Clinical Executive Committee
Thursday 7\textsuperscript{th} May 2015
Agenda

1. Framing and structuring the vision & objectives
2. Transition from Recovery to Transformation
3. Gearing up for Delivery

Purpose

• Outline ideas for development of the programme
• Discuss where you as clinical leadership team fit and how we can best use your skills and knowledge
• Make a decision as to the next steps
Framing our Vision

What will our care system look like in the future?
Our Vision:
The Right Treatment, Right Time, Right Place; shifting care from specialist hospital settings into the community, with more focus on self-care and independence.
Our Vision: The Right Treatment, Right Time, Right Place
Improving planned and proactive care to reduce the need for urgent and unplanned care needs

**Self Care & Independence**

Our vision is that you could be a happy, healthy person with minimal need for health or care support. This includes making healthy lifestyle choices, screening uptake, education & advice, mobilising community resources and taking responsibility for your health and well-being.

**Home Not Hospital & Care Closer to Home**

If you do need health or care support our vision is that you would remain at home wherever GPs feel it is safe or practical to do so. This could be through using the NHS 111 system, community pharmacists, child development centres, voluntary sector support or using technology differently such as telephone/web consultations.

**Community Based Care**

We will deliver more care in community settings; through “Integrated Health and Social Care Hubs” or in dedicated community facilities. This aims to reduce hospital visits. This includes outpatients, therapy services, minor procedures, diagnostic tests and minor urgent care treatment.

**Specialist Planned and Unplanned Care**

Only specialist treatment should be provided in a hospital setting. We aim to offer hospital treatment in fewer locations to ensure you receive the best care possible. We want you to stay in hospital for the least possible time.

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The Integrated Community Hub Concept

**Self Care & Independence**
- Personal /parental responsibility for health and well-being
- Harnessing community & voluntary support (e.g. Social Prescribing, Counselling, Support Groups, Respite)
- Personalised & preventative care (e.g. Falls, Immunisation & Screening)
- Tackling social isolation (e.g. befriending & Youth Services, Teen Mums Support)
- Structured education programmes
- Supporting healthy lifestyle choices

**Home Not Hospital**
- Pro-active disease management
- Avoiding hospital admissions
- Integrating Primary & Social Care & Education

**Care Outside of Hospital**
- Integrated health & social care hubs
- Shifting care into community locations
- Care Closer to Home

**Hospital & Specialist Care**
- Higher volumes through fewer centres
- Right treatment, right time, right place
Bridging the “Care Gap”

- Pathways focussed around the hub
- Rapid and responsive access essential
- Integrating social and health care
- Treatment options, not just re-referrals
- Ensure confidence in the service

Dr Martin McShane
Director for Patients with LTCs
NHS England
Integrated “Care Hubs”

Comprehensive integrated out-of-hospital care for provision, co-ordination and signposting.
This may not necessarily be a physical location, services will be provided in a range of ways.
The Patient Experience – Children

Sophie is 3 and has asthma. She is prone to chest infections and bronchitis, and her mother gets very anxious about her coughing and wheezing. Sophie is regularly admitted to hospital through A&E for ongoing management of her condition.

We are working in partnership with primary care services and community teams to improve services for children.

In the future we would expect that Sophie and her mother would be independent, managing Sophie’s asthma, accessing a range of services in primary care for education and advice or if her asthma deteriorates.

The community asthma specialist nurse would provide education to the nursery school and parents for advice and management of her condition.
The Patient Experience – Mental Health

Darren is 40 and has experienced anxiety and depression for 5 years. Recently Darren has become more unwell and has recently attempted suicide. He is now being considered for an inpatient stay.

We are working in partnership with mental health providers and community teams to develop more proactive care pathways, and improve crisis care for people with mental health problems.

In the future we would expect that there would be robust care management within the community to support people like Darren earlier in their treatment journey. This could include stronger pathways to IAPT, voluntary sector support and other wrap around services.
The Patient Experience – Care for the Frail & Elderly

Rose is 74 with diabetes and COPD. Rose is a frequent attender at A&E and often gets admitted for stays in hospital. Her daughter who is her main carer has noticed that she is becoming confused, and may be at risk of having a fall.

We are working in partnership with primary care services and community teams to develop an integrated frailty service for people with frailty and/or complex needs.

