Northamptonshire

Health and Care Partnership

West Northamptonshire Council

Scrutiny

September 2021

Making system working a reality

Northamptonshire
Health and Care Partnership

- The Northamptonshire Health and Care Partnership (NHCP) underpins the system's desire to move to a more integrated way of working
- iCAN is one of the four major transformation programmes for developing Northamptonshire's ICS
- The journey to get to iCAN started with the TOM programme as part of Northamptonshire Adult Social Services transformation, before the unitary split
- This deck is an introduction to the TOM and iCAN programmes, aligned to the iCAN delivery starting in September 2021.

BACKGROUND TO THE TOM

-Poor customer satisfaction
-Too much bureaucracy
-No integration between organisations

NCC £60m budget overspend reported in the national press

2018

2020

Adult Social Care Diagnostic finds almost half of all adults are not achieving the best outcome for them

Unitary split approved by Cabinet

2019

All of this resulted in a very clear need for transformation

our core transformation principles

1. Practice-focussed
2. Practitioner-led
3. Evidence-based

DESIGN APPROACH

FRONT LINE LED DESIGN

- New ways of working developed by practitioners
- Tested and evidenced to deliver the outcomes that we desired

designing the change

1

We started out by appointing **design leads** - talented, inspiring people from our front-line teams who we trusted would, with the right support, design changes that worked.

2

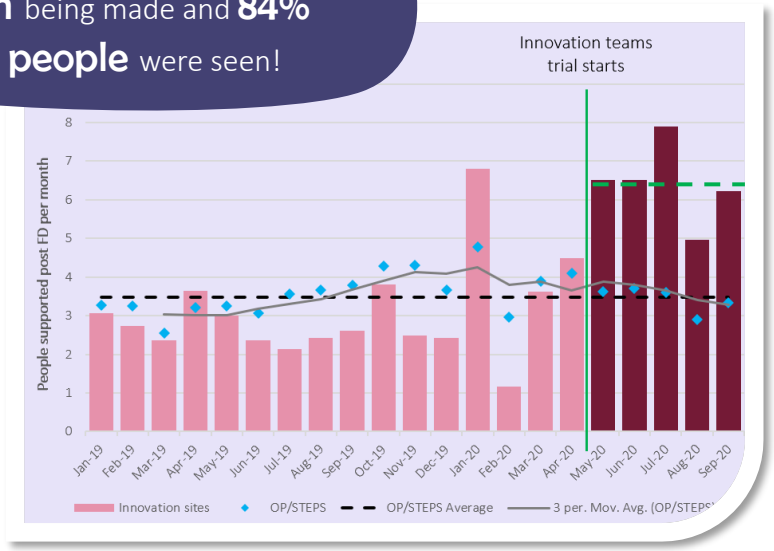
We ran **workshops** with front line staff to shape our initial design, then **trialled the changes** in small teams running regularly feedback sessions with staff.

3

To ensure the changes had made difference, we captured data to help us measure **staff engagement** and **team performance.**

"It feels like we're finally being listened to." Care Manager
"This is refreshing and a change to the way changes have been introduced before" Social Worker
"Absolutely know we are going to transform the system" Service Manager
"We've had the social worker beaten out of us for too long and I think this is going to be a real opportunity to get back to that again" Social Worker

Through the community trial teams we saw **30% more independent decision** being made and **84% more people** were seen!



"It's thanks to the facts and figures that we're able to have these conversations" Team Manager

"Wow we have never had access to data like this, it's going to be so valuable" Team Manager

Some design results...

ADOPT, EMBED AND SUSTAIN

- New ways of working completely embedded as BAU by everyone in the business

Training & documentation

100%

believe that the new way of working would support more timely outcomes

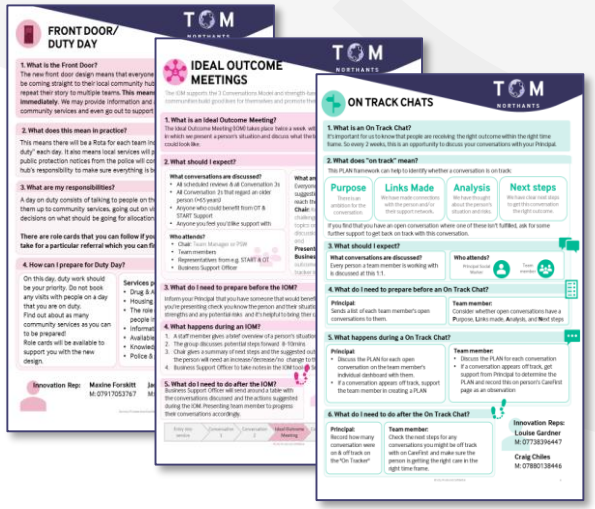
The changes proposed will help us achieve better outcomes for people of Northamptonshire?

