



# Cornwall and the Isles of Scilly: Sustainability and Transformation Plan

## Draft Outline Business Case 21st October 2016



# Contents

Section	Page
Executive Summary	3
1. Introduction	5
2. Case for Change	9
3. Target Operating Model	20
4. Making the change	31
Radical upgrade in population health and prevention	32
Integrated care in the community	36
Transforming urgent and emergency care	45
Redesigning pathways of care	52
Improving productivity and efficiency of system enablers	58
Using strategic levers for better care	67
5. Implementation plan	72
6. Financial projections	78
7. Next steps	83
8. References	

# Executive Summary

This draft Outline Business Case sets out our proposals for transforming the health and care system in Cornwall and the Isles of Scilly, building on our strategic intentions outlined in June. It is a draft document and we will be taking the opportunity over the next few months to shape and refine our proposals through wider engagement with the public and other key stakeholders.

## Case for Change

We know that we face significant demographic, social and financial challenges over the coming years. Our population is increasing and ageing, as people are living longer, but often in poor health with disabilities. There are stark disparities in outcomes between areas of affluence and deprivation, often no more than a few miles apart. We have significant opportunities to address underperformance and variation in our delivery of services, particularly regarding Emergency Department waiting times, delayed transfers of care and people's experiences of key care pathways.

An increasing demand for services, inefficiencies in how we work, variations in practice and a model of care which is heavily reliant on more expensive bed-based forms of care is stretching our resources. It is estimated that there will be a financial deficit of £264m across the system by 2020/21 if we do nothing to transform how we operate.

Successfully addressing these challenges to meet the needs of the people we serve will only be possible through collective action across the local area. We need radical change across the entire health and care system in how we provide services and how local people use them, redirecting resources to more prevention, self-care and community-based provision.

## Target Operating Model

In order to shape how we will work together to plan and deliver services, we have developed and agreed a future Operating Model for our health and care system. This is based on functions rather than separate organisational responsibilities and sets a clear blueprint for collectively delivering the integrated system we need to ensure effective and sustainable services in the future.

Our future operating model is built on six system themes around which we will plan, drive and deliver the changes we need.

### The six system themes of our Target Operating Model



#### Radical upgrade in population health and prevention

An enhanced focus on local population health to improve outcomes and manage demand on the rest of the system.



#### Integrated care in the community

An integrated, place based approach to care in the community will be at the heart of our system.



#### Transforming urgent and emergency care

Enhanced, consistent services responding effectively to crises, preventing issues escalating and enabling quicker recovery.



#### Redesigning pathways of care

Improved pathways across the system, helping to ensure that the future delivery of services is viable and sustainable.



#### Improving productivity and efficiency of system enablers

Aligned and streamlined functions across people, processes, technology and estates to support the whole system.



#### Using system levers for better care

Agile, joined-up leadership and commissioning arrangements with a focus on the needs of the whole population.

The model is shaped around the needs of the local population, based on increasing levels of risk and dependency. Key services and features of our model will be targeted at population cohorts with high to moderate risk factors, which account for the most significant proportion of our activity and spend. We also describe six geographical tiers around which the model is organised. We will need to plan and deliver services at the most appropriate level which achieves the right balance between maximising economies of scale and enabling the tailoring of provision for local needs.

## Making the change

Across the six themes, the Outline Business Case details the 18 priority interventions that we need to make to change our ways of working and implement our future integrated system. For each intervention, we set out our vision for 2020/21, the drivers for change and what we will do to deliver it, as well as the key enablers and interdependencies with other areas of the system.

Our priority interventions include:

*Prevention:* An enhanced focus on tackling the wider determinants of health, improving health and wellbeing and building prevention and self-care capacity and capabilities across the system.

*Primary Care:* Securing the sustainability of General Practice, including delivering at scale through GP 'clusters', which is supported by a wider transformation of Primary Care.

*Integrated Care Teams:* Establishing multi-disciplinary teams of health and care professionals providing short-term and ongoing support in the community.

*Integrated Community Hubs:* Redesigning current community hospital provision to provide an enhanced offer of support which helps patients to step down to lower support, reducing reliance on care in institutional settings.

*Urgent Care Centres:* Establishing strategically located Urgent Care Centres as part of a wider urgent and emergency care network which provide enhanced, consistent and resilient medical cover when it is needed and reduce pressure on acute hospital settings.

*Shared back office:* Developing and implementing a transformed back office with cross-system shared service arrangements delivering a range of support functions such as Finance, HR and Procurement.

We continue to develop options and detailed implementation plans for each of our priority interventions to ensure that we can maximise the impact of our transformation across our whole health and care system.

## Implementation

Our anticipated roadmap provides high-level considerations of the phasing of implementation of our interventions, recognising that key elements of the future system must be established and embedded before other areas of transformation can proceed so that the safety and quality of people's care is not compromised. Due to the interdependent nature of the proposed changes, we need to co-ordinate implementation in order to maximise benefits and achieve the best use of resources across our system.

Early priorities which we will start to implement from 2016/17 and 2017/18 include redesigning of key care pathways to address variations in outcomes and costs and implementing Integrated Care Teams in local communities.

Other interventions will be implemented later, such as the establishment of Integrated Community Hubs and the development of more specialised housing options, due to the scale and detailed level of service reconfiguration required.

## Financial projections

Over the five year period of the Sustainability and Transformation Plan, we are projecting that the health and care system in Cornwall and the Isles of Scilly will reach financial balance by 2020/21. This will be achieved through a combination of our transformational priority interventions set out in this Outline Business Case, as well as 'business as usual' improvement and efficiency savings including QIPPs and CIPs.

## Next steps

Through engagement and consultation on the proposals in this document, we will continue to develop and finalise our plans over the coming months. Interventions will be developed and implemented in different ways, depending on their scale and impact. Some interventions will require formal consultation which is expected to take place once the detailed design work and options appraisal has been completed from June 2017. We can continue at pace with other interventions that are ready to be implemented. We will build on the strong governance we have in place to ensure the effective co-ordination and delivery of our local transformation.



# 1. Introduction

This section introduces our Outline Business Case as the next phase in the development of our local Sustainability and Transformation Plan for Cornwall and the Isles of Scilly. It sets out the background and approach to our work, the progress we have achieved, the overall purpose of the document and how it will be used to deliver the system change we need to ensure integrated, effective and sustainable services in the future.

# Introduction

## Background

In October 2014, the NHS published its Five Year Forward View<sup>1</sup>, setting out the need for health services to become sustainable over a five period. Locally, NHS organisations have been tasked with working together with local authorities to produce Sustainability and Transformation Plans (STPs) which set out how they will respond to the Five Year Forward View.

This plan is a departure from the more traditional organisational units of planning to one which is centred around planning for a geographical place. This new place based approach to planning and delivering health and care services is a recognition that responding to the challenges of the future can only be achieved through collective action from local areas and that this will look very different across different parts of the country.

Even if the policy requirement to have an STP comes and goes, the leaders of the local system absolutely see the importance of having an overarching systems plan to guide the future development of services.

The Cornwall and Isles of Scilly STP footprint consists of Cornwall Council, Cornwall Partnership NHS Foundation Trust (CFT), Council of the Isles of Scilly (IoS), Kernow Health CIC, NHS Kernow Clinical Commissioning Group (KCCG), Royal Cornwall Hospitals Trust (RCHT) and NHS England (NHSE) as a commissioner of local services. We have also built close relationships with and received input from the Devon STP footprint and the arm's length bodies.

In addition to satisfying the NHS policy framework, the STP also provides a response to Cornwall's Devolution Deal <sup>2</sup>which was signed in 2015. One of the key strands of the deal was the progression of health and care integration and the STP is the mechanism through which this area of the Devolution offer will be developed.

There are three phases in our local approach to developing our STP:

<b>Phase 1</b>	<b>Strategic Outline Case</b> Establishing the vision and high-level priorities for the future of our health and care system
<b>Phase 2</b>	<b>Outline Business Case</b> Setting out how we will operate as a single integrated system and building proposals for how we will deliver system changes
<b>Phase 3</b>	<b>Full Business Case</b> Detailed design of final options with public engagement and consultation to lead into implementation

## Phase 1

During Phase 1 of the development of our local STP, we set out the Strategic Outline Case<sup>3</sup> for system-wide change for the place-based planning and delivery of our health and care services. Our system leaders committed to a shared vision for how we will tackle the significant challenges facing our system and maximise the opportunities for more effective, integrated services for local people:

*We will work together to ensure the people of Cornwall and the Isles of Scilly stay as healthy as possible for as long as possible. We will support people to help themselves and each other so they stay independent and well in their community. We will provide services that everyone can be proud of and reduce the cost overall.*

Other key achievements of Phase 1 included:

- Establishing a clear and shared understanding of the scale of the financial gap over the five years of the STP;
- Initial engagement with our stakeholders, including the public, to build our understanding of what is important for them and their understanding of the system challenges;
- Identifying the system priorities to address our challenges and scoping high level proposals for further investigation and development.

## Our progress since Phase 1

While we are still at the beginning of our transformation journey, this Outline Business Case marks significant progress from our previous STP checkpoint in June:

- We have a **much stronger understanding of our current collective challenges** regarding need, supply, performance and financial situation to inform our transformation opportunities and support the case for change;
- We have **agreed a future Target Operating Model for our system** which is based on functions and place-based services, rather than traditional organisational structures and responsibilities. This shows how we will work together as a single system to deliver in a co-ordinated and effective way;
- We are moving from high level strategy to **defining how we will deliver change** through our priority interventions, clearly setting out what needs to happen when in order to operate effectively and sustainably;
- We have used the future Operating Model to transition from thinking about programme priorities to how we deliver transformation based on key areas of the system;
- There has been **wide professional and clinical practitioner involvement** in the development and review of the system model and priority interventions.



# Our approach

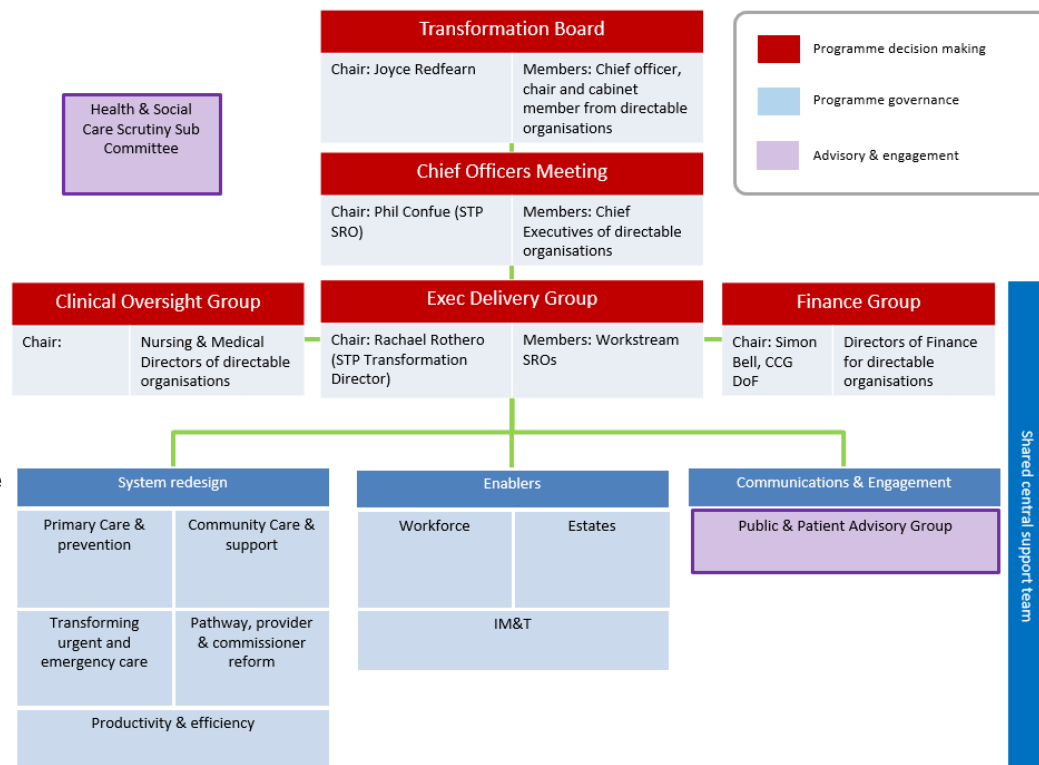
## Proposal development and system oversight

The proposals we set out in this Outline Business Case were developed and owned locally by five programmes centred around system redesign and three programmes around cross-cutting enablers. These were based on the priorities established in our Strategic Outline Case.

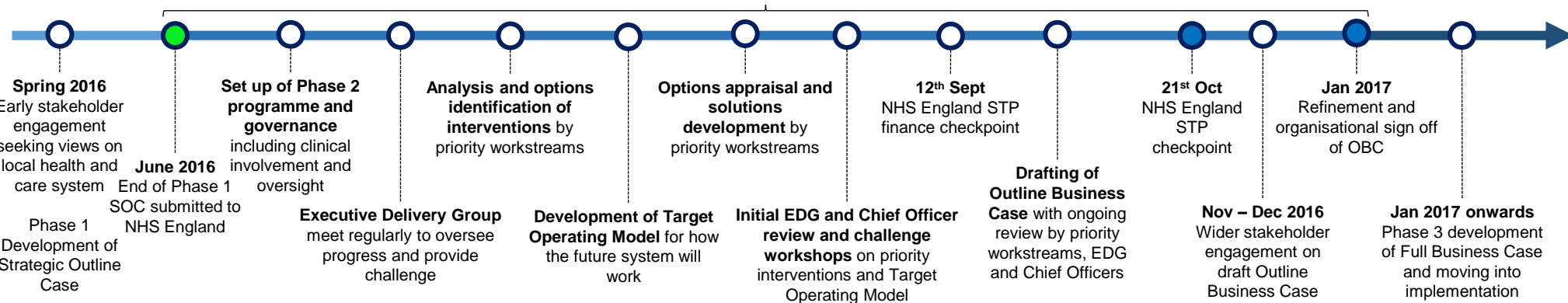
An Executive Delivery Group managed progress and alignment of the proposals throughout this phase of work, linked to a Finance Group developing the detailed savings and investment implications of our proposals.

Senior oversight was provided by regular meetings of the Chief Officers and the Transformation Board, comprising Chief Executives, Chairs and Cabinet Members of the local health and care organisations and chaired by an independent external advisor.

Clinical involvement throughout Phase 2 helped to produce, review and challenge the Outline Business Case. Each of the five system redesign programmes included a Design Authority, consisting of health and care professionals, to ensure clinical co-production of our proposals. Each programme was also led by a dedicated clinical lead. Finally, the South West Clinical Senate are providing additional oversight as a critical friend in the development process. This leadership and engagement has ensured that clinical knowledge and expertise is at the heart of designing an integrated system based around places and local populations.



## Phase 2



Shared central support team

# Purpose of this document

This Outline Business Case is the output from Phase 2 of our work. It sets out our proposals for transforming the health and care system in Cornwall and the Isles of Scilly, building on the strategic intentions outlined in our previous STP submission to NHS England in June. Within this document, we detail:

- The **Case for Change** with a clear understanding of our current local needs, performance, financial situation and commissioner and provider arrangements which will shape our priorities for transformation;
- A **Target Operating Model** showing how we will work together in the future as a single system to plan and deliver services in the local health and care economy;
- **How we will make the change** through our 18 priority interventions which will address current system challenges and improve services and outcomes;
- **Implementation plans** for transforming the system over the next five years which recognise the importance of phased implementation given the interconnected nature of the system and people's pathways;
- **Finance considerations** setting out the anticipated savings and investment projections for our proposals.

Further work will be undertaken to develop these proposals in more detail during Phase 3, including wide engagement and consultation with the public and key stakeholder groups. Detailed intervention designs and implementation plans are therefore not included as part of this document. However, the Outline Business Case provides a clear blueprint for collectively delivering the system change we need to ensure integrated, effective and sustainable services in the future.

## What this document will not do

- It will not set out our plans around children's services, although it does consider the needs of children within the context of families as part of the Radical Upgrade in Population Health and Prevention section. A linked Children and Young People's Transformation Plan for Cornwall and the Isles of Scilly will be co-produced by commissioners and providers, in collaboration with service users and drawing on the expertise of clinicians and practitioners. It will build on the work undertaken over the last 3 years to align commissioning intentions that are based on a shared vision and principles, a common understanding of needs, agreed outcomes and priorities, and meaningful measures. It will draw on learning from the integrated processes and services developed by providers of children's health and social care, such as the Early Help Hub<sup>4</sup>, which aim to identify and respond to additional needs at an earlier stage and prevent escalation to specialist services.
- The OBC does not provide a detailed business case and implementation plan for each priority intervention – this will come later once we have engaged on the strategic priorities.
- The OBC does not set out detailed financial and activity modelling, which will be undertaken as part of the further development and engagement on the priority interventions.

## How we plan to use this document

The OBC contributes to the development of the STP as a whole system plan and by its very nature is strategic in its content. This plan will describe how locally we will make a reality of the NHS Five Year Forward View for Cornwall and the Isles of Scilly. Much greater specificity of the ideas in the OBC will be developed once we have been out to public engagement during the winter of 2016/17. As this is a 5 year plan, it will be constantly reviewed to ensure that we leave sufficient time to plan for service change.

The priorities in the OBC will inform the commissioning and decommissioning priorities for the system. It will provide the basis for operational planning and contracting discussion as the health system moves to a two year operational plan. The relationship between the OBC and delivery on the ground is set out in the adjacent diagram.







## 2. Case for Change

This section sets out the key messages regarding our existing ways of working that drive the need for change across Cornwall and the Isles of Scilly, along with a clear indication of what this means for how we operate in the future. This has helped us to shape how our health and care system will look as well as identifying the priority interventions we need to implement.

Our case for change builds on information and analysis of five different areas:

- **Understanding need:** Looking at population health and other factors which influence demand on our health and care system.
- **Understanding performance:** How well our organisations are currently delivering and supporting improved health and care outcomes.
- **Understanding the money:** Detailing the scale of the financial challenge across the system which requires fundamental transformation of how we operate in order to be sustainable in the future.
- **Understanding what people want:** Highlighting the feedback and views from local people and other key stakeholder groups about their priorities and what the system should look like in the future.
- **Understanding supply:** An overview of the current arrangement of organisations commissioning and providing services in the health and care system.

# Understanding need

Cornwall is faced with four fundamental challenges: our population is changing and growing; our economy is still underperforming; our geography and settlement pattern places strain on the public purse; and the cost of living is increasing inequality. We recognise that there are significant health inequalities across different communities within Cornwall and the Isles of Scilly which we need to address. We want to have a strong focus on tackling these gaps, particularly for our poorest areas which experience some of the worst health outcomes. Our population is ageing, as people are living longer, but often in poor health with disabilities. We need a fundamental transformation in how we direct our effort and resources to lead prevention work and tackle the causes and consequences of deprivation and unhealthy lifestyles, in order to live longer in good health. This cannot be achieved by 'traditional' health and care services alone and it will depend on the wider public and voluntary sectors planning and working together.

1. **Cornwall's population is older than average** with the greatest population increases expected in the older age groups. By 2019, 1 in 4 of our population will be aged 65 or over.
2. **Birth rates are increasing**, however, and young people are choosing to live and stay in Cornwall, so while the STP should plan for the ageing population needs it should not do so exclusively.
3. **Accessibility issues** - Cornwall's size and geography, with its largely remote rural areas interspersed with small urban centres and limited public transport availability, makes service accessibility a significant challenge for the health and care system.
4. **Seasonal demand** - As a popular tourist destination, the number of people in Cornwall surges to four times the resident population in the summer, resulting in high seasonal demand for primary care and urgent care health services.
5. **Poor start in life** – Some children are experiencing poor health in their early years which has a significant impact on their future health outcomes, including a higher proportion of children aged 4-5 who are overweight or obese, higher proportion of 15 year olds who smoke and lower proportion of school readiness than national averages.
6. **Increased proportion of lives spent in poor health** - People are living longer but the length of time that they remain healthy is not increasing. More years are spent living in poor health or with a disability, creating additional demand on health and social care services. On average, men spend 15.7 years and women spend 17.8 years in poor health.
7. **Disease prevalence, co-morbidity and frailty** - Nearly 500 people die early from heart disease and stroke each year; 10% of people aged over 65 years have frailty rising to between a quarter and half of those aged over 85 years.
8. **Redefining the purpose and role of bed based care** - National audits looking at community hospital bed, nursing and residential care home utilisation show that approximately one third of the patients/residents are not in appropriate settings.
9. **Significant health inequalities** - There are stark disparities in outcomes between areas of affluence and deprivation in Cornwall. Overall life expectancy is significantly lower, and with a greater proportion of life spent in poor health, for those living in the most deprived areas of Cornwall compared to those living in the least deprived.
  - Men die 6.2 years earlier and women 3.8 years earlier in the most deprived areas of Cornwall compared to the least deprived.
  - People from the poorest communities spend over 12 years living longer with poor health compared to the most affluent.
  - People with severe mental illness are at risk of dying on average 15 to 20 years earlier than other people.

#### Public Health data taken from:

- Cornwall County Council Director of Public Health Annual Report 2015/16 <sup>5</sup>; Public Health England, Public Health Outcomes Framework <sup>6</sup>

# Understanding need

10. **Economic challenges impacting on poor health** – Cornwall has a low economic output and low wages, with 40% of employees falling below the ‘Low Pay Threshold’, which is linked to higher prevalence of harmful lifestyle behaviours in lower income families. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination.
11. **5 big lifestyle behaviours leading to 5 big diseases** - Smoking, diet, alcohol, physical inactivity and social isolation contribute to the 5 diseases which lead to 75% of deaths and disability.
  - **Smoking** – Higher rate of smoking attributable admissions than national average.
  - **Diet** – Over a quarter of children are overweight or obese.
  - **Alcohol** – Estimated 25,000 people drink at harmful levels costing £75m a year to the health and social care system.
  - **Physical inactivity** – People in the most deprived areas are twice as likely to be physically inactive than the least deprived.
  - **Social isolation** – 15% of all households in Cornwall have a person over 65 living alone.
12. **Higher prevalence of a range of diseases** in Cornwall and the Isles of Scilly compared to nationally, which drive inequalities and increased rates of health service use and hospital admissions. This includes higher rates of coronary heart disease, stroke, diabetes, cancer and lung disease.
13. **Major social factors are a big influence on demand** – 20% of NHS costs are associated with avoidable risk factors to do with diet, physical activity, smoking and alcohol consumption with alcohol related harm accounts for 4,060 hospital stays per year.
14. **Major social factors are amplified for people with mental health.** People with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health.
15. **Valuing mental health equally with physical health** – People tell us they want to have access to services which enable them to maintain both their mental and physical wellbeing. “Parity of Esteem” means that if someone becomes unwell, they have access to services which assess and treat mental health disorders or conditions on a par with physical health illnesses. This is important as in Cornwall we have lower than national rates for recorded mental health issues such as depression and new cases of psychosis. Surveys show 5% of people reporting long term mental health problems, which is higher than nationally. Cornwall also has higher rates of suicide and admissions for self-harm or deliberate injuries.

## What does this mean for how we operate?

Enhance our targeted prevention and intervention activity to address harmful lifestyle behaviours and help to manage demand on the overall system.

Specifically address the stark inequality for those in our most deprived areas through more rigorous and focused prevention work in these areas.

Enable people to look after themselves through improved health education, information and opportunities to self-care and self-manage long-term conditions.

Co-ordinate our efforts across the public and voluntary sectors to tackle the wider determinants of health and raise the overall health of the population as a whole.

Use our devolution deal as a vehicle to underpin and drive this across the entire system.

We will avoid viewing physical and mental health treatment in separate silos in our health and care services.

# Understanding performance

The disparities in outcomes for certain communities in Cornwall and the Isles of Scilly are reflected across key areas of our performance. We need to address how well we deliver services where there is significant variation compared to similar organisations. By tackling gaps in performance across outcomes, pathways, expenditure and how services are run and managed, we can improve the experience of people using our services as well as overall value in the local health and care system.

- 1. National outcomes frameworks show how well we perform and where we need to improve compared to other areas of the country-** Three national outcomes frameworks show our performance across a number of public health, health and social care indicators. While we perform well in some areas, there are significant opportunities to address underperformance and variation in our delivery of services.
- 2. A core commitment to the NHS Constitution<sup>7</sup> - our plans must evidence how we will ensure patients receive the right start to their treatment.** Key NHS Constitution indicators include access standards for A&E, cancer, mental health and ambulance waits, as well as the length of time from referral to treatment for patients on non-emergency pathways. With the exception of cancer diagnosis and one year survival rates, our current performance against these indicators is poor as we are in the bottom quartile or below average in:
  - 4 hour Emergency Department waiting times
  - Dementia diagnosis rates
  - Ambulance waiting times
- 3. Performance areas which are significantly worse than national averages should be targeted.** There are several areas within the NHS Outcomes Framework<sup>8</sup> where indicators for our local population are significantly worse than national averages, which we will need to take targeted action to improve:
  - Number of people who are still smoking when their baby is delivered
  - Numbers of people who are admitted to hospital in an emergency with alcohol related liver disease
  - Numbers of people who are homeless
  - Numbers of people who are considered to be experiencing fuel poverty
  - Number of people who are admitted to hospital with hip fractures
  - Our acute hospitals do not meet the 'Core 24' standard for mental health liaison
- 4. Adult Social Care Outcomes Framework (ASCOP<sup>9</sup> benchmarking shows areas of adult social care that should be targeted.** There are also several areas where ASCOF indicators are significantly worse than national averages which require targeted action:
  - Proportion of adults with a learning disability in paid employment
  - Proportion of adults with secondary mental health services living independently, with or without support
  - Delayed transfers of care from hospital that are attributable to adult social care
  - Proportion of people who use services who find it easy to find information about support

# Understanding performance

5. **RightCare benchmarking data shows variation in outcomes and cost, with a potential financial opportunity of c£29m** - This variation is linked to a number of key care pathways where we perform poorly against a range of key indicators. NHS RightCare<sup>10</sup> methodology helps us to identify where we need to improve delivery in order to reduce differences in performance with other CCGs in the country. It shows that our biggest areas of opportunity are:
  - Musculoskeletal - £7m
  - Trauma and injury -£4.6m
  - Circulation - £4m
  - Other pathways (Neurological; Endocrine) - £13m

There are also significant variations between GP Practices which cannot be explained by population factors, nor are they covered by RightCare, around prescribing spend, diabetes care and referral rates into our acute hospitals.
6. **Implementing Lord Carter’s recommendations <sup>11</sup> from his review of acute hospitals will help to address variation in this area** - In particular, we should tackle: sickness and staff turnover management; management of annual leave, shift patterns, flexible working and technology for rostering; improving the supply chain and management of variation of pharmacy and medicine costs; procurement; estates and facilities management; back office costs and agency costs.
7. **Success against these indicators is critical** in terms of ensuring that people in Cornwall and the Isles of Scilly have timely access to services but it also drives whether we have access to transformation funding, which is key to the delivery of the system changes required, the overall performance assessment of the organisations and level of involvement of national regulators.

