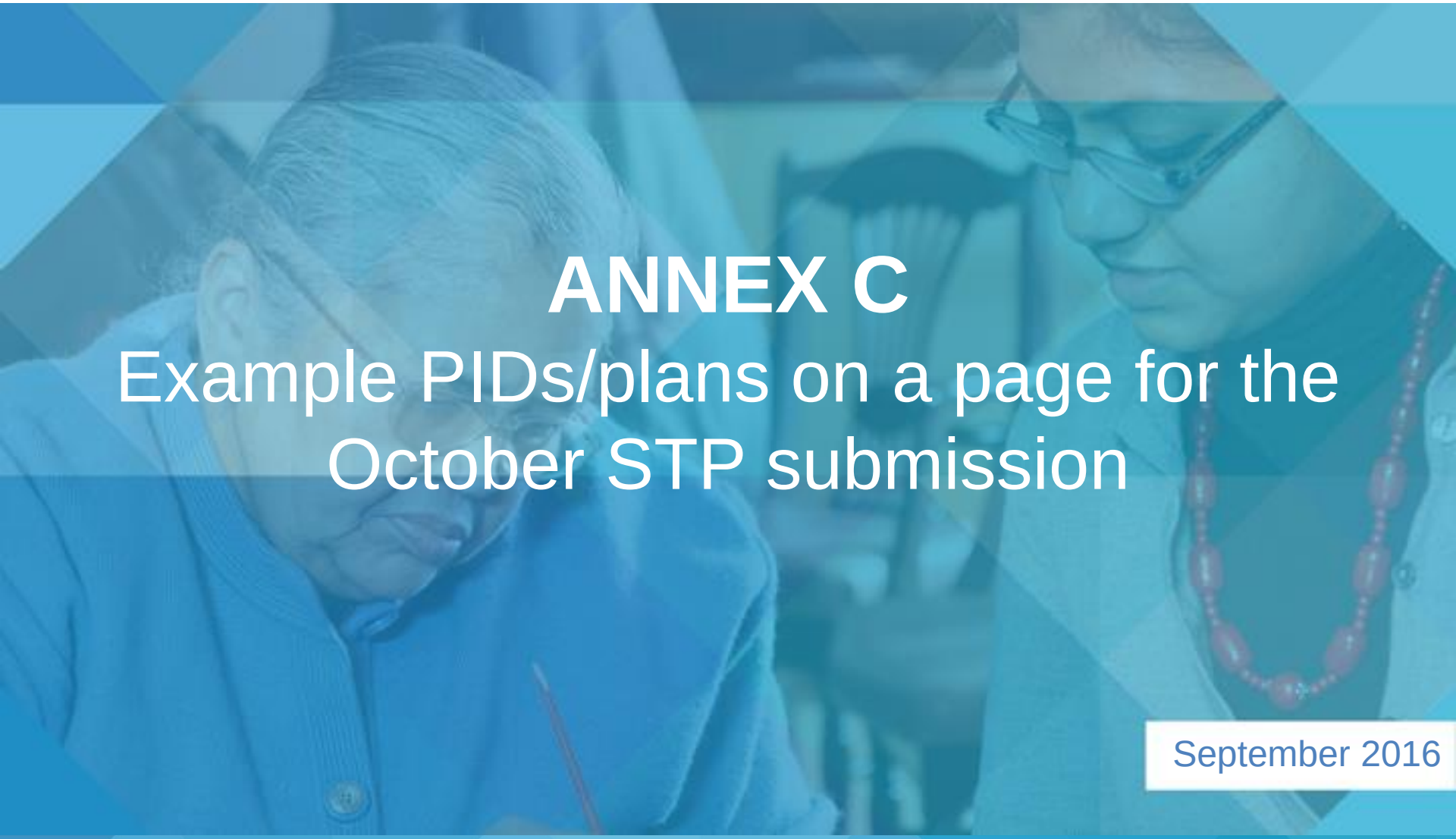


ANNEX C

Example PIDs/plans on a page for the October STP submission

September 2016

Purpose of this document

In June, each STP area shared its emerging thoughts on the 3-5 critical issues in its locality. We now ask to see plans with more depth and specificity outlining how you intend to implement and deliver the proposed transformation schemes as annexes to your submission.

We have now asked you to set out your plan to address the feedback from our July conversation. We don't need another lengthy narrative. It would be helpful if you could provide a summary sheet or 'plan on a page' to set out your overall aims, highlighting key changes between the June and October submissions. This should also include a crisp articulation of the tangible benefits to patients and communities.

