September 2016

PSNC Briefing 047/16: STP aides-mémoire (quick guides)

Local health and care systems have come together in 44 'footprints' to produce a multi-year Sustainability and Transformation Plan (STP) showing how together they will improve services and achieve aggregate financial balance over the next five years – in effect, delivering their own local plans for implementing the Five Year Forward View (5YFV). Further information can be found in PSNC Briefing 046/16: An introduction to STPs.

NHS England has produced several STP aide-mémoire (quick guides). The guides aim to help local leaders work together in tackling the big system challenges, and build on existing efforts to make progress on some of the most challenging clinical priorities. Each guide sets out what success would look like in 2020 with suggestions about how areas could implement them.

The guides are intended to support STP leaders by giving them a range of core issues they should take into consideration as they develop their plans; each footprint has received a data pack which brings together the most important indicators to help in assessing their current position against each of the three gaps (health and wellbeing, care and quality, and finance).

There are different aide-memoires (quick guides) addressing various key topics including an introduction guide; examples include:

Cancer	Diabetes	Digital	Maternity
Mental health and dementia	New Care Models	Personalisation and choice	Prevention
Primary care	Safety	Supporting people to manage their own health, wellbeing and care	Urgent and emergency care and 7-day hospital services

This PSNC Briefing summarises the elements of the guides which are of most relevance to community pharmacy and which will be of interest to LPCs in discussions they have with local commissioners.

Cancer

The independent cancer taskforce report sets out how to achieve world-class cancer outcomes by 2020 across England. STPs should set out how the taskforce's core recommendations will be translated into local action.

Success in 2020:	STPs should set out plans to make progress in the following key areas: • Preventing cancer by addressing cancer risk factors – especially smoking • Diagnosing more cancers early • Improving cancer treatment and care

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Immediate actions from 2016/17 to achieve this:	• As part of the STP's prevention plans, address cancer risk factors including smoking, alcohol, excess weight, diet and physical activity as identified through your local Joint Strategic Needs Assessment. Work closely with local government through joint planning and/ or commissioning • Promote breast, bowel and cervical cancer screening programmes, and ensure local services are well placed to respond to Be Clear on Cancer campaigns
How this will be achieved by the end of the decade:	• Strengthen existing tobacco controls and smoking cessation services, in line with reducing smoking prevalence to below 13% nationally • Implement new standard so that patients are informed of a definitive diagnosis of cancer or otherwise within 28 days of GP referral • Enable online patient access to all test results and other communications

Diabetes

In March 2016, NHS England, Public Health England and Diabetes UK started the roll-out of the NHS Diabetes Prevention Programme with an ambition to slow the projected growth in incidence of type 2 diabetes across 27 parts of England. The STP process provides the opportunity for footprints to jointly develop a comprehensive strategy for doing this.

Success in 2020:	• Reduction in the projected growth in incidence of diabetes • Support more people to manage their own care effectively • Improve treatment and care received
How this will be achieved:	**Reduction in the projected growth in incidence of diabetes** • Develop a comprehensive strategy to prevent obesity and diabetes • Clinical Commissioning Groups (CCGs) and local authorities (LAs) should roll-out the NHS Diabetes Prevention Programme locally • LAs should work with NHS Health Check providers
	Support more people to manage their own care effectively • CCGs should develop a strategy to engage potential referrers • CCGs should encourage GP practices to refer people with diabetes to guidance on self-management from Diabetes UK
	Improve treatment and care received • CCGs should review treatment pathways with providers in order to consider whether adjustments to these could improve outcomes • CCGs should ensure they have a foot care pathway with adequate capacity • CCGs should consider development and alignment of local financial flows, incentives and back office systems (e.g. e-referral systems) to support improved integration between primary and secondary care

Digital

The 5YFV encourages the NHS to 'exploit the information revolution' as has happened in other industries. Personalised Health and Care 2020 sets an ambition that 'all patient and care records will be digital, interoperable and real-time by 2020'. Better use of data and digital technology has the power to support people to live healthier lives and use care services less.