## What does this mean for how we operate?

Ensure that addressing areas of significant performance compared to similar organisations is a key priority.

Target development of key care pathways to address poor performance and variation, including for maternity and early years, diabetes, stroke, musculoskeletal and trauma and injury.

Implement changes to our acute hospital provision to address operational productivity and performance.

We need to ensure that we can demonstrate how we are delivering against the national NHS Constitution standards and the CCG Improvement and Assessment Framework.

# Understanding the money

As a local health and care system, we have a large financial challenge with a projected financial deficit of £264m by 2020/21. The gap between funding and costs is being driven by rapidly increasing demand for services, operational inefficiencies and a reliance on expensive forms of care, typically bed-based, in our current model. We need radical change across the entire health and care system in how we provide services and how local people use them, redirecting resources to more prevention, self-care and community-based provision.

**The forecast health and care spend for 2016/17 in Cornwall and the Isles of Scilly is £1.2 billion.** However, we are spending now per head of population what we will have available to spend in 2020/21.

**Our financial challenge is significant with large planned deficits across every organisation and increasing pressure on resources.** We are predicting a deficit of £64.35 million across the local health and care system in 2016 / 17, broken down by organisation as follows:

Organisation	Forecast deficit
NHS Kernow CCG	£53.7m
Cornwall Partnership NHS Foundation Trust	£0.45m
Royal Cornwall Hospitals NHS Trust	£3.7m
NHS England	(£0.8m)
Cornwall Council & Council of the Isles of Scilly	£7.3m

**Key drivers for the gap between funding and system costs** are the rapidly increasing demand for services, inefficiencies in how we work, variations in practice and a model of care which is heavily reliant on more expensive forms of care, such as bed-based provision.

As a result, it is estimated that there will be a **financial deficit of £264m** by 2020/21 if we do nothing. However, this does not take into account the Resource Allocation and Budgeting rules for the CCG, where any overspend at the end of the financial year is deducted from the following year's allocation, which significantly worsens the financial position.

Funding for commissioning local NHS services for local people is set nationally using a complex formula. The allocation methodology was improved this year to reflect socio-economic disadvantage and remote geography, which are both significant factors affecting Cornwall. Additional investment is provided for national strategic goals, including GP services and specialist services. We will need to deliver our transformation plans in line with this funding allocation. Cornwall is receiving more money than the national formula says that it should, so any growth awarded will be lower relative to national average in some other areas.

We must **bring the system into financial balance as quickly as possible** through a credible plan for change which **maintains patient safety**. We recognise that radical change is needed in the way we deliver our services across the entire health and care system, as well as the way people use them. The scale of the financial challenge means that simply cutting costs to address the deficit is not an option.

From the local authority perspective, the 2% social care precept has been adopted locally to bolster funding. Subject to democratic process the overall budget for adult social care will increase by 9% in 2017/18, 3% in 2018/19 and 4% in 2019/20 to help keep pace with overall demand. However, the Public Health grant allocated nationally is due to see a 2.9% reduction per year in real terms, at a time when we want to invest more in prevention and wider population health improvement.

**Some additional national funding is available to support system transformation.** The Better Care Fund<sup>12</sup> is being used to fund greater integration of health and social care. A protected Sustainability and Transformation Fund<sup>13</sup> will be allocated to support delivery of our local changes. We will need to consider how these funds are used in order to address our local challenges and deliver the transformation that we need.



# Understanding the money

## Key areas of spend by care setting, baseline 2015/16

Care setting	Spend (£000's)	% of total system spend
A&E	11,100	1.0%
Emergency Inpatients	230,003	20.2%
Elective Inpatients	95,319	8.4%
Day Case	63,473	5.6%
Outpatient	58,778	5.2%
Other acute	344	0.0%
Specialised	125,280	11.0%
Community	78,196	6.9%
Mental Health	79,254	7.0%
Continuing care	68,056	6.0%
Prescribing	94,250	8.3%
Primary care	77,614	6.8%
Social care: Children's therapy & LD	8,431	0.7%
Social care: Adult	119,639	10.5%
Public health	28,405	2.5%
<b>Total</b>	<b>1,138,142</b>	<b>100%</b>

In order to better understand our system spend, we have undertaken analysis of key areas of spend using patient-level data. This was broken down by care setting and age profile for the baseline position in 2015/16. Key insights from this analysis include:

- Acute spend dominates overall health and care spend in Cornwall, accounting for 51% of overall spend. Other health spend accounts for 35% and social care spend for 14% of overall spend respectively.
- There is a significant increase in spend at 65 and a majority of care is dominated (46%) by 65+ age profile; projected forwards spend becomes more concentrated in the 65-79 age bracket which accounts for 31% of spend.
- Emergency inpatient spend alone accounts for 20% of the overall system spend. 65+ emergency inpatient spend accounts for 12% of total healthcare spend.
- This trend continues when projected forwards and spend becomes more concentrated by age profile, observed especially in 70-79 which gains 3% of total spend across ages between 2015/16 and 2020/21.

## What does this mean for how we operate?

Target our interventions and available resources in areas and interventions that will have the greatest impact in managing both demand and spend, while also improving outcomes and ensuring safety.

Develop how we operate to improve productivity and efficiency by integrating and consolidating back office functions, processes, technology and property in order to address duplication and fragmented ways of working.

Implement a fundamental transformation of delivery and access to services which manages demand for elective care and promotes prevention, earlier intervention and community-based care in order to reduce pressure on more expensive bed-based forms of care and deliver better outcomes for service users.

# Understanding what people want

We started our conversation with local people at the start of this year, which shaped our Strategic Outline Case and this Outline Business Case. We will continue this conversation when we publicly engage on the draft Outline Business Case during November and December, in order to influence and refine our thinking. Consultation on proposals with the most significant changes to services will take place in summer 2017. However, we will move forward with some changes of a less significant nature without further consultation. We will need radical solutions at scale to address our financial and performance challenges, so there will be very difficult decisions about the types of services we can provide in the future.

- 1. How we have engaged with the public so far** – We led an intensive period of engagement with local people during January to March of this year. 450 people participated in public events at nine locations across the county and 2450 people responded to the survey. (Shaping the future of Health and Social Care in Cornwall and the Isles of Scilly – full report on engagement <sup>14</sup>)
- 2. Recognising our strengths** – People said that we have made good progress on joining up services, dialogue with the public was now open and honest, and some local services are good. We need to maintain and build on these particular strengths.
- 3. Priorities for the future** – Access is the top priority for people, who want quick, prompt and convenient access to services. We have included proposals for how we can improve service access and co-ordination in our Target Operating Model, to help the right care be delivered in the right place at the right time. Other priorities for people include being involved in planning their own care and engaging with staff that are professional, caring and competent.
- 4. Opportunities to improve wellbeing and meet needs at less cost** – People said we should encourage personal responsibility and enable people to keep fit and healthy, encourage healthy lifestyles and community responsibility, and provide ‘tough love’ from the service. Our proposals for how we work in the future include an emphasis on prevention, enabling self-care and delivery of integrated care in the community.
- 5. Issues which need attention** – People thought that access is currently an issue for some services, with too much travel for routine appointments and treatment and long waiting lists for some mental health services. There is also a perception that local facilities such as community hospitals and GP surgeries are underutilised and there is a lack of investment in prevention and early intervention. More efficient use of resources, including estates, is a key system enabler in our proposals for the future.
- 6. Priorities from providers to support more joined up care** – Providers also proposed empowering and enabling people to manage their own health and wellbeing better, as well as investing in local community-based delivery to support access, co-ordination and integration of services. This could be supported by creating care navigators or co-ordinators to support people to have more choice and receive the right care.

# Understanding what people want

7. **This Outline Business Case will be shaped further by engaging with the public** – We will continue our conversation with people who use or will use health or care services now and in the future. The draft Outline Business Case will form the basis for engagement with the public during November and December. During this period, our thinking will be further developed and refined. Formal consultation on proposals will take place in summer 2017 providing the public with the opportunity to further influence and shape proposals
  
8. **We will need to take difficult decisions and we will not be able to consult on every proposal** – The scale of our financial and performance challenges will mean radical changes to what services can be provided and how they can be delivered. We will lead formal consultation on the most significant proposals during summer 2017. Some proposals of a less significant nature where there is a clear option for change may not involve further consultation, as we will need to make rapid progress in delivering efficiencies and service improvements. This is further set out in the next steps section.

## What does this mean for how we operate?

Ensure a clear plan for engagement and consultation with the public as we develop and implement our proposals, building this into our road map for change.

Provide a greater focus on health education, health and wellbeing improvement and prevention to keep people fit and healthy without needing to access other services where possible.

Building more integrated local community-based care, involving dedicated care co-ordinators to navigate the system and support people with choice and receiving the right care.

Improve arrangements for access and co-ordination of services which provides the right level of care for people when they need it and utilises resources most effectively with a focus on helping people to help themselves.

# Understanding supply

There are a number of organisations commissioning and providing services across the health and social care system. There are opportunities to improve alignment, co-ordination and integration in order to improve efficiency and effectiveness.

## An overview of services and sites by provider and commissioner

<b>Royal Cornwall Hospitals NHS Trust (RCHT)</b>	Provides predominantly secondary care services on three sites providing services to between 75 - 80 % across Cornwall and the Isles of Scilly – Royal Cornwall Hospital in Truro, West Cornwall Hospital in Penzance, St Michaels Hospital (SMH) in Hayle.
<b>Plymouth Hospitals NHS Trust (PHT)</b>	Provides the majority of the tertiary care services to the whole county and secondary care services to approximately 100,000 people who live in the East of Cornwall representing 20% of the county.
<b>North Devon HealthCare NHS Trust (NDHT)</b>	Provides some of the tertiary care services and secondary care and community services to approximately 17,000 people who live in the North East of Cornwall.
<b>Cornwall Partnership NHS Foundation Trust (CFT)</b>	Provides mental health and learning disability services for adults and children, operating from two main sites in Bodmin and Redruth & Camborne, with substantial outreach services into the community across the county. In April 2016, CFT acquired a 2 year contract to deliver adult community health services, including community hospital services. The previous provider of these services was Peninsula Community Health CIC.
<b>Ramsey Healthcare</b>	Provides elective NHS services from the Duchy Hospital and the Bodmin Treatment Centre.
<b>Kernow Health CIC</b>	The collective provider voice of the 64 independent General Practices who commission local health services.
<b>General Practices</b>	64 independent General Practices who provide primary health care services
<b>Cornwall Health</b>	Led by Devon Doctors with Kernow Health CIC provides primary care Out of Hours.
<b>South Western Ambulance Services NHS Foundation Trust (SWAST)</b>	Provides emergency and planned ambulance services across the Peninsula, and operates the NHS 111 service for Cornwall and the Isles of Scilly.
<b>Cornwall Council and the Council of the Isles of Scilly</b>	Provides social care and therapy teams to help adults with care and support need live independently in their own homes. This includes older people, people with physical or learning disabilities and mental health service users. The Council also commissions a significant amount of services from care homes and care at home providers.
<b>NHS Kernow Clinical Commissioning Group</b>	Commissions services that improve the health of Cornwall's population and their experience of those services.
<b>NHS England</b>	Commissions Primary Care (General Practice, Pharmacies, Optometry, Dental Services) and specialist tertiary care services.

Existing locations for health and care facilities reflect our geography and settlement pattern. Truro is the administrative and service centre, hosting the main Cornwall Council offices. It is the location for the acute hospital. The acute trust also has two smaller hospitals in Hayle (a centre for planned care) and Penzance (providing sub-acute services and an urgent care centre).

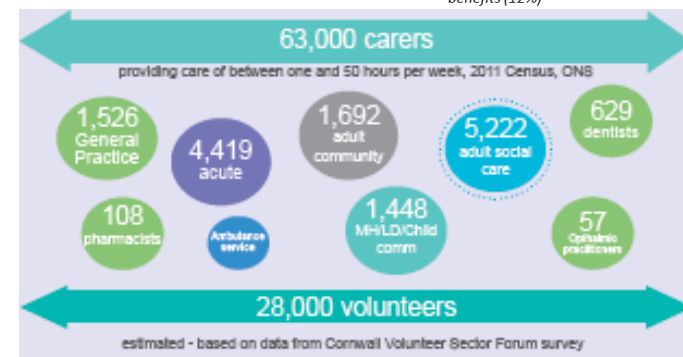
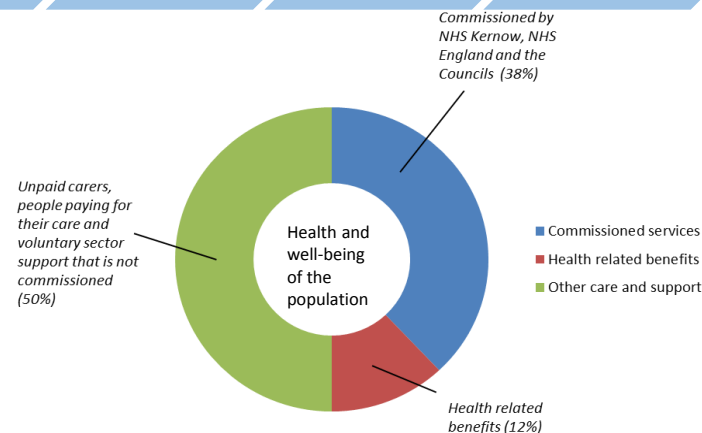
The foundation trust has its administrative centre and provides acute mental health facilities in Bodmin and community and children’s mental health services in Bodmin, St Austell, and Truro. It also runs 12 community hospitals spread across the length of Cornwall, 8 of which are located in the same town as social care offices. It also provides a community hospital on the Isles of Scilly.

In Cornwall, 23% of people can reach an acute hospital for urgent care within 15 minutes. However, 84% can reach either a hospital or minor injuries unit in that time.<sup>15</sup>

There are 64 GP Practices in Cornwall with 54 branch surgeries in smaller settlements. 51% of the Practices and 42% of the branch surgeries dispense medicines. For the Isles of Scilly, there is one GP Practice (with a dispensary) on St Mary’s and it has 4 branch surgeries on the smaller islands.<sup>16</sup>

The location of care homes also reflects our settlement pattern. A small in-reach service is currently provided to care homes with high numbers of hospital admissions by nurse practitioners employed by the provider of community health services. At the end of November 2015, there were 4,702 people supported by Cornwall Council’s Older People and People with Physical Disability team, an increase from 4,680 in October\*.

About 50% of resources providing care and support in Cornwall and the Isles of Scilly are not commissioned services – it is unpaid carers, support from the voluntary sector that is not commissioned or people paying for care\*. Turnover of staff is highest at 37% among Adult Social Care Independent Sector Care workers. This is a major issue in maintaining adequate capacity and improving people’s experience of care and support by developing continuity of care. There is a 15% turnover of NHS Nursing Support workers and a 9% turnover of NHS qualified nursing staff.



\* Data taken from the 2011 Census : An overview of the headline figures for Cornwall<sup>17</sup>

## What does this mean for how we operate?

- Pathways of care may be delivered across a number of organisations so we need to think about how best to align different pieces of the system to deliver improved outcomes but also incentivise movement across different parts of the clinical pathway.
- A significant proportion of the Cornwall population will receive acute services from Devon. It is therefore vital that any changes to services across the Cornwall and Isles of Scilly footprint align to changes in the Devon system.
- There is already a significant sharing of some back office (IT, payroll) but there is both a requirement and an opportunity to critically assess if we can do more to deliver the efficiencies and support the delivery of better system alignment in clinical services.
- We cannot afford to pay for capacity in the system which is not being utilised or being utilised by the wrong people. This is money that could be spent in other parts of our health and care system.
- A number of our assets are in poor condition and are not owned locally by providers. We need to ensure that these assets support the delivery of new models of care and other priorities emerging from the STP.



## 3. Target Operating Model

This section introduces the Target Operating Model we have developed which visually presents the key components of our future health and care system. The purpose of the model is to provide a high-level understanding of how we will work together as a single, co-ordinated system in order to deliver services on a whole population basis, moving from the top-level intentions set out in our Strategic Outline Case in June into an operational framework.

The functional areas of the Operating Model are grouped into five system themes around which we will plan, drive and deliver the changes we need:

- Radical upgrade in population health and prevention
- Integrated care in the community
- Transforming urgent and emergency care
- Improving productivity and efficiency of system enablers
- Using strategic levers for better care

In addition, a sixth system theme regarding work to redesign pathways of care will stretch across the whole model, helping to ensure that the future delivery of services is viable and sustainable.

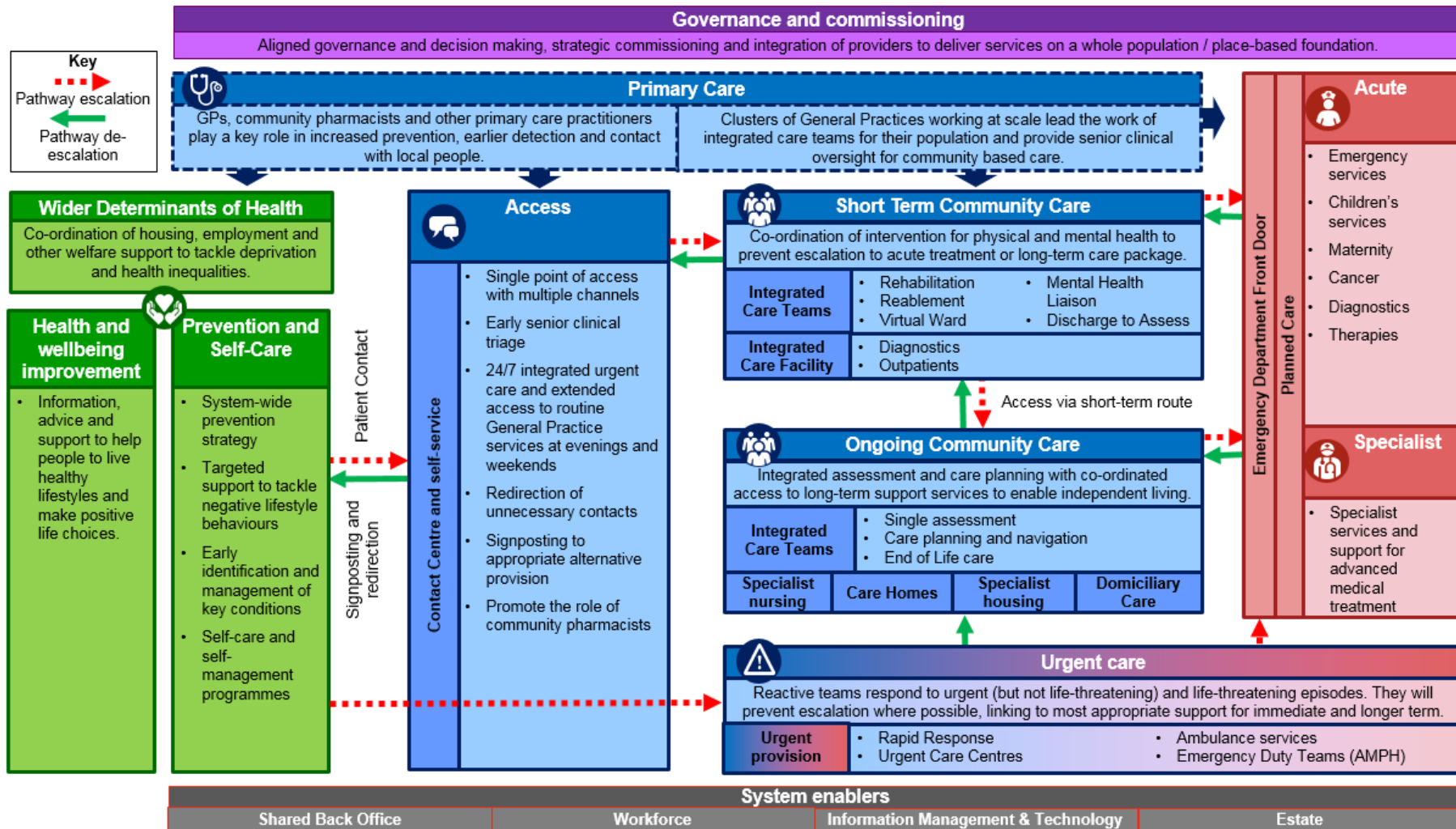
The rest of this section describes the key components of the model in more detail and how they relate to our priority interventions presented in the following section. We also explain how the model is shaped around the needs of our local population based on risk factors and levels of dependency, as well as highlighting how the future system will operate at different geographical levels in Cornwall and the Isles of Scilly.



# Our future Operating Model

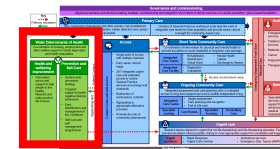
Our future Operating Model is based around functions rather than separate organisational responsibilities, providing a whole system view of the planning and delivery of health and care in Cornwall and the Isles of Scilly. The model highlights the core aspects of each functional area, along with illustrative examples of service provision. It also gives an indication of people's pathways across the system, showing how enhanced support will be provided if issues escalate, as well as stepping down to lower levels of support when people's circumstances improve.

It is important to note that this model does not map all our supply pathways or different provider and commissioner roles in the system. We recognise that current organisational relationships and responsibilities will need to transform in order for the delivery of this whole-system model to be successful.



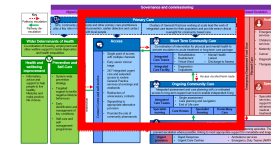
# Radical upgrade in population health and prevention

## How will the system be different?



An enhanced focus on tackling the wider determinants of health, improving health and wellbeing and building prevention and self-care is key to managing demand across the rest of the system. We will work to improve the overall population health across Cornwall and the Isles of Scilly, as well as targeting activities to help higher risk and vulnerable individuals to live healthier, more independent lives. Our system-wide prevention strategy for people at every stage of life will help them to start well, live well and age well.

Description of functional area	How will the system be different?
<p><b>Wider determinants of health</b> Activities which tackle the socio-economic determinants of health across a full range of public, private and voluntary sectors in order to reduce premature illness and improve healthy life expectancy for all.</p>	<ul style="list-style-type: none"> <li>• Responsibility for improving population health extending beyond ‘traditional’ health and care services</li> <li>• System-wide action involving early years, employment, energy, housing and other services across the public, private and voluntary sectors to address root causes of ill health</li> <li>• Using our Devolution Deal to support greater local co-ordination, planning and integration of services</li> <li>• One public sector intelligence for analysis, population and risk stratification, modelling and evaluation</li> </ul>
<p><b>Health and wellbeing improvement</b> Services and interventions which support people to live healthy lifestyles, make positive health choices and reduce inequalities.</p>	<ul style="list-style-type: none"> <li>• Incentivising health instead of the treatment of disease</li> <li>• Rigorous action to tackle health inequalities in our most deprived neighbourhoods</li> <li>• A focus on improving health and lifestyle awareness for key cohorts of the population</li> <li>• Tailoring health and wellbeing improvement programmes to the needs of local communities</li> <li>• Identification of risk factors and lifestyle advice given – making every contact count<sup>18</sup></li> </ul>
<p><b>Prevention and self-care</b> Targeted prevention work to reduce escalation of issues and helping people to manage their own conditions.</p>	<ul style="list-style-type: none"> <li>• Investment in prevention to reduce health costs and lower welfare benefits</li> <li>• Maximising prevention and early detection in all pathways</li> <li>• Key functions across the system working to better enable prevention and support self-care for people</li> <li>• Early identification and management of key conditions such as diabetes and frailty</li> <li>• Place based approach building individual and community capability and resilience</li> <li>• People empowered to manage conditions and meet their own health and care needs in their own home or community, rather than encouraging reliance on more formal support</li> </ul>

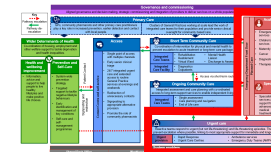


# Integrated care in the community

## How will the system be different?

An integrated, place based approach to care in the community will be at the heart of our system, helping people to receive the most appropriate support at the right time for them. By working in this way, we will manage and reduce overall demand on the system by preventing issues from escalating to more acute settings and enabling faster rehabilitation, recovery, re-ablement and return to independent living.