95%

of people enjoyed the training sessions

... despite most of it being online

I am excited to start!



My Team is AMAZING. I feel listened to as a worker, there is organisation amongst the team and our team manager and now new service manager are very supportive and most importantly approachable.

I think the new way of working is going well in my team and everyone is very positive. We have a good team of staff who are positive and who are happy to learn together.

Engagement & support

NEW OPERATING MODEL

The next steps after TOM: moving to system working

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- As the ICS developed, four major transformation programmes were established by the NHCP, including iCAN. It builds on the work within the TOM programme, expanding across the system to work with health and care partners
- iCAN is a priority because we recognise that frail and elderly care is the single biggest area of demand, activity, acute care, cost and performance improvement areas.
- The iCAN programme's aim is to make radical improvements to the delivery of services to frail, mainly older people.
- We will do this by shifting care to community settings and providing better preventative care, avoiding unnecessary admissions and helping people return to their normal place of residence and stay well at home.
- Without iCAN by 2025 the system of health and care risks being overwhelmed by increased demand. iCAN is critical to enabling the system to cope.

We want to meet the priorities of our Frail and Elderly Population – who said - ‘We Want……..

Northamptonshire Health and Care Partnership

Time to be listened to by health professionals who consider all of my needs not just a single medical presenting issue

Services to be available locally to me, timely access to my GP and less time spent travelling to hospital for appointments.

To have a support person to help me through my Ageing journey who I can go to and can help me to navigate where needed

To tell my story once and it be heard by all those who are supporting me

To have the same choice and opportunities whether I am living alone, whether I have a carer or whether I am in 24 hour supported accommodation

For me to gain skills and confidence to help me manage my long term conditions rather than my long term conditions managing me

When I am in a crisis I want to receive timely and coordinated care in the best place for me at the time

For me and those supporting me to make use of technology but not to the exclusion of actual personal contact – the choice is important for me

In 2020, we carried out a diagnostic to quantify the opportunity

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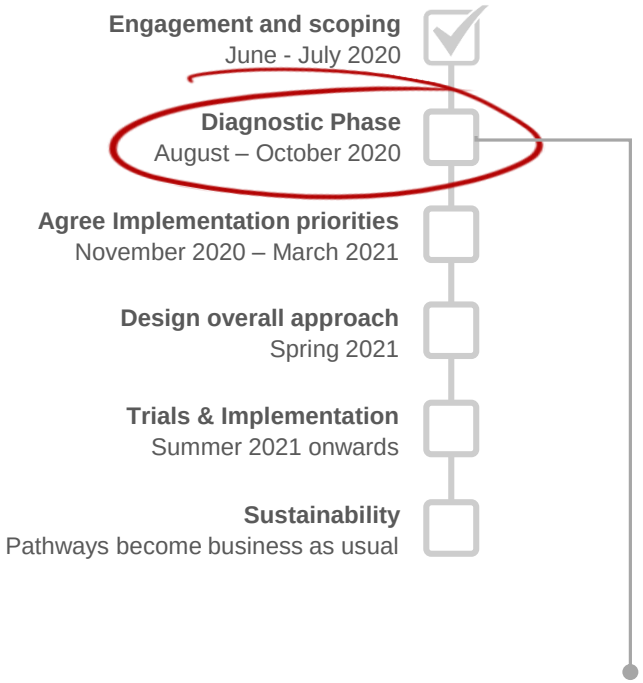


The diagnostic will establish an evidence base to show where the opportunities are to improve outcomes for older people. This will allow us to work out exactly what to change, and how best to change to improve things for the people we care for, and our staff.

Discussions with **>300** leadership and frontline staff

>1 million Data points for analysis

720 beds reviewed for delays and next steps

104 Survey responses

130 cases reviewed with **65** practitioners

>55 hours Shadowing frontline staff

NHS East Midlands Ambulance Service NHS Trust

NHS Northampton General Hospital NHS Trust

NHS Northamptonshire Healthcare NHS Foundation Trust

NHS Kettering General Hospital NHS Foundation Trust

NHS Northamptonshire Clinical Commissioning Group

Saxon Spires

weavers medical

LAKESIDE HEALTHCARE

NASS Northamptonshire Adult Social Services

Northamptonshire County Council

What opportunity did the diagnostic find?