In the future we would expect that Rose would have a full and comprehensive geriatric assessment in the community, resulting in an integrated care plan to include domiciliary and social care support. Care Co-ordination Service would continue to offer dedicated support to reduce the need for hospital treatment, offering education, advice and sign-posting for her and her daughter.

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The Patient Experience – Planned Care

Angela is 48 and suffers from osteoarthritis. Her GP has advised that she may need surgery and has referred her to see a Consultant Orthopaedic Surgeon. She is on a waiting list for an appointment, but her knee pain has become so bad that she now has to walk with a frame.

We are working in partnership with primary care services and community providers to redesign our musculo-skeletal patient pathway.

In the future we would expect that there would be community-based options for people like Angela, which may include physiotherapy or pain management support, such as joint injections as part of an alternative treatment plan to surgery if appropriate.

If surgery is required, Angela would be in hospital for the shortest possible time, with community-based rehabilitation options upon discharge.
Questions / Comments?
2. Transition from Recovery to Transformation
Transitioning from Transactional to Transformational focus

Transactional Focus:
- Short term “annual” recovery programme
- “In-year” benefit requirement
- Stand alone organisational projects
- Reliance on traditional financial projects
- Focus on quick wins and transactional schemes

Transformational focus:
- Proactive & preventative care
- Safety & quality/outcomes based
- Challenging barriers – problem solving
- Planning for the long term
- Pathway approach across organisational boundaries
- Risk / reward incentives / financial flows to leverage benefits
- Increasing the level of ambition
- Culture change

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A Clinically-Led Programme
Clinical Design Triangles: Creating more capacity for Clinicians to lead service design

Driving Clinical Design
Leading the clinical design, galvanising clinical input from colleagues within the multidisciplinary team, championing the project as a “figure-head”

Driving delivery
Accountable for delivery of the project. Resolving issues and risks, supporting the project lead in managing stakeholders and holding to account

Driving the process
Project management, tracking, reporting, supporting the clinical and exec leads in driving delivery of project benefits

Clinical Lead

Exec Lead

Project Manager

Commissioners
Subject Matter Experts
Contracting Teams
PMO Team
Project Leads

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Quality & Safety at the Heart of the Programme
How can we make quality and safety integral to programme design?

Outcomes KPIs and Metrics

Programme Level

Project Brief developed

Project lead completes QIA Checklist with clinical lead

If any quality indicators identify negative impact project lead and clinical lead complete QIA tracker for those indicators

Checklist & tracker reviewed by QIA panel, with Q&A if needed. Then sign off

QIA tracker formally submitted to appropriate forum for tracking

Proposed QIA process

Support for care homes / GP alignment

Preventative Services Market Development Board

Risks

Metrics

Only complete below if Amber or Red

Milestones - expected within this reporting period

Financial Commentary

Projects / Schemes

Milestone details

Financial Position

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Target

LTF

Actual

A&E attendances from Care Homes (not included in Extensivist Case Load)

A

RAG Status

Milestone details

A&E attendances from Extensivist Caseload

Reduced attendances at A&E - suggestion to use reference costs rather than tariff

Outpatient (including first to follow up rates)

Single Point of Access (SPA)

Extra Care Housing

Outcome: Reduction in Acute Attendances (including A&E and OP)

Date: Example only!

Owner: Example only!

Risks

Mitigation

% Change

O RAG

O

Key Performance Indicator

O

RAG

O

Target

Baseline

Current

Position

A&E attendances from Extensivist Caseload

Extensivist (ACT)

RAG Status

Milestone details

GP Front Ending A&E

7 day services across the system

Outpatients (including first to follow up rates)

