Developing a new integrated out of hospital care model in Halton

First progress report

February 2018

Introduction and context

This report has been developed in response to the challenge Halton faces over the next five years. It is not a challenge that can be tackled by one organisation, but something that needs to be approached in partnership.

Halton faces many challenges in common with the rest of the country –an increasingly challenging financial situation, and a growing elderly population with increasing health and social care needs –but it also has distinct local issues -marked inequality among local residents leading to significant health inequalities, and particular challenges in areas such as falls and mental health.

As is the case across the UK, health, social care and community services in Halton are currently being delivered within a fragmented and complex system. This is a result of a complex web of services developing not as a system but independently. There is a need for a single operating model which articulates how care can be delivered most effectively across organisations boundaries.

System fragmentation, expectations of public services and complex population health and care needs, combined with constrained public funding, have resulted in an unprecedented affordability challenge for the borough, which is forecasting a deficit by 2020/21 if action isn't taken.

Across the UK, care economies are developing increasingly bold and transformational solutions to the cost and demand 'sustainability challenge' facing public bodies.

There are numerous examples of good practice throughout Halton, and a number of examples of where effective partnership working across the borough has driven improved outcomes.

With the creation of the One Halton Programme Board –a place based partnership which extends beyond health and social care to include public, private and third sector bodies –Halton has articulated its aspiration to go further. This will be achieved through a whole system, place-based solution to the challenges of improving citizen outcomes while tackling unsustainable levels of cost and demand.

Achieving sustained improvement in population outcomes at the same time as delivering financial balance will require significant change in the relationship between the partners that comprise the health and care system.

Together we have decided to establish a new integrated, place based, health and community care model.

Halton's health and wellbeing challenge

Halton's Health and care system is facing a deficit . Whilst the financial drivers demonstrate a huge incentive for such change, the motivation for providing better quality treatment and care across health and care providers is an greater. By bringing together health and social care services in a more integrated way and creating a new model of out of hospital care we have the opportunity to tackle inefficiencies, poor clinical outcomes and reduce overall costs in the region of £3.9m out of a total system challenge of £14.1m across acute, community, prevention and primary care.

Halton population

By 2030 Halton's current population (126,350) is projected to change with a reduction in both the 0-18 and 19-64 age ranges (3.7% and 47.6%) and an increase in those aged 65+ of 46.4%. Halton has a higher than average aging population and this trend will continue. The 65+ population increased by 3% between 2001 and 2011 compared to a 1.6% increase across England as a whole.

Life Expectancy & Deprivation

48% of Halton's population live in the top 20% most deprived areas in England and 24.5% of children aged 0-15 live in poverty in Halton. Compared to the national average Halton men aged 65+ live 1.4 years less than men across England as a whole with Halton women living 2.3 years less.

Lifestyle

Obesity levels in early childhood and in adults are above the national level with 11% of 4 and 5 year olds and 31% adults obese in Halton. Levels of hospital admissions due to alcohol, especially for those aged under 18 levels remain higher than nationally for both under 18s and amongst the whole population with under 18s. Whilst smoking rates have been falling across the borough smoking prevalence remains above the national average, 20.1% of Halton adults smoke compared to 16.9% for England.

Long-term conditions

Despite improvements in the number of people with long term conditions diagnosed, there is still under diagnosis of hypertension (high blood pressure) where only about 61% of Halton people thought to have the condition are diagnosed. Death rates from heart disease continue to fall but remain the second single biggest killer in Halton. The borough still ranks one of the lowest in England: ranks 126 out of 150 local authorities for heart disease and 111 out of 150 local authorities for stroke (where 1 is the best and 150 the worst).

Mental Health

1 in 4 people attend their GP in Halton to seek advice on mental health problems with levels of hospital admissions due to self-harm are significantly higher than England, 307.4 per 100,000 compared to 191.4 per 100,000 for England .

The State of General Practice

It is anticipated that the expansion of online consultations and improved telephone access via call queuing will improve patient experience when making an appointment. The 2015 survey, designed by the BMA, comprises of 41 questions covering a wide range of issues and had a 44% response rate with over 15,560 responses including:

- **Essentials of GP Practices:** Four in five (80%) GPs rank continuity of care among the top three factors that they think are the most essential components of general practice along with trust and confidentiality between GP and patient (61%) and holistic care (51%).

- **Workload:** More than nine in ten GPs (93%) say that their workload has negatively impacted on quality of care given to patients whilst 71% say their workload has, at times, had a negative impact of the quality of care that their patients receive. At least seven in ten GPs also rank longer consultation times as a key factor that could help them better deliver the essential components of general practice.

- **Work in primary care premises with other community based staff and services:** Three quarters (74%) of GPs say they would like to work in primary care premises with other community based staff and with access to local primary care hubs providing diagnostics, extended care in the community and out of hospital services.

The Picture in Halton

- Halton's practice population rose to 130,860 in 2017 with 1,716 patients per whole time equivalent GP.

- Over 85% of patients reported an overall 'good' experience in July 17 equal to that of the national average.

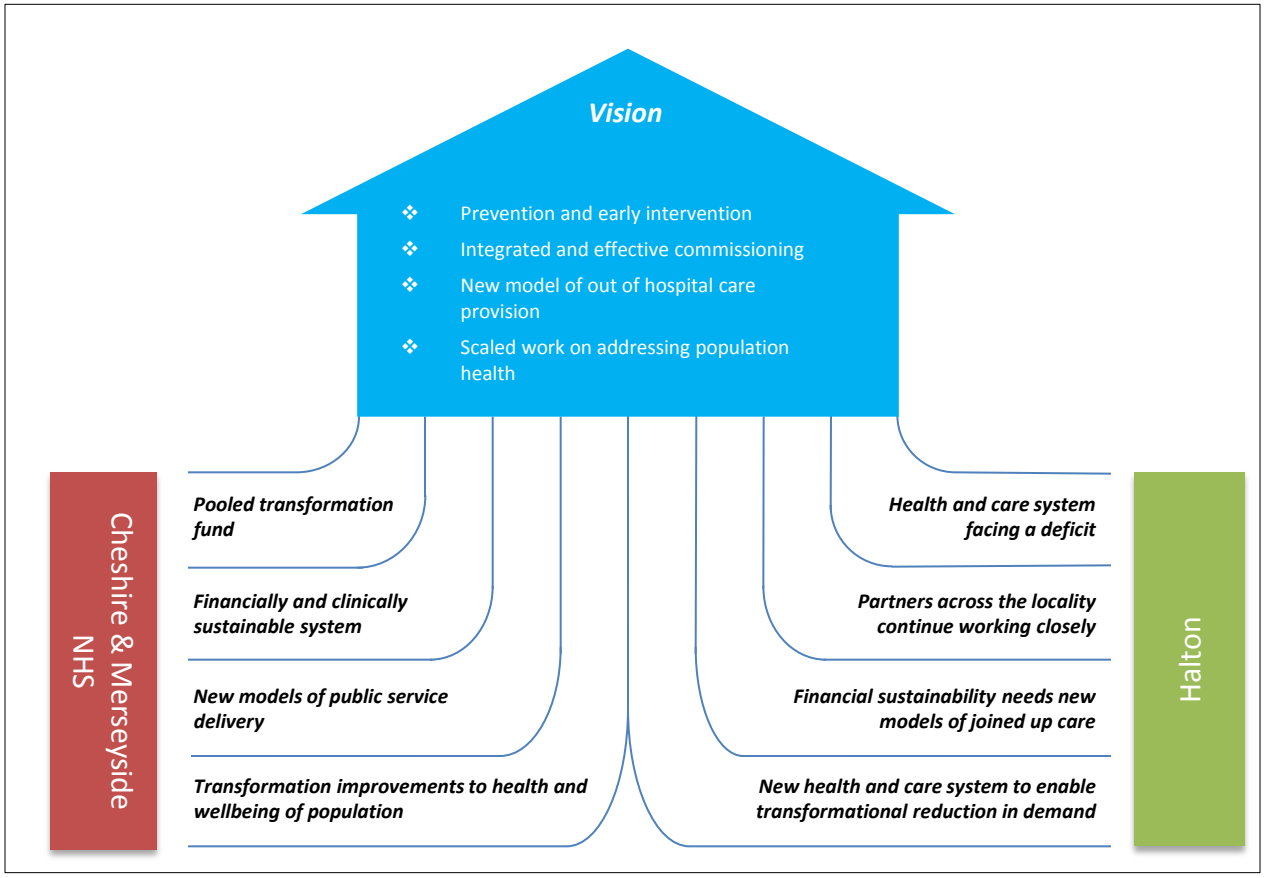
- However there is a 10% difference in those reporting a 'good' experience when making an appointment with Halton's practices (63%) compared to the national average (73%).