Northamptonshire Health and Care Partnership

Home or Community?

Are we preventing escalations from occurring in the community?

35% of escalations were non-ideal and may have been preventable

First Response

Are we ensuring people go to the right place upon escalation?

29% of escalations reviewed could have gone to a lower acuity setting

Front Door Services

Are we ensuring the right people are admitted?

25% of admissions reviewed could have been avoided

In Hospital

Are people discharged as soon as possible?

37% of patients reviewed had no reason to reside

Home or Community

Are people discharged to the optimum setting?

40% of patients could have received a more independent outcome

What could be different for people in Northamptonshire?

Northamptonshire Health and Care Partnership

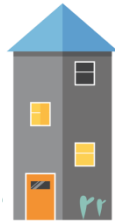
131,000 people over 65 live in Northamptonshire

Every day, 27 over-65s access urgent community intermediate care

Every day, 165* over-65s come to ED, 92* are admitted into hospital as an emergency admission, with 640 in a hospital bed at any time

Some people will still have a need that must be addressed, but we could support more people with a mix of urgent and routine **community based** services

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**



By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**

75-79 people a day will still have a need that requires them to be admitted to hospital, but we could help them **return home quicker**

Some people will still have a need that must be addressed at the Emergency Department but we could help more of them, potentially with short term support, to **go home, rather than be admitted**

We could support more people who have had a need that must be addressed by admission to hospital to be **discharged home** on Pathways 0 or 1 rather than Pathways 2 or 3

By 2025

HOME

At any one time, **170 more people every day would be at home, not in hospital**

*These numbers are pre-COVID

Outcomes - Mavis Ageing Well in 2025… I will have

Northamptonshire Health and Care Partnership

Assistive Technology to maintain my independence

Proactive remote monitoring and reassurance that support is quickly available if I need it

Befriending if I want this

Personalised Equipment to help me self manage my health

My personal holistic plan shared with who I choose and reviewed regularly with me.

Backed up with timely access to specialists as my needs change

Free Wifi & digital platforms

Access to range of local community activities and support groups (in person or virtual)

Mavis

My go to named person from my local integrated team

Outcomes: Why is ICAN good for staff

Northamptonshire Health and Care Partnership

Working across the system has allowed staff to cross fertilise ideas and learn about people and service delivery they had no knowledge of before

The ICAN programme has engaged staff and they see their feedback being listened to and acted on improving staff satisfaction

The ability to improve quality outcomes supports the clinical staff and engages them in transformation

Staff feel part of something bigger and believe they can effect positive change

ICAN gives staff across the system a single vision and purpose focussed on patients and outcomes rather than organisation which they feedback is highly motivating

ICAN Outcomes - Benefits for Professional Care Staff & Clinicians

Northamptonshire Health and Care Partnership

iCAN care will be personalised for the frail person who needs support, with coordination of health and care professionals who will have access to a menu of responsive and available services to preserve independence and autonomy.

Co-production and coordination of care with people and their carers, connecting with the community in the place where they live.

Range of services available to choose from and support for people to make choices about their care

Co-ordinated care supported by a frailty **MDT** including the voluntary sector working with health and care staff enables people to look after their own health and facilitate professional communication

Proactive care and plans to reduce the reliance on reactive care currently provided in the hospitals in our system

Shared digital information to support efficient working and adherence to individual choices and to avoid people having to tell their storey multiple times

Efficient and easy routes to diagnosis, therapies and other treatments to reduce patient, carer and staff frustrations

Support for independence in the person's own home and community as much as possible, with focussed and brief contact with inpatient services when necessary

Patients leaving hospital as soon as they have no reason to reside via a timely and efficient discharge and returning **home as soon as possible**, avoids long term deconditioning and loss of function

Our Roadmap to the ICAN vision

Northamptonshire Health and Care Partnership

Outcomes you're measuring e.g. super stranded old world, to meeting outcomes in community etc. new world

Year 0

Developing ICS

TOM: getting ASC house in order & laying the foundations for Unitaries

iCAN begins

Clearing the decks for increased community capacity

Year 1

Maturing ICS

Clinical leadership team established

New ways of working designed

Northamptonshire Care Record trial begins

Commissioning and completing iCAN diagnostic

Year 2

Thriving ICS

iCAN focus on

- Design
- Build
- Adopt

Build capacity for demand

e.g. Place based care, MDTs in each PCN, Frailty front door

Year 3

Community hubs & rapid response

iCAN focus on embedding new ways of working

Digital tools in place to support long term vision e.g. remote monitoring, NCR rollout