Any proposed shifts in activity from the acute sector should be accompanied by a clear plan to build strong primary care and community based services to provide the appropriate alternative care. Whatever format you choose, your plan will need to set out a clear set of milestones, outcomes, resources and owners for each scheme, as well as overarching risks, governance and interdependencies. This should include which organisation is involved in each initiative to allow you and us to triangulate your STP with local operational plans. We recognise that your plans will be more detailed for 17/18 and 18/19 and more high-level thereafter and subject to the normal rules around consultation and engagement.

This document contains examples from several footprints that prepared Project Initiation Document (PIDs) and Plans on a page for the June submission, which they have permitted us to share to aid you in the process of shaping your October STP submission.

Example #1

Plan on a page: XXX STP

Introduction

- The XXX system footprint is the population of 750,000 people registered with GPs across five CCGs: XXXXX
- Our starting point is generally good, with many examples of high performance and a track record of working collectively to achieve change.
- The system is experiencing increasing pressure and our modelling of the demography and financial challenges clearly shows that we need to respond with much greater transformation if we are to address our 'do nothing' gap of £XXXm by 2020/21.
- We have identified five priorities for change, underpinned by four transformational enablers, which taken together will help us to eliminate our financial gap by 2020/21. In years one to two we will progress six key initiatives to establish early momentum and underpin future work.
- All of our plans are built on collaborative relationships and consensus amongst our system leaders which we will continue to develop to ensure the success of our STP, and which provide the foundations for an integrated health and social care system in the future.

Our priorities for the next 5 years

P1 **Priority 1:** Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.

P2 **Priority 2:** Action to improve long term condition outcomes including greater self management & proactive management across all providers for people with single long term conditions

P3 **Priority 3:** Frailty Management: Proactive management of frail patients with multiple complex physical & mental health long term conditions, reducing crises and prolonged hospital stays.

P4 **Priority 4:** Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

P5 **Priority 5:** Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.

Six initiatives on which we will focus in 2016/17-17/18

1. Ensure that people have the skills, confidence and support to **take responsibility for their own health** and wellbeing
2. Lay the foundations for a new model of **general practice, provided at scale**. This includes work to further the development of GP federations to improve resilience and capacity.
3. Transform the '**social care support' market** including a comprehensive capacity and demand analysis and market management.
4. Design a **support workforce** that is fit for purpose across the system.
5. Implement a **shared care record** that is accessible to professionals across the STP footprint.
6. Develop **integrated care decision making hubs** to provide single points of access to services such as rapid response and reablement with phased implementation across our area by 2018

Summary Financial Analysis

- The XXX system will spend c£1XXXon health and social care in 2016/17.
- Although there are modest increases in funding over the period to 2020/21, demand will far outstrip these increases if we do nothing.
- We have assumed health providers can continue to make efficiency savings of X% pa, and demand can be mitigated by X% pa. This is in line with historic levels of achievement. Including broader efficiencies from Social Care will deliver about £XXXm by 2020/21.
- If a further £XXXm can be saved across our five priority areas, this coupled with an allocation of £XXm from the national Sustainability and Transformation Fund (STF) will bring the system into balance by the end of the period

STP 2020/21 Summary

	Do Nothing £000s	Solutions £000s	Do Something £000s
Commissioner Surplus / (Deficit)			
Provider Surplus / (Deficit)			
Footprint NHS Surplus / (Deficit)			
Indicative STF Allocation 2020/21			
Surplus /(Deficit) after STF Allocation			
Social Care Surplus / (Deficit)			
Total Surplus / (Deficit)			

An underpinning programme of transformational enablers includes:

A. Becoming a system with **a collective focus on the whole population. B. Developing communities and social networks** so that people have the skills and confidence to take responsibility for their own health and care in their communities. **C. Developing the workforce** across our system so that it is able to delivery our new models of care. **D**. Using **technology** to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.