Aligning the system and place vision

In 2014/15 Halton started its journey towards an integrated model of care with a shared vison across health and social care.

A vision to encourage self-care, improve the general health and wellbeing and provide the right level of treatment and care close to home, so that everyone in Halton lives longer, healthier and happier lives.

To tackle the growing challenges facing Halton requires a fundamental shift across the system to one not centred on hospitals but on integration at every level focused in the community promoting self-care and prevention. It will demand strong relationships and collaboration amongst clinicians and communities along with accelerated system frameworks.



Integration is key to our strategic approach with all partners working together to deliver a joint strategic commissioning function, asset based delivery in communities, training for all health and care staff in delivering self-care messages, along with the development of community multi-disciplinary teams wrapped around Primary Care. Improving the health of local people requires changes in behaviours and living conditions across Halton. It also means that accountability for population health is spread widely across these communities, not concentrated in single organisations or within the boundaries of Halton's health, social and Third sectors. The challenge for the future of Halton's health and care economy is to reduce the costs of care with a particular focus on preventing unnecessary hospital admissions, reducing duplication and fragmentation and joining up health and social care. In order to achieve this Halton will need to state a strategic commissioning intent to shift care out of hospital into community settings.

Design framework

Four phase design process

The out of hospital model will need to be designed across four recognised phases as described below. This is now a recognised design process and will serve to ensure Halton benefits from generating traction and accountability.

	Phase 1 Align	Phase 2 Define	Phase 3 Detailed Design	Phase 4 Deliver & sustain
				
Purpose	***Align local leaders*** *on the need for change and the level of ambition.*	*Determine the* ***new model of integrated care*** *and define this in a high level blue print.*	*Co-create the* ***target operating model (TOM)*** *to describe how the system will be led, governed and incentivised.*	***Embed*** *the necessary capabilities and structures so that the changes are sustained by creating a* ***culture of continuous improvement***

Activities

Phase 1 Align

- **Vision** – ensure clarity of vision to improve health of the population, quality of care and achieve long term financial sustainability.
- **Case for Change** summarises the health and care gaps, the drivers of the gaps (informed by hypotheses) and the "do-nothing" scenario..
- **Design principles agreed** (via surveys and interviews) which will be used to create options and identify "big shifts".
- Stakeholder **engagement & communication** plan in place.

Phase 2 Define

- The **options for new care models** identified and tested against the design principles and the extent to which they address the gaps.
- System **demand, capacity and financial model** tests impact of options.
- The preferred option for the new care model is described as a **service model blue print** using **personae** to describe the impact on **user –centred experiences**.
- **Target operating model** structure including key processes and enablers defined.
- **Transformation roadmap** for next steps sets out critical path
- **Business case** for detailed design (phase 3) and deliver & sustain (phase 4) including business change planning.

Phase 3 Detailed Design

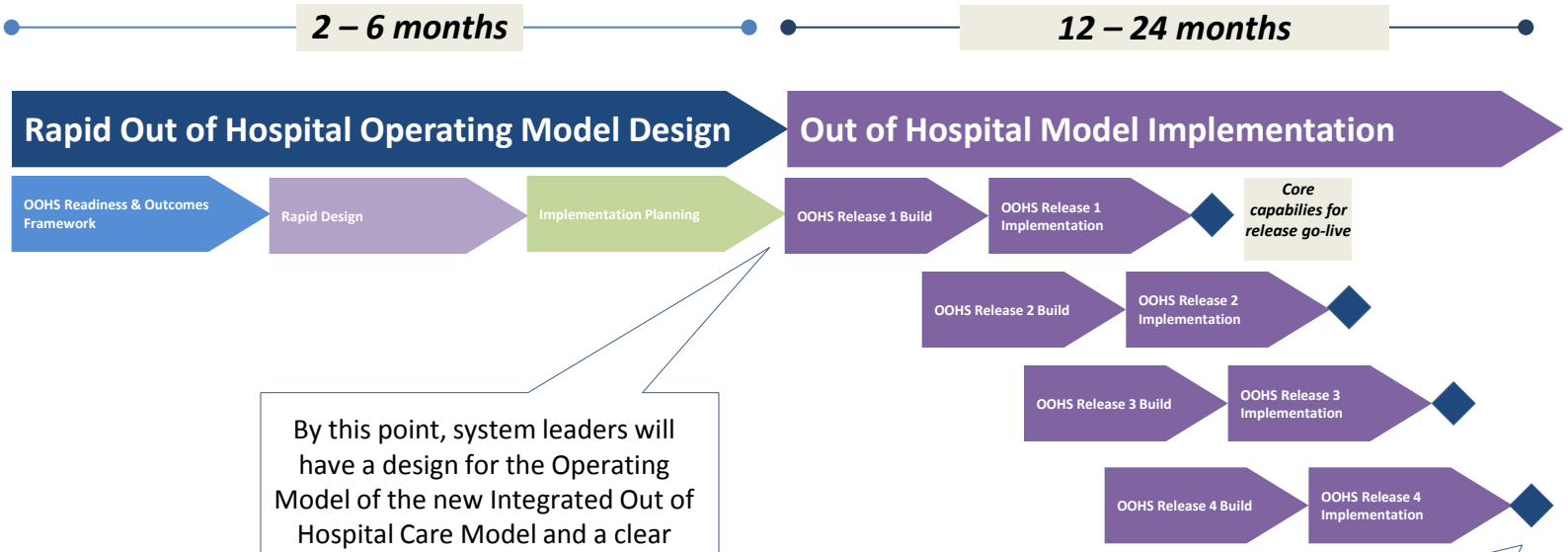
- **Detailed design of the target operating model (TOM)** including the following:
- ✓ **Governance and leadership** established to enable the system to implement the plan, make decisions and track implementation and improvement.
- ✓ **Population** budgets agreed and informed by **user-centred** pathways
- ✓ **Key process,** both clinical and business, defined.
- ✓ **Enablers** such as workforce needs, new outcome based payment mechanisms, technology solutions and integrated data & analytics defined.
- ✓ **Organisational form** options considered and preferred option designed including contracts and incentivise that drive the right behaviours. E.g ACO, PACs, MCPs.
- **Business change management** including program management capacity and capability and a sequenced critical path in place.