Year 4

Full integrated pathway in place

iCAN focus on sustaining new ways of working

Year 5

Focus shifted from hospital to community to enable appropriate use of acute capacity

Sustained new ways of working

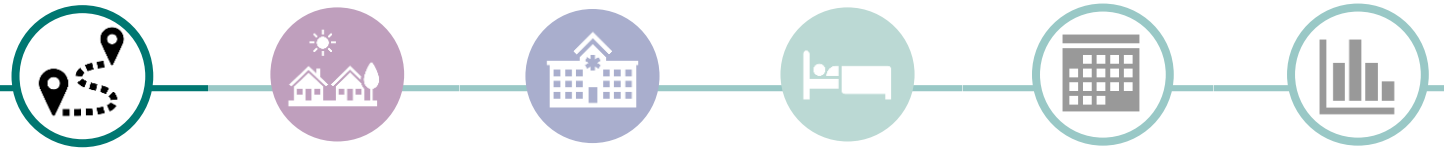
Next 5 year vision for Northamptonshire

2025 VISION!

The work has been organised into 3 pillars

Northamptonshire Health and Care Partnership

COMMUNITY RESILIENCE	Ensure that frail people in the community receive the right care and support at the right time so that they can live as independently as possible	*Maintaining people's wellness and independence to reduce crisis escalations*
FRAILTY ESCALATION & FRONT DOOR	Ensuring that frail patients are only admitted to hospital if they need an intervention that can only be delivered in hospital	*Ensuring we have the right capacity and structure in the community so only those that need it go to hospital*
FLOW AND GRIP	Ensuring that patients receive the right care at the right time with access to the right services, so that they can live as independently as possible	*Reducing the number of patients without a 'Reason to Reside'*



Community Resilience Summary

Northamptonshire
Health and Care Partnership

Our Community Resilience mission is to...

Maximise independence and long term happiness by helping more people remain at home in the community

Provide holistic planned care in the community which reduces avoidable escalations

Reduce unplanned primary care demand

through...

Taking a strengths based approach to independence

Providing linked community services of the right size and quality to meet demand

Making appropriate interventions to reduce escalation

To achieve this we will...

Forge a strong network of community links, volunteer, health and social care services

Provide urgent community response

Proactively support the hospital discharge and recovery programme

Put the person at the centre of their care, leveraging remote monitoring and anticipatory care as appropriate

Use data and technology to inform people's needs and give us live visibility of what actions we need to take

Frailty, Escalation & Front door summary

Northamptonshire Health and Care Partnership

Our frailty, escalation & front door mission is to

Enable people with frailty to access the services they need

Prevent avoidable admissions into the acute setting

Give people input into the care they receive

through...

Providing easy access to the information required for decision making

Listening to what our population wants and needs

Co-production between acute, community, and voluntary sector services

To achieve this we will...

Use data to guide improvement processes and ensure positive change

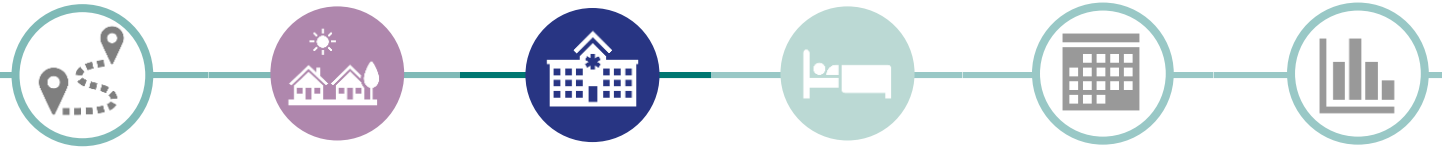
Increase knowledge of frailty system-wide through training

Connect ED staff to community and specialist services

Keep people informed & involved in care decisions

Support EMAS to utilise the appropriate pathways

Promote connections between primary care (GPs) and ICT



Flow & grip summary

Northamptonshire Health and Care Partnership

Our flow & grip mission is to

Reduce unnecessary time in hospital beds

Maximise independence by helping more people return home

Improve the experience of people in our care

through...

Improving ward flow & control

Embedding true discharge to assess

Putting the person at the centre of their care

To achieve this we will...