Mirror to organisational scorecards
Developing an Innovation Culture

7 dimensions identified as key determinants of innovative organisations.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk taking</td>
<td>The degree to which there is intellectual and emotional support for people to try something new, test ideas, with recognition that not all will work.</td>
</tr>
<tr>
<td>Resources</td>
<td>The availability of information, money, protected time and authority to innovate. Creative ideas do not all cost money or consume a lot of time, but recognition that lack of these will stifle innovation.</td>
</tr>
<tr>
<td>Widely shared knowledge</td>
<td>The degree to which knowledge is widely gathered from within and outside of the organisation, rapidly transmitted and honestly communicated. Sharing of best practice and spread of ideas to springboard innovation.</td>
</tr>
<tr>
<td>Specific targets</td>
<td>The degree to which line managers make clear that innovation is highly desired in specific areas that are strategically or operationally important.</td>
</tr>
<tr>
<td>Tools &amp; techniques</td>
<td>The degree to which the organisation supports a conscious and methodical process for innovation that allows free-flow of ideas, but doesn’t rely on only “creative people” to come up with new ideas.</td>
</tr>
<tr>
<td>Rewards &amp; recognition systems</td>
<td>The degree to which innovation efforts is recognised and rewarded. This should not just focus on whether ideas have been successful in the traditional sense, but also focus on learning which can be used to support the next new idea.</td>
</tr>
<tr>
<td>Rapidly formed relationships</td>
<td>The degree to which high-performing teams and networks of self-motivated individuals can be easily formed to bring different skills and styles together across the multi-disciplinary team</td>
</tr>
</tbody>
</table>

Paul Plsek: Consultant, author, and speaker on creativity, innovation, and large-scale change in health care across the US and UK
This will highlight areas to focus on – for example:

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk taking</td>
<td>3</td>
</tr>
<tr>
<td>Resources</td>
<td>4</td>
</tr>
<tr>
<td>Widely shared knowledge</td>
<td>5</td>
</tr>
<tr>
<td>Specific targets</td>
<td>5</td>
</tr>
<tr>
<td>Tools &amp; techniques</td>
<td>2</td>
</tr>
<tr>
<td>Rewards &amp; recognition systems</td>
<td>3</td>
</tr>
<tr>
<td>Rapidly formed relationships</td>
<td>7</td>
</tr>
</tbody>
</table>
Planning for Sustainability

“When new ways of working and improved outcomes become the norm.”

There is evidence that 70% of all organisational change fails to be sustained. The NHS Institute for Innovation and Improvement identify 10 factors relating to process, staff and organisational issues that play a very important role in sustaining change in healthcare.
Testing & Measuring Change Systematically

Accepting that some ideas need an iterative approach

What are we trying to achieve?

How will we know that the change is an improvement?

What changes can we make that will result in the improvements we seek?

Act  Plan  Study  Do

AIMS  MEASURES  CHANGE PRINCIPLES & EVIDENCE  TESTING IDEAS IN CYCLES
Current & Pipeline Schemes:
Delivery framework / high level timeline as currently reported

<table>
<thead>
<tr>
<th>2015/16</th>
<th>Future Pipeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016/17</strong></td>
<td><strong>2017/18</strong></td>
</tr>
<tr>
<td>Q1 15/16</td>
<td>Quality</td>
</tr>
<tr>
<td>Q2 15/16</td>
<td>CHC (ECC placement)</td>
</tr>
<tr>
<td>CHC</td>
<td>£827k</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>Meds Mnt</td>
<td>£1.4m</td>
</tr>
<tr>
<td>Unplanned care</td>
<td></td>
</tr>
<tr>
<td>Planned care</td>
<td></td>
</tr>
<tr>
<td>Contractual</td>
<td></td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td></td>
</tr>
</tbody>
</table>

Work in progress to model these over future years where appropriate but otherwise no schemes in future year’s pipeline at this stage

- Ensuring a healthy pipeline of schemes will be critical to delivery of a sustainable transformation programme

- Categorisation of schemes in this way doesn’t work well for the way we need to move forward
This Becomes a Long Term Plan
Delivery framework / high level timeline

In year 1 we will need some traditional “recovery” schemes, but we will start to invest in longer term “transformational” schemes alongside that.

Over the next 5 years we will systematically reduce our reliance on “recovery” schemes so that our programme delivers long term recurrent quality and financial benefits.

By year 5 we expect to have minimal “recovery” schemes.
Integrated Governance Structure

Our integrated Governance structure supports the Commissioning Cycle and procurement processes throughout the project life cycle.