In autumn 2015, local health and care systems began to develop Local Digital Roadmaps (LDRs) setting out how they will improve digital maturity and become paper free by 2020. STPs should demonstrate how they will drive and implement LDRs.

Success in 2020:	**Digital maturity in secondary care providers is significantly increased** • Patient information is recorded once, digitally, at or close to the point of care • Clinicians alerted promptly to key patient events and changes in status, supported by knowledge management and decision support tools • Improved management, administration and optimisation of medicines, availability of assets and effective staff-rostering
	Information is digital (paper-free) and flows between primary, secondary and social care providers seamlessly • Patient information at the point of care is available digitally (irrespective of where it was recorded), on a secure, timely and accessible basis • Transfers, referrals, bookings, orders, results, alerts, notices and clinical communications are passed digitally between organisations • Telehealth and collaborative technologies being used to deliver care in new ways
	Patients, carers and citizens use digital technologies to manage their health and wellbeing • Patients digitally book and manage their appointments, request and manage their prescriptions and consent to share personal information • Patients can view, understand and contribute to their digital record, and manage how this is made available to family and carers • Approved digital tools and applications used across care settings to facilitate: care planning and shared decision making; education and access to resources; monitoring and feedback on health and wellbeing; and administration of personal budgets

Mental health and dementia

STPs provide areas with an opportunity to think more holistically across mental and physical health, rather than just in a mental health 'section'. The Five Year Forward View for Mental Health (MH5YFV) and Dementia Implementation Plan give the NHS a blueprint for realising improvements by 2020. STPs are the mechanism for putting this into action, changing service delivery for people by the end of the decade.

Success in 2020/21:	• Improve access to and availability of mental health services • Develop community services, taking pressure off inpatient settings • Providing people with holistic care, recognising their mental and physical health needs
Immediate actions from 2016/17 to achieve this:	• Work with experts by experience (people who use services and their families/carers) and other partners to develop the mental health aspects of the plan • Continue to deliver a two-thirds dementia diagnosis rate and start to improve the support for people living with dementia and their carers, for instance through improving care planning • Design integrated physical and mental health services to improve the physical health of people with severe mental illness and the mental health of people with other long-term conditions (LTCs), through joint commissioning approaches and integrated multidisciplinary teams

New Care Models

New care models are at the heart of the Forward View's triple aim: to improve the health of populations; to improve care patients receive and their experience of it; while delivering the best value possible for taxpayers. The strongest STPs will be a blueprint for how areas expect to develop and spread new care models, making the greatest possible use of technology and a reshaped workforce.