Use data to give us live visibility of what actions we need to take

Connect hospital teams to community services

Keep people informed & involved in care decisions

Optimise tests & procedures both in hospital & in the community

Stop long-term care assessments in hospital

Commissioning the right services to meet peoples needs

How will the iCAN benefits impact West Northants Council?

Northamptonshire Health and Care Partnership

VISION

Home or community

Escalations in the community are prevented

First response

People go to the right place upon escalation

Front door services

Only those that need to be are admitted

In hospital

People are discharged as soon as possible

Home or community

Discharge is to the optimum setting

IMPROVEMENT OPPORTUNITY

5% reduction
in over-65 escalations which would have resulted in admission

5% reduction
in over-65 attendances which would have resulted in admission

5% reduction
in over-65 admissions from A&E

7% reduction
in over-65 bed days through reducing length of stay

10% reduction
in the cost of care for over-65s upon discharge

Potential benefits for West Northamptonshire Council: Reduction in Care Costs through Reduced Admissions

Northamptonshire Health and Care Partnership

During the assessment ~£1m of savings for WNC (up to £2m at stretch target) was identified through reducing admissions, and avoiding the associated increase in care costs. These savings are already assumed in the MTFP

Care Type	WNC ASC
Residential/ Nursing	1 £ 166,483
Homecare	1 £ 876,046
Short Term	2 £ 974,059

WNC: £2.02M

Long Term Care 1 *13.8% X 2019 Discharges X Increase in Care Cost Upon Discharge Review (£160 per week) X 52 Weeks*

From ASC Financial Review

Combined Reduction in Admissions

Short Term Care 2 *13.8% X 2019 Discharges X Increase in Care Cost Upon Discharge Review (£160 per week) X 15 Weeks*

From ASC Financial Review

Financial Benefits

Northamptonshire Health and Care Partnership

- By 2024, the programme will be delivering a recurrent gross saving of £13.3m per year (stretch target of £18m),
- At this stage we have assumed additional costs as follows
  - £2.74m for additional community health resource (being qualified)
  - Internal programme costs to run the programme and support the enablers at £1.85m for year 1 & 2 and reducing over 5 years
  - a maximum contingency envelope for any other potential costs that emerge
  - West Northants Council business rate pilot money for admission avoidance. £345k for 2021/22 will be put as the contribution to iCAN programme to support the savings delivery that are already built into the MTFP.

WNC involvement in iCAN

Northamptonshire Health and Care Partnership

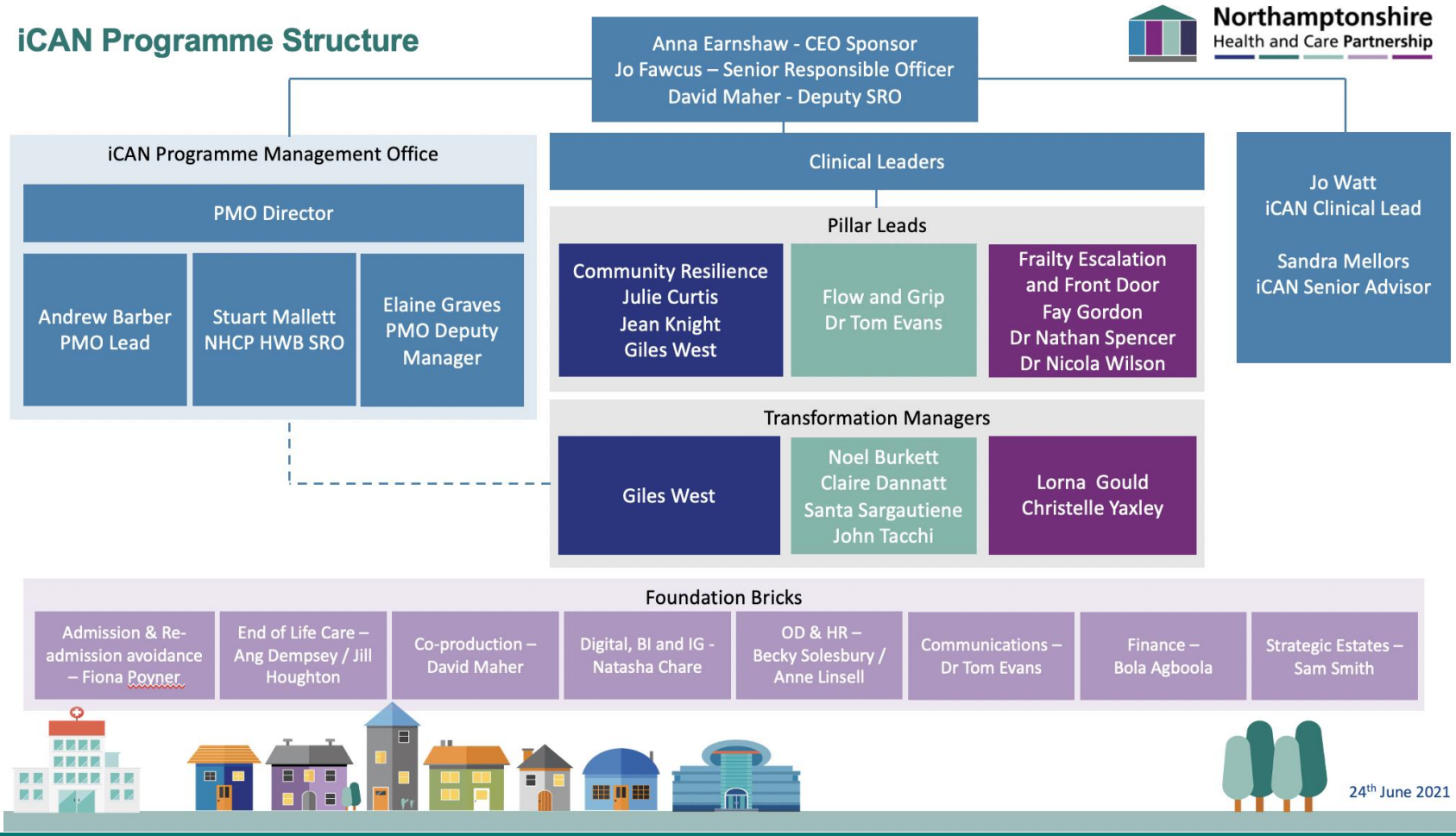
The whole iCAN programme relies on the system working together to improve flow and outcomes.