Description of functional area	How will the system be different?
<p><b>Access</b> Activities regarding first contact and presentations to the health and care system which support the most appropriate initial response, pathway and use of resources to meet individual needs.</p>	<ul style="list-style-type: none"> <li>Establishing a consistent approach to patient and service user contact across the system in order to better assess requests for service, resolve contacts as early as possible and reduce avoidable demand</li> <li>Active signposting and redirection to alternative advice, support and treatment which can more appropriately meet need</li> <li>Potential development of a main point of access which can be used by professionals and the public for health and care contacts</li> <li>Use of multiple channels for contact, including online, mobile applications, telephone and face-to-face</li> <li>Proactive targeting of vulnerable groups to help early identification and management, preventing the escalation of issues</li> </ul>
<p><b>Primary Care</b> Local generalist healthcare services and practitioners as the key initial point of contact and treatment, playing a leading role in planning, co-ordinating and delivering care and support in communities.</p>	<ul style="list-style-type: none"> <li>Closer co-ordination and collaboration across General Practices in 'clusters' to support effectiveness and sustainability</li> <li>Enhanced role and promotion of community pharmacists and other primary care practitioners (e.g. paramedics) to release GP capacity, with greater streaming of people directly to the person who can deliver the care they need</li> <li>Closer links with communities, healthy lifestyles teams and associated voluntary activities to underpin connected communities that provide care and support</li> <li>Senior clinical triage and oversight across key prevention, contact and delivery of care</li> <li>Targeted risk identification &amp; care management for individuals with complex needs, including frailty &amp; learning disabilities</li> </ul>
<p><b>Short term community care</b> Health and care services and professionals providing support over a relatively short duration to help prevent physical and mental health issues from escalating, or enabling quicker step-down from acute settings.</p>	<ul style="list-style-type: none"> <li>Provided by integrated multi-disciplinary teams, working under the leadership of local GPs, supporting a shift in focus from 'disease' to 'problem-solving' the needs of the patient. Multi-disciplinary team roles and team composition tailored to meet the needs of different local areas</li> <li>Enabling specialist clinical roles and services to deliver in the community and away from hospital settings</li> <li>Rapid response and short term interventions to prevent issues from escalating and requiring a longer term care package</li> <li>Discharge support from acute settings to community for people with physical and mental health issues to help rehabilitation, recovery, re-ablement and quicker return to independence</li> </ul>
<p><b>Ongoing community care</b> Health and care services and professionals assessing, planning and managing longer-term care packages for individuals with complex and ongoing support needs.</p>	<ul style="list-style-type: none"> <li>Provided by integrated multi-disciplinary teams, working under the leadership of local GPs, supporting a shift in focus from 'disease' to 'problem-solving' the needs of the patient. Multi-disciplinary team roles and team composition tailored to meet the needs of different local areas</li> <li>Joint health and social care assessment and creation of care plans to meet needs and access to services</li> <li>Proactive care management which empowers people and fosters independence, not dependency on the system</li> <li>Care co-ordination to include support for patient to navigate effectively around the health and care system</li> </ul>



# Transforming urgent and emergency care

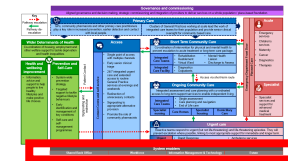
## How will the system be different?

By providing an enhanced and consistent service offer to respond effectively to crises, people will receive the support they need to prevent issues escalating and improve recovery. There will be closer integration and networks between care in communities and urgent and emergency care. This will control pressure on our acute and specialist hospital settings, which will continue to provide high quality expert treatment for people whose planned or unplanned care needs cannot be met elsewhere.

Description of functional area	How will the system be different?
<p><b>Urgent Care</b> Services which rapidly respond to urgent injuries and illnesses, addressing immediate care needs before directing people to the most appropriate provision in the system for ongoing treatment and support.</p>	<ul style="list-style-type: none"> <li>• New model of care which provides an enhanced offer of support through dedicated Urgent Care Centres</li> <li>• Reliable, effective urgent care facilities working at an appropriate scale with a sustainable clinical workforce</li> <li>• Consistency and clarity for the public on how they can access the care most appropriate to their needs</li> <li>• Increased integration and consistency in how people receive information, guidance and access to care out of hours</li> <li>• Moving towards an Emergency Department Front Door to better manage access and how patients are assessed and treated</li> <li>• Dedicated mental health provision to respond rapidly to crisis episodes over 24 hours and 7 days a week to prevent further escalation</li> <li>• Linked to urgent and emergency care networks across and beyond Cornwall and the Isles of Scilly</li> </ul>
<p><b>Acute</b> Planned and unplanned care provided in a hospital setting, which can include more advanced medical consultation, therapies and emergency treatment in the Emergency Department.</p>	<ul style="list-style-type: none"> <li>• Emergency Department no longer viewed as the default point of access for minor injuries and illnesses and has a core focus on providing the specific clinical expertise for the most urgent or life-threatening cases</li> <li>• Safe and timely transfers of people with physical and mental health issues who are well enough to leave hospital to a community setting where their health and care needs will be assessed</li> </ul>
<p><b>Specialist</b> Clinical consultation and treatment in a dedicated hospital setting for highly complex needs and conditions.</p>	<ul style="list-style-type: none"> <li>• Continued access to specialist physical and mental health support in Cornwall and across the wider South West region when needed by patients</li> </ul>

# Improving productivity and efficiency of system enablers

## How will the system be different?

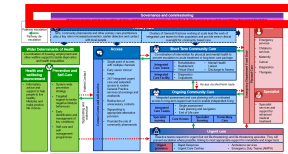


A place-based holistic approach to health and care services in Cornwall and the Isles of Scilly must be underpinned by aligned and streamlined support functions. There are significant opportunities to improve productivity and efficiency through integration of people, processes, technology and property which will remove duplication and fragmentation, leading to more effective service delivery on the ground.

Description of functional area	How will the system be different?
<p><b>Shared Back Office</b> Clinical and non-clinical organisational support functions such as administrative support, Finance, HR, Procurement and ICT.</p>	<ul style="list-style-type: none"> <li>• Increased collaboration and consolidation of back office services, building on existing shared arrangements, to ensure consistency and efficiency of support across the system</li> <li>• Increasing use of self-serve and automation for many transactional back office services</li> <li>• Standardisation and simplification of core processes to remove duplication and fragmentation of effort</li> <li>• Potential delivery by third party or Strategic Partner depending on function and needs</li> </ul>
<p><b>Workforce</b> Evolution in workforce composition, as well as strategic and operational arrangements relating to workforce planning, management and development.</p>	<ul style="list-style-type: none"> <li>• Collaborating to make more efficient and effective use of our permanent, temporary and agency workforce</li> <li>• Enhanced training and capability development to support delivery of integrated care in the community, including care co-ordination and key worker roles</li> <li>• Maximising the workforce development for primary care through portfolio career options for GPs and career development for practice staff and community teams</li> <li>• Planning and recruitment of more specialist roles delivering from out of hospital settings</li> <li>• There will be a shared approach with the independent providers (care homes and care at home) to ensure workforce supply and effective career pathways</li> <li>• A career development / talent management approach enabling care workers to enter into the nursing profession</li> </ul>
<p><b>Information Management and Technology</b> Infrastructure, processes and systems relating to data, business intelligence, analytics, integrated records and other technology.</p>	<ul style="list-style-type: none"> <li>• Single view of an individual's contact with the health and care system with integrated records and care plans</li> <li>• Mobile working technology to allow staff to work flexibility and efficiently across locations</li> <li>• Use of technology and multiple channels of contact to support access and delivery of services, such as e-consultations</li> <li>• Data-driven understanding and insights on people's use of the health and care system to inform further improvements</li> </ul>
<p><b>Estates</b> The strategic and operational planning and management of all properties and estates across the health and care system in Cornwall and the Isles of Scilly.</p>	<ul style="list-style-type: none"> <li>• Collective approach to the public sector estate to maximise utilisation and dispose properties where no longer required</li> <li>• Increased co-location of health and social care professionals</li> <li>• Increased co-location of a wide range of health services and specialisms to improve integration of care and support</li> <li>• Rationalisation and consolidation of estate following greater integration and increased use of mobile working and technology opportunities</li> <li>• The Devolution Deal used as a vehicle to maximise the flexibility and use of our public sector estate</li> </ul>

# Using strategic levers for better care

## How will the system be different?



Agile, joined-up leadership and commissioning arrangements will oversee the health and care system in Cornwall and the Isles of Scilly, providing a focus on the needs of the whole population and the effectiveness of the system from end-to-end. The scale and extended influence enabled by collaborative working, supported by greater understanding of how one area of the system impacts on another, will ensure key strategic levers can be used for better care and improved outcomes for local people.

Description of functional area	How will the system be different?
<p><b>Governance</b> System leadership, decision-making and oversight arrangements responsible and accountable for strategy, delivery, quality and performance.</p>	<ul style="list-style-type: none"> <li>• Strong, aligned governance arrangements which supports decisions making on a whole system population basis</li> <li>• Focus on the best use of finite resources available, independent of organisational and professional boundaries</li> <li>• Shared vision, culture and values driving joined-up delivery of services</li> <li>• Recognising collective accountability to the people of Cornwall and the Isles of Scilly</li> <li>• Open and honest relationships recognising that there will always be differences of opinion</li> </ul>
<p><b>Commissioning</b> Functions and processes relating to analysing, planning, procuring and reviewing services required to meet local needs.</p>	<ul style="list-style-type: none"> <li>• Shift towards a shared integrated commissioning function</li> <li>• Use of capitation based budgets</li> <li>• Greater focus on strategic commissioning and macro-level market management to support the developing needs of our local populations</li> <li>• Reintegration of commissioning of primary care and specialised services locally from NHS England</li> <li>• Increased micro-commissioning through delegation of more transactional functions and personal budgets</li> </ul>



# Our health and care system population

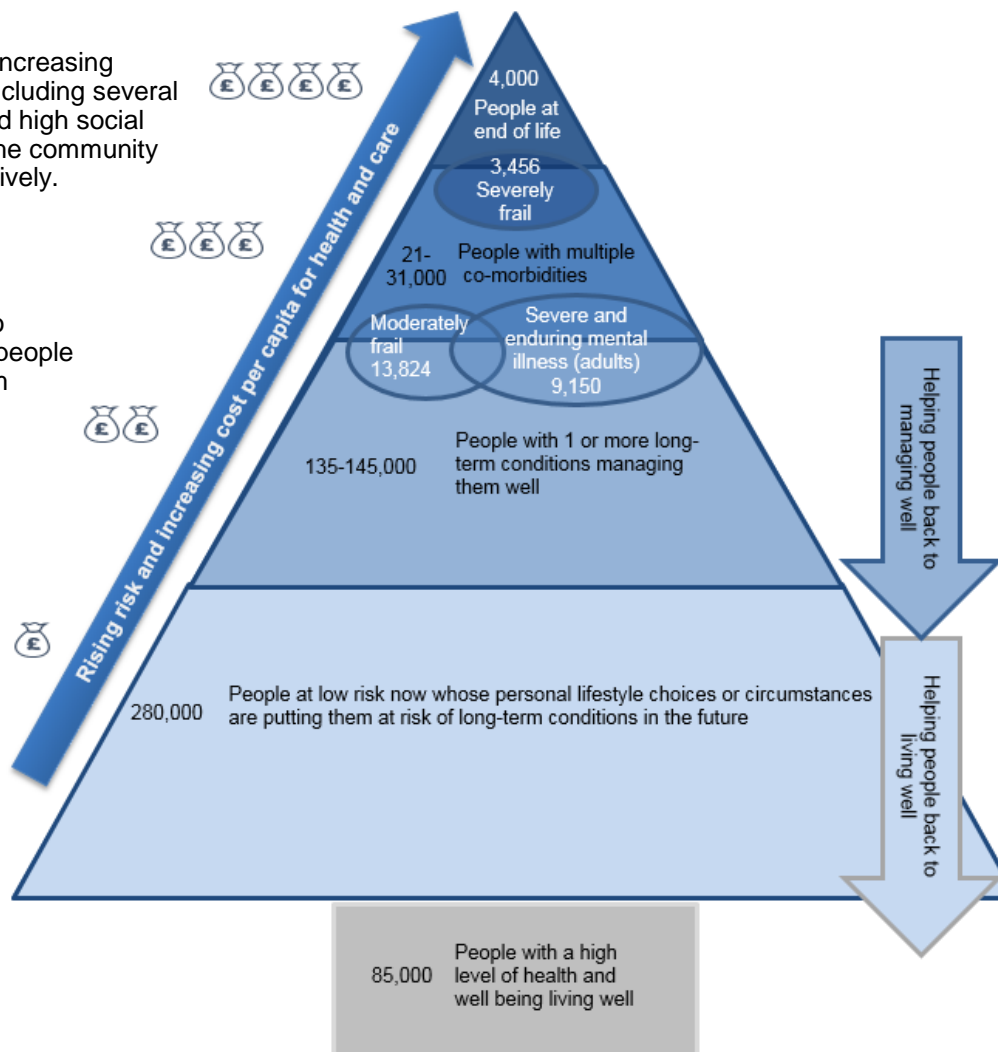
Our Target Operating Model is shaped around the needs of the local population, based on increasing levels of risk and dependency. Key services and features of our model will be targeted at population cohorts with high to moderate risk factors, which account for the most significant proportion of our activity and spend. The whole system will work to proactively address these factors, co-ordinating care in the more appropriate setting and helping people to increase their independence. Access through primary care and other channels, as well as urgent care, acute and specialist services, will cover the whole population, ensuring relevant services for any single episode or continuity of care needs. (Data extracted from Commissioning for Value: Where to Look January 2016 , NHS Kernow <sup>19</sup>)

As our population ages, we will have an increasing number of people with complex needs, including several physical and mental health conditions and high social care needs. Ongoing integrated care in the community will manage their needs safely and effectively.

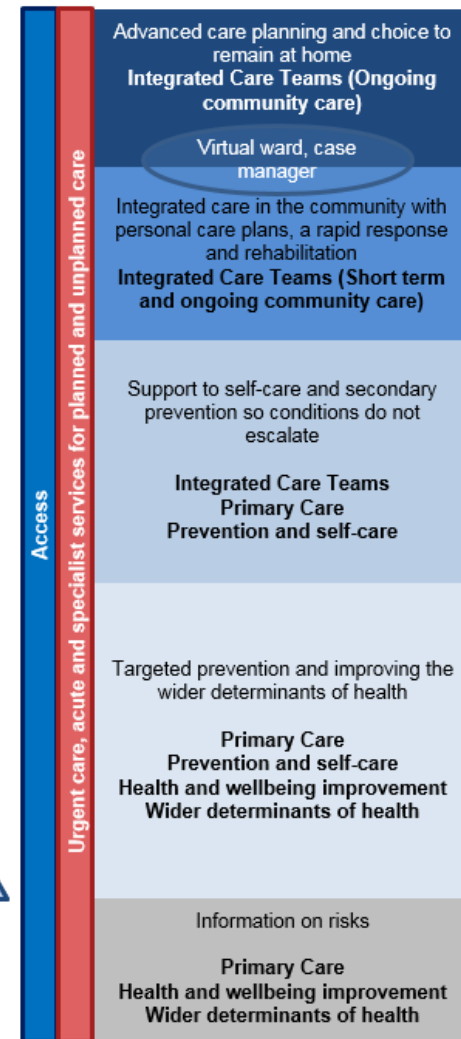
For people at a rising risk, we will work to prevent issues from escalating and help people back to managing well through short-term interventions and community support.

For the large proportion of our population who are at low risk, an enhanced focus on prevention and improving population health will help to prevent risk factors from rising.

We want to increase the numbers of our population who have a high level of health and wellbeing, ensuring that any contact with the health and care system is responsive, proportionate and returns them back to living well quickly.

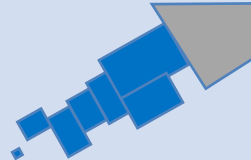
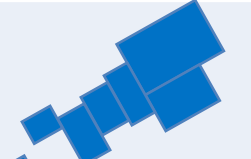
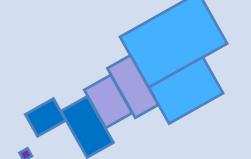
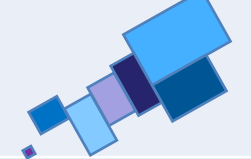
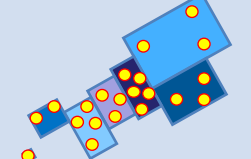
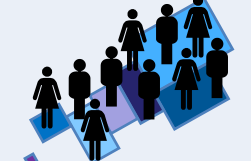


## Care features of our TOM



# Our health and care system geography

The large area and dispersed communities of Cornwall and the Isles of Scilly creates several challenges for our health and care system. We have described six geographical tiers around which the Target Operating Model will be organised. We will need to plan and deliver services at the most appropriate level which is sustainable and maximises economies of scale while also allowing the tailoring of provision to meet the various circumstances and needs of different communities.

Map	Tier	Number	Population size	Description	Example services in each tier
	<b>Tier 1 – Peninsula (Cornwall, the Isles of Scilly and Devon)</b>	1	1,600,000	Extended area beyond the STP footprint covering the South West region for provision of services at a scale which is not sustainable by Cornwall and the Isles of Scilly alone.	<ul style="list-style-type: none"> <li>Specialist trauma services</li> <li>Specialist mental health placements</li> <li>Emergency Departments at Derriford and Barnstaple</li> <li>Shared IM&amp;T</li> </ul>
	<b>Tier 2 – Cornwall and the Isles of Scilly</b>	1	560,000	Planning and delivery footprint which maximises economies of scale and consistency across Cornwall and the Isles of Scilly.	<ul style="list-style-type: none"> <li>Emergency service</li> <li>Aligned and co-ordinated system strategies and planning</li> </ul>
	<b>Tier 3 – Area</b>	3	160,000 – 215,000	Three areas – North East, Central and West – which provides some economy of scale while also ensuring local accessibility and tailoring of services.	<ul style="list-style-type: none"> <li>Urgent care centres (with diagnostics)</li> </ul>
	<b>Tier 4 – Locality</b>	6 (plus loS)	65,000 – 105,000	Sub-divisions of the three areas to provide more localised services where there is an appropriate level of need to be met.	<ul style="list-style-type: none"> <li>Rapid response team</li> <li>Multispeciality community provider models</li> </ul>
	<b>Tier 5 – GP Clusters and Community Networks</b>	20 (plus loS)	15,000 – 45,000	Clusters of General Practices working at scale grouped around key towns and linked to community teams and services to provide care and support to the local population.	<ul style="list-style-type: none"> <li>Integrated Care Teams</li> <li>Clinical pharmacist per 30,000 population</li> <li>Mental health practitioner per 30,000 population</li> <li>GP in-reach into care homes</li> </ul>
	<b>Tier 6 – Individual</b>	560,000	1	Increased emphasis and empowerment of individuals to make positive lifestyle choices, live healthier lives and better manage their own conditions.	<ul style="list-style-type: none"> <li>Personal budgets</li> <li>Personal responsibility for health &amp; wellbeing</li> </ul>

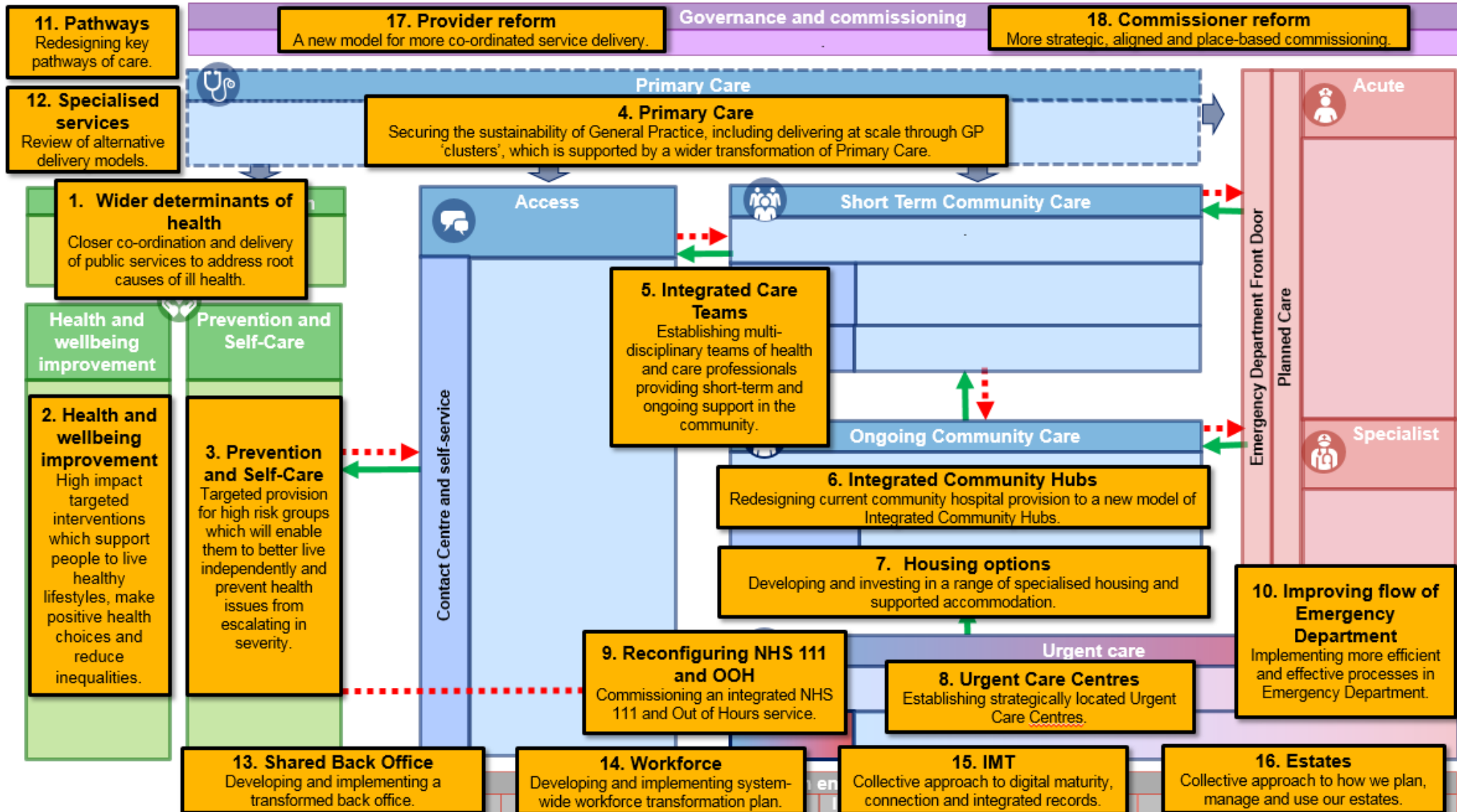
# How the TOM links to geographical areas

Each functional area of the Target Operating Model can be broadly matched to a geographical tier in order to show how the system would operate at different levels of Cornwall and the Isles of Scilly. Particular services and interventions would be planned and delivered at different levels and will be subject to further detailed design and consultation with the public.

Functional area	How will services be planned and delivered?
Wider determinants of health	Strategy and service planning at Tier 2 to ensure co-ordinated setting of priorities, allocation of resources and monitoring of impact regarding prevention across the whole provision of public services in Cornwall and the Isles of Scilly.  Delivery at Tier 5: GP Clusters and Community Networks to ensure tailored provision of prevention activity and improved engagement with local populations. Tier 6: Individuals for personal responsibility for health, well-being and self-care.
Health and wellbeing improvement	
Prevention and self-care	
Access	Tier 2: Cornwall and the Isles of Scilly – Ensuring a consistent approach to first contact and routes within the system to ensure the optimum pathway of care and support and most appropriate use of resources.
Primary care	Tier 5: GP Clusters and Community Networks – Broad and accessible provision of primary care to reduce demand on more specialist resources and creating capacity to target high risk groups.
Short term community care	Tier 4: Locality – Co-ordination of Integrated Care Teams structured with resources tailored to meet particular population needs and priorities in the locality.
Ongoing community care	Tier 4: Locality – Using local knowledge regarding populations and markets to best co-ordinate and manage care packages for individuals in the locality.
Urgent care	Tier 3: Area – Locating more specialist resources in Urgent Care Centres to improve accessibility for individuals and reduce demand and pressure on acute provision.
Acute	Tier 1: Peninsula – Co-ordination of acute services at scale to efficiently, effectively and safely meet the needs of the population in the South West region.
Specialist	Tier 1: Peninsula – Co-ordination of specialist services at scale to efficiently, effectively and safely meet the needs of the population in the South West region.
System enablers	Tier 2 : Cornwall and the Isles of Scilly – Reduced fragmentation, duplication and other inefficiencies in people, process, technology and property in order to support a whole system approach.
Governance and commissioning	Tier 2: Cornwall and the Isles of Scilly – Providing the strategic direction, management and economies of scale to ensure the delivery of outcomes, quality, consistency and value across the whole system.

# Our priority interventions

We have identified 18 priority interventions that we want to implement so that we can address current challenges facing the system and deliver more integrated and effective services in the future. The interventions can be mapped against key components of the Target Operating Model. Most of the interventions are interdependent and we will need to co-ordinate implementation in order to maximise benefits and achieve the best use of resources across our health and care system.





## 4. Making the Change

This section details how we will be making the changes to our local health and care system through the 18 priority interventions that we have identified, grouped around the six system themes. Each system theme is introduced with an overview covering:

- Our 2020/21 vision for this area of the system;
- The list of priority interventions with a strapline summary of the proposal;
- The current challenges that we are facing as a system that these priority interventions will address;
- The key measures of success which will demonstrate how we have achieved the changes that we need. We have used relevant indicators from the Public Health, Adult Social Care and NHS Outcomes Frameworks, plus the CCG Improvement and Assessment Framework.

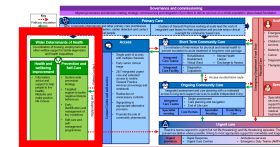
For each priority intervention, we present:

- **Our 2020/21 vision:** How our health and care system will look in five years following our transformation in this area.
- **Why we need change:** The current challenges we are experiencing and the opportunities that we have to improve system effectiveness, efficiency and sustainability.
- **What we will do:** Setting out the actions that we will take to implement the intervention, along with the anticipated benefits for the system and local people.
- **Key enablers to make this happen:** Supporting actions needed to ensure the intervention is viable and sustainable, particularly considering leadership, finance, technology and estates requirements.
- **How this intervention relates to other areas of the system:** Drawing out key links with other system changes, highlighting the interconnected nature of our transformation.



# Radical upgrade in population health and prevention

## Overview



By 2020/21, we will have adopted a bold and brave approach in focusing resources on improving local population health, preventing avoidable illness and therefore reducing demand for health services. People will be empowered to take control of their own health and wellbeing at all stages of their lives. Wider public services across Cornwall and the Isles of Scilly will work together with the health and care system to maximise prevention and early detection. The health and wellbeing gap between our most and least deprived communities will be reduced. Our holistic system-wide prevention strategy encompassing universal provision and targeted programmes will enable all our citizens to start well, live well and age well.

### Our priority interventions

#### Wider determinants of health

Closer co-ordination and delivery of public services including early years, employment, skills, energy and housing to address root causes of ill health.

#### Health and wellbeing improvement

Implementing a range of high impact targeted interventions which support people to live healthy lifestyles, make positive health choices and reduce inequalities.

#### Prevention and self-care

Investment in prevention and targeted provision for high risk groups which will enable them to better live independently and prevent health issues from escalating in severity.

N.B. Due to their interconnected nature, the 2020/21 vision and system challenges are consistent across all three priority interventions in this section. Visions and drivers for change for each intervention listed above are therefore not set out separately, although this is the standard format for the rest of the interventions in the document.

### Key system challenges addressed

Overall **population growth and an ageing population** will continue to place ever-increasing pressure on limited system resources.

**Significant health inequalities** across Cornwall with stark disparities in overall life expectancy and healthy life expectancy between our most and least deprived communities.

