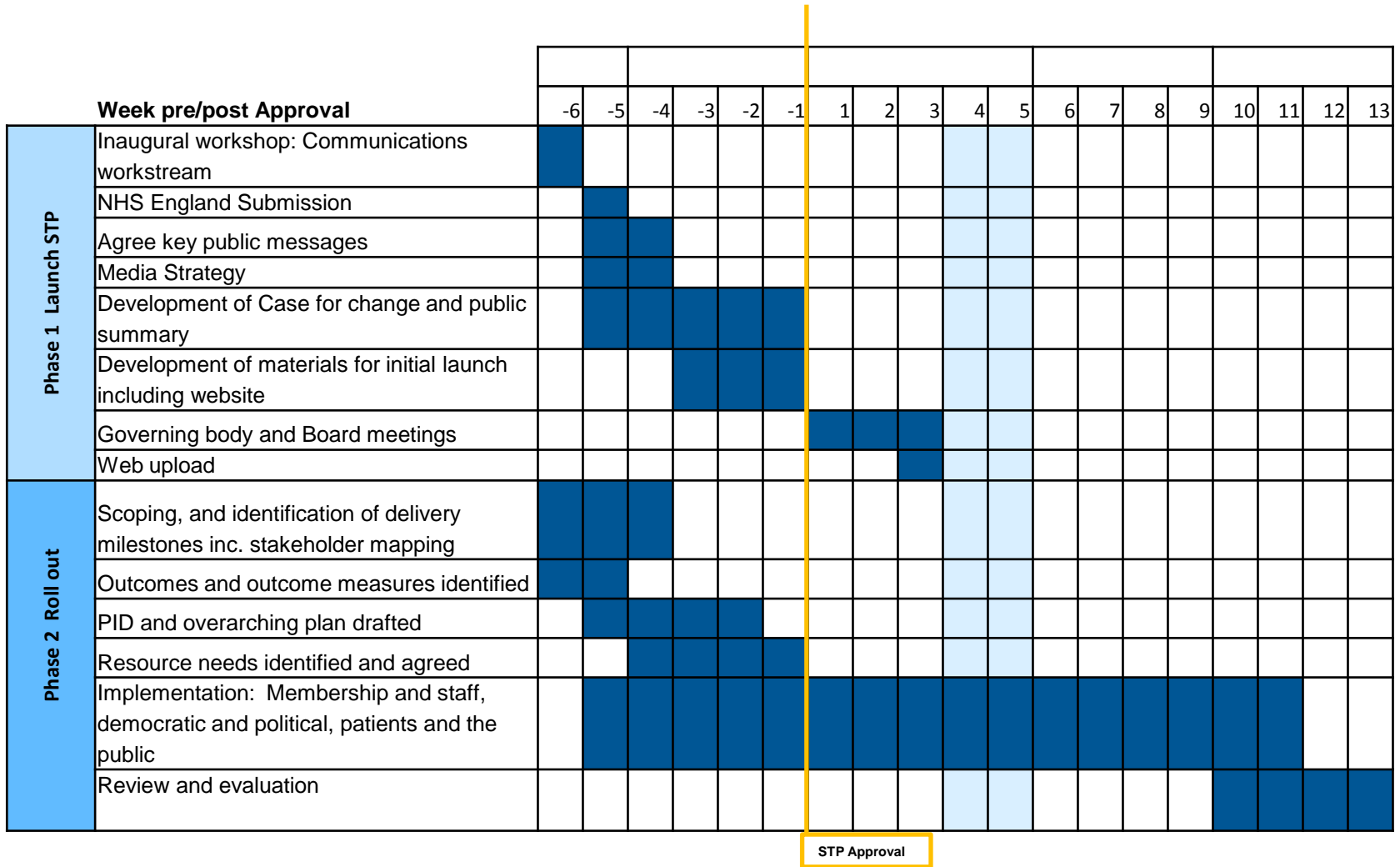
- Build on the established collaborative communications approach for Northamptonshire
 - Delivers an aligned communications approaches and responses to build public confidence in health and social care services
 - Plans a county-wide approach to ensure that positive news regarding health and social care services across Northamptonshire is effectively present in what people read, hear and watch
 - Ensures that information about opportunities for public and user involvement in shaping emerging plans is widely available
 - Provides mutual support and pools resources as appropriate to ensure key reputational issues are managed as well as providing clear, accurate and consistent information for patients and the public
 - Ensures there are appropriate opportunities available and resourced for public and user involvement, and information sharing
- 4. A primary care STP development session is being planned for November, and a small primary care working group has been established.**