WNC involvement is key to the successful delivery of the programme.

Anna Earnshaw is the SRO for iCAN

Stuart Lackenby leads the contract review and sits on the steering group

Members of the WNC team are involved in the design process and lead some of the bricks in order to ensure a system approach



CURRENT PERFORMANCE IN WEST NORTHANTS

OLDER PERSONS

New Ways of Working

3 conversations model and a strengths based approach. Restructuring into locality teams to connect to communities

Current Results

28% reduction in long-term Residential placements. 26% reduction in size of homecare packages

Further development

Developing our 3 conversations approach further and building link with our communities. Strengthening practice in our hospital flow

Risks and Challenges

Capacity in the homecare market and an increased reliance on interim beds

WORKING AGED ADULTS

New Ways of Working

3 conversations and strengths based working in locality teams. Development of progression and "Moving on" teams

Current Results

42% reduction in package increases across LD and PD

Further development

Increasing our use of progression as we continue to move out of lockdown

Risks and Challenges

Specific performance management risks in certain teams

REABLEMENT

New Ways of Working

Regular multidisciplinary meetings to challenge next steps, flow and effectiveness

Current Results

44% increase in the number of successful reablement episodes

Further development

Further increase the capacity of the service and improve manager visibility of performance to drive higher effectiveness

Risks and Challenges

Capacity in the homecare market risking onward flow

WORKFORCE PRODUCTIVITY

New Ways of Working

On track chats and visible productivity measures

Current Results

21% increase in the number of relationships closed, mainly driven through our community tams

Further development

Support LD and Inclusion to reach similar productivity levels as our community teams

Risks and Challenges

Increased backlogs in brokerage causing challenges for onward flow

The iCAN programme presents us with a fantastic opportunity to address some of these challenges and support the effective running of the entire system