Five **lifestyle behaviours** (smoking, alcohol, physical inactivity, diet and social isolation) contribute to the high prevalence of five diseases which cause 75% of premature death and disability.

Large proportion of our population (approximately 280,000) are at low risk now but whose personal lifestyle choices or circumstances are putting them **at risk of long term conditions in the future.**

**People say that we have not invested enough in prevention** and enabling self-care. We can improve awareness, understanding and resulting changes in behaviour which enables the general public to take more personal responsibility and make better use of resources in the health and care system.

### Key measures of success

PHOF 0.1 Healthy life expectancy at birth – male and female

PHOF 2.03 – The percentage of women who smoke at time of delivery

PHOF 1.17 - The percentage of households that experience fuel poverty (based on the "Low income, high cost" methodology)

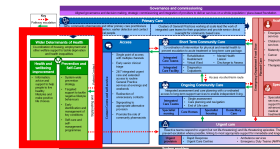
PHOF 2.06ii - Child excess weight in 10-11 year olds

PHOF 2.18 - Hospital admissions for alcohol-related conditions (narrow definition)



# Intervention: Wider determinants of health

## What we will do



At the broadest population level, we propose to deliver a range of programmes to tackle the wider socio-economic determinants of health to reduce premature illness and improve healthy life.

We want to focus on three high impact changes regarding wider determinants of health:

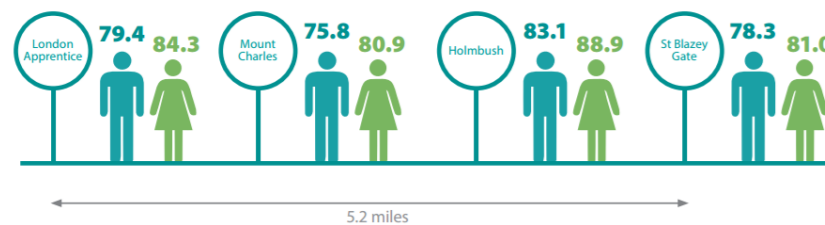
**Promoting the best start and emotional resilience** – A co-ordinated approach to addressing the key issues affecting children and young people in our communities. We will enhance how we protect children from harm through a domestic violence and referral programme and reducing variation in uptake of national immunisation programmes. Improved mental health provision will increase awareness and treatment of mental health problems, including through Increased Access to Psychological Therapies and rolling out Headstart, a whole school approach to promoting emotional resilience as part of the CAMHS Transformation Plan.

**Employment and Healthy Workplaces** – Expanding employment and skills opportunities for people requiring extra support, such as those with mental health problems and long term conditions, as well as supporting employers to create healthier environments for everyone in their workforce.

**Improving access to affordable, good quality housing and reducing fuel poverty** – Delivering our house building programme including affordable homes to enable people to stay and work in Cornwall, and preventing homelessness. Reducing fuel poverty via energy efficiency and housing improvement schemes to address winter cold and other environmental root causes of ill health.

All of these areas would build on the significant opportunities provided by our Devolution Deal to develop a more integrated approach to tackling deep-rooted issues across all public services in Cornwall and the Isles of Scilly. While we recognise that the timescale for realising financial savings from this approach will be lengthy, the long-term benefits are significant:

- Helping to reduce avoidable ill health and demand on the whole system by addressing socio-economic root causes;
- Health is optimised in all policies across public, environment and economic sectors and Devolution opportunities;
- All children enjoy healthy early years and have the best start in life and emotional resilience;
- More people have access to affordable, good quality and warm homes;
- Workplaces promote the health of their employees and education, training and employment opportunities are increased among those most excluded, helping to address health inequalities.



**Life expectancy across one bus route**  
Life expectancy at birth (2008-12) on G4 bus route (St Austell) <sup>6</sup>

### Key enablers

**Aligned leadership** with a cross-partner agreement prioritising prevention across the health and care system, including key outcome measures and agreed funding.

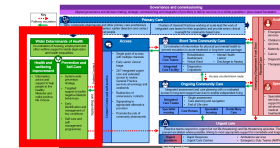
**Devolution opportunities** - Our Devolution Deal creates an opportunity to take on more responsibility, control and co-ordination locally to shape delivery of public services and influence health and wellbeing outcomes, particularly regarding Employment, Energy and Housing.

### Other TOM interdependencies

**Governance and commissioning** to support the development and implementation of strategies and policies which address socio-economic determinants of health in a cohesive manner

# Intervention: Health and wellbeing improvement

## What we will do



We want to help those people who are currently at low risk whose behaviours or circumstances put them at risk of illness and long-term conditions in the future. A range of more targeted work would seek to enable people to improve their health and wellbeing by making more positive choices.

We want to focus on four high impact changes regarding health and wellbeing improvement:

**Whole system strategy to tackle childhood obesity**, including the potential for local restrictions on promotions for high calorie foods and marketing to children, as well as increasing the availability of healthy foods through public procurement.

**Physical activity and using the natural environment** - Getting everyone active every day through active travel, workplace and schools, and working with leisure providers creating 'naturally healthy' green hubs. These will promote activity for all ages in the natural environment and the health benefits of access to good quality green space.

**Place based community pilots** which will work to address variation in root causes and behaviours at a local level, tailoring approaches to build individual and community capability and resilience in that area. This will develop learning which can be rolled out elsewhere in Cornwall.

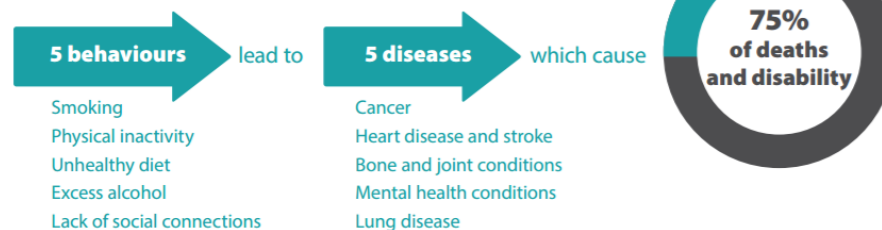
**Identification and brief advice** targeting harmful lifestyle behaviours including

smoking and alcohol consumption. This will include co-ordinated smoking prevention programmes, alcohol identification (AUDIT-C) and brief advice in primary, community and secondary care.

The key health outcomes and benefits that we expect to achieve from our changes in this area include:

- Fewer people smoke and smoking cessation services achieve increased quit rates;
- More people in Cornwall will be more physically active as part of daily life, especially in the natural environment;
- Alcohol consumption is reduced and related hospital admissions are lowered;
- Communities involved in promoting wellbeing are more economically and socially resilient;
- More people volunteering in the community, especially health and social care volunteering which can improve wellbeing and reduce social isolation.

The Live Well Model<sup>6</sup>



### Key enablers

**Aligned leadership** with a cross-partner agreement prioritising prevention across health and care system, including key outcome measures and agreed funding.

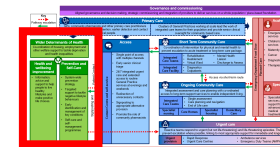
**Business intelligence and data analytics** to support targeting of interventions and monitoring of impact and outcomes

### Other TOM interdependencies

**Primary Care and Access** to help early identification, signposting and referrals to targeted programmes of support which help to address harmful lifestyle behaviours and reduce subsequent demand on the health and care system.

# Intervention: Prevention and self-care

## What we will do



We expect to deliver targeted provision for high risk groups, such as frailty and Long Term Conditions (LTC), which will enable them to better live independently and prevent health issues from escalating in severity.

While the whole system will work to help people to self-care and live more independently, we want to focus on three high impact changes in this particular area:

**Self management and self care programme:** We will create a self-care service to inform, enable and support people to manage their own care. There will be structured education programmes for Long Term Conditions (LTC) and Patient Activation Measures (PAM)<sup>19</sup> will be used to identify those able to manage their LTC and patients where more support is needed.

**Diabetes prevention programme:** Local delivery of a nationally commissioned programme to reduce progression to Type 2 diabetes compared to usual care by 26%.

**Early identification and management in Primary Care** to diagnose and manage long term conditions such as hypertension and diabetes with access to appropriate support, including provision through Integrated Care Hubs.

**Admission avoidance for high risk groups:** We will reshape our community falls prevention service and explore the introduction of a fracture liaison service to carry out bone assessments and design patient management plans following their first fall, helping to ensure recurrent incidents and the need for urgent and acute treatment is avoided. In order to reduce harm from alcohol, we could also implement an Alcohol

Assertive Outreach Team as an extension to our drug and alcohol services (DAAT) to offer more intensive support.

By delivering the interventions proposed above, we would expect to achieve the following outcomes:

- More people have knowledge and control over their own health and conditions, and know where to go for care when they need it.
- Number of injuries due to falls and hospital admissions in people aged 65+ are lowered, through improved and better co-ordinated preventative services.
- More people with risk factors (diabetes, hypertension, atrial fibrillation and hypercholesterolemia) have their conditions detected early and managed.

### Key enablers

**Aligned leadership** with a cross-partner agreement prioritising prevention across health and care system, including key outcome measures and agreed funding.

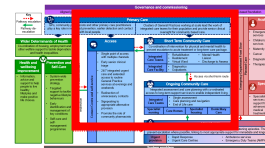
**Significant investment in order to implement proposals** – The high impact changes proposed here and in the previous two intervention areas are based on the fully engaged scenario and require approximately £20m of investment.

**Commitment across the whole system** to the principles of prevention, recognising that the financial savings and return on investment will only typically be achieved over a 5 – 10 year period.

### Other TOM interdependencies

**Primary Care** - GPs, community pharmacists and other Primary Care practitioners will play a key role in ensuring appropriate signposting, advice and access to relevant programmes to support prevention and self-care which enables greater independence and reduces demand elsewhere in the system.

**Integrated Care Teams** will need to promote and support prevention and self-care, enabling the quickest return to independence as appropriate for every individual, as well as in reach into care homes to support health and wellbeing to support avoidable admissions.



# Integrated care in the community

## Overview

By 2020/21, we will have created and embedded a new model of care built around people and their communities that brings together primary, community, mental health and social care, in order to meet the specific needs of the population we serve. Patients and users will be empowered to live independently, remain socially active and take responsibility for their own health and wellbeing; and carers will be enabled to maintain their own wellbeing to continue their caring role. Care will be consistent and efficient, avoiding duplication of effort in situations where people are seen by multiple health and care providers. Assessment, care planning and reviews will make the most effective use and expertise of clinical and professional time and resources.

### Our priority interventions

#### Primary Care

Securing the sustainability of General Practice, including delivering at scale through GP 'clusters', which is supported by a wider transformation of Primary Care.

#### Integrated Care Teams

Establishing multi-disciplinary teams of health and care professionals providing short-term and ongoing support in the community.

#### Integrated Community Hubs

Redesigning current community hospital provision to provide an enhanced offer of support which helps patients to step down to lower support, reducing reliance on care in institutional settings.

#### Housing options

Developing and investing in a range of specialised housing and supported accommodation to meet local needs which enables quicker return to care in the community and independence.

### Key system challenges addressed

**Fragmented support** results in uncoordinated care, missed opportunities for prevention, risk of 'falling through the gaps', higher costs and a negative impact on outcomes.

Ageing population with multiple and complex health and care needs will **continue to increase pressure on the whole system** if there is not a fundamental transformation in the provision of care.

The volume and quality of accommodation and community assets does not support independent living and results in **too many placements into residential care**.

**Lack of effective care and support options** in the community, at home or in the provider market, with high costs of care packages.

**Huge demand and pressure on the acute hospitals** and high reliance on expensive bed-based care.

**Too many delayed transfers of care**, where people who are medically fit to leave hospital cannot do so due to a lack of accommodation options.

### Key measures of success

ASCOF/PHOF 1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like

CCG IAF Diabetes patients who have achieved all of the NICE-recommended treatment targets (Three targets for adults-HbA1c, cholesterol and blood pressure: one target for children-HbA1c)

PHOF 4.14i/NHSOF 1.22 - Hip fractures in people aged 65 and over (Persons)

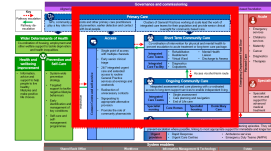
ASCOF Proportion of over 65s who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (effectiveness of the service).

NHSOF 2.2 Proportion of people who feel supported to manage their own health

ASCOF Delayed transfers of care from hospital per 100,000 population

# Intervention: Primary Care

## Our vision for 2020/21



Primary Care is at the heart of our health and care system, and by 2020/21 it will be transformed in order to provide the effective leadership, co-ordination and delivery of care required to meet the needs of people in our local communities. We will enable people to care for themselves, in their communities, and will expand the roles of community pharmacists, practice nurses, HCAs and other primary care practitioners to ease the pressure on our GPs. We will improve the provision of prevention services, early identification, self-care support and treatments, while also releasing capacity for GPs to target care on highly complex and vulnerable people. Clusters of GPs working together at scale will improve access and the range of services currently delivered in our acute hospitals; this will also include mental health and urgent care provision. Clinicians across primary care will lead the work of integrated multi-disciplinary teams providing and managing community-based support, ensuring a personalised focus on co-ordinated care and the improvement of outcomes.

## Why do we need to change?

**Demand is continuing to increase.** There has been a 15% increase in patient contacts between 2010/11 to 2014/15 and a 63% increase in telephone consultations. This increase in demand is going to continue, especially with our elderly population growing and associated complex physical and mental health needs. General Practice plays an important role in supporting people to avoid hospital admission, and this role will need to expand with an increase in the range and types of services available in a primary care setting.

**Patient expectations are also changing.** People now require a more flexible approach to service provision, requiring primary care to offer digital access, more convenient and extended opening times, and for certain patients, a longer appointment duration geared towards their specific needs. This will need funding, a change in payment mechanisms and requires Practices to work together to support their shared communities.

**The supply of practitioners will not be able to meet current or future demand.** The GP workforce has only increased by 4.75% and there are difficulties in recruiting new GPs and retaining trainees. Over 20% of GPs and 31% of practice nurses are due to reach retirement in 5 years time, adding further pressure to our local workforce needs. Fewer younger GPs are interested in become Practice Partners, seeking instead a portfolio career. This places greater risk on those senior Partners who remain, therefore we need to consider how we change the skills mix.

**The future sustainability of General Practice** - There are 64 General Practices and 54 branch practices operating largely as autonomous businesses, often operating independently of each other for their own practice population. The practice populations range significantly in size from 2,363 through to 31,362 with 40 practices having a population less than 9,000. The business model and scale at which General Practice is currently operating is unlikely to remain sustainable given changes in demand, workforce challenges and funding. New business models need to be delivered.

**An ageing estate** - Much of the primary care estate is not fit for purpose. Buildings are getting older and a lack of historic investment means they are not future-proof facilities. Housing development and population growth is not catered for, and the increasingly integrated nature of health and care mean facilities need to be more multi-functional. Whilst some practices are in good future-proof facilities, many GP Partners view their practice estate as a liability rather than an asset.

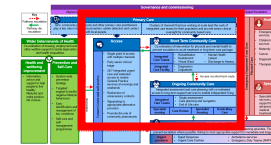
**New technologies and ways of working can help us better meet demand** through more effective self care, better prevention and early detection, better use of digital technologies, with a more flexible workforce.

**Opportunities for local commissioning of Primary Care services** - NHS England currently commissions primary care services but responsibility for commissioning General Practice is increasingly being devolved to local CCGs. Working in partnership with NHS England, and with the support of local GPs, we will strengthen the role and influence of local commissioners, and work towards securing the full delegation of General Practice commissioning of primary care services, as part of a wider reform of health and care commissioning.



# Intervention: Primary Care

## What we will do



We will work with General Practice to enable it to cope better now and gear itself for the future through a combination of immediate support, investment, demand moderation and infrastructure development.

**Releasing GP Capacity** - We will deliver the GP Forward View<sup>21</sup> 10 high impact actions to reduce admin burden and release capacity in general practice, covering active signposting, new consultation types, reducing numbers of non-attendances, developing the team, increasing productive work flows, building personal productivity, increasing partnership working, implementing social prescribing, supporting self care and developing QI expertise.

**Moderating Demand** – We will work with communities and clinicians across health and care to promote healthy lifestyles, help people to self-care, reduce avoidable demand and provide lower cost, quality alternatives to hospital based services. We will aim to ensure that no one attends the Emergency Department because they have been unable to secure an urgent GP appointment, and to offer more urgent care services through enhanced minor injury services.

**Workforce** – GP practices will work together with other NHS and care providers to create roles that attract and retain GPs and we will use the assets Cornwall and the Isles of Scilly has to attract younger doctors. With the national commitment to 5,000 extra doctors, 3,000 new mental health workers, 1,500 clinical pharmacists, and £21m investment into practice nurses and practice managers, we will support general practice to work together to capitalise upon these additional staff.

### Key enablers

**National Investment** – We will work with NHS England to ensure practices receive their share of the additional £2.4bn being invested in general practice and that our share of the additional transformation packages (worth over £500m nationally) is directed to support practices across Cornwall & Isles of Scilly.

**Estates** – Whole system estates strategy will provide options for practices wishing to divest from their estate or move to co-located points of delivery. Opportunities for making better use of publicly owned estates and developing the right estate will be appraised.

**IM&T** - The need to deliver the Local Digital Roadmap, with enabling technologies and priorities such information sharing, systems interoperability, and single care planning approaches.

**Care integration** - There will be much closer integration of specialist community and care services with GPs and other Primary Care practitioners for physical and mental health issues. GPs will play a key role in leading and coordinating Integrated Care Teams in the community.

**New models of provision** – We will support GP practices who wish to work closer with their neighbouring Practices to support a larger population base, whilst retaining their local community commitment. The Multi-Specialty Community Provider (MCP) model enables clusters of Practices to come together to support a larger local population - grouping together clusters with registered population of c15,000 to c40,000 into larger population groups of 80,000-100,000. We will enable and support scoping the delivery of care across these 6 x MCP alternative model footprints made up of 20 clusters of practices.

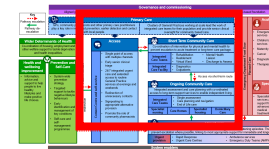
**Extending provision** – Working at scale will enable enhanced access for routine services in the evening and weekends; more flexible consultation times; an expanding range of services; in-reach to care homes; earlier detection and management of ‘at-risk’ patients; and the provision of ‘virtual wards’ for the management of frail and vulnerable people.

**Use of technology to support new ways of working** – We will deliver a coordinated GP IT strategy as part of the wider Local Digital Roadmap<sup>22</sup>, increasing the interoperability between practices and other care providers, and as part of our One Public Estate Programme<sup>23</sup>, enabling care practitioners to access their IT tools wherever they use a public sector building. Digital technology will also enable alternative modes of consultation through a range of different solutions from telephone to online consultations, telehealth and telecare, to patient activation and self-care tools and apps.

### Other TOM interdependencies

Key role across all areas of the TOM in planning, signposting, coordinating and leading care and support across the system, as well as access and patient contact, and the leadership of Integrated Care Teams providing care and support in the community.





# Intervention: Integrated Care Teams

## Our vision for 2020/21

By 2020/21, we will have created and embedded Integrated Care Teams providing shorter term, rapid and intensive care when people need it and person-centred care planning, co-ordination and navigation for people with complex ongoing needs, as well as support for their carers. This will enable us to provide the seamless service which people have told us they need - local community-based delivery to support access, co-ordination and integration of services.

Short term community care will provide an integrated, flexible and responsive approach to support people to recover from an episode of ill health, injury or life changing event, which enables a quicker return to their ordinary way of living.

Ongoing community care will help people to maintain their independence for as long as possible and enhance their quality of life through a shared understanding of needs and co-ordination of support and provision of care.

## Why do we need to change?

There is currently **no integration of community health and care teams** across Cornwall and the Isles of Scilly, with the exception of mental health.

Lack of integration in systems and delivery can lead to individuals '**falling through the gaps**' in care – e.g. primary/secondary care, health/social care, mental/physical health care. Approaches that seek to address fragmentation of care are common across many health and care systems, and the need to do so is increasing as more people live longer, with complex co-morbidities.

There are currently multiple points of access with care often feeling **fragmented and uncoordinated**. Both the Clinical Commissioning Group and the Council are purchasing ongoing care separately, even from the same providers.

The pathway **analysis around complex patients** (the top 2% of individuals by spend<sup>19</sup>) shows that they make up a significant proportion of the people admitted to hospitals and many of them are re-admitted multiple times in any one year.

Whilst there are more developed services to support discharge from hospital including the development of Discharge to Assess<sup>24</sup> locally, there is not a **comprehensive and integrated offer which also focuses on admission avoidance**.

Our current **rapid response and re-ablement** offerings are not equitable, with not enough focus on the full range of step up services to avoid hospital admissions.

There is **no standardised approach to assessment, care planning and case management** for people with complex and long term needs. Indeed, many people with these needs do not receive their health and care services in a case managed way.

Carers provide significant support to others to help them remain as well and independent as possible. In doing so, **carers provide our biggest prevention service**. We need to support and help them continue in their caring role for as long as possible.

The proposed model for short term and on-going integrated community care services is in direct alignment with the recommended proposal agreed by the Council of the Isles of Scilly to develop a 'pioneering health and social care hub'. The integrated care hub will be underpinned by the self care, healthy living and prevention agenda and a competent workforce to support the frail and vulnerable adult population on the IoS through the delivery of: Multidisciplinary assessment and planning to support care management; Nursing and high level needs residential care for those with dementia; Respite, intermediate and palliative care; Re-ablement, rehabilitation and therapy services; Outpatients, urgent care and step-up and step-down community beds. Further work will explore the options to maximise opportunities to ensure the estate is fit for purpose and sustainable. The application of new technology in relation to services, systems and the workforce will be investigated along with the development of an integrated single provider/commissioner model.

# Intervention: Integrated Care Teams

## What we will do

We propose establishing **Integrated Care Teams (ICTs)** which operate at a local level across Cornwall and the Isles of Scilly. The number of ICTs will emerge in line with the development of the Clusters of Practices model within Primary Care. ICTs will be a core component of delivering health and care support in the community.

ICTs will support people with complex learning disabilities, severe and enduring mental health difficulties and frail older people, and their carers. Risk stratification will be used to help identify and respond to more vulnerable groups.

The skill set of the ICT workforce will be competency based across health and care to meet the needs of the population, Case managers, social work professionals and generic support workers. Key functions of the ICT will include advanced clinical assessment, diagnosis and treatment.

More specialist functions may be provided at an area or county level, such as diagnostics and the creation of a Single Point of Access.

Integrated Care Teams will offer both short term and ongoing care according to needs:

**Short-term community care** - ICTs will provide the co-ordination and delivery of time limited intensive support at home or in a community facility to maximise independence and enable people to resume living at home safely.

- **Rapid response, recovery and re-ablement** to enhance step up and step down in physical and mental health.

### Key enablers

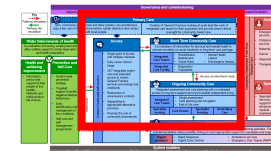
ICTs will need to develop **new capabilities and processes** to identify priorities, allocate limited resources, and test and apply innovation in local communities.

**Joined-up procuring of placements** for people with long term needs.

**Effective support for Carers** from the new Cornwall Carers Service, the independent sector and the wider community.

**Effective and timely social work practice** as measured by the strategic and critical performance indicators for Adult Social Care.

**Digital and technological opportunities** must be exploited to enable more effective information sharing to underpin shared assessment and care planning.



- **Discharge to assess** – A key priority for our transformation by rolling out an existing pilot more widely across the county.
- **Single point of contact** – To provide advice and signposting.

**Ongoing community care** – For people with a range of health and care problems which may be episodic or longer term in nature, Integrated Care Teams will effectively provide and co-ordinate support through a wide variety of sources in order to avoid people experiencing fragmented care and falling through the gaps.

Key features of ongoing community care provision will include:

- **Single assessment** of care needs with people being assessed only once as opposed to multiple assessments by different professionals. This will include more specialist support as required e.g. stroke, end of life and mental health.
- **Care navigation** with joined up planning of care and a named co-ordinator who acts as navigator and retains responsibility for the experience of the patient and their carers throughout their journey
- **Case Management** that provides patient's with the most complex needs with care and regular review to agree treatments or ongoing support requirements
- **Arranging person centred support** by engaging and purchasing care and support from a range of providers, including housing options (which is detailed as another priority intervention within this section of the OBC).

### Other TOM interdependencies

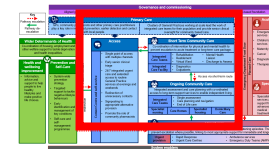
**Primary Care** - ICTs will be aligned to groups of local GP practices so that there is much better co-ordination of people at risk of deteriorating needs in a given area. It will be vital that there is a strong vertical relationship between the ICTs and the GP clusters.

**Access** – There will be a streamlined and centralised entry point to the ICTs, referred to as a Single Point of Access (SPA). It will respond to all urgent, routine and non-routine referrals.

Improving access to **urgent care and specialist services**, including the use of community hospitals, is critical to ensuring the success of the ICTs.

# Intervention: Integrated Community Hubs

## Our vision for 2020/21



By 2020/21, community bed provision will continue to play a key role in providing care to those who need it but they will be one component of an integrated care community. Our traditional bed based community hospitals will be repurposed to become our Integrated Community Hubs, which will be nursing and therapy led, enabling people to get back to their normal place of residence as rapidly as possible. They will be located alongside a range of community resources to provide people with a more holistic and integrated service quicker and closer to their homes. People will have access to beds as an alternative to admission to the acute sector where they are medically stable. The hubs will also focus on the promotion of independence and rehabilitation as part of a coordinated and integrated health and care community offer.

## Why do we need to change?

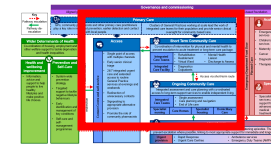
**People should not stay in hospital** any longer than is medically necessary and we want to enable a swifter return to the comfort of home when it is appropriate to do so.

Clinical evidence indicates better health outcomes are **achieved through recovery at home** or in another community setting once hospital care is no longer required. In particular, older people are less likely to return to independence the longer they remain in hospital and they are more vulnerable to hospital acquired infections.

In Cornwall, we have **high numbers of delayed transfer of care** where people remain in hospital even though they are medically fit to leave. This can prevent other patients who are severely ill from accessing acute services.