**Setting Strategy**
- Health needs assessment
- Setting corporate strategy & direction

**Designing Services**
- Pathway design & development of specifications
- Holding to account for delivery of benefits

**Commissioning Case Development & Approval**
- Procurement processes (if required)
- Provider options/decision processes

**Mobilisation**
- Idea generation & critique
- Clinical modelling

**Monitoring & Evaluation**
- Procurement Group
- CEC & Clinical Leads
- LCG, CRG & CEC

**Governing Body Sub-Groups**
- Finance & Performance Committee
- Quality & Governance Committee
- Primary Care Committee

**Governing Body**
- CEC & Clinical Design Triangles
- Set-up / Implementation

**Procurement Group**
- Self Care & Independence
- Home Not Hospital
- Integrated Community Based Care
- Specialist Care

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Potential CEC / Transformation Board Agenda Items

1. Regular Status Reporting - Gateway Status

2. Programme Level Performance Reporting
   Programme level KPI dashboard

3. Decisions on potential new ideas, pipeline projects & gateway progressions

   1. Idea
   2. A3 Plan on Page
   3. Commissioning Case

4. Escalation of issues / emerging risks that cannot be resolved by the project leads

5. Free-flowing discussion around idea generation and problem solving

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Proposed Programme Governance Structure

Governing Body
Monthly

Clinical Executive Committee (CEC)

Transformation & Sustainability Board (TSB)

Finance & Performance Committee & Quality & Governance Committee

Idea generation & critique

Locality Commissioning Groups (LCGs)

Approval & sign-off for schemes, reporting to Governing Body

Enabling and cross-cutting work

- Quality & Equality
- Medicines Management
- Planning & Resources
- Comms & Engagement
- Clinical & Programme Assurance
- Programme Management Team

Two Clinical Design Triangles to lead “in hospital” and “out of hospital” projects. Board Level responsibility for CHC & Transactional schemes unchanged.

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**Programme Portfolios**

### Joint Director of Acute Commissioning & Contracting
- Ophthalmology
- Stroke & Cardiology
- MSK
- Ambulatory care
- Community Paediatrics
- Diabetes
- Emergency activity & discharge planning
- Other Joint projects with Southend CCG
- Acute care

**The Big 6**

### Director of Integration & Transformation
- Primary prevention
- Self-care
- Risk stratification / predictive modelling
- Falls prevention
- Care co-ordination & Case management
- Intermediate care, reablement and rehabilitation
- Mental and physical health needs
- End of end of life care
- Children’s services
- Primary Care

### Chief Finance Officer
- Transactional/Recovery schemes
- Financial modelling & enabling work streams
- PMO
- Corporate Services
- Comms & engagement
- Procurement

### Chief Nurse
- Quality & Equality
- Safeguarding
- Medicines Management
- Continuing Healthcare

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3. Gearing up for Delivery
Programme Support Requirements
Additional project management support will be required in the short term.

It is proposed that Senior Programme Leadership support is in place in the early stages of implementation.

It is proposed that dedicated Project Leads support Clinical Leaders and Execs to deliver projects across 2 clinical triangle areas.
Costs of Delivery

The following table outlines the proposed cost of delivery until the end of September 2015

<table>
<thead>
<tr>
<th>Level</th>
<th>Requirement</th>
<th>Cost</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Director</td>
<td>5 days per week from 11&lt;sup&gt;th&lt;/sup&gt; May to 30&lt;sup&gt;th&lt;/sup&gt; September</td>
<td>£54k</td>
<td>Oversee the programme, managing delivery and maintaining focus, reporting to Kevin McKenny</td>
</tr>
<tr>
<td>Project Manager X2</td>
<td>5 days per week from 18&lt;sup&gt;th&lt;/sup&gt; May to 30&lt;sup&gt;th&lt;/sup&gt; September</td>
<td>£44k x 2</td>
<td>Project manage a portfolio of projects within a Clinical Triangle</td>
</tr>
<tr>
<td>Project support officer (NHS)</td>
<td>Full time asap, fixed term for period of 1 year, start date depending on appointment</td>
<td>£25k</td>
<td>Lead the PMO elements of the transformation programme</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£167k</td>
<td></td>
</tr>
</tbody>
</table>

A Programme Support Officer role has been developed, this will be recruited on a fixed term basis. To ensure we do not lose momentum in the short term it is proposed that we continue to commission support from Attain who specialise in delivery of this kind of work. A formal review will take place at the beginning of September (potentially in partnership with Southend CCG) to determine the level of support required for the future.
Summary & Key Messages

1. Hugely positive foundation to build on

2. A few things we can do quickly to move things on in the transformational journey e.g.
   – Rationalise some of the reporting duplication
   – Introduce project management support to create capacity for clinical leadership and SME input at the right time
   – Clearly articulate what the payback/delivery will look like over the next 5 years

3. Some things that will require a medium-long term culture change and organisational development approach to ensure a truly sustainable and transformational organisational approach
Discussion / Decision