Phase 4 Deliver & sustain

- New **integrated care model** in place, delivering the services in line with the user needs with a culture of continuous improvement.
- New **corporate operating model** and leadership team in place delivering governance, business processes, technology and financial and contractual levers.
- **Training programmes** underway to address building skills and empowering staff.
- Effective **PDSA** process & structure in place creating a culture of continuous improvement.
- Tracking of **core KPIs** and embedded BI to track progress and support decision making.

Initial high level roadmap

The release plan for the out of hospital model implementation will be developed over the coming months and will bring together the existing core elements of integrated system wide working (e.g. new Children's Model) with the emerging thinking on scope, structure and phasing for an integrated care model across Halton. Work will be needed to validate this initial roadmap.



By this point, system leaders will have a design for the Operating Model of the new Integrated Out of Hospital Care Model and a clear plan for implementation. Plan will include the capabilities and scope of service to be "dropped" in each release. Transition resource requirements have been identified/mobilised.

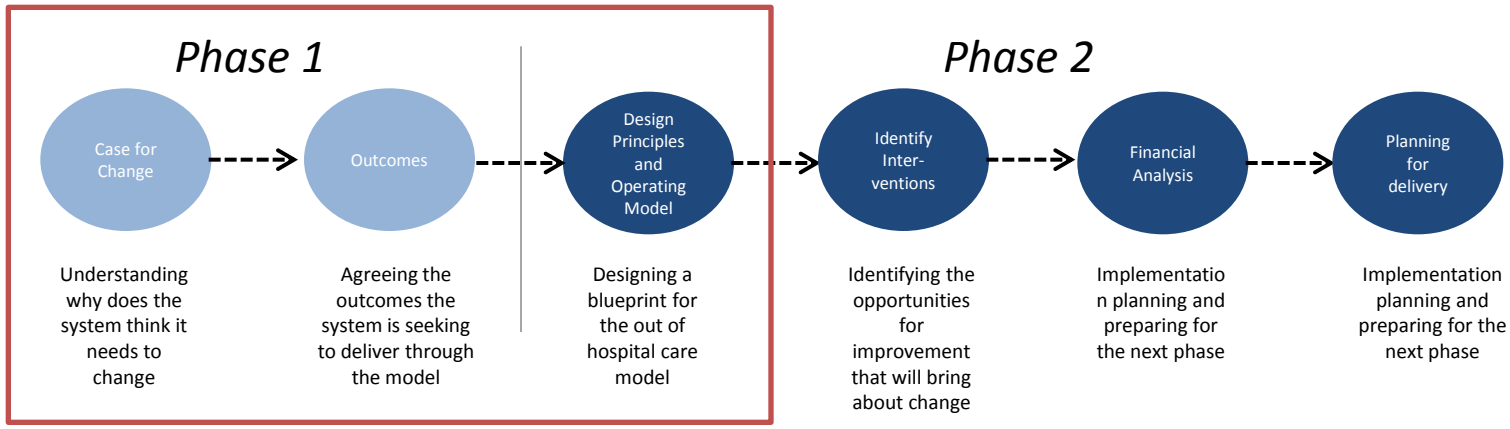
By this point, the OOHS will be live, delivered through carefully managed releases. The release strategy is agreed in the Rapid OOHS Operating Model Design in line with Halton needs OOHS intentions, for example they may include : Primary Care Reform, ICNT, Discharge to Assess, AAA, Children's New Model, Share to Care expansion, etc.

Designing the out of hospital model

Designing a solution

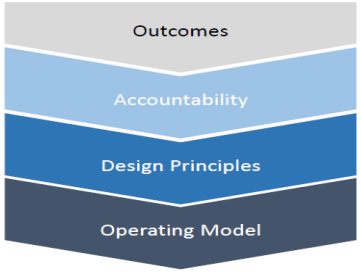
The system design for a new out of hospital delivery model needs to reflect the challenges the One Halton Programme Board is trying to address. It needs to offer an opportunity to improve health outcomes in the borough, improve the experience of those in receipt of services and reduce the overall cost of provision to ensure services remain sustainable in the long term. In order to produce a design that will satisfy these requirements, the GP Federation and Bridgewater is proposing that it follows a systematic four stage approach.

The journey of the model over four phases is a tried and test construct and we will stick with that but simplify wherever possible. During this initial phase we will focus on a smaller number of process steps as outlined below.



This section of the report:

- proposes a series of outcomes and 'I statements' that the Board should agree to focus on;
- explains the role of the different organisations that comprise the new delivery system;
- identifies the design principles the Board should agree to help it design the new out of hospital operating model;
- provides a summary explanation of the emerging new operating model;
- offers some initial and emerging further detail on the components of the operating model ; and
- outlines a test bed concept to prove concepts of the new model to ensure rapid change and impact.



Initial priorities and focus through January and February

At the start of December 2017, the GP Federations and Bridgewater were formally asked to lead the development of a new out of hospital delivery model for Halton. All three organisations set about developing a formal working partnership and engaged at Board level to debate and discuss their working approaches.

During January an event was held between the teams from all three organisations to debate and discuss working together and the principles of a new clinical model. Additionally, work was also undertaken to develop an outline programme for the new of a new model and the methodology and approach that is preferable to enabling this. Much of that is now contained and documented within this first stage report.

With the organisations clearer about how they would work together, a series of rapid engagement events were then held with wider groups within the Halton system including hospitals, mental health voluntary sector and social care sector.

It is the belief of the three lead organisations that they need to build on key elements of the work already conducted during the One Halton incarnation, supported latterly by AQuA.

Our approach will become increasingly focused on being a collaborative one to developing a blueprint for a new out of hospital care model.

That means we will need to be clear about the outcomes we need to deliver, the high level design principles and possible options for an operating model.

The three immediate priorities for the work programme during January and February are outlined below. This section of the report covers the outputs of this stage.