There are currently 13 community hospitals with a total capacity of 314 beds and a cost of £32m per year which are not used effectively, not fit for purpose and are not sustainable:

- **35% of community hospital bed days are being used by people who are clinically fit to be discharged.** This could indicate that we are transferring issues around capacity from the acute to community hospital setting, instead of improving the whole system<sup>25</sup>.
- **85% of admissions are from acute beds**, and have become the default discharge from hospital rather than going home. This means that the community bed provision cannot be used more to prevent escalation and avoid admission to acute hospitals<sup>25</sup>.
- Compared to most other health and social care economies, we have significantly more community beds per population and we could be **using these resources more effectively across our local system.**
- The **number and condition of our community hospital estate is not sustainable**, with major health and safety issues at some sites and considerable capital investment required across the entire portfolio to reach an adequate standard. In addition, the small scale of some sites is not economically viable going forward.



# Intervention: Integrated Community Hubs

## What we will do

We propose to reconfigure the current 13 community hospital sites by developing the new model of Integrated Community Hubs which will support the establishment of a broader service offering in the community and maximises an individual's wellbeing through joined-up place based care.

Detailed work is required to develop these proposals but we anticipate that these Integrated Community Hubs will include the following key characteristics:

- Working as an **integral part of the whole elderly care bed base** with medical cover usually from a team of GPs from local practices and specialist clinicians. They should be used for step down (after a short stay in the acute) and step up care to avoid acute admissions. We continue to explore the best locations for future provision, but these step up / step down beds could be provided on the community hospital sites or developed as part of the new housing offer.
- Providing enhanced **admission avoidance** working closely with Integrated Care Teams acting as 'Frailty units'. These will be one stop assessment centres for the frail elderly (replacing outpatient clinics), focusing on: comprehensive geriatric assessment; re-ablement and rehabilitation; prevention (co-opting third sector and community resource) and admission avoidance such as falls assessments.
- Equitable access to the Integrated Community Hubs across Cornwall and the Isles of Scilly for those patients who are not able to be discharged or cared for in

their normal place of residence.

- **Maximisation of technology** such as video consultations, creating live links for urgent care and maximising the links to third sector groups in the local community to enhance and support patient care.
- **Focus on attracting and retaining staff** by offering high quality training placements including the potential for training opportunities for community, primary care and integrated care teams.
- **Services delivered from high quality fit for purpose facilities** which addresses in the medium term the current issues relating to the quality of the environment, staffing/recruitment difficulties and efficiency. This may mean that these services can no longer be delivered from the existing sites.

We will develop a detailed options appraisal to move to a new model of Integrated Community Hubs, consulting on the detailed configuration of specific sites. This will enable us to implement the agreed model during 2018/19.

### Key enablers

**Digital and technological opportunities** to enable more effective information sharing to underpin shared assessment and care planning and quicker and easier access to specialist diagnostics and advice.

We anticipate our **future estates proposals will include release of capital** to support changes of use from community hospital to extra care/supported living.

The design and success of the new model of Integrated Community Hubs will require commissioners and providers to put in place **payments systems, governance arrangements and organisational forms which allow providers to exploit improvement opportunities** across traditional boundaries.

### Other TOM interdependencies

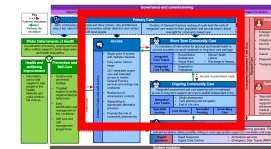
**Acute settings:** In most cases, there will only be very short stays (less than 48 hours) for older people in acute settings, with rapid transfer out to home ('home by default' approach) or to one of the community facilities for further assessment and treatment.

**Urgent Care Centres:** It is anticipated that the Integrated Community Hubs will be co-located with Urgent Care Centres to ensure workforce and financial viability, working in partnership with the acute trusts.

**Integrated Care Teams:** Integrated Community Hubs will be closely aligned to the ICTs, providing staff bases, health and social care outpatients, and services to enhance health and wellbeing.

# Intervention: Housing options

## Our vision for 2020/21



By 2020/21, residents of Cornwall and the Isles of Scilly with particular health and care needs will have improved housing options with a better supply, mix and choice of homes. This range of provision will be shaped to meet the requirements of vulnerable adults who require housing with care and support. Homes will be of good quality and will be in individuals' preferred neighbourhoods. With access to good support, advice and financing models, an increasing number of people with care and support needs will be attracted to the improved housing offer and able to take advantage of it.

## Why do we need to change?

Older people spend more time in their home than any other age group and are **more at risk of loneliness and poor health**. It is therefore essential that the place they live suits them to optimise their physical and mental health.

There has been **considerable growth in the numbers of people who need or would benefit from housing with care and support**. By 2025, we are estimated to require the following additional units of housing growth across Cornwall and the Isles of Scilly<sup>26</sup>:-

- Sheltered Housing: 4,800 - 5,100
- Housing with care (including Extra Care): 3,700 - 3,800
- Registered Care Homes – residential care: 2,200 - 2,400
- Registered Care Home – nursing care: 1,000 - 1,100
- Supported Living: 550 (by 2020)

*Note: given that approximately a third of people in residential care can manage in Extra Care, some of the future Residential Care growth is likely to be diverted to developing more Housing with Care than is set out above.*

This estimated growth assumes that our existing provision continues to be fit for purpose and that we have no closures. We know that this is unlikely to be the case, given that we have had 9 care home closures since October 2015 resulting in a net loss of 106 beds.

Addressing this growth is essential so we are able to meet our statutory health and social care needs.

We **need an expanded range of housing options in order to meet the expected growth** in demand but also to ensure that housing is affordable and effectively delivers the outcomes we want across health and social care.

Currently there is a strong community dependency on **outdated, reactive and expensive bed-based care and support packages**.

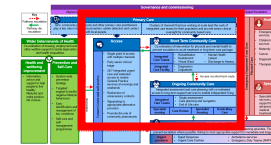
The **level and intensity of care and support should adjust flexibly** to meet needs arising from changes in health so that people can remain in their own home for as long as possible. This is vital to transform our services.

People can be enabled to live independently for longer with **increased use of technology** and thus reduce dependence on the health and care system.



# Intervention: Housing options

## What we will do



**We propose developing our range of housing options for people who need Housing with Care and Support through a series of key measures. We will develop a special vehicle to support us to scale up the growth required.**

The steps that will take to deliver this intervention include:

- Implementing our Community Based Support and Housing Strategy 2017-20<sup>26</sup>.
- Developing a robust financial model to provide a strong evidence base of how a capital investment in Housing with Care and Support will have a sector wide reduction in costs (Business Case, with opportunity costs and benefits realisation, in development and due for completion in Nov 2016).
- The programme delivery of the Housing Strategy Delivery Plan to develop the following in Cornwall:
  - Adult Placement Accommodation in the Community
  - Housing with Care
  - Housing with Support Schemes
  - Innovation technology Solutions
  - Short term accommodation

In order to achieve this, we will need investment of capital funding and land assets.

We will consider how best to utilise all public sector sites, including NHS owned sites which are no longer required for their current use, as well as seeking additional external funding from central government to support this programme. This will be managed within the One Public Sector Estate Programme.

Our establishment of an expanded offer of housing options in this way will deliver benefits including:

- **Supporting people to have a healthy, longer term independent living** by remaining in their own homes or supported in other provision within the community and **thereby reducing pressures on health and care services over the longer term.**
- **Improving outcomes for people.** There is a growing evidence base that there are significant health benefits of good housing options that suit people as they age. For example, HAPPI3<sup>27</sup> has indicated that the right models of housing could significantly impact on reducing the risk of falls and improving mental health problems.

We are also exploring the opportunities which exist in relation to land ownership and lease arrangements of registered providers in Cornwall.

It will take several years to realise the full benefits of such a programme but we will not be able to meet growing demand in a sustainable and affordable manner without radical action across the whole system.

### Key enablers

**Strong political support and local commitment** to ensure that this type of accommodation established through the housing development programme is mainstreamed and no longer seen as specialist.

**Proactive market engagement** with independent sector to ensure appropriate market place to sustain the range of accommodation options required.

The **Devolution Deal for Cornwall** will be a key mechanism for enabling us to manage our public estate locally to best meet the needs of the population.

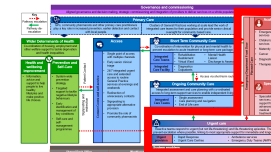
### Other TOM interdependencies

Effective use of voluntary and community sector providers in **prevention and early intervention.**

Effective **rapid response and re-ablement** community services.

**Development of wider community resilience**, including social networks and social interaction to improve quality of life and psychological and social wellbeing.





# Transforming urgent and emergency care

## Overview

By 2020/21, people with urgent care needs will receive a highly responsive service that delivers care in the most appropriate setting - centrally where necessary to deliver specialised care and locally where possible, minimising disruption and inconvenience for patients and their families. Rapid support will also be provided for those experiencing a mental health crisis. Providing urgent care in this way will ensure individuals get support when they need it, improving outcomes and helping to prevent issues from escalating. People with more serious and life threatening emergency care needs will receive treatment in centres with the best expertise and facilities to maximise chances of survival and good recovery.

### Our priority interventions

#### Urgent Care Centres

Establishing strategically located Urgent Care Centres across Cornwall and the Isles of Scilly which provide enhanced, consistent and resilient medical cover when it is needed.

#### Reconfiguring NHS 111 and Out of Hours

Commissioning an integrated NHS 111 and Out of Hours service to provide effective and co-ordinated access to information, signposting and care 24 hours a day, 7 days a week.

#### Improving flow through Emergency Department

Implementing more efficient and effective processes for how people accessing the Emergency Department are assessed and directed through to the most appropriate treatment and care which will meet their needs.

### Key system challenges addressed

**More people are using urgent and emergency care** which is putting huge pressure on local services and leading to mounting costs for the local health economy.

Many people choose to go to **Emergency Department services as the default setting** to fix problems which could be more easily accessed and better managed elsewhere.

**Complexity, inconsistency and limited workforce resilience in current urgent care facilities** does not adequately provide for clinical safety or sustainability.

**Levels of demand are impacting on effective delivery** and our urgent and emergency services are not meeting key national quality and operational standards, such as the 'Core 24' standard for mental health liaison including severe mental illness, delirium and dementia.

**Too many people are being admitted to beds for too long**, which does not deliver the best health outcomes.

### Key measures of success

NHSOF 3.1 Emergency admissions for acute conditions that should not usually require hospital admission

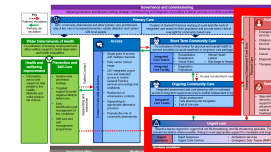
CCG IAF Emergency admissions for urgent care sensitive conditions

Emergency Department 4 hour target performance to be 95% or better

Key performance indicators relating to NHS 111 and Out of Hours, as well as access to GPs

# Intervention: Urgent Care Centres

## Our vision for 2020/21



By 2020/21, Urgent Care Centres will play a much greater role for delivering care to patients in Cornwall requiring rapid treatment for injuries and illnesses which are not life-threatening. Urgent Care Centres will include an enhanced offer of services and clinical staff, ensuring that patients are treated appropriately, rapidly, in the most appropriate setting, and without subsequent transfer to acute services. Local people will have a clear understanding of the services offered by Urgent Care Centres and they will be confident that they will receive suitable support to meet their needs. As a result, there will be fewer attendances at the Emergency Department.

## Why do we need to change?

There are currently 12 Minor Injury Units provided by Cornwall Partnership NHS Foundation Trust, one MIU provided by a GP provider in St Ives and one Urgent Care Centre provided at the West Cornwall Hospital in Penzance by the Royal Cornwall Hospitals NHS Trust. In addition many people from Cornwall access MIUs in Devon, such as Plymouth and Okehampton. These urgent care facilities are not consistent in opening hours nor the service that they provide, but are seeing sustained growth in attendances.

**More people are using urgent and emergency care** which is putting huge pressure on local services and leading to mounting costs for the local health economy. This is a trend experienced nationally but the increase is much more significant and sustained in Cornwall and the Isles of Scilly and we need to implement solutions that will meet the local needs and circumstances. The urgent care pathway must respond effectively to people with physical and mental health needs.

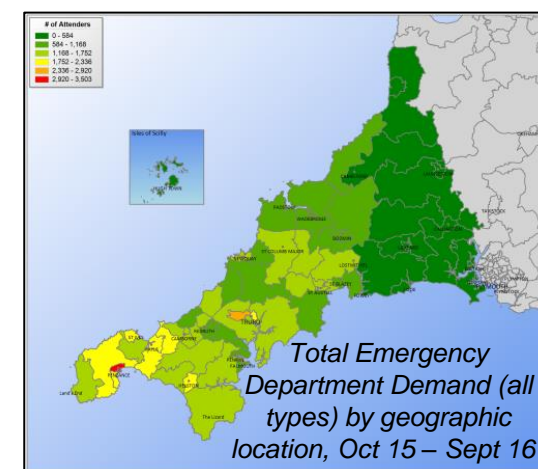
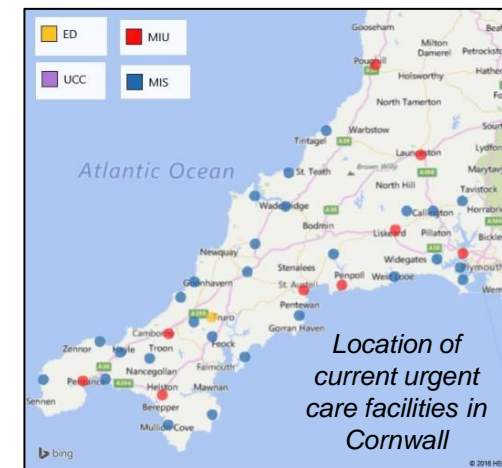
People tell us that the inconsistency in how urgent facilities operate means that they are **unclear about what services are available** and where they should go to access the most appropriate care. As a result, many people choose to go to **Emergency Department services as the default setting** to fix problems which could be more easily accessed and better managed elsewhere.

There are different levels of clinical leadership for Minor Injury Units and Urgent Care Centres, adding to the **complexity and inconsistency of current arrangements**. Minor Injury Units are led by a nurse practitioner and typically handle less serious injuries than would be treated by an Urgent Care Centre.

The **limited availability of staffing** means that the Minor Injury Units also lack resilience and appropriate workforce cover, which has led to closures at short notice and potential clinical safety risks.

**Many buildings are in an inadequate state**, with serious concerns about health and safety issues and overall building standards for a number of Minor Injury Units.

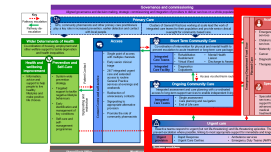
Finally, national guidance from NHS England has helped to shape how the reconfiguration of Minor Injury Units and Urgent Care Centres can lead to a successful and sustainable system.



\*Count of attenders to ED located in Cornwall

# Intervention: Urgent Care Centres

## What we will do



We propose to replace the current Minor Injury Units with a new model of strategically located Urgent Care Centres across the spine of Cornwall. The Centres will provide enhanced, consistent and resilient clinical cover to meet the urgent care needs of all residents and visitors.

We will develop a detailed options appraisal to move to a new model of Urgent Care Centres, consulting on the detailed configuration of specific sites. This will enable us to start to implement the agreed model in Spring 2018.

All Urgent Care Centres will include the following key characteristics:

- Consistent approach around opening hours and access to services;
- Provides a capability for walk-in services for patients in hours and a dedicated location providing out of hours clinics;
- Attendance through ambulance conveyancing for agreed conditions;
- Each Centre will deliver a wide range of clinical services for injury and illness above the specification currently provided across Minor Injury Units, providing access to an enhanced range of diagnostic tests.
- Where feasible, co-location with existing Emergency Department or Integrated Community Hubs to maximise the effectiveness and availability of scarce clinical resources.

There will be considerable benefits from establishing the new model of Urgent Care Centres:

- Consolidating into a smaller number of sites will provide the scale of attendances required to make an enhanced offer of clinical staff and services at each Urgent Care Centre viable.
- Consistency and reliability of service offer will improve understanding and access for residents and visitors in Cornwall.
- There are further opportunities to consolidate other services at Urgent Care Centre sites, such as round the clock prescribers and community mental health services. This aligns with the development of Integrated Community Hubs which increases local access to more specialist services and further reduces admissions to the acute hospital.

In order to achieve the improved range of care, support and reliability at each Centre, we will need to consolidate provision into fewer sites.

### Key enablers

Further development of options and consultation on configuration and specification of Urgent Care Centres

Estates review and consolidation of sites to support enhanced offer

Explore options for temporary mobile (pop up) capacity for areas where there is significant (often seasonal) demand change

Extension and clarity on the locally enhanced service in primary care for minor injury services

### Other TOM interdependencies

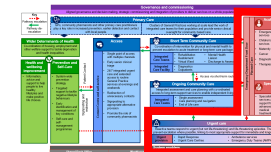
Greater emphasis on earlier and extended **primary care** availability to further manage any subsequent demand on Urgent Care Centres.

Close link with reconfigured **NHS 111 and Out of Hours** services providing urgent care advice and care.

**Integrated Community Hubs:** Many of our MIUs are currently located on community hospital sites and therefore remodelling community hospitals is intrinsically linked, to improve clinical viability.

# Intervention: Reconfiguring NHS 111 and Out of Hours

## Our vision for 2020/21



By 2020/2021, people in Cornwall and the Isles of Scilly with non-life threatening urgent care needs will get the right advice first time and access to the right service seven days a week. There will be a number of access points, including online, telephone and face-to-face, but the approach will be aligned and integrated to ensure overall consistency and effectiveness.

## Why do we need to change?

**NHS 111, Out of Hours services and other urgent care provision are not currently well-aligned, resulting in duplication of effort and a complex, fragmented experience for service users.**

**NHS 111** is the non-emergency number where advice, signposting and referrals are provided by highly trained advisors, supported by health care professionals. The service is provided locally by the South Western Ambulance Service Foundation Trust.

- There has been a huge increase in call volumes, which are approximately 17% higher than in July 2015.
- There are considerable workforce issues regarding the recruitment and retention of call advisors and clinical staff, which is causing delays to answering calls and overall responsiveness.
- The pressures of call demand and inconsistent workforce has led to a number of performance issues, including an unnecessary number of referrals to 999 services, and an 'Inadequate' rating from the Care Quality Commission highlighting concerns about safety, effectiveness and the ability to respond appropriately to individual needs.

The **Primary Care Out of Hours Service** provide clinical telephone triage, face to face appointments at treatment centres and some home visit appointments by GPs and Emergency Care practitioners for people who cannot access their local GP. The service is accessed through NHS 111 and the healthcare professional telephone line.

- There is duplication of effort and extended waits for callers, as considerable clinical time is spent re-triaging and re-grading calls which come through NHS 111.
- Some national quality requirements are not currently being met, particularly around GP coverage.
- A lack of integration with Minor Injury Units and Urgent Care Centres causes confusion and frustration for service users.

# Intervention: Reconfiguring NHS 111 and Out of Hours

## What we will do

**We will recommission a new integrated NHS 111 and primary care out of hours service to commence by 1st December 2017.**

Existing resources, including GPs, which are currently committed to a range of different contracts will be reconfigured into a more holistic service delivered by a single provider, making better use of limited workforce.

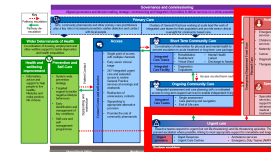
The new model will provide rapid access to patients requiring clinical advice and treatment when they cannot access their own GP.

The new provider will be expected to collaborate with other relevant providers to ensure the most appropriate and effective response for people requiring urgent advice and care.

The reconfiguration of NHS 111 and Out of Hours support will be an essential component of a wider urgent care pathway which is aligned, efficient and appropriately resourced.

It is anticipated that this new model will provide the following benefits:

- More efficient service configuration, with simplification of contact points and streamlining of services and processes;
- Improved patient understanding, navigation of the system and confidence in the advice that they receive. As a consequence, they will experience better access to the most appropriate urgent or emergency care service.
- Reduce unplanned 999 calls and 999 conveyancing by more effective triaging of calls, ensuring these resources are as focused as possible on the most urgent and life-threatening cases;
- Based on recent audits, there would be also be fewer Emergency Department referrals and attendances if calls received earlier clinical triage, helping to reduce pressure on acute services;
- Overall improvement in access to local triage, including social care out of hours, to offer speedy advice and care to enable patients to stay at home or be treated close to home.



### Key enablers

**Digital and technology opportunities** to support the range of contact channels for advice and guidance.

**'Virtual Hub'** using telephony and technology to network clinicians from different services in different locations to provide clinical triage would be one potential option to support reconfiguration. This could help with attracting more clinicians to provide telephone triage by removing the barrier of long journey times to get to work during unsocial out of hours periods.

**Strong market engagement and phased approach** to reconfiguration and alignment with other areas of the system, including Primary Care and Urgent Response services.

### Other TOM interdependencies

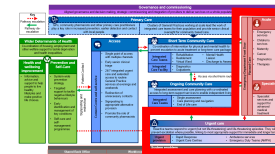
**Urgent Care Centres:** Potential opportunities to align services with Urgent Care Centres to enable broader range of access, such as timed appointments with clinicians.

**Primary Care:** Supporting the wider range of advice, signposting and treatment for patients.

Potential to build 'warm transfer' to wider range of service lines including the patient's own GP and Extended Hours GP clinic options.

# Intervention: Improving flow through Emergency Department

## Our vision for 2020/21



By 2020/21, our Emergency Department services will continue to provide immediate care and treatment when needed, with a core focus on patients who have urgent and life-threatening cases. Overall improvements in services, processes and systems will provide safer, faster and better care for those accessing the Emergency Department. This will be supported by our transformational changes in the wider system which will work to reduce the escalation of issues and better manage care and support in the community, including through the enhanced Urgent Care Centres and Integrated Care Teams.

## Why do we need to change?

**There has been considerable growth in the number of Emergency Department (ED) attendances in the last year**, increasing by nearly 10% in and out of hours, through all sources, stretching the clinical resources available.

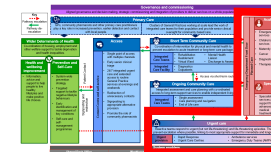
**Additional demand is creating significant financial pressure for the system.** An extra £1.1m was spent on increased ED attendances by local health commissioners in 2015/16 compared to 2014/15.

**Patients often default to using Emergency Department services due to lack of understanding and reliability of alternative services.** We need to ensure people can access the most appropriate care and treatment at the right time which offers the most effective balance between access, outcomes and use of resources.

**We want to improve the overall performance of our Emergency Department** and this will be helped by better managing demand and patient flows. We do not currently meet the national target of 95% of a maximum 4 hour wait for Emergency Department services, with performance ranging from 60% to 90%. The latest Care Quality Commission report also highlighted safety issues as a significant contributory factor to the 'Inadequate' rating of our Emergency Department. These immediate concerns are being addressed through the Emergency Care Improvement Plan.



# Intervention: Improving flow through Emergency Department



## What we will do

In the new model, we will continue to operate an Emergency Department at the Royal Cornwall Hospital at Truro, with patients in the East continuing to utilise Devon's Emergency services as required. These services will support people with emergency care needs, with the whole system working in a more integrated way to manage other urgent cases.

We will look to improve the streaming and assessment processes for patients before and after their arrival at the Emergency Department through the appraisal and implementation of several key changes in our acute settings:

- Review of the stream of medically expected and other specialty patients through the Emergency Department, with the separation of ambulatory and medical from Emergency Department patients, to reduce unnecessary queues and ensure patients are seen and assessed as quickly as possible by the right clinician.
- Review of acute medicine beds to examine our overall requirement and distribution, including the impact of planned improvements to community based care for admission avoidance and step down and a subsequent review of required acute medical resources from all providers, including mental health support.

- Expansion of direct admission from the Emergency Department to a greater number of specialty beds, which will support and drive "Patients to right bed or destination first time". This commenced in October 2016 for a much wider set of clinical conditions and pathways.
- Ensuring compliance with the Emergency Care Improvement Programme's 10 principles of effective emergency care. A gap analysis is currently being undertaken to assess further actions required.
- Deliver an enhanced team working approach across the Emergency Department with many health providers (e.g. SWAST, GPs, mental health) inputting to the Emergency Department, with organisational boundaries and handovers less visible to patients.

By working in this way, we will:

- Reduce the numbers of patients requiring admission into a hospital bed.
- Improve the overall experience of patients being treated in the Emergency Department, ensuring that they receive the right care in the most appropriate and safe manner.
- Improve the overall productivity and efficiency of the Emergency Department, ensuring the most effective use of resources.

### Key enablers

Clarity of function and improved utilisation of acute GPs to further drive admissions avoidance and improve patient flow, while ensuring the value of advice to GP prior to admission is preserved (the latter potentially through the NHS 111/OOH specification).

Improved access to acute mental health support for adults and children to help improve how these particular needs are met, with assurance and clarity of required Place of Safety.

Estate requirement review to formally assess options and benefits from co-locating all emergency assessments on one floor of the Royal Cornwall Hospital in Truro, combined with the need to potentially co-locate an Urgent Care Centre with integrated support and clear front door for patients.

Continued close working with ED provision in Devon.

### Other TOM interdependencies

**Overall system:** The wider urgent response pathway and integrated care in the community is designed to provide advice and treatment in the most appropriate setting, preventing the escalation of issues and reducing overall demand in acute settings.

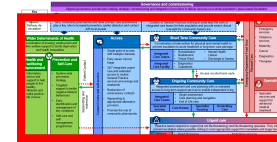
**Urgent Response:** The effective implementation of enhanced Urgent Care Centres with a clear and consistent service offer will be needed to reduce overall demand on Emergency Department provision in Cornwall.

**Access:** The integration of NHS 111 and Primary Care Out Of Hours service, providing earlier clinical triage, should reduce the number of Emergency Department referrals.

**Primary Care:** Greater emphasis on earlier and extended primary care availability to further manage any subsequent demand on Urgent Care Centres.