Quality Assurance: KPIs & KEIs

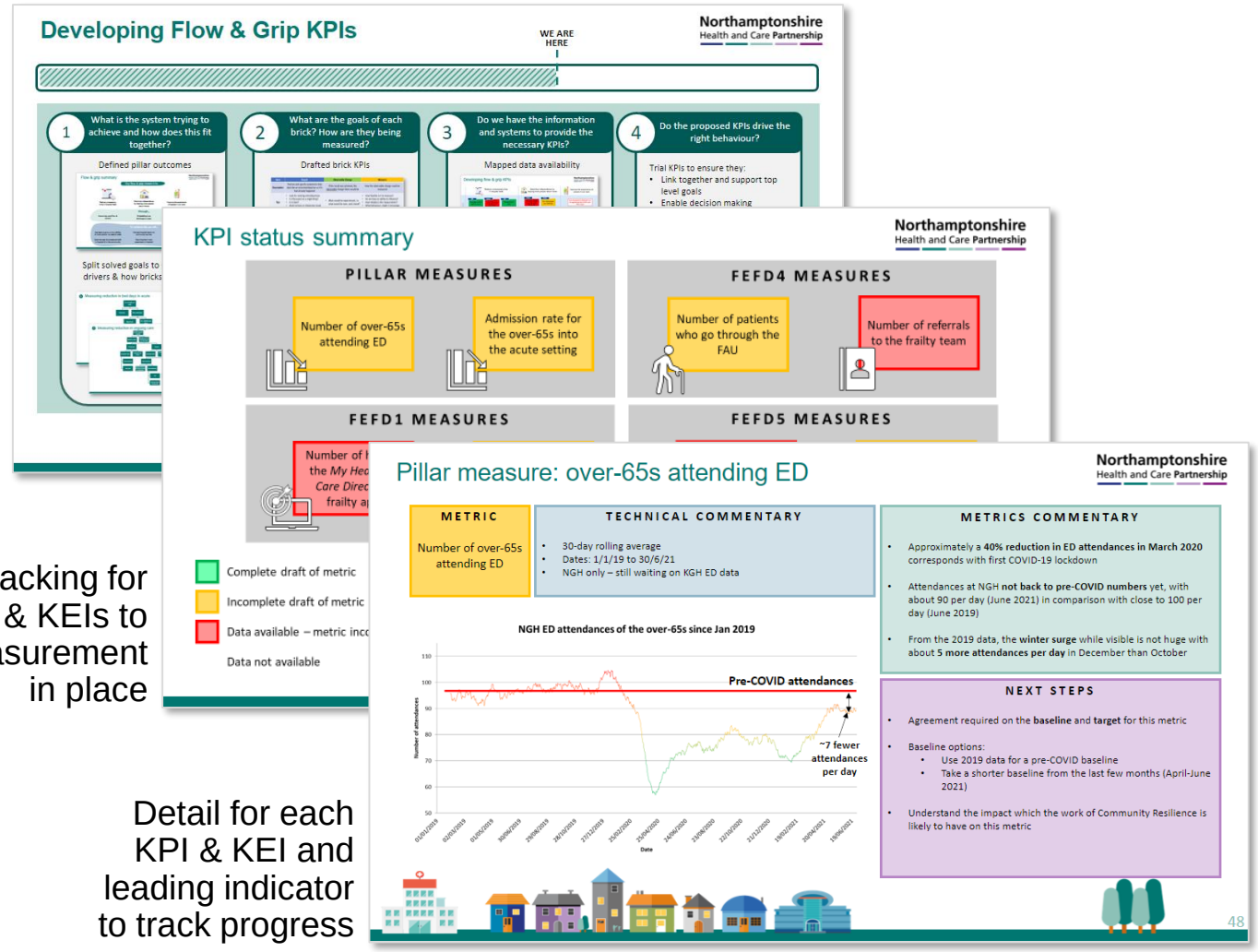
Northamptonshire Health and Care Partnership

- KPIs & KEIs and leading indicators will be established to support improvement cycles, allowing us to identify if the actions we're taking are driving the right outcomes.
- Each pillar is developing a suite of KPIs & KEIs that will sit underneath the high level programme KPIs & KEIs that will be used to track progress, ensuring that the programme is on track to deliver the overall outcomes.
- When we move to being an ICS collaborative, this suite of KPIs and KEIs will be essential