Outcomes	Design Principles	High Level Operating Model
A set of outcomes from the national 'I' statements will be developed during January and February and presented to the Board for discussion and consideration. These will be needed to influence and shape the final operating model design.	Local GPs will initially meet to reflect on and agree a set of high level design principles. Subsequently stakeholders from Halton will be asked to attend a workshop to reflect on the principles, identify those they agreed with, make amendments and add new principles where they considered key points to be absent.	From the development of the design principles a first draft discussion of a new out of hospital model will be described at a high level for the Board by the end of February. Subsequently a number of workshops will be run where attendees will be asked to consider the purpose and value of an operating model, examine some examples from elsewhere and the interventions .

Strategic goals

We have developed an overarching ambition with goals we believe are important for a new out of hospital delivery system. We recognise that more work will be required to firm these concepts and statement up but they are recommended to the Board as our starter for discussion and development.

To ensure Halton residents benefit from a sustainable, safe and effective out of hospital delivery system

Strategic Goals
Manage demand for services by promoting self-care independence and prevention
Enable health and social care service integration wherever possible and appropriate
Design services around users and not organisations
Treat people in the home and community for as long as it is appropriate and possible
Reduce dependence on oversubscribed specialist resources such as emergency services, non-elective admissions and care homes
Manage length of stay in hospitals, avoid delays to discharge and prevent readmissions where possible
Allow system efficiencies to be realised – duplication and over supply is eliminated while “cost shift” from one service line or organisation to another is avoided
Create the climate for staff from different professional backgrounds to work together in a positive, open and trusting multi-disciplinary climate
Allow every member of staff to be trained in having new conversations with residents that focus on assets rather than need; and
Make full use of digital technology, including development of a joined-up electronic record

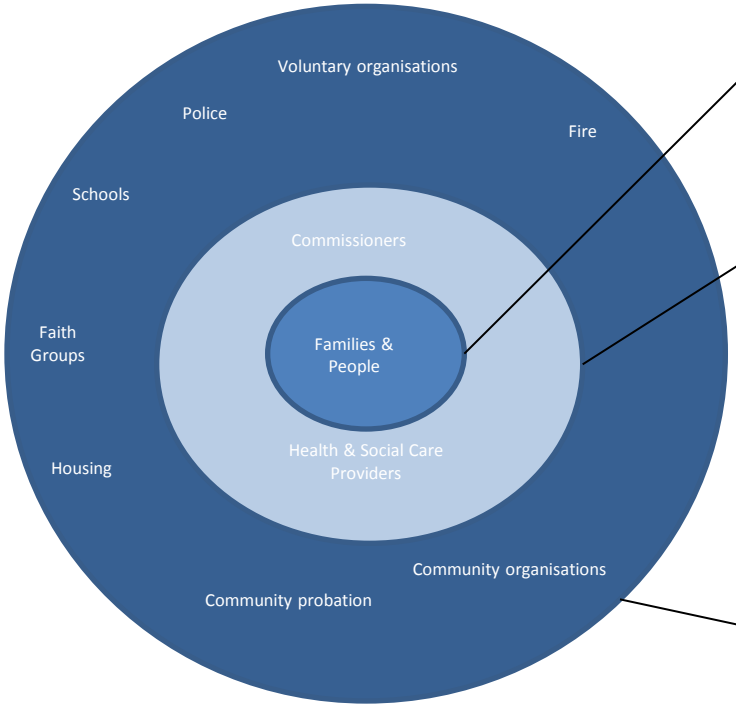
Statements to help the public understand what will be different

Our view is that the new out hospital delivery system should focus on the achievement of a small number of key outcomes (shown below) for the patients and residents of Halton. Underlying each outcome, should be a series of supporting "I-statements" which are intended to reflect the aspirations and priorities or residents and service users, as we as professionals envisage them. More work should be undertaken to clarify and confirm the precise nature of these.

Core Outcomes	***Resident focused I Statements***
Enable physical and emotional wellness, independence and reduced reliance on heath and social care services	• I am part of the community and access it in a way that is meaningful to me • I have ways to cope myself when things don't go to plan • I feel part of where I live and know where and how to find help and support • I am in charge of my care
Prioritise resources in prevention and early intervention according to need and risk	• I get all the information and support I need to live a healthy lifestyle • I know who is looking after me today • I know where to go to get additional information and advice when I need it • I have a flexible long-term care plan to keep me as well as possible
Deliver more co-ordinated, integrated and personalised care orientated around a community	• I access care in a way best suited to me • I access care that is joined-up and consistent • I work with care professionals who know me and not just my needs • I share in decisions about my care options
Provide health and social care services at home, in the community or in primary care, unless there is a more appropriate setting	• I have care available to me where I want it • I have a care plan for dealing with crises/unexpected circumstances • I don't need to see a healthcare professional unless its really necessary to do so • I receive care in a way best suited to my particular circumstances and am a full partner in my care
Support a sustainable health and care system	• I play my part in supporting the sustainability of the wider system through taking responsibility for my own health and wellbeing • I don't go to hospital when it is not necessary to do so • I am confident that, in years to come, I will still have access to the support and care I need
Provide a quality of care that is amongst the best in the country	• I receive an excellent quality of care and support • I understand the system and feel confident in it • I have confidence in the skills of the professionals who deliver my care

A new partnership

Building a new out of hospital model will need to involve a wide range of organisations – partners working together for a common aim. The Board is recommended to agree the following descriptions of their involvement.



Centred around the individual and communities
The new delivery system will encourage and promote self care and individual resilience. In this, it acknowledges that there are significant factors which it can impact and will work to address these where possible.

Core partners
All the services provided by some partners will fall in the remit of the out of hospital delivery system. These partners include commissioners, i.e. the CCG, the council and health providers –including the acute, primary care, community and mental health providers. This would also include services provided directly by the council, e.g. public health and adult social care.

Wider delivery partners
Some partners will deliver a range services which directly contribute towards the objectives of the new out of hospital delivery system, while their primary purpose is not explicitly in the delivery of health and social care. As such, they will be partially accountable for the outcomes agreed. This would include organisations such as the police, the fire service, schools, commissioned voluntary services, probation, housing providers, registered social landlords and some social care providers.

There will also be a number of community groups and networks which provide an essential capability and resource in order to make this work. These would include faith groups, volunteer groups and formal and informal community organisations such as sports clubs. Understanding this landscape is critical for targeting prevention and for care management (e.g. some social prescribing).

Design principles

A dedicated workshop has bene run to help identify and agree a number of design principles which will underpin the future design of the operating model. These will be critical for making difficult decisions about how the operating will function going forward.

The design principles will play an important role in helping to maintain the integrity of the design of the new out of hospital delivery system as the programme moves through its next phases of work –detailed design and implementation. At various points during the process, the Board will be able to check back to the principles that were agreed originally to ascertain whether or not they are heading in the right direction.

Design Principles

The design principles shaping the new out of hospital delivery system are as follows:

1. A health, social care and well-being system that is based on a co-designed, person-led and community-centred approach
2. Designed system will ensure care is accessed at the right time and place and delivered by the right people
3. Dedicated resource to coordinate multi-disciplinary care management
4. A focus and emphasis on prevention, education, strength-based working, early intervention and social support within our communities
5. Use technology to support people at home and develop the 'Halton Care' record as an enabler to integrated health and social care
6. Optimise and share the use of Halton's collective environment
7. Unify our collective workforce around a common purpose, consistent ways of working and a shared culture
8. Create and stimulate innovation within an evidenced based approach
9. Engage all partners across Halton in the design and where appropriate delivery of the new Out of Hospital model.