# Redesigning pathways of care

## Overview

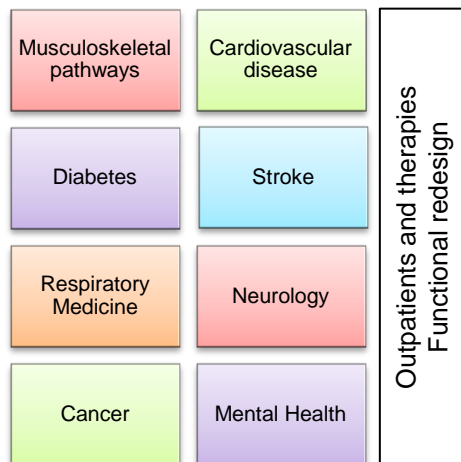


By 2020/21, we will have established cross community / provider pathways of care that maximise the health of our population. Pathways will be based on the best clinical practice, reduce variation and offer good value for money for commissioners. They will be designed to ensure that effective prevention is maximised, patients with long term conditions are kept well in their own homes and if needed secondary care services are responsive and meet the requirements of the patient. Patients will not fall into silos or between organisations but understand who is providing the care they need and in what environment. By improving our pathways, we expect to narrow the difference in life expectancy between the most and least deprived communities.

### Our priority interventions

#### Pathways

Programme of change for redesigning key pathways of care across the system, including:



#### Specialised services

Review and implementation of alternative delivery models for relevant services, such as cancer services and specialised surgery.

### Key system challenges addressed

**Higher prevalence** of a range of diseases in Cornwall compared to nationally, which drive inequalities and increased rates of health service use and hospital admissions.

**Significant differences across the county in access to appropriate levels of care**, with variations in pathways depending on GP practice and acute provider.

Demographic changes including overall population increase and an ageing population mean that we will have **insufficient capacity to meet demand** through current models.

**People are treated in silos** which can constrain joining up of information, care and transition to other support.

**Some of our outcomes are suboptimal** with key care pathways performing poorly against a number of indicators.

### Key measures of success

Reduced variation in patient outcomes

Improved patient experience and service satisfaction as a result of receiving the right services at the right time

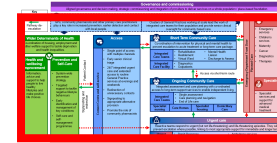
Increased number of indicators rated 'Green' against key care pathways where performance is currently sub-optimal, including diabetes, stroke, and musculoskeletal.

Improvements in key public health measures, such as obesity, diabetes and smoking prevalence

Improved access to children's mental health provision

# Intervention: Pathways

## Our vision for 2020/21



By 2020/21, our pathways across the system will support the most efficient and effective delivery of care and support for people in Cornwall. We will see a significant reduction in variation, better patient experiences, and improved outcomes, activity and costs compared with similar Clinical Commissioning Group areas.

## Why do we need to change?

**New paths of care are essential** to enable the Cornish health community to deal with the population growth and also the increasing prevalence of some diseases, such as cancer.

We will also **prioritise pathway improvement in areas where we know our performance is weaker** and the opportunities are greatest, such as stroke targeted improvement in 2016/17 and changes in the frailty model of care.

We have **moved our perspective from treating illness to keeping the person well**, increasing primary prevention and primary care to reduce demand and moving resources away from secondary care. Our pathways will ensure patients do not fall between organisations and care provision and teams across providers are integrated to improve the experience of care for the individual, such as the redesign of therapy provision.

We recognise the role that workforce redesign has in pathway development. We will ensure the use of scarce resource are targeted for those who need it most and ensure our pathways make best use of the skills of our health professionals as well as of new and emerging roles.

We need to **reform the historical outpatient model**, dramatically reduce follow-up appointments and introduce technology and solutions that better meets the needs of the population, such as increasing the availability of urgent appointments and hot clinics. Specialist clinical time can then be re-focused on the most unwell in either community or acute locations.

We will ensure that as well as determining the optimum path of care for the patient that we also consider the **optimum location, provider and facility** for the care to take place. We will right size the bed base for acute care and rehabilitation as well as reviewing the location of outpatient facilities.

The RightCare programme provides a national framework for benchmarking our performance and a methodology for improvement. We will use this approach to focus our efforts on areas where the return will be greatest for both quality and value.

We need to **strengthen the linkages between physical and mental health** to address the needs of both the physically and mentally unwell population. We know that we have a higher rate of depression (13.12%) than both the South West region (12.75%) and England (11.68%). People with mental health problems receive poorer physical health care, and those living with severe mental illness are at risk of dying on average 15-20 years earlier than the general population. They are three times more likely to attend A&E and almost 5 times more likely to be admitted as an emergency<sup>28, 29</sup>.

We will consider the implications of our ageing population on the future workload for our providers. We know that certain diseases are more prevalent in the over 65s, the leading causes of death of persons aged 65 and over are heart disease, cancer and chronic lower respiratory disease. We will need to right size our services to ensure that capacity is available to manage predicted demand changes.

# Intervention: Pathways

## What do we need to do

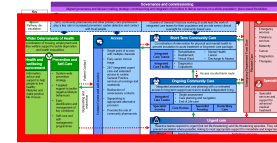
We have already begun to apply and embed pathway changes following the introduction of the Provider Consortium in 2015, we will continue the clinically led programme of change in:

- **Stroke:** Right size the rehabilitation bed base, review the model for TIA service delivery **and focus on management of atrial fibrillation in the community.**
- **Therapies:** Adopt the proposal for integrated therapy services. Work to standardise pathway care across 5 initial therapy pathways, covering Frailty, Musculoskeletal/ Orthopaedics, Respiratory, Neuro -rehabilitation and Stroke.
- **Diabetes:** Roll out the virtual clinic for diabetes across GP practices.

We will fully adopt the Right Care methodology to deliver the following pathway improvements:

- **Most significant improvements in lives saved:** Circulation; Trauma and injuries; Respiratory; Neurological services.
- **Most savings in elective admissions to hospital:** Musculoskeletal; Cancer; Circulation; Trauma.
- **Most savings in non-elective admissions to hospital:** Trauma and injury; Circulation; Gastrointestinal; Neurological.
- **Most savings in prescribing:** Neurological; Respiratory; Musculoskeletal.

When developing these pathways, we need to ensure that we are aligning them to proposed changes in the Devon STP footprint.



### Address inequalities in mental health to delivery parity of care with physical health care

Create system changes which better support our 'High complexity patients', the top 2% of individual patients that we spent most on, which would improve outcomes and costs. Headline analysis of this 'high complexity patient' cohort indicated<sup>19</sup>:

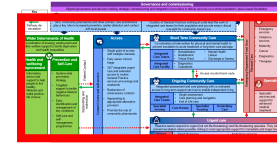
- Total of 1736 individuals costing £32m per year, which is £18k per person per annum
- Average patient had 8 admissions per year for 3 different conditions
- 90% of this cohort had an outpatient attendance per year, with an average of 10 outpatient appointments per year

**Ensure that there is capacity in the system to deal with the growth in the increasingly elderly population.** Model the changes in disease prevalence to ensure capacity is matched appropriately as well as maximising prevention.

**Modernise the outpatient service:** Develop options to deliver an increasingly responsive outpatient service, reducing follow-ups and maximising the use of technology.

# Intervention: Pathways

## What we will do



**We will adopt a programme of change for redesigning pathways of care as an early priority, which will be clinically led and delivered.**

Patient and public opinion will be sought to support the change programme. Programme Office methodology will be used to ensure that the changes are well planned and that benefits are monitored. Local and national data will be used to benchmark performance and to capture further opportunities for improvement.

We are using the RightCare methodology locally in key pathways:

- **Musculoskeletal:** Pathway proposals to increase the input of therapists with the potential to reduce demand for hip and knee surgery are under development for implementation in 2017/18.
- **Coronary Heart Disease:** Initial scoping of opportunities and workshops has shown opportunities in the nursing service and primary care management of patients. Areas for further work have been identified and will be prioritised accordingly.

Further work will be undertaken to develop these pathways, the diabetic and stroke pathway in 2016/17 and then to adopt more pathways into the programme removing variation, reducing cost and improving care.

**By ensuring care is given by the most appropriate professional** we will be able to ensure the most vulnerable receive targeted attention to increase wellbeing and reduce the need for more costly interventions e.g. improving the management of

### Key enablers

**Clinical engagement** across all providers to support closer alignment and co-ordination of activity across pathways.

**Contracting models** that are able to recompense new models of care equitably for providers.

Availability of commissioner and provider **resources** to embed pathway changes.

Improved **Information Management and Technology** to support communication between different providers of health care and patients.

diabetic patients to prevent complications such as sight loss, stroke, amputation and renal impairment.

**Out of county placements:** We have a significant gap in local provision for Mental Health service users, with rates for out of county placements more expensive and carer visits more difficult than if these individuals were supported locally.

**We will significantly reduce the number of Out of County Placements by commissioning and managing capacity locally in a more integrated way.**

There has been a **significant growth in prescribing** locally since 2014. The CCG has intervened to significantly reduce this when compared to rates in 2015. However even a small growth of 2.5% against the same period in 2015 equates to an additional £23m<sup>16</sup>.

**The best value pathways developed using the RightCare methodology will also consider appropriate prescribing with the ambition of reducing costs.**

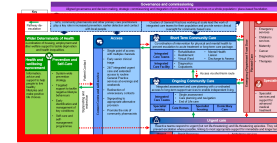
Commissioners will have responsibility for recommissioning services in line with new criteria and providers will need to take responsibility for the delivery of new pathways within the new contract terms.

### Other TOM interdependencies

Implementing optimal pathways, systems and networks of care which drive down variation in quality and health outcomes are critical for ensuring that the transformational system changes set out in the Target Operating Model are viable and sustainable.

# Intervention: Specialised services

## Our vision for 2020/21



By 2020/21 we will have reviewed existing services and implemented alternative service models where they can be shown to benefit the population for all specialised services commissioned by both local commissioners and NHS England, such as specialised mental health services, cancer services and specialised surgery.

## Why do we need to change?

We know that our geography, population size and deprivation provide us with **challenges in the provision and access to specialised services**. 58% of specialist service expenditure is outside of Cornwall and 14% is outside of the peninsula. Even where the acute aspect of care is provided outside of the county we will endeavour to maintain elements of the pathway locally.

We spend over £120 million on specialised services. It is important that this money delivers high quality sustainable services for the population. We need to find ways to **meet demand for specialised services within the funding envelope** as well as providing efficiencies. Headlines from the expenditure data are:

- £120 million is spent on specialised services - 15 % of this spend is on Cancer, 10% on neurosurgery and 10% on mental health services.
- 42% is spent in Cornwall, 44% in Devon and 14% in the rest of England.
- Specialised Children's services are largely provided in Bristol.
- Specialised mental health services represent the largest expenditure outside of the peninsula.

We will ensure that the specialised services which are provided locally are both sustainable and of a high quality. We need to be particularly mindful of the workforce requirements and local supply of highly specialised skills.

Where services do not meet national specifications (e.g. population size), we need to understand whether the quality of service is maintained for the population and what, if any interventions need to be adopted in order to continue with well governed, viable services.

We **need to sustain existing arrangements for the local provision of services** within networks, such as transfer of patients following stem cell transplants back from Plymouth to Truro and expand this model where feasible.

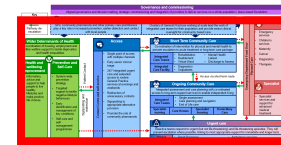
We recognise the importance of local services and will collaborate with our partner organisations in Devon to develop models that will sustain local services, e.g. aspects of specialised cardiology.

We know that **there will be growth in some specialised services**. 70% of cancer services are provided locally, bariatric surgery has a role to play in the reduction of obesity and diabetes, and there is increasing demand for specialised mental health interventions. The commissioning arrangements for these services need to reflect local priorities.



# Intervention: Specialised services

## What we will do



**We will review and implement alternative service delivery models for relevant specialised services.**

Specialised commissioning are engaging with providers to understand the opportunities for changes in service delivery. NHS England has stated their intention of working with Cornwall as one of two rural STPs to understand where and how we can link with neighbouring STPs ensuring a viable population footprint on which to plan future services.

Service reviews will be clinically led and involve all relevant stakeholders, including the strategic networks and operational delivery networks, in determining the best value option for the local population.

We will work with 'system leaders' to build new models of care with other providers such as operational networks, spoke and hub models or hospital chains with the ambition of bringing the best specialist services within reach of our population that are appropriately governed and resourced.

We will ensure that we focus our efforts on priority areas:

- Cancer services where we know the growth in the over 65's will present capacity issues;
- Children and adolescents mental health where we know the lack of facilities in

Cornwall presents difficulties for the population;

- Dermatology where we know we have issues in attracting workforce and a have a high prevalence rate for skin cancer.

Changes in technology will provide a framework on which to build more locally accessible services e.g. Skype consultations reducing the need for travel and increased telemedicine to support clinicians delivering care at a local level.

We will adopt national best practice to improve pathways of care e.g. improved mental health services.

Working with Devon, we will implement a pilot commissioning model for specialised Secure Care. This will identify opportunities to shift resource from hospital care to community pathways. Secure Pilot savings can be re-invested in to regional and local secure and general mental health pathways.

### Key enablers

Engagement with Specialised Commissioning and the Providers of Specialised Services across the peninsula

Clinical leadership

Data and analytics to support planning process

Availability of resources from providers and commissioners to support any change process and embed changes

Effective engagement with commissioners, providers and the public

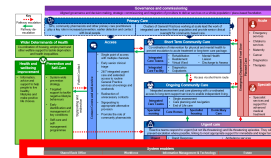
### Other TOM interdependencies

Primary Prevention

Primary Care

Wider pathways work on RightCare

Individual Trust and Commissioner plans



# Improving productivity and efficiency of system enablers

## Overview

By 2020/21, greater alignment and integration of our support functions and infrastructure will enable us to seamlessly operate as a single system on the basis of place and local populations. Shared back office functions will create more streamlined and efficient support across our organisations and collective workforce approaches will ensure that we can provide the capacity and capabilities to meet the needs of our transformed system. Improved sharing and co-ordination of information, technology and estates will lead to more effective and efficient ways of working.

### Our priority interventions

#### Shared back office

Developing and implementing a transformed back office with cross-system shared service arrangements delivering a range of support functions such as Finance, HR and Procurement.

#### Workforce

Developing system-wide workforce transformation plan; combining assets and utilising STP as an opportunity for career progression, new ways of working & retaining a mobile, motivated workforce.

#### Information Management & Technology

Adopting co-ordinated approach to supporting care organisations to reach digital maturity and connect with each other for delivery of services; enabling people to access data to inform their care.

#### Estates

Establishing a collective approach to how we plan, manage and use our estates to support efficient and effective service delivery across the health and care economy.

### Key system challenges addressed

**Fragmentation and duplication** in activities across the system due to different ways of working and organisational infrastructures.

**Lack of standardisation in processes and technology** creates barriers to working across organisations effectively.

**Difficulties in recruitment and retention** in the workforce, which is also restricted by organisational boundaries and disconnected by geography and technology.

**High levels of agency expenditure** in provider organisations and a lack of workforce resilience and flexibility across the system.

**Limited integration of information** and records leads to a lack of awareness about the patient experience across the system, which can affect the efficient and sensitive provision of care.

**Fragmented IM&T architecture** with multiple disparate systems and organisational data silos.

Some expensive and high quality **estate poorly utilised at present** and other sites are old with significant backlog maintenance issues.

### Key measures of success

Greater proportion of system spend on the direct delivery of services as a result of more productive and efficient support functions

Reduction in use of agency staff and resulting agency costs across the system

Improved rates of staff satisfaction and retention across local health and care organisations

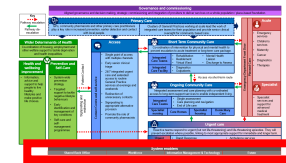
Improved digital maturity of local health and care organisations

Reduction in unoccupied or unused floor space across the estate portfolio of the system

Reduction in running costs across the estate portfolio of the system

# Intervention: Shared back office

## Our vision for 2020/21



By 2020/21, Cornwall and the Isles of Scilly's system will be supported by a transformed back office. Our corporate services will evolve in order to support and enable our transformation journey and we are mindful of sequencing our transformational agenda in the most logical manner. Our vision is to build on the solid foundations of the range of outsourced and shared services we already have in place within our footprint, to ensure we are best placed to achieve far reaching and safe service change. We will adopt a model of professional and administrative support which draws on the very best examples of delivering shared services nationally, optimises the use of technology and automation, standardises and simplifies 'in-scope' transactional activity and introduces a level of tiered service provision that will enable further efficiency savings to be realised.

## Why do we need to change?

We already utilise a range of consolidated back office functions, make use of a range of outsourced corporate services and have recently merged two of our previously three institutional provider organisations. As a result of this transaction we have in place a challenging synergy realisation plan concerning back office functions that will save £4.79 million recurrently. The scale of further challenge has been quantified in consideration of our broader efficiency challenge. Our dispersed and isolated geography presents real challenges to our ambition, whether that concerns collaboration across a larger footprint or our ability to benefit from economies of scale. We have a shared ambition to realise £2 million of recurrent savings from our back office aspirations across our STP footprint by pursuing further efficiency savings through:

**Increased efficiency** – Where services are not currently shared, back office provision is currently duplicated across our health and care system. There are numerous teams delivering very similar services in dispersed locations throughout the county. We have an opportunity to centralise support (which will also enable us to reduce our dependency on our current estate). Though a number of our services are already shared, our benchmark performance suggests there is a further opportunity to address this.

**Process standardisation** - Few of the processes we rely upon have been standardised across our system. The different organisations involved in the commissioning and provision of health and care services across Cornwall and the Isles of Scilly tend to rely on bespoke systems and processes that have evolved over time, rather than been designed.

**Improved levels of service** – Back office service performance across our system is variable. Consolidating and centralising the support services that are available to the front line will enable us to improve the quality of the support offered.

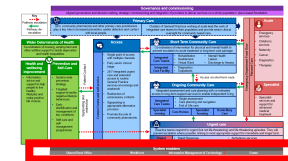
**Professionalisation** - Though our back office staff do work together to share learning at the moment, we are missing opportunities to offer a more structured approach to professional development. Consolidating provision will enable us to strengthen this, building centres of excellence for specific service areas. Similarly, because the capacity within our back office functions is dispersed, we are not offering some of the career opportunities that would be available to staff in a larger scale professional support service.

**Better technology** - Many of our back office support teams rely on systems that have been superseded by more advanced technological offers and do not lend themselves well to integration with cloud-based platforms. In some instances, we still rely on manual processing. We have yet to fully appreciate the potential benefits of adopting digital and automation as standard.

**We have pressing quality and financial challenges to address within operational services and will design our back office aspirations to ensure we are best able to support this agenda.**

# Intervention: Shared back office

## What we will do



Although our design principles require further work at a holistic level they are relatively simple: back office functions will be reconfigured to provide best practice support to operational services during a period of significant change; will be consolidated across our health and care economy; and will contribute to our challenging efficiency requirements.

- Whilst we have work to do to fully develop and define our ambition, we are committed to doing this as a partnership from a population health perspective, irrespective of the impact on organisations. We will undertake further analysis to ensure that we are challenging enough, in the context of the financial challenge we face.
- All back office functions are in scope, including: finance; HR and payroll; IM&T; procurement; facilities and estates management; governance and risk and legal services. We need to understand best practice and how that differs from our starting point and undertake a robust benchmarking exercise against our existing back office status in order to assess benefits of continuation or migration to our new shared support services.
- In order to contribute a fair share towards the efficiency agenda and offer first class support to our operational services our back office, changes will be progressed at scale and with pace, taking advantage of our emerging contractual joint vehicle by utilising this in advance of our journey towards an Accountable Care System.

- We have work to do in order to understand our desired end state with the primary stimuli being to enhance our analytical capabilities; our financial and economic modelling capacity; develop professional intrigue and an environment of positive challenge.
- We understand that we will need to consider the volume of activity that our future shared service will be dealing with and will consider whether this warrants greater cross-border collaboration with other footprints in the South West or whether one of the existing national shared service providers might be the right option for our future plans.

Although we are yet to fully appraise the options available, our future model of provision will deliver benefits for local people and the health and care system as a whole by:

- **Improving efficiency** – By reducing duplication, streamlining our approach, improving effectiveness and taking advantage of economies of scale, we will improve efficiency and deliver significant financial savings.
- **Ensuring there is greater resilience** – Centralising our support functions will enable us to respond more effectively during periods of peak pressure and provide greater cover across our back office functions.
- **Providing expert advice and support** – The new arrangement will enable us to improve the quality of the support services we offer by enabling more senior members of staff to specialise in particular areas, rather than being notionally responsible for several services at once.

### Key enablers

**Significant investment to establish shared service** – Funding will need to be secured to cover redundancy payments, other potential amendments to terms and conditions, office and accommodation costs, business process reengineering costs and investment in technology and systems.

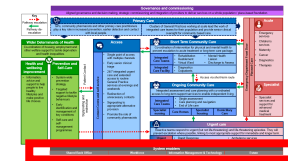
**Technology** – Current systems will need to be replaced or integrated to support the shared service, requiring considerable developer capacity and supplier support.

**Workforce** – While many current staff would transfer to our shared service, in many instances a substantial level of retraining and skills development will be required. Similarly, the shared service will need to build in organisational development capacity of its own to help develop a coherent culture and approach.

**Estate** – Depending on the decisions we make about using existing providers and/or collaborating with other footprints and organisations, we may need to remodel aspects of our shared estate to facilitate the centralisation of key functions.

# Intervention: Workforce

## Our vision for 2020/21



By 2020/21, people working across health and social care will focus on providing safe, effective and person-centred care to support people to live longer, healthier lives at home and in a safe setting. We will do this by adopting new ways of working, being flexible and working together to reduce duplication in effort, increasing both patient and staff satisfaction. We will collaborate across organisations to establish seamless career pathways and inform educational institutes of new curricula to support these with the intention of developing, retraining and retaining a skilled and motivated workforce.

## Why do we need to change?

The health and social care workforce represents 1 in 10 of the working population in Cornwall and the Isles of Scilly. Our staff are our most valuable assets, representing between 60%-70% of our total resources. However, there are some significant system-wide workforce challenges which potentially undermine our ability to deliver both sustainable services in the current model as well as a transformation of the health and social care system.

Our key workforce challenges include:

- It is **difficult to recruit to a number of key qualified and non qualified roles**, particularly qualified nurses, GPs, geriatricians and social workers with acute shortages around home carers. There are also problems retaining staff in some areas, with turnover levels as high as 36% for care workers, nursing and health visitors. The average staff turnover level in the health sector in Cornwall is approximately 12%.
- We also have an ageing population with a **significant proportion of our workforce who are shortly going to retire**. This is particularly the case across community nursing and GPs and we do not have the capacity coming through to replace staff that retire. Those aged 24 and under represent 10% of the workforce, with those over 60 representing 15%. However, we have oversupply of staff in other parts of the workforce, such as Pharmacists. We need to explore opportunities for areas of the workforce to be more flexible.
- There are **high levels of staff dissatisfaction and absence levels** and it is reported that many people are feeling undervalued. This is exacerbated by the five year pay restraints, significant increases in demand and complexity of work.
- The **seasonal nature of the unqualified labour market** exacerbates workforce pressures and capacity issues at key times of the year where there is significant movement in people changing jobs.
- There is a **misalignment between existing ways of working and the needs of patients**:
  - There is a disparity between health and care sector Terms and Conditions. This can make the creation of integrated teams more challenging as well as resulting in competition for staff across organisations.
  - The Terms and Conditions do not allow for people to work across organisational boundaries at a time when we are trying to change the model of care to be much more flexible.
  - There have been significant increases in the use of agency resulting in the further inflation of staffing costs.
  - The workforce is also disconnected by geography and technology.

# Intervention: Workforce

## What we will do

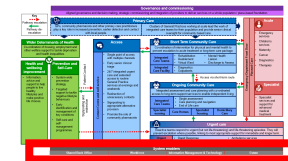
We will develop a whole system Workforce Plan for Cornwall and the Isles of Scilly with clear implementation timescales and joint governance to oversee delivery. We will undertake workforce modelling aligned to new place based models of care and financial constraints.

The integrated and system-wide workforce transformation plan will focus on the following areas:

- We will gain an enhanced understanding of the composition of the existing wider health and care workforce;
- We will research into successful workforce models and good practice developed elsewhere;
- We will develop a career framework that crosses organisational and sector boundaries;
- We will collaborate to improve our ability to recruit the best people for every health and care role;
- We will develop the workforce to be the best they can;
- We will work together to improve the retention and engagement of our workforce.

To support the interventions described to change the model of care we will facilitate:

- Shift from specialist to generalist roles across the system utilising tried and tested models such as the Calderdale Framework;
- Introduce a Workforce simulation model (WRaPT) to assist with the future planning of our workforce;
- Support the development of multi-disciplinary and multi-agency team working across organisations with intuitive education and training programmes;
- Align the needs of our population to the skills required and analyse current and new roles to fulfil those needs;
- Support the development of whole-system pathways of care; mapping current state, learning from best practice sites and implementing within Cornwall;
- Inform education institutions as to future role requirements and training/accreditation required to develop a responsive and sustainable integrated workforce.



### Key enablers

**Robust transformational leadership programme** leading to a culture of change-ready, empowered and innovative staff.

**Further developed and sustainable voluntary and independent sector** who can continue to support our communities once the need for medical interventions has been fulfilled.

**Organisational development and talent management system** across Cornwall to provide an opportunity-rich environment.

**Person-centred model** acknowledging the asset-rich community already in existence and how a shift from traditional, paternalistic care is the desired future state.

### Other TOM interdependencies

New, placed-based model of **integrated care in the community**, aligning multi-disciplinary teams to work collaboratively with existing support networks.

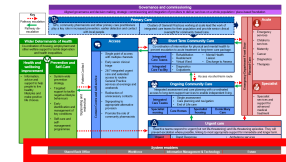
**Robust IM&T strategy** to support new ways of working and training/development.

**Estates** which facilitate the co-location of a multi-disciplinary workforce.



# Intervention: Information Management & Technology

## Our vision for 2020/21



### “One Person, One Digital Record”

By 2020/21, all care professionals will have immediate access to an integrated digital care record underpinned by an information sharing solution that removes ambiguity, confusion and barriers to “safe sharing” between care professionals, organisations and local people.

Information Management & Technology will provide an innovative, flexible and collaborative set of technologies that will deliver commissioning priorities and be a key enabler of new models of care to meet the needs of our population.

We will have a “whole system” approach to our Enterprise Architecture based on common open technology standards set across the Cornwall Footprint.

## Why do we need to change?

As a health and care system, we have a **fragmented Information Management & Technology architecture** with multiple disparate systems and organisational data silos. This makes sharing information across care settings complex and confusing, creating a frustrating experience for care professionals and service users. It can be **difficult to establish a single view of all various care interventions** and the service user is often required to repeat their story multiple times or supplement the information available as they navigate along their care pathway. Enabling care partners to access shared care plans, end of life preferences, risk assessments for vulnerable children and adults and routinely share these with other care professions will enable the new models of care.