Process for developing Pillar & Brick level KPIs & KEIs

Status tracking for all KPIs & KEIs to ensure measurement in place

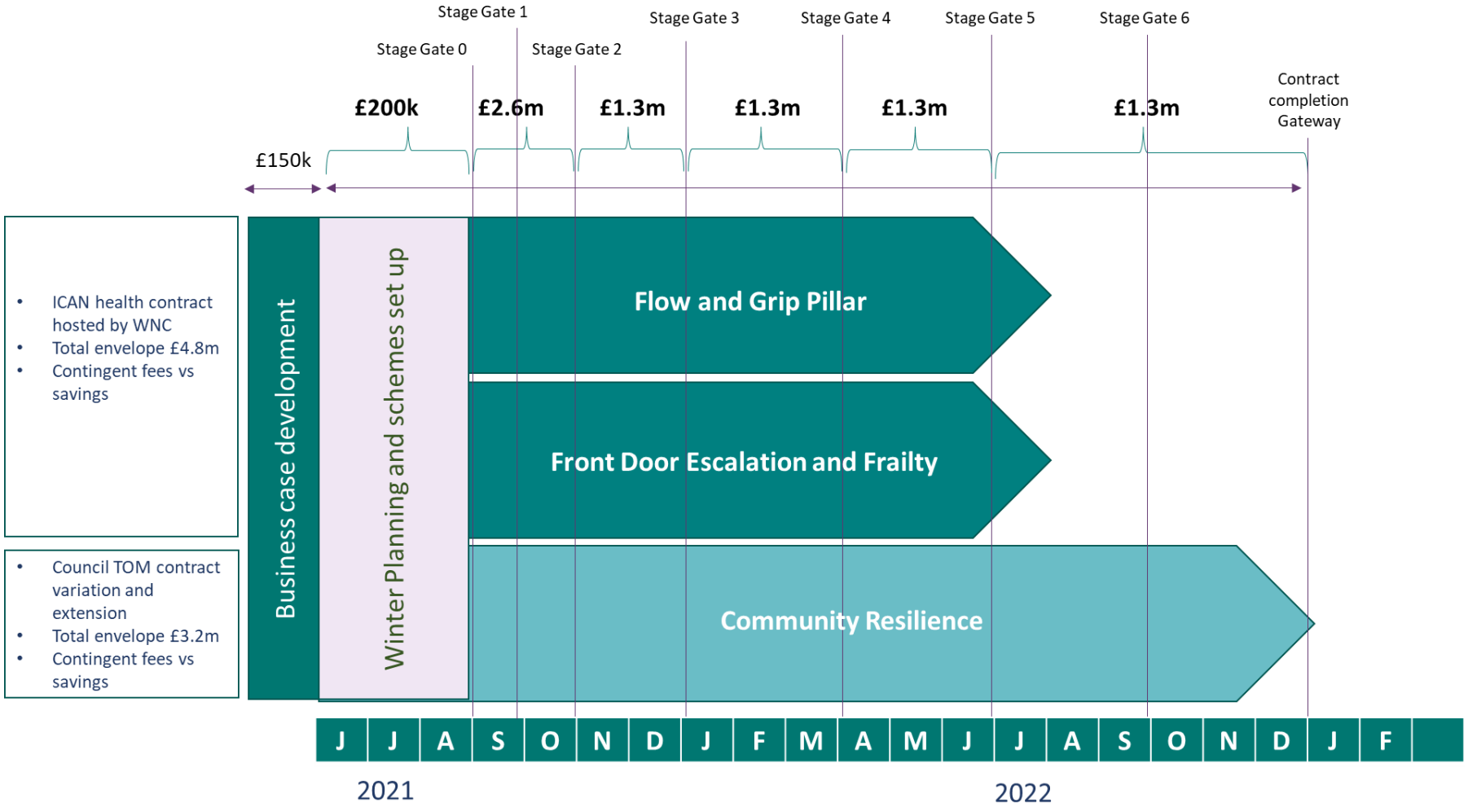
Detail for each KPI & KEI and leading indicator to track progress



Quality Assurance Approach – Contract Review

Northamptonshire Health and Care Partnership

- The contract review group monitors progress against KPIs, deliverables and milestones
- Contract has built in gateways to allow check points of deliverables and benefits.
- Reviews will be attended by finance leads and key stakeholders including NHSE/I
  - An operational and finance rep from WNC will sit on the contract review panel.
- We will not progress unless evidence clear that achieving benefits



Initial focus within iCAN is on supporting winter

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Helping set up the programme to deliver ***measurable impact*** in a ***prioritised manner***

To enable the two focused deliverables (2 & 3) it was necessary to get really clear on programme goals (1)

1 What is the system trying to achieve and how does this fit together?

Gain clarity on pillar **outcomes** to achieve the overall vision

2 What are the goals of each pillar and brick? How can they be measured?

Define **measures** of success to understand our programme impact

3 What are the project plans and what impact can they have in the short term?

Identify **key short-term activities** to maximise impact on winter & define longer term changes

Delivery challenges

Northamptonshire Health and Care Partnership

- Pre COVID hospital occupancy ran at 100%
- Occupancy was kept at 87% or below in COVID but now rising fast
- Lengths of stays are high and outside the nationally set targets.
- Care homes are fragile and we are seeing closures.
- We face significant challenge in maintaining, recruiting and retaining workforces
- Winter pressures typically add £3m - £5m a year in costs for additional beds with poor outcomes for people