Key deliverables are likely to be:

- Scoping objectives for delivery of communications and engagement plan, and indicative outline delivery plan
- Stakeholder mapping
- Outline communications and engagement plan
- Communication collateral (briefing material) prepared and shared with key stakeholders including identification of core messages and Frequently Asked Questions (FAQs)
- Overarching events/governance meeting calendar developed in tandem with the detailed work programmes being developed by individual workstreams
- Specific budget identified to support production of communication collateral
- Need for additional communications and engagement to be scoped and options developed, including partner agencies, interim support or commissioning agency/ consultancy support

Communication and Engagement Strategy (4/4)

Our Indicative Timeline (ability to accelerate/slow)



IM&T (Northamptonshire LDR updated and available on request)

Vision

Expressed in the words of the local citizen as 5 "I" statements

- I only give my details once and do not have to answer questions about my care wherever I go
- My record belongs to me not the person looking after me and I understand how my information gets used
- I'm confident my care will be safe because the people caring for me have access to my information when they need it
- I am confident people are able to actively identify the risks to my health and wellbeing and contact me to and make sure I get the services I need
- I can use technology to support my own care at home if I choose to

Key Digital Capabilities

Capabilities we believe we need to achieve in order to make this vision reality for the people of Northampton.

1. All partners have paperless or paper light operations enabled
2. Electronic prescribing for all by 2020
3. Staff can access the information and technology they need to work anywhere (starting with any healthcare facility, then any public sector building, and finally anywhere in the county)
4. Information is held securely and shared appropriately with those that need it
5. Partners are all able to identify people at risk and are using consistent methodology and data to do so
6. Access to information at the right time in the right place for care is enabled for all
7. Consistent and high quality data is available in a timely manner across the system and we are able to link data sets using a common identifier (NHS No)
8. Duplication of effort and/or systems is removed where possible and we purchase technology together where ever this is possible and will increase efficiency
9. There is online access to self-help for citizens
10. Technology is used to support independence at home whenever possible
11. We work towards a single login for staff and citizens for their information
12. Discharge summaries are no longer required because the care record is available and provides equivalent information at the transfer of care
13. Care planning and advanced care planning for end of life across multiple providers is enabled
14. Staff are IT literate, competent and confident to use technology when it's deployed
15. There is a real time view of where patients and/or beds or services are to enable air traffic control across pathways and new models of care
16. Business change is fostered as a culture to ensure that operations adapt alongside technology developments

Outcomes

Care & Quality:

- Improved economy planning
- Improvement in client care – relevant data available at point of need
- Reduced incidents as data shared
- Appropriate sharing as agreements agreed and in place

Health and wellbeing:

- Citizens can take control of their own wellbeing
- Citizens most in need identified for support
- Targeted initiatives for the benefit of the citizens and economy

Finance and efficiency:

- Pooled resources
- Utilise staff skills/ draw on partners e.g. education
- Infrastructures aligned, agile working improved

We have identified a set of enablers that will be put in place across the system in order to achieve our new integrated model of care (1/2)