Initial target operating model key features

Key Feature	*What this means*
Self Help	• Building parental confidence to manage children's illness and injury • Building confidence in people to manage long term health conditions, mental health and disabilities • Building in people to manage changes that happen with age • Building confidence in people to be able to navigate and access services at the right point in the health and care system
Prevention	• **Everybody's responsibility.** All partners have an essential role to play in tackling the wider determinants of health, and there will need to be shared, consistent capabilities developed across organisations that would allow supportive interventions to occur in a holistic way no matter where someone accesses the system. This might mean partnering with schools and workplaces to promote healthy eating and physical activity, or with the fire service to educate groups regarding fire safety. • **Data enabled.** A better understanding of where to invest in prevention would improve the chance of specific, targeted programmes. • **Aligned to the challenges that Halton faces.** Some specific areas –falls, mental health, alcohol abuse –will require a joined up borough wide approach. Specifically, in terms of mental health, prevention programmes will need to ensure that those with mental health needs are having their physical preventative needs met. • **Behaviour focused.** Prevention interventions need to start young, by working collaboratively with schools in targeted areas, and focus on small changes to healthy behaviours and choices.
Rapid Access and Managing Crisis	• **A integrated rapid response team** in front of A&E -made up of trained nurses, healthcare assistants, rehabilitation experts and physiotherapists, and community resources would perform a triple function: avoiding unnecessary admissions in the first place (by being positioned at the front end of A&E), accelerating discharge by helping patient move into a community or home setting (and supporting intermediary care arrangements), and by diverting those with non-medical urgent needs away from A&E to more appropriate services. • **Actively feedback to other parts of the system to avoid future contacts.** Sharing information with other parts of the system about where interventions should be targeted (e.g. police; care homes; GP; housing) • **Use of other parts of the system to support urgent support.** Facilitated by the single point of access (contact centre) and MDTs, there may be more appropriate responses to crisis –e.g. care facilitated in the community by the care manager, or temporary/ permanent institutional care to support individuals with high levels of need.

Initial target operating model key features

Key Features	*What this means*
Care Co-ordination & access	• **Integrate access** across the system with standardised functions that are consistent across the system. • **Reduce avoidable contact.** By using digital services to reduce demand through self service (appointment booking, information and advice) and by strengthening community support and resilience and connecting people to support using local networks and assets • **Reduce inappropriate referrals.** A triage function using skilled staff and use of directory services to reduce repeat contacts. Where needs are complex, a key worker acting in a link role for the individual may provide a navigation function to enable timely and simple contact and interaction • **Reduce duplication.** Shared record accessed and available –with the ability to build on core or minimum levels of information • **Reduce length of stay in hospital and delayed transfer of care.** Real time capacity and demand management throughout the health and social care urgent and intermediate care system -which highlights available capacity for specific services • **Promoting wellbeing and improving self care.** Skilled and trained point of contact staff that delivering preventative advice. Targeted outbound work with individuals that are at risk of escalation if they are not supported early
Proactive Care Management	• **Proactive**. In actively targeting and tracking people through effective risk stratification and planning, it is possible to provide more care in less acute settings. The case manager would be required to work closely with the GP and specialists to develop a care plan. • **Multidisciplinary.** Chains of communication will need to be established so that –for instance –housing providers can be actively involved in discharge planning, or so that schools can provide flexible support if needed. This would need to actively include management of mental health as well as physical health. • **Consistent.** For those with complex needs, evidence suggests that having a named care manager provides essential continuity of care. This individual would be the primary point of contact for patient and professionals and bring together community resources and the wider out of hospital team to support the patient, including through acute episodes and discharge.

On the ground this will mean

In practice…

24/7 Urgent Care and Crisis response

- Same day appointments and flexible appointment lengths in the community for all acute illness
- Extensive expansion of services in urgent care centres as they become fully integrated with primary care
- More rapid and responsiveness crisis intervention services in the community to prevent hospital admissions

Multi-Disciplinary Teams

- Integrated multidisciplinary teams working together in the community as a single team around 'hubs'
- Expansion of MDTs tasked with active case management of both 'at risk' and 'low risk' groups to reduce current and future hospital admissions

Community Care Teams

- Multi-organisational integrated health, care and community resources built around 'hubs' with support from town or borough wide specialist services
- Care continuity for the elderly and patient with chronic/long term conditions
- Increase management of chronic disease groups with acute, community and voluntary sector partners

Discharge

- Integrated pathways and services to support acute colleagues discharge patients into the community
- Use of reablement first approach for anyone requiring a long term package of care
- Intermediate care capacity (step up/down) to support people returning home

Asset/Strength based delivery

- Expanding capacity and support in the community for asset/strength based working
- Skilled and trained staff promoting asset based conversations and preventative advice supporting vulnerable people and those at risk of becoming vulnerable

Organised around primary care 'hubs'

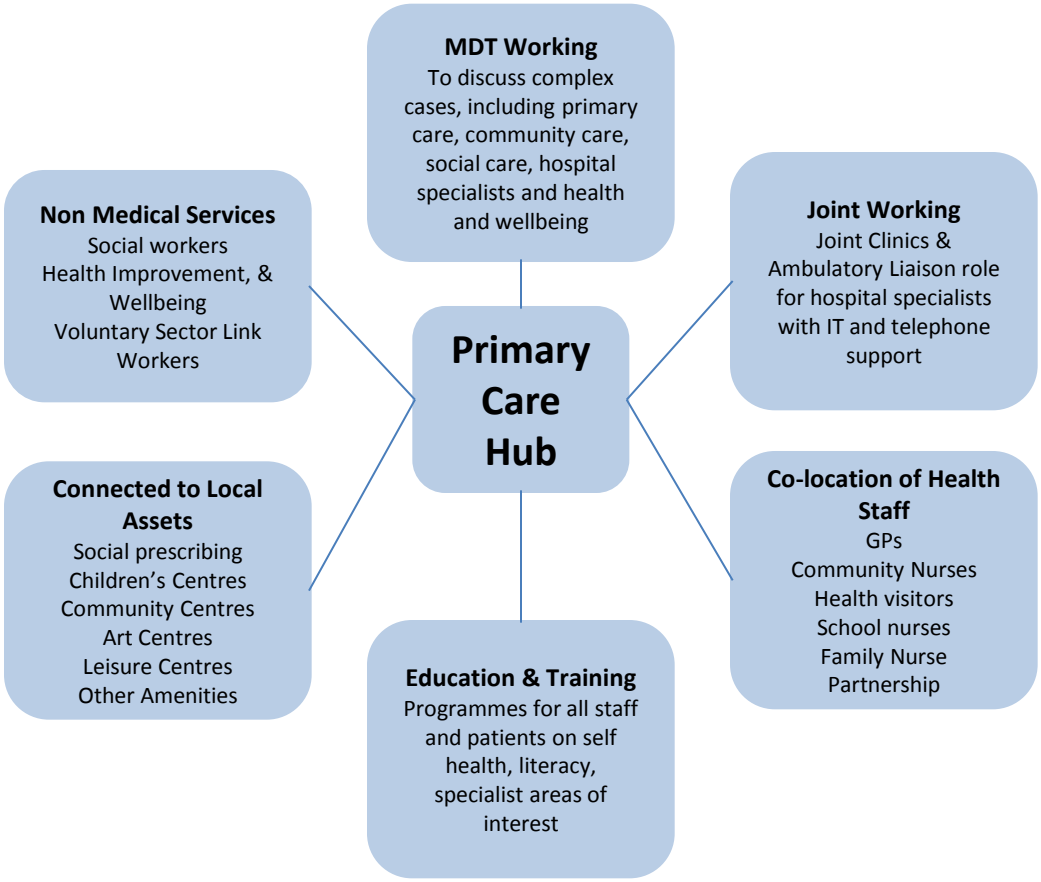
There are four hubs in Halton; two in Runcorn and two in Widnes.