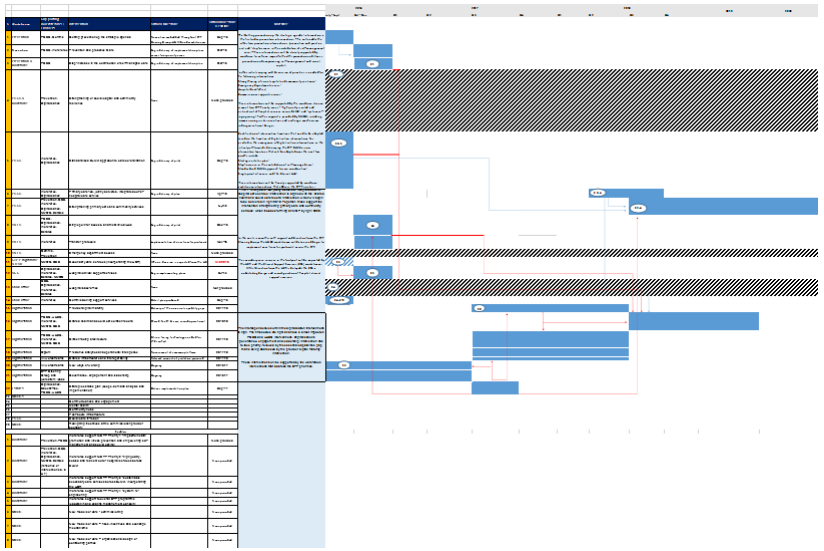
Example #2

Section 6: Look forward and critical path

STP Programme started work to identify the dependencies, the elapsed times to implement, and the sequence in which implementation activity needs to take place to progress the suite of actions required to realise our vision and to establish our preferred delivery model.
Key messages emerging from initial exercise about what we need to do when to meet our STP priorities are:

- The "Getting prevention up the strategic agenda" intervention is the 1st order prevention intervention. This a crucial enabler for the other prevention interventions.
- Prevention interventions will need to receive strong support from our Workforce workstream if we are to achieve impactful health, promotion and illness prevention and to empower self-management and build social capital.
- Further scoping work with relevant workstreams is required to test how the following interventions are brought into sharper focus and then developed between now and September:
  - ✓ Strengthening social capital and community resilience
  - ✓ Re-calibrating access to XXX's emergency departments
  - ✓ Strengthening the services and system-wide leadership of clinical support services not just in hospital but across all care
  - ✓ Maximising the strategic contribution of a reinvigorated, scaled commissioning support service platform
  - ✓ These interventions will need to receive strong support from our Workforce and NMOC workstreams.
- Taking priority is Digitisation's "Governance, engagement and leadership" intervention which will create a jointly-owned mechanism, vested with executive power, to operate and take place-based decisions across the STP footprint.
- Other STP interventions that will depend on progress with Digitisation include those seeking:
  - ✓ A step-increase in the contribution of self-managed care
  - ✓ A standardised XXX approach to care coordination
  - ✓ A single point of access and the associated Clinical Hub
- That we align the implementation plan for "Primary care-led, jointly delivered, integrated out-of-hospital care service" intervention with the "Shared health and social care record" intervention, which is expected to be delivered in April 2018.
- In the next six months, the U&EC workstream will deliver and begin to implement new "Transfer protocols" across the STP.
- Planning for secondary care services in the footprint, which will be overseen by the XXX Secondary Care Services Transformation Board, will be impacted by the HCR but also enabled by the Clinical Support Services and Back Office workstreams. These interventions will also need to receive strong support from the Workforce workstream.

1st cut critical path for XXX STP interventions



1st cut view of workstream interdependencies across XXX STP interventions

	1st perspective								
	Prevention	**PCSC**	**U&EC**	**CSS**	**Back Office**	**Digital**	**Estates**	**NMOC**	**Workforce**
Prevention		Social capital	Know where to go / who to call	-	-	Population analytics	Identification of most used preventative services	Population analytics	Self management
PCSC	Secondary prevention		SPOA / Clinical Hub	Community pharmacy services	Support interventions	Predictive analytics	Support plans	MCP and commissioning	Self management. PC Leadership development
U&EC	Public education	SPOA/ Clinical Hub		Community diagnosis services	Hospital back office	Shared H&SC record. infrastructure.	Support plans	Clinical hub commissioning	Recruitment & retention. 7 day working.
CSS		Services accessible in a community settings	7 day diagnosis services		Support plans	Shared H&SC record. infrastructure.	Support plans	Commissioning	Recruitment & retention.
Back Office	-	Support interventions	Respond to hospital back office direction changes	Support plans		Shared H&SC record. infrastructure.	Shared plans	Support plans	Integrating workforce across the STP
Digital	Shared H&SC record	Shared H&SC record	Shared H&SC record. Interoperability.	IT operating systems (e.g. PACS)	IT operating systems		Transferable IT operating systems despite location	Analytics	Training & development
Estates	Support engagement plans	Primary care requirements	Location of the hub. A&E configuration.	Reconfiguration impact	Shared plans	Support plans		Suitable location for service delivery	Flexible, mobile and virtual workforce
NMOC	Self-care	MCP	Clinical Hub	Align with new commissioning direction	Support interventions	Predictive analytics	-		New ways of working
Workforce	Development of new skills and expansions of roles	Primary care development. New roles in community and social care. Upskilling.	Transfer protocols	Size and ways of working	Size and ways of working	New ways of working	Suitable locations across the footprint	All previous and commissioning skills.	