Success in 2020:	**Population health models – Multispecialty Community Providers (MCPs) and / or Primary and Acute Care Systems (PACs) – will have spread across STP areas, providing a much greater proportion of care out-of-hospital** • Existing Vanguards serve an expanded population, partnering with additional primary care and community services (MCPs) and in some cases acute hospitals (PACS) • Strong relationships with primary care and community services lead to the formation of new MCPs / PACS; taking explicit responsibility for a population's health and in time a whole population budget, based on the GP registered list • These models deliver much greater integration between primary and acute care; physical and mental health, and health and social care; delivering tangible and quantifiable results in, for example, reducing bed-days, emergency admissions and costs per capita, while maintaining or improving the quality of reported patient experience
	Care homes will be connected to the health and care system, reducing unnecessary hospital admission • People who need, or are at risk of needing care delivered in a care home are actively identified; maintaining their health and independence • These people will be proactively managed by integrated health and care teams, and their care is jointly commissioned by the NHS and local government
	Action on the underpinning enablers, especially technology and workforce • New care models harness digital technology, including fully integrated datasets, supplying real time business intelligence with predictive analytics • Expansion of online services and service redesign making the most of mobile technologies, wearables and apps • Care delivery is by multi-disciplinary teams with redesigned jobs that are more rewarding, sustainable and efficient. New roles such as health coaches, physician assistants and care navigators, pharmacists employed in community hubs or primary care, and community paramedics are widespread
How to get there:	**Accelerate progress and expand coverage of existing Vanguards** • Improve the underlying health and life chances of people and tackle inequalities • MCPs and PACS support people to manage their own health and care, by working with LA and voluntary partners, to develop self-management resources, peer-to-peer support and carers' networks • Analyse and segment the population to deliver highly intense, personal and preventative care for small, changing cohorts of patients with the very highest needs and costs • MCPs / PACS should integrate with a local urgent and emergency care network that joins up and streamlines NHS 111, GP in- and out-of-hours, GP extended hours, minor injury units, walk-in centres, community pharmacies, and A&E into a coherent pathway of care. Care homes should also be wired into this system, with their own 'express' pathway • All new care models require new working practices. This is particularly true of MCPs / PACS, which must build integrated multidisciplinary teams that co-ordinate care for high-need patients, employing new roles such as 'extensivists' (a GP or a geriatrician employed to work exclusively with frail older people who are at high-risk), care navigators, and pharmacists based in community or primary care. Primary care will need to replace the traditional one size-fits-all '10-minute face-to-face practice consultation, followed by outpatient referral or prescription' approach with a more differentiated one, focused on the highest need groups
	Catalyse the next generation of Vanguards Not all parts of the STP area will be ready to move at the same pace on new care model development from 2017/18. As voluntary models, new care models depend on the enthusiasm of patients,

	clinicians, and other professionals who will make them a reality. As STP leaders consider how to stimulate the next generation of Vanguards, lessons from the first wave may be helpful: • New care models only get off the ground if they are based on strong and trusting local relationships and by engaging people in the pursuit of the triple aim. A strong partnership with primary care is crucial for both MCPs and PACS (as both are founded upon list-based general practice). In many areas, models have developed from GP federations. Acute Care Collaborations are similarly built on existing clinical relationships and patient flows • MCPs and PACS have much in common: they are two UK-specific versions of integrated and accountable care organisations; they have the same focus on population health management and their care delivery models will look very similar. The key difference between an MCP and PACS is the scope of services. The choice between these two models is fundamentally driven by the local context and, crucially, the strength of relationships between primary and acute care providers • Connecting care homes to the health and care system brings rapid results. It does not require new organisational forms or complex rewiring of payments and contracts. It is about new ways of working between local government, primary care and community services. Each STP area is expected to make a sustained effort to improve services offered to care home residents; preventing unnecessary hospital admissions from them

Personalisation and choice

Working alongside population based models of care, integrated personal commissioning (IPC), personal health budgets (PHBs) and meaningful patient choice enable patients to personalise their care to better meet their needs and preferences.

STPs provide the opportunity to harness excellence where it exists within the STP footprint and accelerate wider adoption (e.g. where there are existing IPC sites, localities with high performance in PHBs, or where pioneer areas are preparing to test enhanced choice in maternity care).

Success in 2020:	**PHBs and integrated personal budgets, including NHS and social care funding, are available to everyone who could benefit (in line with NHS Mandate requirements).** • In each footprint at least 1-2 people per 1,000 of the population has a PHB or integrated personal budget incorporating NHS funding
	• **Patients make meaningful choices about whether, where and how they receive their healthcare**. Patients are able to say: - I have discussed with my GP/ healthcare professional different options and pros and cons including, where appropriate, whether to have treatment; - I was offered a choice of where to go for my care or tests, as appropriate; - I was given an opportunity to choose a suitable alternative provider when I was going to wait longer than the maximum time specified in my legal rights; - Information was available and I was able to find it in a format that was accessible, helping me make a decision about my needs; and - I was given sufficient time to consider what was right for me
How to get there:	**PHBs and integrated personal budgets including NHS funding are available** • Invest in evidence-based approaches to improve people's knowledge, skills and confidence for self-management, e.g. care planning, education, health coaching, peer support, group based activities, asset based approaches and realising the value
	Patients make meaningful choices about whether, where and how they receive their healthcare • Initiate local patient awareness and engagement campaigns to promote choices available to patients, drawing on the national awareness campaign and media materials for local

	adaptation • Embed choice in protocols, referral and clinical pathways, and increase utilisation of the NHS e-Referral Service, to enable efficient and effective choice • Commissioners and providers to ensure there is a range of accessible information available locally that supports patients to make meaningful choices • Enable patients to choose about whether, and if so, where to have treatment by implementing shared decision making principles consistent with RightCare