Covering the two towns, the hubs allow multiple organisations to work together more seamlessly to support patients with complex needs who could otherwise receive disjointed care, with multiple referrals and handovers.

The hubs will need to exist both virtually and physically with health, care and wider community resources co-located where possible. Each hub will be made up of specialist and community workers from different health, social care and voluntary and community organisations across Halton.

People will be referred directly into the Community Care Team wrapped around hubs to receive a joined-up care plan. This provides a joined up approach helping those people at risk now and those at risk in the future to stay well and out of hospital. This ensures that people referred get the right care, at the right time, in the right place and by the right person.

The partner organisations and community resources within the hubs and Community Care Team are described as follows:



Scope of services

It will be critical to agree the scope of services that can be transitioned to a new delivery system as early as possible as this would be a core enabler to achieving the greatest possible level of benefit from enhanced integration and collaboration. While early integration is a key enabler to realising maximum benefit from system wide redesign, Board members also need to recognise there are a number of contractual, regulatory, and financial considerations which would require further review before a final decision can be made on transitioning services into the new delivery system.

Our initial thoughts are outlined below to enable that debate.

Services to be included at Day 1	Services not included at Day 1 but maybe suitable for later date	Services not likely to be included nor or in the future
Primary care Community health care Adult social care Children's social care Public health Mental health Well being/3rd sector	Community safety services such as: • Mental health triage • Victim support • Probation Ambulance Leisure/libraries Primary care Optometry Primary care Dental Services for youths Housing Schools – post 16 provision	Fire protection Road safety Youth justice

Work will be needed through the next phase of development to refine this list into a more considered list of services and to then gain agreement across the Halton system as to what features within the new out of hospital delivery system

Test bed concept

Building momentum in this programme of work is critical, therefore, identifying a small number of 'quick wins' is seen as strategically significant. These projects will test the commitment of partners and their willingness to embrace new ways of working. Importantly, they will demonstrate to patients, staff, commissioners and system regulators that Halton is actively making changes happen in the communities.

Three 'quick win' projects have been identified, each of which will require a multi-disciplinary approach and yield benefits that will either direct support improvements in accessing services or provide better/most effective patient care.

1. Integrating community nursing and general practice, focusing on the treatment room service
2. Increased mental health provision in primary care
3. Establishing a new MDT for patients with COPD/Respiratory illness.

Each 'quick win' project will be developed, delivered and piloted in a different Community Hub. If successful, and resources are available to support this, they should be expanded and provide services across all four Community Hubs. As such, evaluation of the projects is essential therefore clear success criteria will need to be agreed at the outset.

These projects must not detract focus or resources from the overall programme of work; they need to run in parallel.

Given the nature of the projects, collaborative working with partners will be fundamental from the outset to achieve this.

Strategic enablers

Strategic enablers

Identifying and designing enabling functions to support the successful design, transition and implementation of the new out of hospital operating model, including overcoming the barriers to change, will be critical to realising the vision and targeted benefits of the Halton's plan for system transformation.

It will be important for the relevant professionals to identify the range of key barriers likely to be experienced when delivering large scale change, and the key enablers required to achieve both the large scale system wide transformation and the differentiated 'future state' operating model comprising the out of hospital delivery system.

At this stage initial thoughts are that there are likely to be numerous barriers and enablers which at this stage are categorised into six key areas, accepting that more discussion is needed:

- Information Management & Technology (IM&T)
- Governance and Leadership
- Contracting and Commissioning
- Transformation capacity and capability
- Estates
- Workforce
- Financial and activity analysis

This section of this report captures the enabling functions key to realising the new out of hospital operating model.

Strategic enablers

Enabler	*Key considerations*
IM&T	• Business Intelligence Strategy and Function capable of fully developing the Outcomes Framework and data analytics to inform decision making across the new delivery system • Business Intelligence driven approach to whole population risk stratification and targeted preventative and pro-active interventions. • Technology enabled identification of early discharge candidates. • Single view of an individual's contact with the system with integrated records and care plans. • Mobile working technology to allow staff to work flexibility and efficiently across locations. • Use of technology and multiple channels of contact to support access and delivery of services, such as e-consultations. • Data-driven understanding and insights on people's use of the health and care system to inform further improvements.
Governance & Leadership	• Corporate form to be adopted for the new delivery system. • Governance and accountability arrangements. • New contracting framework for the new delivery system. • Payment mechanisms between partners. • Draft contracts for organisations within and subcontracted to the new delivery system.
Transformation capacity and capability	• Programme management, the development of a detailed implementation and benefits realisation plans. • Programme governance, oversight and accountability arrangements • Capacity and capability to develop the new out of hospital plans and implement changes at a whole system scale, including corporate processes e.g. (risk management, financial reporting etc.). • Identifying and agreeing sources of transition investment funding to enable system transformation and realise required benefits

Strategic enablers

Enabler	*Key considerations*
Estates	• Collective approach to the public sector estate to maximise utilisation and dispose of properties no longer required. • Increased co-location of health and care professionals. • Increased co-location of a wide range of health services and specialisms to improve integration of care and support. • Rationalisation and consolidation of estate following greater integration and increased use of mobile working and technology opportunities.
Workforce	• Collaborating to make more efficient and effective use of permanent, temporary and agency workforce. • Enhanced training and capability development to support delivery of integrated care in the community, including care co-ordination and key worker roles. • Maximising the workforce development for practice staff and community teams. • Planning and recruitment of more specialist roles delivering from out of hospital settings. • A career development / talent management approach enabling care workers to enter into the care profession. • Joint training and OD.
Contracting and commissioning	• The governance structures and contracting mechanisms that will be required to define feasibility for all partners, compliance and acceptability for regulators and commissioners • Shift towards a shared integrated commissioning function. • Exploration of possibilities around capitation and whole population management. • Greater focus on strategic commissioning and macro-level market management to support the developing needs of our local populations. • Increased micro-commissioning through delegation of more transactional functions and personal budgets.