Example #3

Plan on a page

Our commitment

Partners across the wider health and care community are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve.

Clinical and financial performance, and outcomes improvement

2016/17

2017/18

2018/19

2019/20

2020/21

Drive delivery of 16/17 recovery plan

Engage, design and consult of new models of care to address inequalities and reduce reliance on bed based care

Deliver further financial improvement

Engage, design and consult on reconfigured new models of care for acute and specialist services to secure clinically sustainable services, reduce duplication and variation and improve user experience

Promote prevention and early intervention

Implement primary care strategy

- Build equitable mental health and emotional well being capacity
- Mobilise new model of fully integrated health and social care placed-based community support in all localities
- Reduce bed stock
- Commence specialist and acute reconfigurations implementation

Realise benefits in reduction in variation and reduction in excess demand access and improved outcomes

Clinical and financial sustainability secured

Improvements in health/patient experience outcomes demonstrated

Key priorities	Prevention & early intervention	New Models of Care	Mental Health	Primary Care	Acute & specialist services	Children & Young People	Bridging the financial gap

Example # 4 – for setting out schemes

Priority ❷: ease pressure on the non-elective pathway

Context and goals

Context

% of acute bed days and % of non-elective admissions are accounted for by frail older people (>75s)

- This group represents just % of the population
- Growing trend, as the number of frail older people increases
- Please refer to Page 10 for CPR example

Rapidly rising demand on acutes for non-elective care, with projected %% growth in next 3 years

- % rise in admissions over last 2 years, with associated operational pressures: STP falls in bottom quartile nationally with % of A&E patients seen within 4hours compared to national average of %

'Do nothing' scenario would lead to need for additional beds within acute sector by 2018/19

Aspirations to improve care has been limited by fragmented approach within system

- Limited focus on proactive, preventative services
- Lack of incentives across the system for services to work together to deliver seamless care and support
- Difficulty in sharing patient information

Goals

Primary goal is to keep non-elective bed days flat by 2018/19 when compared to 2015/16

Initial focus on frailty (>75s) and end of life (EoL[1]) pathway redesign to keep bed days flat

- Integrated care: locality based, integrated primary, social and community care for the frail population
- Care home residents: lead provider model for integrated community services
- EoL[1]: co-ordinated services with shared care records and complex care registers
- Pre and post hospital: support at home including discharge-to-assess (D2A[2]) and redesigned step-up

Wider plans impacting all non elective admissions and other complex cohorts (e.g. diabetes, COPD[3]) are also underway

- LTCs: integrated complex care and increases community outpatient care (see also priority 1)
- Re-commissioned ambulance service focusing on hear and treat/see and treat
- NHS 111/00H: increase calls and reduce inappropriate transfers
- 24/7 mental health crisis: increased access (see also priority 4)
- Emergency paeds and dental: improved system responses to reduce acute demand
- Optimise opportunities to increase and maintain evidence based preventative interventions including around CVD[4] , alcohol, falls, and smoking

1. End of life 2. Discharge to assess 3. Chronic obstructive pulmonary disease 4. Cardiovascular disease

Example # 4 – for setting out schemes

Priority 2

Draft and confidential for internal discussion and planning purposes only

Emerging view

Activity view of pathway

Reducing admissions...