The **IT system landscape has evolved over many years** with each care organisation investing independently in best of breed “point” solutions to meet its own specific requirements. This has created a complex care landscape built on a mixture of new and legacy technologies that are not readily capable of sharing information and are incompatible in some cases.

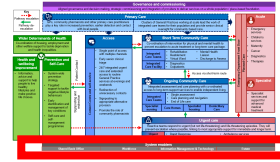
The different organisational boundaries means there are areas of overlap creating **duplication as well as gaps in the information flow**. This has led to a variable experience for care professionals and service users with the need for repetition and an increased risk of information being missed. Although progress has been made in recent years to improve interoperability between systems within the same care setting, information sharing between organisations has been hindered by technical incompatibilities, process design, organisational policy and culture.

IM&T platforms do not currently deliver the desired levels of interoperability between care settings and need considerable investment. Each organisation has responsibility for its own IM&T architecture. Royal Cornwall Hospitals Trust does provide infrastructure support services for Health partners covering application hosting, data storage, a single Community of Interest Network (CoIN), cyber security and end-user device management. However, each health organisation is responsible for setting its own application strategy and system portfolio. Cornwall Council currently deliver infrastructure services and applications independently of health partners. **Separate strategic planning, commissioning and use of IM&T** means that we are not using our combined investments in technology to create a single joined-up infrastructure capable of supporting collaborative working between care professionals and information sharing across care settings.

All our Secondary Care organisations are below the national average for a number of the Universal Capabilities (as defined by the NHS England Digital Maturity Index). The **continuing dependence on paper based records and manual intensive ways of working** are major obstacles to increasing digital automation and interoperability between systems and care settings.

# Intervention: Information Management & Technology

## What we will do



We will support all care organisations to reach digital maturity and connect with each other for the delivery of services, as well as enabling people to access data to inform their care.

Build the foundations: All care organisations need to reach digital maturity. We will:

- Provide technology leadership, governance and design authority through the newly formed Digital Care Cornwall board of CIOs and CCIOs.
- Implement an information sharing solution that removes ambiguity, confusion and barriers to the “safe sharing” of information between care settings.
- Significantly improve the digital maturity of all our care providers by 2018 through the deployment and sustained take-up of the nationally mandated NHS England “Universal Capabilities” and innovative use of enabling technology and standards.
- Create ‘one public infrastructure’ enabling staff to access care systems across NHS and Council facilities in Cornwall and the Isles of Scilly and Devon.

Leverage the capability: Connect all the digitally mature organisations. We will:

- Procure and deploy the infrastructure which enables information exchange between organisations to create a consolidated view of records held for a person.
- Provide the enabling technology to support Integrated Care in the Community and Transforming Urgent and Emergency Care.

- Interoperability between care settings to enable information to flow between care settings safely and securely to care pathways and ensure that all transfers of care between care settings are digital and seamless.
- “Virtual” consultations & triage to provide people with the choice of remote access to care professionals and delivery of Virtual Hubs for Out of Hours services.
- Increased use of digital channels for patients to be able to directly transact with care providers including bookings.
- Digital Support at Home and in the Care Homes by extending the reach of care professionals through the increased use of assistive and monitoring technology and the provision of interactive tailored Prevention and Self-Care programmes.

Exploit the opportunities: Enable citizen access and harness the data. We will:

- Create a single view of the records held for a person and provide people with the ability to access and upload information to their integrated digital care record.
- Support the delivery of safe, high quality care by embedding best practice pathways, protocols and clinical decision support into our digital care systems.
- Provide commissioners and care providers with integrated real time care system intelligence and predictive analytics to enable proactive management.

### Key enablers

**Significant investment** using the additional national funding available for IM&T development.

**“Whole system” Leadership and Governance model** – Including co-ordinated IM&T strategy and single Information Sharing Agreement.

**Improving the capability and capacity of IM&T** by sharing skills, expertise and infrastructure between organisations.

**Innovation** - We will actively seek to provide innovative and effective solutions by exploiting the enabling capabilities of technology.

### Other TOM interdependencies

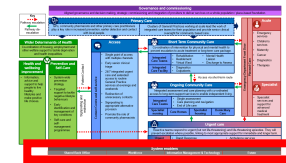
Key role across all areas of the Target Operating Model in providing the enabling technology for care professionals and people to access, share and process information from different care systems and settings.

Key role in the provision of an integrated digital care record.

A more strategic and joined-up approach to IM&T across the care settings will support the delivery of clinical and business capabilities for Integrated Care in the Community and Transforming Urgent and Emergency Care.

# Intervention: Estates

## Our vision for 2020/21



By 2020/21, our estate will be collectively planned and organised to effectively support the new ways of working that we are developing across the whole system in Cornwall and the Isles of Scilly. Our enhanced focus on community-based care will mean we need to consolidate and use our existing estate differently with properties that are fit for purpose and adaptable. By working collaboratively together, we will maximise the efficiency of our estate, ensuring it is utilised as much as possible and configured to best meet the needs of the local population.

## Why do we need to change?

As a health and care system, we have a large estate portfolio with significant variation in size and utilisation, which includes:

- 1 secondary / tertiary care teaching Hospital Trust within the county
- 21 ambulance bases
- 2 private hospitals / treatment centres
- 100 pharmacies
- 13 community hospitals / Minor Injury Units and 17 other community health facilities
- 254 care homes
- 64 GP practices operating from 129 premises
- 14 mental health properties

**Lead responsibility for the health estate (excluding GP surgeries) sits with four organisations:** Royal Cornwall Hospitals Trust, Cornwall Partnership NHS Foundation Trust, Community Health Partnerships and NHS Property Services. Separate strategic planning, commissioning and use of estates means that we are not using our properties as effectively as we could to support effective clinical delivery.

**Several sites are not fit for purpose and would require considerable maintenance investment.** For example, several Health and Safety issues have been identified at some of our Minor Injury Units. When last assessed, the majority of community NHS sites had condition ratings of B/C or poorer. Some sites would not be possible to bring up to acceptable levels of functional suitability regardless of the amount of investment made. There is also a significant backlog of maintenance liability across the whole estate.

Our proposed system transformation and new models of care will require fundamental estate changes in order to be successful:

- Shift from acute into community settings.
- Optimisation of primary care provision dispersed across the wide geography of Cornwall and the Isles of Scilly.
- Co-location of more services in strategically located areas in order to enable more streamlined, enhanced and effective delivery for patients and service users.
- Upscaling of the development of housing options to increase capability and capacity to relocate activity from acute and community hospitals.
- Integration of health and social care.

# Intervention: Estates

## What we will do

We will aim to integrate strategic property management functions through the development of our shared back office proposals.

We will explore opportunities to devolve assets locally to assist with the delivery of the STP plan as opposed to them being retained by NHS property services.

In order to support the implementation of **integrated care in the community**, we will focus our estates strategy on:

- Developing supported housing and key worker housing to support local priorities
- Exploring how primary care can transform and operate at scale supported by Estates & Technology Transformation Funding and Private Public Partnership models. Innovative ownership models are to be developed.
- Rationalising community hospitals with targeted investment for modernisation once the future model is confirmed.

In order to support the implementation of **urgent and emergency care**, we will focus our estates strategy on:

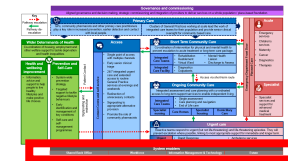
- Establishing a single co-ordinated urgent care system delivered through effectively positioned sites to deliver safe and efficient services, which is likely to result in streamlining some of the Urgent Care and MIU estate

### Key enablers

**Information Management and Technology** – integrated systems to facilitate co-location and reduced dependency on physical properties.

**Leadership and aligned governance** to support collective decision-making regarding the use and responsibility for estates

**Retention of capital receipts locally** – disposals receipts need to be retained locally to help fund the significant investment requirement needed to transform the health and social care estate into one which is sustainable and fit for modern health care provision, to the benefit of the Cornish people.



- Capital investment in the acute hospital Emergency Department to facilitate the new urgent care spine linked to integrated 111 and Out of Hours.

In order to effect systems savings, efficiencies will be driven by :

- Working towards the Lord Carter estates targets on unused and underused space, back office consolidation, non clinical space and estates and facilities running costs.
- Intelligent use of shared resources, both back and front of house across the primary care and community estate.

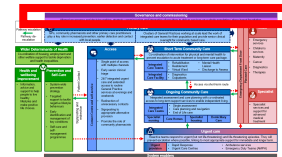
In the longer term, we will also consider:

- How improvements in technology can further support the consolidation and reconfiguration of our estate, for example the use of virtual hubs and digital consultations.
- Opportunities for co-location to support implementation of key areas of the Target Operating Model, including wider shared back office functions and options for a consolidated main point of access for information, advice and referrals across the whole health and care system.

Investment will be required in terms of both non-recurring revenue and capital to effect estates change in order to reconfigure the acute estate, develop a simplified Urgent Care Centre offering, rationalise and modernise the community estate and transform the primary care and social care estate. The level of investment will be determined by the STP as models of care and estates configuration develop. All possible funding streams including PPP will be pursued.

### Other TOM interdependencies

A more strategic and holistic approach to estates across the system will support the realisation of other key areas of the Target Operating Model, particularly the delivery of integrated care in the community away from more acute hospital settings.



# Using strategic levers for better care

## Overview

By 2020/21, organisations across our system will be much more closely integrated and aligned in how services are commissioned and provided, working together to support the best outcomes for the people of Cornwall and the Isles of Scilly. By pooling our strength and resources, as well as sharing decision-making and accountability, we will improve how we strategically manage and influence the system overall. As our new model and ways of working mature, more transactional planning, commissioning and management activities can be devolved to levels which are even closer to the populations served.

### Our priority interventions

We are still working through what the best models for our future system will look like, but our work will include an exploration of MCPs and Accountable Care Systems.

#### Provider reform

Potential development of an Accountable Care System to drive improvements in care and reduce overhead costs.

#### Commissioner reform

Move towards more strategic, aligned and place-based commissioning across the system.

### Key system challenges addressed

**Fragmented planning and delivery of services** due to operating as separate organisations, leading to reduced outcomes for local people.

**Duplication of effort and costs** across the health and care system.

**Lack of co-ordinated approach to monitoring outcomes and impact**, with limited understanding of the end-to-end impact of strategic decision-making on the whole system.

**Inconsistency in establishing and managing organisational priorities** which prevents the whole system from maximising the impact of its total resources.

**Disconnect between providers and commissioners** regarding the availability and use of local resources .

### Key measures of success

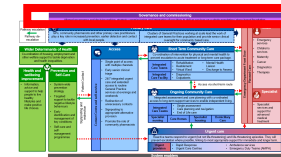
Provider and commissioner reform are key to achieving an effective, integrated and sustainable system in the future. Measures of success can therefore be drawn from all areas of health and social care.

Key tangible areas showing the delivery of the transformation we need could include:

- Reducing the number of inappropriate referrals
- Reducing the cost of care packages
- Reducing GP levels of activity where other, more appropriate, support could be provided
- Minimising delayed transfers of care
- Reducing spend on medicines and prescribing
- Reducing the number of Emergency Department presentations and admissions
- Reducing demand for elective hospital services

# Intervention: Provider reform

## Our vision for 2020/21



By 2020/21, we will have established and embedded a new model which enables more efficient and effective co-ordination of delivery across multiple organisations and will drive improvements in care and reduce overhead costs. Our organisations will work closely together with shared ownership and accountability for the delivery of improved health and care outcomes across Cornwall and the Isles of Scilly.

## Why do we need to change?

### Current context

Current providers include: Royal Cornwall Hospitals Trust, Cornwall Partnership Foundation Trust, Cornwall Council, Ramsey Healthcare, GPs, GPs as specialist providers; South Western Ambulance Service Foundation Trust; care sector providers; and the voluntary sector. Plymouth Hospitals and North Devon HealthCare NHS Trusts provide services to approximately 20% of the population and Cornish patients receive very specialist care from tertiary centres, such as Bristol and London.

The two large acute providers are in financial deficit; primary and social care sectors are under significant financial and operational pressure; and Cornwall Partnership Foundation Trust has recently doubled in size following community services acquisition resulting in facing new business challenges.

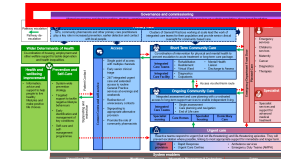
These characteristics, combined with the financial outlook, scarcity of labour, rising demand and increasing co-dependency are such that we must act together to streamline provision and offer more integrated care.

We need to put the interests of our patients and public ahead of any individual interest or organisational protectionism. Providers have committed to work together and in tandem with commissioners we will implement a new model, such as an Accountable Care System, to drive improvements in care and reduce overhead costs.

### We will adhere to the following design principles to ensure reform is timely and effective:

- Organisation form will support the future care model, set out in the STEP and active desired outcomes (quality, experience, cost).
- The development path should be clear, but recognise the stages of maturity of different partners.
- Must achieve 20% productivity and efficiency improvement.
- Be delivered with minimal disruption, with particular regard to impact on patients and staff.
- Be as simple as possible and be legally compliant, but not bound by risk adverse interpretation.
- Be consistent with the development of a strategic commissioning function and absorb tactical commissioning over time.
- Develop in parallel to the reform of acute and specialist services across the Peninsula.





# Intervention: Provider reform

## What we will do

**We will explore the development of an Accountable Care System to drive improvements in care and reduce overhead costs.**

The mechanisms by which integrated service delivery can be achieved range from acquisition/merger through to informal partnership arrangements, with various contractual alliances in between. There is no single solution which can be adopted from elsewhere, although other health and care economies are more advanced. We will therefore learn from good practice in other areas as we go forward.

An Accountable Care System is one possible model for Cornwall and Isles of Scilly. An ACS is primarily a vehicle through which the various partners agree to contract together to take shared ownership and accountability for the outcomes set by Commissioners. Normally an ACS will be funded through some type of capitation budget and will incorporate sub-contracting and tactical commissioning.

Our actions to achieve a new model of co-ordinating delivery by 2018/19 will build on the work of the existing Provider Consortium and will include:

- Kernow CIC, Cornwall Partnership Foundation Trust, Royal Cornwall Hospitals Trust and Social Care will renew our Collaboration Agreement setting expectations for the development of the ACS. Devon NHS Trusts will also be part of our planning for patients in the East of the County.
- Our Agreement will be underpinned by contractual joint vehicles for particular projects, with our first priority being Urgent Care.

- Cornwall Partnership Foundation Trust and Kernow CIC will continue to develop integrated care teams in localities, enabling more people to be supported in the community.
- Other partners, such as the South Western Ambulance Services Foundation Trust and the voluntary sector, will be active partners for relevant services.
- We will implement various joint working models such as shared services, clinical service redesign, and joint workforce deployment.
- Our Boards will come closer together, taking more joint accountability for health outcomes and budgets.
- Providers will subsume tactical commissioning over time and have greater freedom to flex resource across pathways.

The form of organisation will change over time and is not an end in itself. We expect that as primary care and localities mature, community and primary care will be fully integrated offering a greater range of services, only using acute and specialist services as part of defined pathways.

### Key enablers

**Commitment from each Trust Board or Governing Body** which will drive reform with confidence.

**Relevant supporting contracts and legal agreements.**

**Staff engagement, innovations and support** so that reform is underpinned by operational knowledge and expertise.

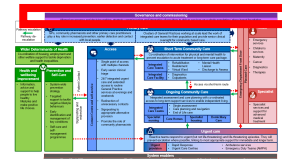
### Other TOM interdependencies

Provider reform is the umbrella for much of the change set out in this Outline Business Case. As partnership working matures, service and care transformation will be easier to embed, as many of the current organisational and financial barriers will be removed.

Provider reform must be fully aligned with Commissioner Reform and be underpinned by new contract and finance models.

# Intervention: Commissioner reform

## Our vision for 2020/21



Health and social care commissioning will be joined up, through a commissioning partnership with staff, processes and governance, focused around the needs of the population we jointly serve. Our commissioning strategy will set the high level outcomes for the place which in turn defines and shapes our approach to working with providers and local communities. Our success in this will be measured by the achievement of shared outcomes and the delivery of the triple aim – improved population health, improved experience, and reduced cost per capita. We will have shifted more resource away from managing the consequences of ill health to supporting people to remain healthy, promoting self-care, increasing community resilience and independence, with a core offer that provides responsive, community based services when needed.

## Why do we need to change?

**Financial pressures** – Both health and social care commissioners are facing huge budgetary pressures. We need to ensure we maintain core services whilst finding the way to reduce expenditure and live within our budgets.

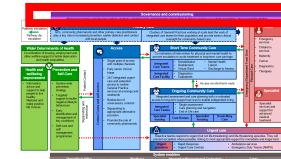
**Fragmented planning** – Health and social care commissioning is fragmented across a range of NHS and Local Government bodies. This promotes disjointed planning, procurement, and contract management and evaluation, and risks creating gaps, duplication and confusion in processes. It also encourages fragmentation in the provision of services.

**Targets versus outcomes** – Health and social care commissioners serve a common population, and yet do not work towards a shared set of population outcome measures, so are not guided to achieve the same outcomes. Often commissioners focus on short term targets and not longer term outcomes.

**Population outcomes** – We benchmark regionally and nationally as having some of the worst clinical and social inclusion outcomes for a range of long term conditions.

**Conflicting regulatory frameworks** – Working to different rules, health and social care is funded differently and subject to different performance management regimes. This means that whilst serving a common population, our priorities may vary.

**Budgetary accountability** – Decisions about what care and support people need is made at an individual level by provider organisations and their staff. However, the financial consequences for such decisions are often not borne by the provider, but the commissioner. This does not align decision making responsibility with budgetary accountability.



# Intervention: Commissioner reform

## What we will do

We will work together to move towards more strategic and aligned commissioning which is focused on Cornwall and the Isles of Scilly as a place, rather than bounded by existing organisational responsibilities.

**Place based commissioning** – Cornwall and the Isles of Scilly is a place. Health and Social Care commissioners will take responsibility for all public funding, and work together to deliver within the defined place based budget for Cornwall and Isles of Scilly.

**Shared outcomes** – We will measure our collective success through shifting patterns of spend away from institutional care settings to community based services, focusing relentlessly on achieving agreed and shared outcomes.

**Convergence** – We will strive to reverse the fragmentation of commissioning process, resources and practice, and our approach to commissioning will support providers to deliver integrated services in the communities.

**Devolved accountability** – We will seek to locate budgets and accountability with the place where decisions are made. Our commissioning practice explicitly understands risk transfer and the conditions supporting risk management, which is then owned by providers.

**Assets and resources** – Our commissioning responsibility will remain more than just shaping revenue and capital expenditure – it is also about direction and making the best use of all assets, our workforce, estates and knowledge.

**Maintaining core services** – We will work together to define and preserve the core NHS and council offer to the public that we can afford, whilst allowing sufficient flexibility in local delivery to meet varying population needs and circumstances.

### Key enablers

**Governance** - We will strengthen governance within and between organisations, and will work together across health and social care to drive delivery of our aims.

**Market development** – We will establish a single route to dialogue with the provider sectors we share, and agree a shared approach to the management and development of the shared market sectors.

**Commissioning intentions** – We will develop a single set of commissioning intentions for health and social care from April 2017 onwards.

**Estates** - We will continue to enable our teams to work from each others' facilities, and seek to collocate staff working on shared commissioning priorities, through joint delivery of the One Public Estate programme.

**IM&T** – We will continue to jointly support the development of the Cornwall Digital Health Strategy.

**Workforce** – We will seek out opportunities for our teams to learn and develop together, and recognise the importance of strong relationship and trust.

### Other TOM interdependencies

#### Linked to enabling workstreams:

- Estates
- Information Management & Technology
- Workforce, Leadership and Development
- Communications and engagement



## 5. Implementation plan

This section presents our anticipated roadmap for realising the system transformation that we have described through the priority interventions. It provides high-level considerations of the phasing of implementation, recognising that key elements of the future system must be implemented and embedded before other areas of transformation can proceed so that the safety and quality of people's care is not compromised.

For each priority intervention, we set out when each of the key changes will be established across the five years of the Sustainability and Transformation Plan timeline. Due to the interdependent nature of the proposed changes, we need to co-ordinate implementation in order to maximise benefits and achieve the best use of resources across our health and care system.

More detail is provided on activities for the remainder of 2016/17 and 2017/18 than later years due to the proximity and urgency of the changes needed. Further work on specific implementation plans for each priority intervention, as well as the phasing of implementation over the STP period, will be undertaken as we further refine and engage on our proposals over the coming months.

		2016/17	2017/18	2018/19	2019/20	2020/21
Radical upgrade in population health and prevention	Wider determinants	<ul style="list-style-type: none"> <li>• Delivery of Headstart - emotional resilience in schools</li> <li>• Refresh of CAMHS transformation plan</li> <li>• Increased team to support healthy workplace programme and Making Every Contact Count training.</li> <li>• Development of ESF employment programmes and implement (Jan 17)</li> <li>• Delivery of fuel poverty (central heating fund )</li> <li>• Strategic Housing Review underway.</li> </ul>	<ul style="list-style-type: none"> <li>• Preparation for procurement of Integrated Children's Services</li> <li>• Delivery of CAMHS transformation Plan (perinatal/infant mental health; IAPT)</li> <li>• Prepare for further devolution deal (fuel poverty; housing)</li> <li>• Develop business for Housing Strategy</li> <li>• Implementation of improving access to employment programmes (ESF).</li> <li>• MECC roll out</li> </ul>	<ul style="list-style-type: none"> <li>• Procurement of Integrated Children's Services</li> <li>• Implement Housing Strategy and capital programme</li> <li>• MECC roll out</li> <li>• ESF employment programmes underway</li> <li>• Delivery of devolution deal</li> </ul>	<ul style="list-style-type: none"> <li>• Delivery of integrated children's service</li> <li>• Review of improving access to employment (ESF)</li> <li>• MECC roll out</li> <li>• Implement Housing Strategy and capital programme</li> <li>• Delivery of devolution deal</li> </ul>	<ul style="list-style-type: none"> <li>• MECC roll out</li> <li>• Implement Housing Strategy and capital programme</li> <li>• Delivery of devolution deal</li> </ul>
	Health improvement	<ul style="list-style-type: none"> <li>• Development of a prevention and primary care framework</li> <li>• Development of system leadership for Childhood obesity and physical activity.</li> <li>• Research and innovation phase of environment and health hubs</li> <li>• Appointment of capacity support for community and voluntary sector and place based pilots</li> </ul>	<ul style="list-style-type: none"> <li>• Identification and Brief Advice (IBA) in care pathways</li> <li>• Implement Childhood obesity whole-system approach &amp; Sugar Tax in place by Sept 2017</li> <li>• Implementation of environment and health programme (LNP)</li> <li>• Coproduction and innovation pilots with community and voluntary sector</li> </ul>	<ul style="list-style-type: none"> <li>• Managed networks for early identification and management in primary care (CHD)</li> <li>• Physical Activity in Schools programmes</li> <li>• Preparation for devolved budget for health and well being (community and voluntary sector).</li> <li>• Delivery of weight management services</li> </ul>		
	Prevention & self care	<ul style="list-style-type: none"> <li>• Establishment of prevention champions group</li> <li>• Proposal submitted to NHSE for Diabetes Prevention Programme</li> <li>• Development of Business case for Self care and self management programme</li> <li>• Business case for admission avoidance</li> </ul>	Implementation of programmes: <ul style="list-style-type: none"> <li>• Diabetes prevention programme</li> <li>• Self care and self management</li> <li>• Fracture Liaison Service</li> <li>• Alcohol Assertive Outreach Team</li> </ul>	Review of programmes		



		2016/17	2017/18	2018/19	2019/20	2020/21
Integrated care in the community	Primary care	<ul style="list-style-type: none"> <li>Establishing a Primary Care Resilience and Transformation Board Oct 2016</li> <li>Supporting the rapid expansion of the Community Educational Provider Network (CEPN) Programme Nov 16</li> <li>Extending GP Access pilot – Nov 2016</li> <li>General Practice resilience programme to be launched – Dec 16</li> </ul>	<ul style="list-style-type: none"> <li>As part of the One Public Estate, develop an options study for the future of property in General Practice Jan 17</li> <li>Under the CEPN Programme, develop a new workforce model for practices / practice clusters (including mental health workers &amp; clinical pharmacists) June 17</li> <li>Under the CEPN Programme, support the fast adopter practice sites to develop partnership working to work at scale Jan – Jun 17</li> <li>Online consultation system – from Sep 17</li> <li>First 3 Localities and 10 clusters operating at scale Oct 17</li> </ul>	<ul style="list-style-type: none"> <li>CCG takes on delegated accountability for Commissioning General Practice – April 2018</li> <li>Full roll out of extending GP Access – April 2018</li> <li>Further roll-out of Multi-specialty Community Providers (MCP ) like model aligned to Urgent Care Centres</li> </ul>		
	Integrated Care Teams (ICTs)	<ul style="list-style-type: none"> <li>End of life commence</li> <li>Discharge to Assess (D2A) pilot commence Oct 16</li> <li>Roll out D2A by Jul 17</li> <li>Full Business Case (FBC) prep for Integrated Care Teams (ICTs) including scope and composition by July 17 (rapid response)</li> <li>FBC prep for Single Point of Access and referral (SPA) July 17</li> </ul>	<ul style="list-style-type: none"> <li>Consultation complete by Sept 17</li> <li>Start implementation including case management process, phasing of roll out of ICTs by locality and composition Nov 17</li> <li>Mobilisation of SPA commence Nov 17</li> <li>Implementation of ICTs Mar 18 and SPA phase 1 (internal)</li> <li>Joint care homes/home care contracts in place</li> </ul>		<ul style="list-style-type: none"> <li>Implementation of SPA April 19 phase 2 (public facing)</li> </ul>	
	Integrated Community Hubs	<ul style="list-style-type: none"> <li>Commence engagement of Outline Business Case (OBC) ideas Nov 16</li> <li>FBC including full options appraisal by July 17</li> </ul>	<ul style="list-style-type: none"> <li>Consultation complete by Sept 17</li> <li>Prepare FBC for estate reconfiguration plan aligned with Urgent Care Centres &amp; outpatients</li> <li>Mobilisation of agreed estate options and workforce</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of Integrated Care Hubs phase 1</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of Integrated Care Hubs phase 2</li> </ul>	
	Housing options	<ul style="list-style-type: none"> <li>FBC by Nov 16</li> <li>Commence implementation of Community Based Support and Housing Strategy 2016 – 20</li> </ul>				