Enablers	Description
	<p>Following discussions around the June submission of the STP it was confirmed that there would be little opportunity to access additional capital over the next two two three years. At this stage, the health Economy has agreed that IM&T and the implementation of the LDR are the key local priority.</p> <p>In respect of acute configuration the drive of the STP is to develop a single service across the county. Both hospital estates have significant levels of backlog maintenance attached to them and despite the lack of available capital in the short term, there is now an idea opportunity to develop a plan to provide sustainable estate solutions to a modern acute service. This will have to be created using the existing estate over the short term but options for redeveloping the acute estate to support the new models of care will be created over the coming months, This may be an incremental process and alternative sources of capital will need to be explored to support delivery of this. KGH have a pressing concern relating to their A&E department estate and currently have temporary build in situ which is time limited. The Trust have appointed, in principle, consultancy support to create an OBC to propose the model for an urgent and emergency care hub that aligns and supports the direction set out in this STP.</p> <p>A corresponding strategy for out of hospital services will be developed on the same basis. The key priority in the short term for capital in order to deliver a single service solution across the acute hospitals and to support the development of out of hospital services estates is a key enable and will need significant investment.</p>
Estates	<p>These will be underpinned by the following principles:</p> <ul style="list-style-type: none"> ▪ Optimise use of existing estate and ensure that federations/super practice consider the full breadth of out of hospital estate (incl primary care, community care, social care, voluntary services, etc.). <ul style="list-style-type: none"> – Use all estate more efficiently than at present and use shared space where necessary across the footprint – Ensure choice of location for new care model allows community based workforce to be co-located as appropriate and share knowledge & best practices ▪ Enable delivery of our transformed and enhanced clinical models by identifying what is required and where and supporting plans for strengthening our estates infrastructure accordingly ▪ Focus on maximising utilisation across the entire estate, thereby supporting seven-day working whilst releasing savings through disposal and increasing efficiency ▪ Respond to the “Carter” challenge to reduce NHS trust non-clinical footprint by 35% ▪ Ensure that our estate can deliver the aspirations of the GP Forward View by developing the estate and investing in the infrastructure ▪ Create the framework and basis for moving toward a ‘one public estate’ approach and supporting governance to facilitate change

We have identified a set of enablers that will be put in place across the system in order to achieve our new integrated model of care (2/2)

Enablers

Description

Contracting and commissioning

CCGs will create a single commissioning framework across Northamptonshire. This will then look to develop an integrated commissioning and contracting process across the system which supports outcome based contracts supported by key performance metrics and will look to be significantly less transactional than the existing model.

We will incentivise desirable behaviours using risk/gain share models where appropriate, which will be based around the STP deliverables. Where there is a pipeline, we will work to ensure this is contractualised and tracked appropriately, so that final implementation can be measured and is in line with contractual requirements.

We will look to bring organisations closer together, so that collaborative working is enhanced through contracting models, not limited by them. Through a focus on outcomes and performance delivery, we will encourage organisations to work collectively to deliver change, with an open and transparent sharing of information to enable decision making and delivery. We will use prime provider and alliance-type models to deliver countywide change and ensure that providers work together to achieve the transformation required.

The system will look to maximise utilisation of the standard NHS contract but look for how we can flexibility commission activities through the GP Federations/super practice. In the longer term we will look to move to a form of capitated budgets but recognise that to achieve this is will require significant work. The system will look to share learning from other health economies who have already progressed this work and continue to work with specialised services.

We will use the National Contract to ensure that providers deliver their statutory/constitutional duties, as well as work in partnership with commissioners and other providers alike. Where performance is not as expected, this will be managed through contract management processes, as well as STP reporting mechanisms to ensure that delivery remains on plan and STP requirements are not jeopardised.

Clinical governance

The system will retain a clinical oversight group as part of its delivery structure which test and challenge the clinical robustness of the developing plans and ensure integration and system wide working is fully assessed.