Financial and activity analysis

During this next phase of the programme, the scale of the financial challenge facing the Halton health and care system will need to be analysed and quantified. Subsequently the task will be to identify opportunities to address the gap through the implementation of a new operating model for out of hospital delivery.

A key consideration will to understand where there might be opportunities to generate savings based on where activity is higher in Halton than is the case in comparable areas.

An initial view it that this type of activity analysis will be done over two stages:

1. An analysis of benchmarking data for peers to identify savings opportunities and more detailed activity modelling. The benchmarking used will be the same peers as NHS England Right Care methodology, benchmarking against systems with a similar demography to Halton. An initial high level view of that framework suggests the main areas of spend will include:
    - A&E attendances (including and excluding walk in centres);
    - Emergency admissions;
    - Elective referrals;
    - Non-elective length of stay; and
    - Outpatient appointments

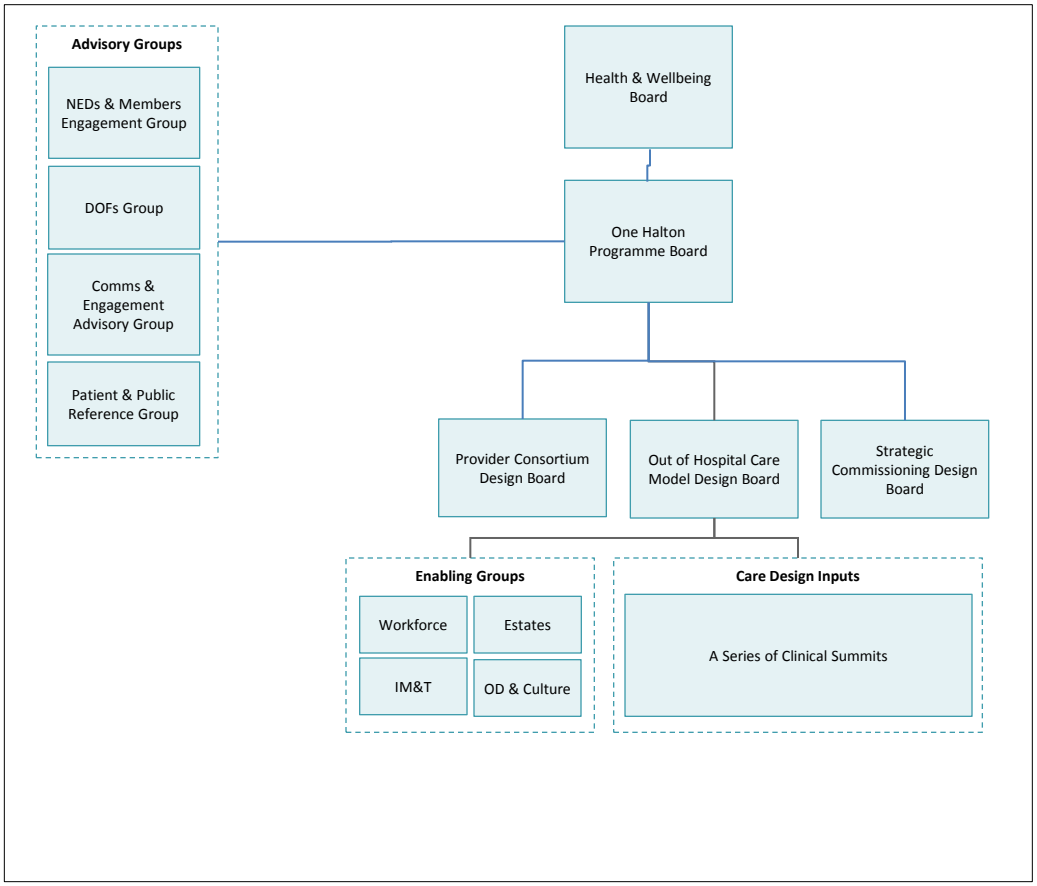
2. Where Halton is found to be performing significantly below the median or upper quartile in terms of its peers, further analysis will undertaken using Secondary Uses Services (SUS) and social care data to begin to understand in more detail what is driving cost in the system. This should allow activity analysis by age, gender, GP practice lists and levels of deprivation, to be carried out.

The engagement of the financial teams across the system will be key to this area of work being carried out. Whilst the focus will be on the out of hospital delivery model our suggestion is that this workstream should report directly to the One Halton Programme Board and support both groups. The recently produced KPMG spreadsheet tracking the financial impact of initiatives will become a key output of this work.

Programme Governance & Management

Governing the out of hospital programme

There are two aspects of governance that will need to be considered if we are to succeed in establishing a new integrated service model – the 'internal' corporate governance and the 'external' contracting governance. Whilst these issues are formally on separate sides of the commissioning / provision split, the nature of this development means that they are necessarily closely inter-twined. Given the complexity and innovation implied by the design logic outlined above, and because of the broad scope being suggested for integrated services, it makes sense to look at this as a strategic programme, working and operating in-between a range of interested organisations. Thus it will be necessary to design a programme governance structure that not only ensures strategic progress is achieved but that accountability is built in.



Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance arrangements are in place to oversee the delivery and evaluation of this complex work programme.

The suggestion in structural design here is as follows:

- There is already an agreement to develop a provider consortium and this should have a small group to oversee its design
- There is already an agreement to develop commissioning in Halton and this should have a small group to oversee it
- The GP Federation has been asked with Bridgewater to lead the design of a new out of hospital model and this will need a group to oversee that work
- That will need a variety of workstreams to look at clinical model design and enabling works design

All three should report to the One Halton Programme Board.

Governing the out of hospital programme

We are advocating that there should be a series of advisory groups to look after NED/Cllr engagement and briefing, finances in the system, comms and engagement and also public involvement. Theses should support the overall transformation programme on behalf of the One Halton Programme Board and should be linked in at that senior programme board level.

The final suggestion is that the One Halton programme considers and agrees how it oversees the secondary care transformation changes that will be required in the hospital sector either because of the Cheshire and Merseyside NHS level work or because of the consequences of the out of hospital model changes.

Making It Happen

In order to get this started we believe we need to establish a programme governance structure that should be in effect the executive steering group and comprise the relevant organisational management and leadership. Thus this group would incorporate senior operational representation from the following:

- Bridgewater
- North West Boroughs
- Halton Council – Adults and Childrens Care
- Halton Public Health
- Warrington & Halton Hospitals
- St Helens & Knowsley Hospitals
- Voluntary & Third Sector provider representative organisation
- Commissioner representative

We recommend that it also should include the technical support experts from the enabling workstreams. These will need to be identified and the leadership and Chairmanship of the group should rest with the GP Federations and Bridgewater but should link in the overall SRO.

The group should meet fortnightly as a minimum given the level of work required in volume terms. It's remit is not to govern but to make things happen and specifically to oversee the test beds.

Programme management and resourcing

Due to the distinctive requirements, it would be useful to establish a twin-track, short cycle development process.