		2016/17	2017/18	2018/19	2019/20	2020/21
Transforming urgent and emergency care	Urgent Care Centres	<ul style="list-style-type: none"> <li>Commence engagement of OBC ideas Nov 16</li> <li>Full Business Case including full options appraisal by July 17</li> </ul>	<ul style="list-style-type: none"> <li>Consultation complete by Sept 17</li> <li>Commence mobilisation for preferred model Oct 17</li> </ul>	<ul style="list-style-type: none"> <li>Implementation commences on agreed model for Urgent Care Centres April 2018 – phasing to be informed from consultation * <b>dependency on GP extended hours / LES plans</b></li> </ul>		
	NHS 111/ OOH	<ul style="list-style-type: none"> <li>Procurement of new integrated NHS 111 and primary care out of hours service</li> </ul>	<ul style="list-style-type: none"> <li>Mobilisation of contract from May 17</li> <li>Commencement of contract Dec 17</li> </ul>			
	Improving flow through ED	<ul style="list-style-type: none"> <li>Commence 'Patients to right bed or destination first time' Oct 16</li> <li>Complete gap analysis of compliance with Emergency Care Improvement Programmes 10 principles</li> </ul>	<ul style="list-style-type: none"> <li>Emergency floor options – implementation plan</li> <li>Medical bed base - mix by specialty and associated resourcing resolved</li> </ul>			
Redesigning pathways of care	Pathways	<ul style="list-style-type: none"> <li>Pathway improvement workstreams for MSK/ CHD</li> <li>Diabetes workshop for primary pathway planning</li> </ul>	<ul style="list-style-type: none"> <li>Bed savings from implementation of frailty &amp; end of life pathway</li> <li>Reduce variation in GP management of medical conditions</li> <li>New model for MSK/ CHD</li> <li>Develop prescribing action plan</li> <li>Introduce new therapy model</li> <li>Complete RightCare work programme</li> </ul>	<ul style="list-style-type: none"> <li>Transformation of outpatient delivery model with access to Information Technology</li> </ul>		
	Specialised		<ul style="list-style-type: none"> <li>Develop new model of care with Devon providers</li> </ul>	<ul style="list-style-type: none"> <li>Repatriation of specialised mental health services</li> </ul>		

		2016/17	2017/18	2018/19	2019/20	2020/21
<b>System enablers</b>	<b>Shared back office</b>	<ul style="list-style-type: none"> <li>• Delivery of synergy realisation plan to save £4.79 m recurrently</li> <li>• Map current cost of provision and appraise options</li> <li>• Benchmarking exercise against existing back office status to identify savings contribution</li> <li>• Develop critical success factors and undertake options appraisal</li> </ul>	<ul style="list-style-type: none"> <li>• Analyse and develop clarity on how back office functions will be structured and procured and run by the STP in the future</li> <li>• Develop and define ambition regarding back office services in advance of Accountable Care System journey</li> </ul>			
	<b>Workforce</b>	<ul style="list-style-type: none"> <li>• Establish baseline staff in post across Cornwall footprint</li> <li>• Sign off Info share agreement to implement WRaPT across all organisations – held by KCCG</li> <li>• Align annual business planning with STP plan to ensure synergies with workforce plans</li> <li>• Map key service redesign pilots and implications to future skills and workforce requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Map service changes and implications to workforce for all planned interventions</li> <li>• Following consultation produce system-wide integrated workforce plan</li> <li>• Map skills and development required for workforce plan</li> <li>• Devise recruitment and retention strategy to enable mobilisation of roles across organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Review, refresh and revise workforce plan</li> <li>• Continue to develop future workforce skills requirements with educational institutes</li> </ul>		
	<b>IM&amp;T</b>	<ul style="list-style-type: none"> <li>• Information Sharing Agreement in place</li> <li>• Single Digital Roadmap for Cornwall and IoS underpinned by common interoperability standards adopted</li> <li>• “First of Type” deployments of GP Connect</li> <li>• Info sharing between GP Practices and with Secondary Care enabled</li> </ul>	<ul style="list-style-type: none"> <li>• Electronic Transfers of care deployed</li> <li>• End of Life and Shared Care plan deployed</li> <li>• Virtual consultations and secure hotspots deployed</li> <li>• Blueprint for “One Public Infrastructure” and interoperability model agreed</li> </ul>	<ul style="list-style-type: none"> <li>• Technology for Community Hubs, ICTs and virtual triage deployed</li> <li>• Interoperability architecture deployed</li> <li>• Integrated Digital Care Record (IDCR) defined</li> <li>• Digital support for care workers</li> </ul>	<ul style="list-style-type: none"> <li>• Universal Capabilities and digital channels for citizens deployed</li> <li>• End to End Care Pathways and Information Flows deployed</li> <li>• First of type IDCR deployed</li> </ul>	<ul style="list-style-type: none"> <li>• Citizen owned IDCR deployed across system</li> <li>• Shared care plan deployed</li> <li>• One Public Infrastructure underpinned by single</li> <li>• Decision support for Care Professionals at the point of need</li> <li>• Improved analytics for commissioners and providers</li> </ul>
	<b>Estates</b>	<ul style="list-style-type: none"> <li>• Develop holding plan for community estate to ensure targeted investment (Nov 2016)</li> <li>• Determine future stewardship / beneficiary of capital receipts of NHSPS estate by April 2017</li> <li>• Undertake space demand assessment and property supply appraisal</li> <li>• Option appraisal to identify sites and solutions</li> </ul>	<ul style="list-style-type: none"> <li>• By July 2017 – Community estate property plan – identifying investment / dis-investment and disposals with delivery programme</li> <li>• By Sept - First wave site specific FBC's</li> <li>• Sept onwards – begin delivery of first wave site change programme.</li> </ul>	<ul style="list-style-type: none"> <li>• Site specific FBC's as per programme - on-going</li> <li>• Delivery of site change programme – on-going</li> </ul>		

		2016/17	2017/18	2018/19	2019/20	2020/21
Using strategic levers for better care	Provider reform	<ul style="list-style-type: none"> <li>Review and renew Collaboration Agreement with main providers to set expectations of the development of an Accountable Care System (ACS)</li> <li>Engage with the development of the Devon ACS with particular regard to more specialised services</li> </ul>	<ul style="list-style-type: none"> <li>Agree contractual joint vehicle methodology and priority of order of projects across the full range of services to move to formal collaboration in response to commissioners</li> <li>Providers establish formal collaboration to take on agreed accountability for micro commissioning 'early adopter' pathways</li> <li>Implement joint arrangements for specific service changes tied into new service contracts e.g. Urgent Care</li> </ul>	<ul style="list-style-type: none"> <li>Providers establish formal organisational form to take on a larger % of total budget for services</li> <li>Agree outcome based contracts and reconfiguration to enable service transformation</li> </ul>	<ul style="list-style-type: none"> <li>Accountable Care system in place</li> <li>100% of relevant service budget in formal collaboration</li> <li>ACS to mature as Primary Care develops</li> </ul>	
	Commissioner reform	<ul style="list-style-type: none"> <li>Fully develop the Place Based Commissioning Strategy setting the outcomes to shape approach to working with providers and local communities; measured by the achievement of the Triple Aim</li> <li>Commissioners commence alignment of budgets, people and processes for specific service areas</li> </ul>	<ul style="list-style-type: none"> <li>Commissioners establish a joint vehicle for integrated commissioning, delegate transactional functions to providers to enable micro-commissioning for specific 'early adopter' pathways</li> <li>Reintegrate commissioning of primary care and agreed specialised services</li> <li>Align health and social care commissioning</li> </ul>	<ul style="list-style-type: none"> <li>Commissioners integrated into a single commissioning function with shared resources and adoption of more strategic commissioning with outcome based contracts</li> </ul>	<ul style="list-style-type: none"> <li>Place Based Strategic commissioning for 100% of relevant budget</li> </ul>	



## 6. Financial projections

This section provides our projections for addressing the financial challenge in Cornwall and the Isles of Scilly over the period of the Sustainability and Transformation Plan through the delivery of the priority interventions and other system savings.

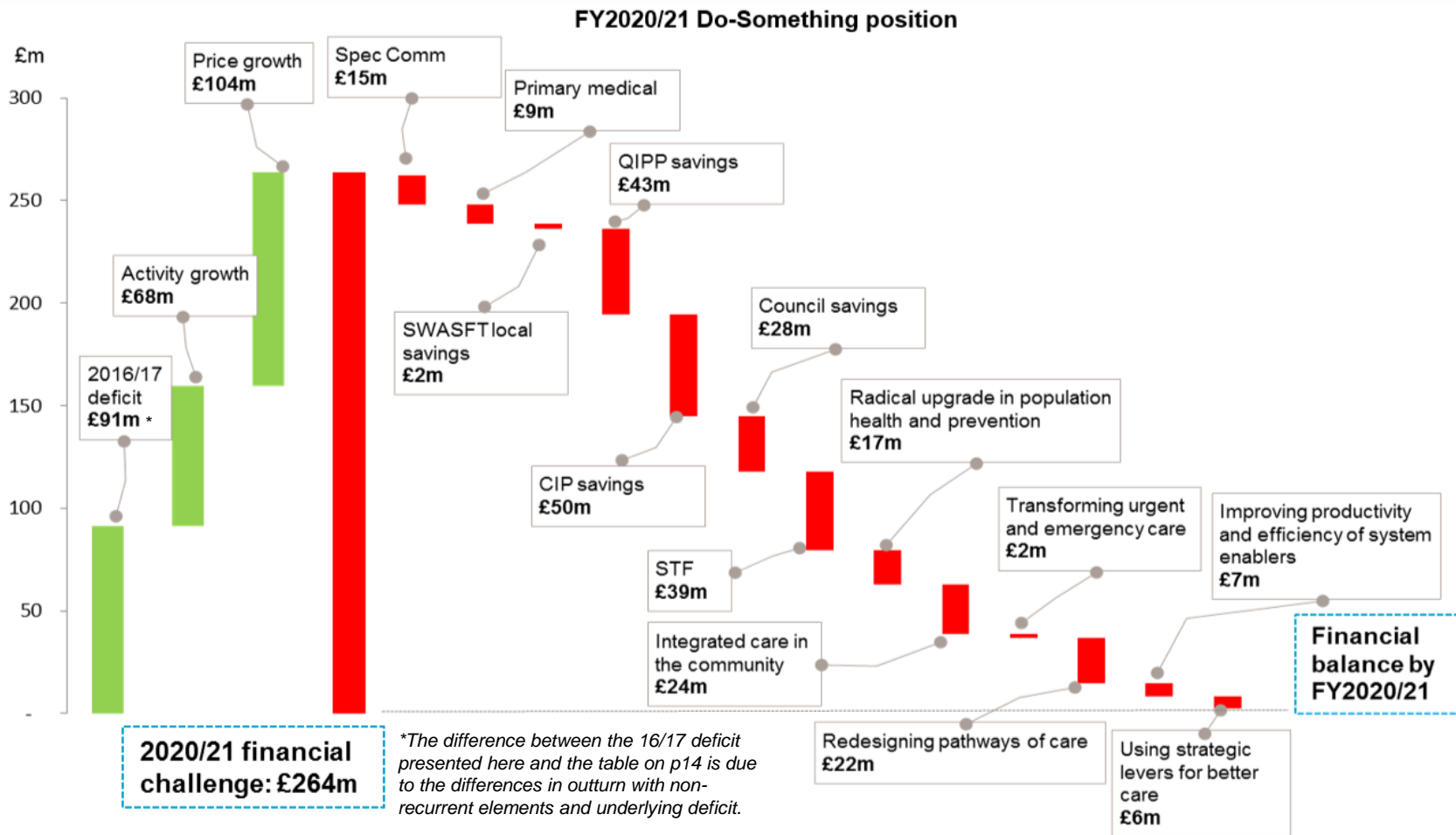


# Financial projections – Overall system savings projections

We have developed and updated a robust system financial model to understand the likely resource available to the system between 2016-17 and 2020-21, based upon currently known resource allocations, growth, currently planned expenditure before and after savings plans in 2016-17 and potential growth in costs linked to demographic and estimated inflationary changes over the following four financial years. Netting off organisational inter-trading gives a true picture of the sources of income available to the system and a clear view on what the resource is actually currently and projected to be spent on.

The gross financial challenge is currently estimated at c.£264m by 2020-21, including projections of the financial challenge in Adult Social Care and Public Health of £41m. This excludes any impact of Resource Accounting and Budgeting (RAB) resource reduction and Sustainability and Transformation funding. The 2016-17 normalised position including 2016-17 'business as usual' savings, Adult Social Care and Public Health is c.£91m.

Modelled interventions are currently estimated to close the affordability gap in 2020-21. This is also after the indicative Sustainability Fund allocation of £39m in 2020-21.



# Financial projections – Overall system savings projections

Over the five year period of the Sustainability and Transformation Plan, we are projecting that the health and care system in Cornwall and the Isles of Scilly will reach financial balance by 2020/21. This will be achieved through a combination of our transformational priority interventions set out in this Outline Business Case, as well as ‘business as usual’ improvement and efficiency savings including QIPPs and CIPs.

**Priority Interventions** – The implementation of our 18 priority interventions to deliver a more integrated, effective and efficient system will contribute a total of £78m to address the financial challenge by 2020/21. The savings identified here relate to the realisation of our future operating model and the fundamental transformation in how services are provided and how people use them.

The overall savings opportunity has been modelled for each intervention, taking into account fixed costs, recurrent and non-recurrent adjustments and required investment in order to deliver the anticipated benefits. The impact of each intervention has been calculated using local knowledge, expertise and assumptions, typically drawing on a range of options for implementation. Where possible or necessary, this modelling has been supported by using available national evidence and good practice from elsewhere in the country.

Due to the interconnected nature of the system, we recognise that savings from interventions will accrue to different organisations though different benefit levers, but the impact of the transformation will benefit the whole system and improve outcomes for the people of Cornwall and the Isles of Scilly.

**‘Business as usual’ savings** – This refers to other initiatives which are distinct from the system transformation to be driven through the priority interventions. The ‘business as usual’ savings typically relate to organisational efficiencies and do not involve strategic change, although they may also require considerable change and development for organisations within the system. Quality, Improvement, Productivity and Prevention (QIPPs) savings and Cost Improvement Plans (CIPs) for NHS organisations are the main contributors to the total ‘business as usual’ savings of £147m. Further details on these savings are provided later in this section.

## Delivery of savings over the STP period

Significant changes in functions, operational delivery and system culture are required in a manner which does not compromise patient safety. While our overall transformational and ‘business as usual’ plans mean that we expect to achieve financial balance by 2020/21, the scale and complexity of the transformation mean that we will not realise substantial savings from our priority interventions in the short term. Our emphasis on prevention, self-care and integrated care in the community is intended to manage demand on the overall system and achieve sustainability over the medium to long term.

## Control totals

As a consequence, the system does not expect to be able to meet the end of year positions set through the Control Totals for Kernow CCG, the Royal Cornwall Hospitals Trust or Cornwall Partnership Foundation Trust for the financial years 2017/18 and 2018/19. This is the collective decision of all local health and social care commissioners and providers after full consideration of the risks and implications. Through our plans set out in this OBC and our business as usual activity, we understand the steps that we need to take to stabilise our financial position.

We will continue to move at pace for the early delivery of productivity and efficiency savings related to system transformation, such as the identified RightCare and Carter opportunities, during these years to help address the financial gap while we further develop wider service reconfiguration. Working together, we are confident in our ability to return to financial balance by 2020/21 through our full commitment to delivering an integrated, effective and efficient health and care system.

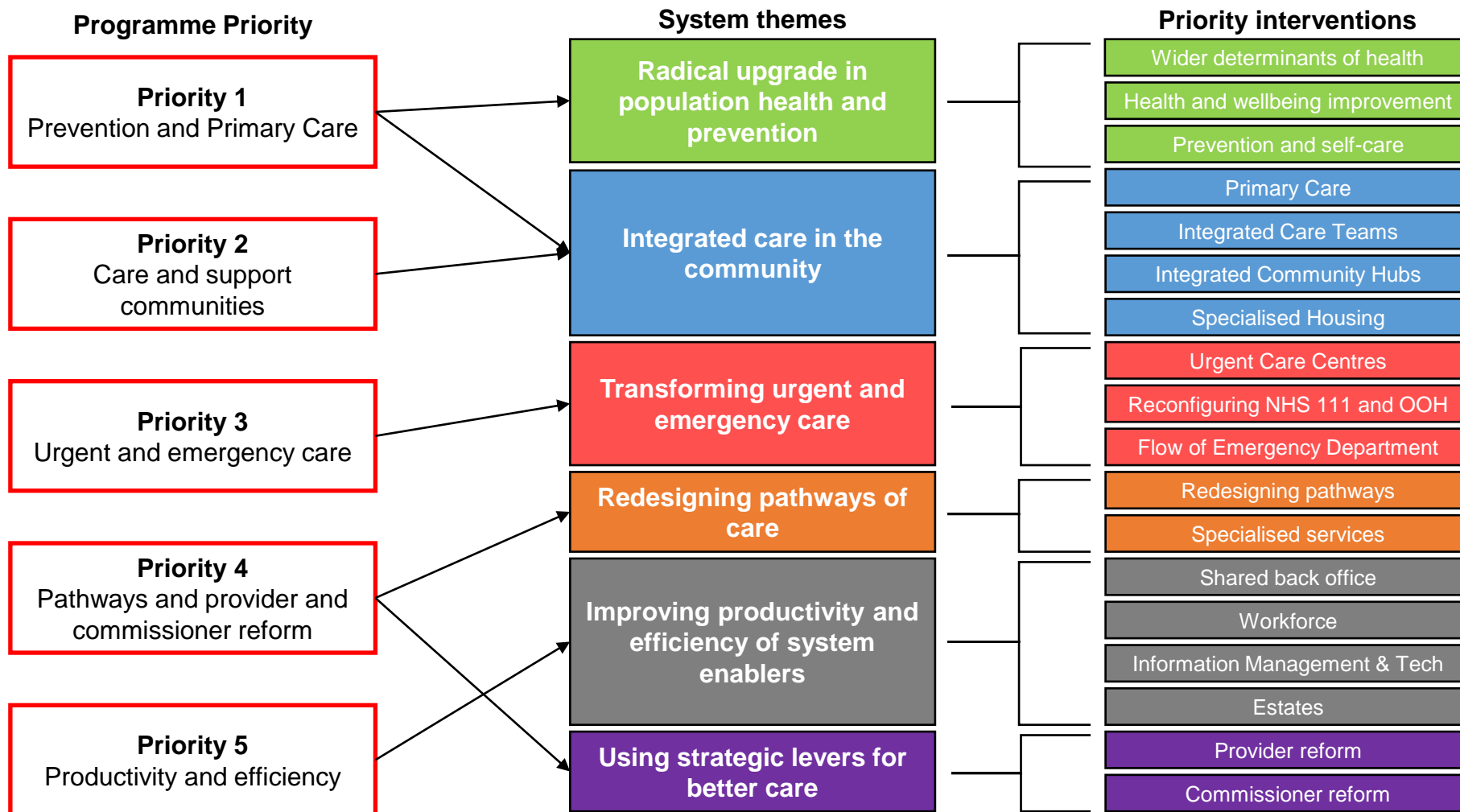
Control totals FY17/18 and FY 18/19		
	2017/18	2018/19
Kernow CCG	(£19.9m)	(£12.3m)
Royal Cornwall Hospitals Trust	£1.3m	£4.7m
Cornwall Partnership Foundation Trust	£0.5m	£0.8m
STP Total (Health)	(£18.1m)	(£6.7m)



# Financial projections – Interventions methodology

Following our Strategic Outline Case, the programme for developing the transformation areas of our local STP was structured around five priorities. These priority workstreams led the appraisal and options development for our anticipated transformation areas, including local modelling and assumptions about the financial impact of the emerging interventions. As our work has advanced and our transformation plans have matured, our identified interventions have been aligned with the future Operating Model for our health and care system.

The diagram below shows the relationship between the existing Programme Priorities and the future system themes consisting of the 18 priority interventions around which we will plan, drive and deliver the changes we need. The financial impact of our plans are presented around these system themes.



# Financial projections – Notes on OBC and STP finance templates

The October submission reflects the progress made since earlier submissions. In line with national expectations, the Plan includes significant benefits from Prevention and Right Care pathway workstreams over the next four years. These should lead to a more effective pattern of resource use across health and social care through the period of the STP, and beyond, but are still in the development stages locally due to the scale of the delivery that is both required and anticipated. For the Prevention work in particular, there remains additional validation work with partners around the timing and funding of the interventions, and the articulation of the savings across the points of delivery and sectors. The Plan does not explicitly factor in benefits from the established programme of public health interventions – part of fully defining the gains in future years from the Prevention workstream is expected to include careful scrutiny of the current investment (£170m over the next five years) and ensure that it responds to the same ‘return on investment’ rigour that underpins the STP ambition.

The financial solutions in the templates reflect the levels of granularity in the workstreams. Further development will include more detailed analysis of cost reductions over sub-headings and activity impacts by expenditure type.

The financial position in 2020/21 shows a STP position marginally ahead of balance in-year, having recovered from a 2016/17 position of significant system overcommitment. The current over-trading in the system will necessitate continued investment restraint during the STP period, with close working across Health and Care partners to create real system change to move towards the vision established in the STP Target Operating Model. The scale of change required to reset the system will entail a lead in on major changes, consistent with community engagement and transparency. Recognising this challenge, the financial projections for the next two years still fall short of the control totals set by NHS England and NHS Improvement. Although we are aware that there may be some income sources available from the balance of the STF funding set aside in the NHS England budget to meet an element of the national priority investments, we would expect the overall position to remain short of the national control total aspiration at this checkpoint. The submission does still reflect receipt of the notified STF funding for the Trusts. We wish to continue to work with the regulators to agree a way forward that best meets the needs of both the local population and the national NHS delivery obligations.

We note that the STF contribution for Cornwall Foundation Trust for the next two years continues to be set according to its historic income levels, rather than the adjusted position following the transfer of community services to them on 1 April 2016. The STP templates still reflect the notified position.



## 7. Next steps

# Next steps

## Over the next 3 months

From 9<sup>th</sup> November, we will be out to engage with stakeholders on the draft Outline Business Case. We will be seeking views and challenge on our proposals from a range of groups including citizens, staff, local politicians, organisational boards and various different interest groups including our most vulnerable and hard to reach. This will build on the extensive engagement undertaken during the development of the Strategic Outline Case. Exeter University will continue to work with our STP and provide both support and advice in the shaping of our engagement products and an independent assessment of the findings. The engagement period is due to be concluded by early January 2017.

During the same period we are also seeking robust external challenge on our OBC via a number of other forums including:

1. A sub committee of the Health & Social Care Scrutiny Committee has been established to provide oversight of the developing plans. During the engagement period they will seek to examine the OBC and will conduct their own assessment of the validity of the proposals.
2. The South West Clinical Senate will be conducting a desktop review of the OBC document. As our plans develop through Phase 3 and the development of the Full Business Case (FBC), the Clinical Senate will conduct a more thorough appraisal. This is likely to take place in March or April of next year.
3. We have an NHS Assurance checkpoint scheduled for 11<sup>th</sup> November.

The Outline Business Case is due for formal approval by the Transformation Board at the end of January. This will subsequently go to organisational boards for sign off in February.

## NHS operational plans and local authority business planning

Our Outline Business Case will inform both the NHS 2 year operational plans and the council's business planning process. CCG and provider plans will need to be in place and contracts signed by 23<sup>rd</sup> December. The local authority, as part of its annual business planning process will be out to engage on its business plan and Mid Term Financial Plan that was set in 2014. It is due to approve its refreshed plan with Cabinet in January 2017.

## Over the next 12 months

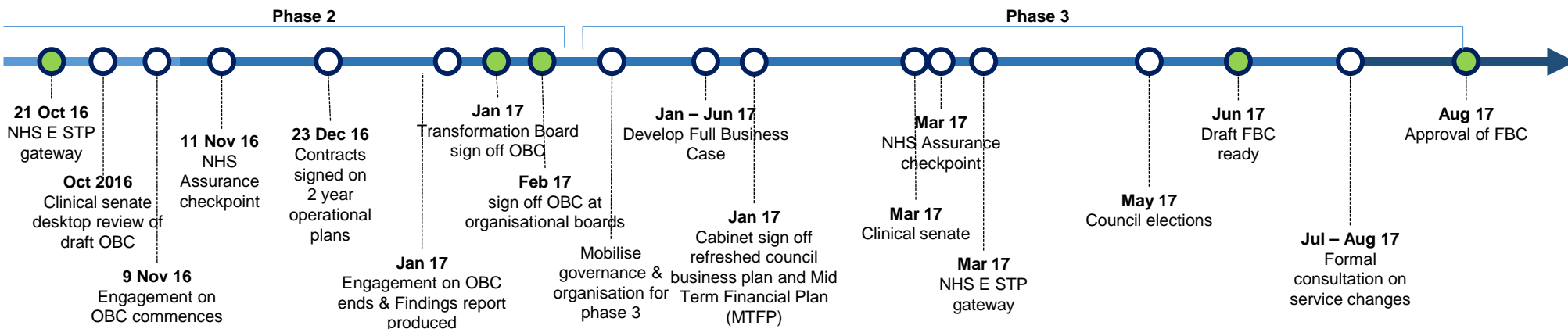
Once approved as part of the local OBC gateway, each of the interventions described in this document will have a number of alternative routes to take. The majority of the interventions have further detailed design and appraisal work to be undertaken and this will be delivered as part of our Full Business Case (FBC) process. This process is expected to be conducted between February and June 2017.

## Consultation on significant service changes

Some of the interventions such as those related to Urgent Care Centres and Integrated Community Hubs will meet the legal requirements for formal consultation. This is expected to take place once the detailed design work and options appraisal has been completed from June 2017

## Implementation

Other interventions described in this document are either already 'in-flight', or at a point of readiness to begin implementation (e.g. Discharge to Assess). To ensure we are equipped to manage both implementation and FBC development we are in the process of reviewing the governance and organisation needed for the next phase, building on the strong governance we already have in place.





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