Prevention

The 5YFV says a 'radical upgrade in prevention' is needed to improve people's lives and achieve financial stability of the health and care system. The NHS spends more than £15.5 billion per annum treating illness which directly results from alcohol and tobacco consumption, obesity, hypertension, falls, and unhealthy levels of physical activity. Most of this treatment is avoidable.

STPs provide the NHS with an opportunity to work closely with local government and other local partners to build on existing local efforts and strengthen and implement preventative interventions that will close the local health and wellbeing gap, such as:

- providing targeted advice and integrated care to tackle excessive alcohol consumption and smoking;
- creating healthy environments in health and care settings to improve diets and keep people in work, and support action to reverse trends in childhood and adult obesity; and
- intervening earlier and managing conditions better to keep people healthier for longer and reduce their care needs.

Success in 2020:	**Targeted advice tackling unhealthy behaviours is provided at the point of care** • Alcohol consumption is reduced and related hospital admissions are lowered by 2020/21, through implementation of system-wide targeted advice and care • Smoking prevalence is reduced (in line with the national ambition to reduce prevalence to 13%) and attributable hospital admissions in people aged 35+ lowered by 10% by 2020/21, by implementing a local, joined up approach to advice and care
	A healthier environment is created by health and care providers and local employers • Employment of people with LTCs is improved, so the gap between the overall employment rate and the rate for people with LTCs is reduced, as a result of a more supportive work environment for people living with a LTC, with a focus on people with mental health needs and/ or learning disabilities • The health and wellbeing of staff employed by health and care providers is improved through meeting the three indicators outlined in the 2016/17 CQUIN (Commissioning for Quality and Innovation)
	Improved patient pathway, from early action to better management. • More patients with diabetes, hypertension, atrial fibrillation (AF) and hypercholesterolaemia have their condition diagnosed and optimally managed, through an enhanced use of pharmacies and community settings • Number of injuries due to falls in people aged 65+ are lowered, with admissions due to falls decreasing by 10% by 2020/21, through improved and better coordinated preventative services
How to get there:	**Targeted advice tackling unhealthy behaviours is provided at the point of care** • Address high-risk drinkers and emergency admissions • Screen and refer patients to stop smoking services - LAs commission local Stop Smoking services to provide high-quality smoking cessation support to referred patients

	A healthier environment is created by health and care providers and local employers • Encourage a healthy diet and improve weight management services: - CCGs and local government co-commission provision of weight management services (tier 2, tier 3 and tier 4) and post-surgery services to support overweight and obese individuals to achieve a healthier weight through interventions based on national guidance. Actions should be taken to improve access to these services and support better integration with mental health services
	Improved patient pathway, from early action to better management • Improve detection rates and management of high blood pressure, high cholesterol, atrial fibrillation and raised blood glucose: - CCGs encourage primary care to: ensure patients receive optimal care and drug treatment where relevant, e.g. hypertension and AF patients; extend the role of pharmacists in clinical management; and support patient activation and self-care; and - CCGs and local government encourage NHS Health Checks, primary care and NHS Diabetes Prevention Programme providers (where in place) to jointly implement effective referral pathways • Identify patients at risk of first or repeat falls and provide preventative support so they remain healthy

Primary care

The General Practice Forward View (GPFV) sets out a national programme to invest £2.4 billion by 2020/21, tackling workload, building the workforce and stimulating care redesign. STPs should translate the aims and key elements of the GPFV into local plans.