Frailty

- Provide integrated primary and community care for the frail population

Care Homes

- Develop lead provider model for integrated community services for care home residents

Die Well

- Develop co-ordinated EoL[1] services with shared care records and complex care registers

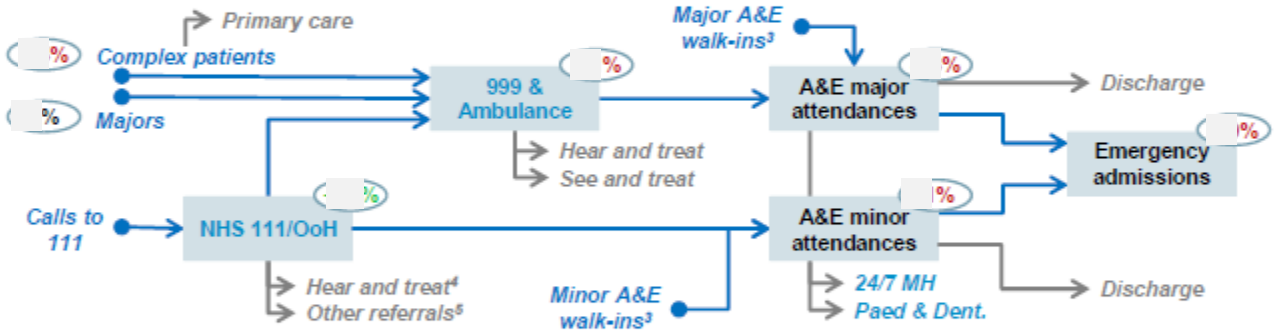
LTCs

- Provide integrated complex care & redesign LTC outpatient care in the community

...& more rapid discharge

Discharge

- Support at home following discharge incl. D2A[2] and redesigned step up



NHS-111/OoH

- Increase publicity for NHS 111
- Expand clinical triage capabilities with broader range of clinicians
- Improve algorithm to avoid unnecessary referrals to 999 and A&E

999 & Ambulance

- Expand clinical support desk (CSD), with broader range of clinicians to reduce ambulance dispatches
- Improve paramedic capabilities to treat on the scene
- Optimise process for paramedics to seek telephone advice

24/7 Mental Health

- Increase access to and capacity in 24/7 mental health crisis services

Paeds & Dentistry

- Improve system response to surges in emergency paediatric demand
- Improve emergency dental capacity and availability to avoid A&E and inpatient activity

1. End of life 2. Discharge to assess 3. Includes GP referrals 4. Includes calls ended before triage and hear and treat 5. Primary care and other services 6. Change if initiatives delivered in 2015/16
Source: CCG financial plans 2015/16; Hospital episode statistics 2014/14, HSCIC; NHSE Statistics; NHS 111 Situation Report 22/11/2015; BCG local clinician interviews

Example # 4 – for setting out schemes

Priority 2

Frailty: overview of process to date and next steps

Aim is to keep non-elective bed days flat by 2018/19 when compared to 2015/16

Overview of process

% increase expected in >75 non elective admissions over the next 3 years

- Given this projected increase in demand, frailty has been identified as an initial focus area

Key levers identified through national best practice, leading to development of "strawman" models of potential patient care pathways within Mid and South Essex

- 4 working groups, led by clinicians, have been focussing on different elements of the overall pathway

Need to ensure pathways have common interface with acutes

- When 3 acutes reconfigured, processes in and out of hospital need to be standardised
- Local variations on pathways outside of hospital needed to ensure needs of local population are met

Groups are also developing outcomes for each part of the pathway, and aligning KPIs to each to measure outcomes

Broader Complex Care Leaders Group established to test and challenge group output

Engagement planned with public and wider organisations to obtain feedback on outcomes

4 clinician led groups include: identification and care planning; proactive care delivery; frailty assessment units (FAUs); end of life

1. Five year forward view

Next steps

Q2 16	Q3 16	Q4 16
• Develop outline / strawman • Develop outcomes • Understand gaps to current service • Proposals for double running costs/capita	• Public and staff engagement on proposals • Development of more detailed blueprints • Commissioners realign services/commission additional services (dependent upon funding) • Locality dashboard in use to monitor activity	• Where possible realigned services live in time for winter (e.g. frailty assessment units - FAUs) • Where additional funding received commissioner proposals put in place • Monitoring of KPIs to know if actions making an impact

Ambition to achieve complete transformation of how care for people living with frailty provided

- Evidence from the Vanguards (Salford, Sunderland, Morecambe Bay) points to system integration and partnership working towards a new model of care (5YFV[1])
- Accountability for broader population health is most effective delivery mechanism

Thurrock CCG is already exploring possibility of forming an Accountable Care Partnership (ACP) for this group

- In line with Priority 1 (localities and primary care), particularly Level 4