- Aligned clinical standards to operate across the Northamptonshire health and care system
- Shared metrics across providers to track performance and improvement
- Shared clinical governance arrangements for providers
- Review clinical governance and risk for new staff groups and increased voluntary sector involvement

Regulatory

The system will need to develop a new single relationship with all regulators including NHSE and NHSI to ensure there is a common understanding and management of the pressures both performance and financial as the system goes through the transitional stages of the plan.

Strategic level review of risks and mitigations/controls

Description of Risk	Mitigations and controls
<p>Engagement Risk</p> <p>There is low take-up and public engagement with new H&SC systems and services, and the offer is not seen as sufficiently relevant to need</p>	<ul style="list-style-type: none"> ▪ Continuing public engagement to ensure views are captured and that, as appropriate, service changes are influenced ▪ Continuing public communication to ensure news of, and reasons for, changes are notified before they occur ▪ Appropriately resourced and supported delivery and identify ways to invest in the workforce and processes necessary to deliver the plan
<p>Partner Risk</p> <p>Lack of buy-in by key stakeholders and the public, and little engagement from third-party stakeholders in H&SC</p>	<ul style="list-style-type: none"> ▪ Strong system leadership across all partners ▪ Subsidiarity and devolved structures are used to drive change ▪ MoUs, strategic partnerships and formalised stakeholder management ▪ Continuous engagement with all key stakeholders via comprehensive communication and workshops, with a continuous focus on advocacy and impact
<p>Financial Sustainability Risk</p> <p>Resources are insufficient to support system transformation and long term funding is inadequate to sustain the Northamptonshire health and social care system to continue to provide needed products and services</p>	<ul style="list-style-type: none"> ▪ Ensure that the transformation budget is suitable to enable successful implementation of early initiatives in out-of-hospital services ▪ Adoption of funding models that maximise the interplay between core resources and transformational funding
<p>Design Risk</p> <p>The Quality and scale of services are variable and/or poor, and best value incentives and indicators in the system are inadequate</p>	<ul style="list-style-type: none"> ▪ Inter-organisational/agency system design methodologies to ensure best possible service design is achieved ▪ Iterative design processes will be implemented to get us to the right place ▪ Ensure the right workforce and IT capabilities are in place to the right timescales
<p>Delivery Risk</p> <p>Organisational and patient support systems and infrastructure are inadequate to underpin Northamptonshire services from the perspectives of capacity and quality</p>	<ul style="list-style-type: none"> ▪ Pan-system delivery strategies ▪ Implementation of rigorous quality control checks and mechanisms ▪ Secure additional resources to ensure that appropriate skills and capabilities are available through the workforce
<p>Organisation Risk</p> <p>Organisational capacity, capability and sustainability is inadequate for the operational continuation of the H&SC service delivery model</p>	<ul style="list-style-type: none"> ▪ Ensure continuing engagement and communication with clinical leaders to retain buy-in to delivery of the STP and look to them to cascade those messages throughout their staff ▪ Ensure plans maintain a focus on clinical and financial sustainability
<p>Stakeholder Risk</p> <p>Individual organisations are unable to deliver their part of the system change and thus effect delivery of the whole system plan.</p>	<ul style="list-style-type: none"> ▪ Clear reporting and governance systems in place to highlight issues arising early and assess and adjust for impact; ▪ Close working relationship with all regulators to manage any impacts

Next Steps

The Northamptonshire system has developed a clear direction of travel for the STP and strengthened the granular plans around implementation

- Implementation of the governance and delivery structure to drive through implementation including identification and confirmation of resources to support the STP;
- Start discussions with NHSE and NHSI for access to potential additional funding;
- Operationalisation of the plan and finalisation of contracts for 2017/18 and 2018/19;
- Implementation of the LDR to support integrated working across the system;
- Development of a system wide estates strategy to support new models of care over the next 2 to 15 years;
- Development of the workforce strategy and detailed implementation plans that will support the new models of care;
- Implementation of the communications and engagement strategy.