Success in 2020:	**Support and grow the primary care workforce** • Introduce new roles to support patients beyond traditional GP consultations, including 3,000 primary care mental health counsellors/therapists, physician associates and 1,500 clinical pharmacists in community settings
	Improve access to general practice in and out of hours. • People have easier and more convenient access to GP services, with the option to book appointments either in or out of hours (after 6.30pm weekdays, and weekends)
	Transform the way technology is deployed and infrastructure utilised. • Patients benefit from new ways of interacting with services, providing alternatives to face-to-face contact including the use of phone and online consultations • Primary care records shared across the local health economy, including community pharmacy, with the introduction of common standards, paperless transfer of notes and digital summary care records • Patients benefit from improved infrastructure and 'fit for purpose' premises
How to get there:	**Support and grow the primary care workforce** • Adapt ways of working to ensure GPs are operating at the top of their licence, for example, through use of clinical pharmacists in a community setting and upskilling other health care professionals to manage less complex health problems • Facilitate an expanded multidisciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets
	Improve access to general practice in and out of hours • Build wider primary care, including dental, optometry and community pharmacy, into plans for alternative pathways of care

	• Design approach to link extended access with GP out of hours, urgent and emergency care and NHS 111 • Simplify and align access points for patients
	Transform the way technology is deployed and infrastructure utilised • Incorporate primary care requirements into Local Digital Roadmaps including interoperability; digital record sharing; and expansion of online services for patients – focusing initially on transactions such as repeat prescriptions • Identify technologies that facilitate new models of care; for example, remote access to diagnostics; telephone or online consultations; assistive technologies for self-care, etc. • Optimise use of community assets and other public sector estate, especially local government

Safety

STPs provide an opportunity to tackle key local and national safety challenges by working together; encouraging organisations to learn from each other and address patient safety issues that often span across patient pathways and organisations.

Success in 2020:	**Support a culture of safety for patients and staff** • Improved incident reporting and continued improvement of a safety culture, demonstrated by increased reporting rates • Participation in a local patient safety collaborative and other relevant initiatives encouraged, supporting the delivery of improvement • Implementation of all relevant national patient safety alerts issued by NHS Improvement
	Appropriate use of antibiotics and improvement in infection prevention and control • Appropriate antibiotic prescribing among primary and secondary care clinicians, including reduced overall prescribing and broad spectrum antibiotic prescribing • Demonstrable improvement in infection rates through prompt identification and modification or removal of infection risk factors, earlier diagnostics and appropriate treatments, a 50% reduction in inappropriate prescribing and compliance with the Code of Practice (2015) for the prevention and control of infection and related guidance
How to get there:	**Support a culture of safety for patients and staff** • Organisations regularly assess their own safety culture using recognised tools such as the Manchester Patient Safety Framework • Participate in initiatives, such as patient safety collaboratives with Academic Health Science Networks; the Sign up to Safety Campaign; and others to increase capability for improvement and knowledge • Make sure staff and patients/ families are involved and supported in investigations • Ensure all investigations result in effective improvement/ action plans, leading to learning not blame
	Appropriate use of antibiotics and improvement in infection prevention and control • Use Public Health England's 'fingertips' portal to understand local data on antimicrobial resistance (AMR), antimicrobial stewardship (AMS), IPC, and prescribing • Create a single plan for AMR that includes AMS and IPC across the footprint to ensure coordination of efforts by primary and secondary care • Consider behavioural insights when planning programmes to raise awareness and influence among professionals and public

Supporting people to manage their own health, wellbeing and care

People who manage their own health, wellbeing and care both have a better experience of care and a reduced

demand for high-intensity acute services. However, 40% of people have low levels of knowledge, skills and confidence to manage their health and wellbeing and 44% say they would like to be more involved in making decisions about their care. The health and care system can do much more to support people to make better informed choices and to be more active in managing their own health, wellbeing and care.