The Strategic Commissioning work-stream should focus on:

- economic efficiency;
- contract requirements;
- service specification;
- financial flows;
- information and ICT design; and
- outcome monitoring.

The Provider Development work-stream will need to focus on:

- model of care design;
- corporate and clinical governance;
- consortium development; and
- long term financial planning.

Both work-streams will need to co-operate on the development of integrated models of care.

On this last point, the most important consideration is the nomination of clinical leads for each of the areas in the potential scope of an integrated care system.

This may result in a large number of groups, and serious consideration needs to given to how this process needs to be supported.

The programme will primarily be supported by the GP Federations and Bridgewater's teams but will need additional input from the CCG, HBC (given the importance of social care) and also likely external expertise which will no doubt need some investment.

Skillset	Likely deployment source
Financial forecasting and cost modelling	CCG / BCHFT
Economic appraisal and modelling	External
Activity forecasting and modelling	CCG
Change Management	Council / CCG
Service Redesign	CCG / BCHFT / Feds
Programme Management	BCHFT / HBC / CCG / Feds
Clinical Leadership	Feds / BCHFT
Corporate governance and legal	External Legal
Clinical governance	CCG / BCHFT / Feds
Communications and engagement	BCHFT / HBC / CCG

Consideration is needed to provide transformational funding to support the initial set-up and ongoing costs for programme management, for example where skills are not available within the Halton health economy. A source is likely to be the Cheshire & Merseyside pooled fund arrangement to support strategic development of place based commissioning and delivery systems. A proposal will need to work developed to quantify those costs.

Communications and engagement approach

Effective communications and engagement is essential for the development of a new model of out of hospital care.

Our patients, their carers and our stakeholders, the people who rely on local health and care services, are uniquely placed to help us develop the services we will provide, and advise us on what works best for them and the areas that could be improved on.

As the way health and care services are provided and used changes, we want to make sure our patients, carers and stakeholders feel fully informed and involved in the decisions we make. We also want to make sure that we do this in a way that meets NHS standards and the statutory duties of those organisations involved.

An effective communications and engagement strategy will help us to raise awareness of the services available to patients, provide information on common conditions to support self-management and diagnosis of care as well as encouraging healthy lifestyles. We want to involve patients and members of the public in discussions and decisions about how their healthcare will be provided in the future and to be given information to enable help them to do this. This includes informing patients and the public about the healthcare services available to them locally and nationally and offering easily accessible, reliable and relevant information to enable them to participate fully in their own healthcare decisions and choices. To do this, we will deliver high quality communications and engagement.

We will take a planned and sustained approach to communications and engagement to fulfil our vision for our residents to have access to the best health and care services available, the opportunity to improve their physical, mental and social wellbeing and to be involved in decisions about their own health and care.

We will engage and communicate so that:

- People know who we are and what we do.
- People know what services we provide and how to access them.
- People can make informed choices about their health and lifestyle.
- We can equip people with the skills and knowledge to be able to self-care and self-manage their conditions.
- Health services are used effectively.
- People can publicly hold us to account.
- Our strategic objectives and the delivery of our plans are supported through engaging people, partners and stakeholders.
- Our care model develops through better involvement and engagement of the people who use services.
- Service provision is joined up.
- Quality of care improves.
- The reputation of, and confidence in, the local NHS is upheld.
- Other parts of the NHS can learn from our development.

Summary and key next steps

Summary

We believe that this is all achievable but there are some considerable challenges and risks and being realistic historically, we have not managed to fully have a system working together in a way that our aspiration now envisages. We ultimately need to prove that we can do this.

However, our priority focus has been on bringing the two GP Federations and Bridgewater together as it was requested by the system to lead this work. With that relationship now gaining strength and confidence after just 10 weeks of working together, the focus has started to turn towards engaging more widely across the system. That has posed a risk in such much as there has been a notable absence of senior level adult and children social care as well as a only small clinical workforce attendance, which we understand because of diary limitations and the timescale of running to present something of this magnitude to the Board after just eight weeks of work. All of this has also been achieved in the context of trying to develop new relationships in an environment of significant leadership change within the commissioning sector.

Our plans going forward are reliant and dependent upon deeper and greater engagement on much more complex and detailed design concepts. We specifically need to ramp up the engagement process with the clinical workforce which will mean giving much greater diary notice and therefore far greater planning.

Our approach is to blend strategic development with tactical execution using things like PDSA cycles to test and prove the concepts of our model. This will allow us to refine and change things in real time and ensure therefore that our policy making approach is not a traditional linear public sector one.

Our starting point of those tactical approaches are described as out ‘test beds’ and encompass the integration of community and primary care teams around the hubs – starting with the community nursing teams. There is strong Board level commitment from Bridgewater as well as the same level of Board commitment from the two GP Federations to get on with this to show some real on ground change and impact, which will also help bring the GP community along on the journey.

Over the next few pages we have started to outline what we see as some of the key next steps. We do not believe this to be exhaustive and there will be more to add as we progress this journey.

Key next steps

Excellent progress has been made in advancing the development of plans for Halton's new out of hospital delivery system over the eight weeks since the start if the new year. However, to maintain this momentum and be in a position to put forward a compelling case for change, attention must rapidly turn to the next phase of work required. This will entail carrying out a more detailed design and implementation planning across a number of programme workstreams and testing the concepts.

Workstream	Priority activities
Developing a detailed target operating model	• Baseline current activity across the system • Understanding the core components that will comprise the new delivery system and how they will operate, including descriptions of future processes • The size the new delivery system will need to be and the staff groups that will comprise its workforce • Identifying the initiatives that are part of the model i.e. risk stratification and modelling their impact • The design of the approach to implementation (phasing and sequencing) • Identifying where there is duplication and the scale of potential opportunities • Confirm the scope of services to be commissioned and provided by the new delivery system • Scope of budget(s) • List of services • Confirming the operational and support resources being brought into the scope of the new delivery system
Designing the enabler functions	• Understanding of current enabling capabilities and opportunities to scale up and identification of gaps in current arrangements • Potential IT solutions, costs and timescales for implementation • Understanding of the future estates strategy • Confidence regarding the culture an a recognition that it will be one system comprised of a number of organisations initially
Financial and activity modelling	• Financial impact of the new model for the care economy refined to reflect detailed design and implementation plans • Develop a business intelligence strategy

Key next steps

Workstream	Priority activities
Designing corporate governance structures and contracting mechanisms	• Defined structural form adopted for the new delivery system • Governance and accountability arrangements • New contracting framework for the new delivery system • Payment mechanisms between partners and providers • Draft contracts for organisations within and subcontracted to the new delivery system
Programme management and implementation planning	• Understanding of how implementation activities will need to be phased and dependencies managed • View of how and when benefits will be released • Change readiness assessment report and transition engagement strategy • Detailed implementation plan • Benefits realisation plan • Consultation and engagement strategy • Communications strategy, plan and implementation • Programme leadership and technical inputs identified and agreed resourcing profile in place
Piloting Test Beds	• Developing the pilot methodology i.e. PDSA • Identifying the scope of the pilots