Success in 2020:	**Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices** • Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action • Patients and clinicians are supported by decision aids to help people think through the pros and cons of different care, treatment or support options
	Care planning and self-management is hardwired into how care is delivered • Meaningful care planning takes place for people with LTCs or ongoing care needs which guides the choices and actions of the patient and her/his professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or carers • People living with long-term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing, including: - self-management education: formal education or training so people develop knowledge, skills and confidence to manage their own health and wellbeing; - peer support: people supporting each other to understand their condition(s) and to manage its impact; - health coaching: to help people set goals and take action, improving their health and lifestyle; and - group based activities: activities that encourage healthier living and reduce social isolation (e.g. exercise classes or community choirs)
	Social action beyond the NHS helps people improve their health and manage their wellbeing • The STP area works with their LAs to support the local population in building community capacity and resilience • Social prescribing is widely provided by primary care and whole population care models • Strong partnerships between the NHS and voluntary groups deliver health prevention and support for patients, carers and their families • STPs employ asset based approaches: community-based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing
How to achieve this:	**Care planning and self-management** • Undertake structured conversations between people and practitioners to identify individuals' goals and the support needed to achieve them. Develop single plans that are outcomes based and owned by individuals • Offer tailored support based on need, including anticipatory care planning, social prescribing, health coaching and/ or integrated personal commissioning or personal budgets • Enable patients to better self-manage through improving information and health literacy. Useful tools include the self-care forum factsheets • Undertake ongoing reviews of individuals' support needs to ensure it reflects changing goals, needs and priorities
	Social action and community mobilisation • Implement social prescribing to connect individuals to non-medical and community support services

	• Develop a local menu of support options to allow easy access for people and simpler referral routes for professionals • Use evidence based IT to support the process of connecting people with their communities

Urgent and emergency care and 7-day hospital services

A set of 10 clinical standards have been developed to improve the quality of care no matter when patients are admitted. STPs should focus on a sub set of four priority standards to ensure patients admitted to hospital in an emergency receive the same quality of assessment, diagnosis, treatment and review throughout the week. Progress on the other six standards is also encouraged as these will be important in enabling delivery of the priority standards

Success in 2020:	**Provide responsive urgent care services outside of hospital, ensuring care close to home** • To succeed, STP footprints will need to make progress on other policy areas including developing an enhanced primary care offer and improving community support for long-term condition management
	Single point of access for clinical advice • A 24/7 integrated urgent care service implemented in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls from the public and all healthcare professionals • Services marketed so patients understand what is available to them
How to achieve this for UEC:	**Provide responsive urgent care services outside of hospital, ensuring care close to home** • Provide targeted support for specific groups. - Support people to manage their own health and ensure that care plans include what to do at times of crisis and relevant information for urgent and emergency care services - Support self-management for people with LTCs • Enhance urgent care services and pathways - Implement referral pathways between Urgent and Emergency Care providers, e.g. paramedic to GP - Enhance the role of community pharmacy see Quick Guide: Extending the role of community pharmacy in urgent care
	Single point of access for clinical advice • Ensure access to electronic records – Implement enhanced access to the Directory of Services and NHS Summary Care Record (SCR). • Ensure the eight key priorities of delivering Integrating Urgent Care are addressed: 1. a single call to get an appointment out of hours; 2. data can be sent between providers; 3. capacity for NHS 111 and out of hours is jointly planned; 4. the SCR is available in the hub and elsewhere; 5. care plans and patient notes are shared; 6. appointments can be made to in-hours GPs; 7. joint governance across Integrated Urgent Care providers; and 8. there is a clinical hub containing GPs and other health care professionals
How to achieve this for 7-day hospital services:	All STP areas should be planning for, or already implementing, 7-day hospital services. Ten early implementer areas, covering 25% of the population in England, have set an ambition to deliver 7-day hospital services by March 2017. The remaining areas should aim to implement 7-day hospital services standards by 2018 or 2020.

If you have queries on this PSNC Briefing or you require more information please contact Zainab Al-Kharsan, Service Development Pharmacist.