Hertfordshire and West Essex
Sustainability and Transformation Plan

Our Journey to Better Health
October 2016

COMMERCIAL AND IN CONFIDENCE

Executive Summary

Through the creation of the Hertfordshire and west Essex Sustainability and Transformation Plan, the NHS and county councils have embraced the opportunity to work together to improve the health and wellbeing of our population.

Building on the draft submission of 30 June and subsequent feedback, this plan demonstrates that NHS and social care in Hertfordshire and west Essex have come together as a single system, based on a robust governance structure, to deliver sustainable plans to achieve transformation and financial balance by 2020/21.

In collaboration with the public and using the expertise of our health and social care workforce, we will meet the challenges posed by rising demand that will result in a combined NHS and social care deficit of £548M by 2020/21 if nothing is done, and ensure that we deliver national policy ambitions of the Five Year Forward View.

We will work closely with residents of all ages to support them to live as healthily and independently as possible, encouraged and empowered by health, social care, community and voluntary services, all working together. This vision is based on three key programmes of work:

- **Prevention**
  Aiming to improve health and wellbeing and reduce demand for services by:
  - supporting communities to make the right lifestyle choices
  - helping people with long term conditions to live as well as possible for as long as possible
- **Integrated primary and community services**
  - supporting people to maintain their independence
  - locating frequently used services close to where people live
  - delivering the priorities expressed in the 'Five Year Forward View' shared vision for the future of the NHS (including Mental Health and Primary Care)
  - reducing demand for hospitals, relocate services from hospitals
- **Acute hospital services**
  - partnerships between East and North Hertfordshire NHS Trust and Princess Alexandra Hospital NHS Trust, and West Hertfordshire Hospitals NHS Trust and the Royal Free London NHS Foundation Trust, in order to support improved patient care, clinical and financial sustainability and deliver services more efficiently
  - reducing variations in care and services
  - standardising protocols and pathways.

By analysing the ways in which NHS and social care resources are used in our area, we have identified five priority areas for improvement which will deliver the greatest benefits in terms of health outcomes and financial value. These are:

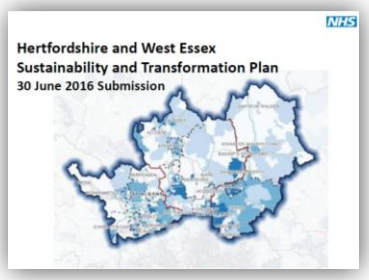
- frailty services
- the prevention and effective management of diabetes
- the prevention and effective management of chronic obstructive pulmonary disease (COPD)

- preventing stroke and rehabilitating patients after stroke
- ensuring that mental and physical health are given equal priority

These transformation initiatives, allied to other efficiency initiatives, will deliver system-wide savings of £452M (£402M NHS, inclusive of Sustainability and Transformation Fund (STF) allocations, and £50M social care) which balances our NHS budget, but leaves a risk of £101M attributable to social care. While resulting in an overall balance, these plans do not yet result in the control totals for 2017/18 and 2018/19 being met, and further work will be necessary to achieve these.

1. Context

This document builds upon the 30 June 2016 submission made by the Hertfordshire and West Essex Sustainability and Transformation Plan (STP) 'Footprint'.



Aims of the STP

In line with stated national requirements placed upon all STPs, we will:

- drive improvements in health and care;
- restore and maintain financial balance;
- deliver core access and quality standards.

In common with every health and care system in England, the leaders of the health and care organisations in Hertfordshire and west Essex have grasped the opportunity to work together with our residents, clinicians, representative bodies and voluntary organisations to produce a five year 'Sustainability and Transformation Plan', based on the needs of our 1.5 million population. Our plan demonstrates how we will deliver better health and patient care within the funding available to us, whilst improving the efficiency of NHS and social care services.

Across our area, which has been called a Sustainability and Transformation 'Footprint' area, there are: 160 GP practices, two county councils, two Health & Wellbeing Boards, two Healthwatch patient organisations, 13 district and borough councils, three acute hospitals, two mental health providers, two community providers, an ambulance trust and a significant number of other partners. Patients also travel for a range of services outside of our immediate area.

Responding to feedback from the June 2016 checkpoint submission

We have developed our ambitions based in part on the feedback we received following our initial STP submission in June. The STP footprint brought together

organisations that had not previously worked together and this was reflected in our submission. The feedback was

- the health system had not come together to form a single plan
- robust governance processes were yet to be established
- financial plans were not finalised

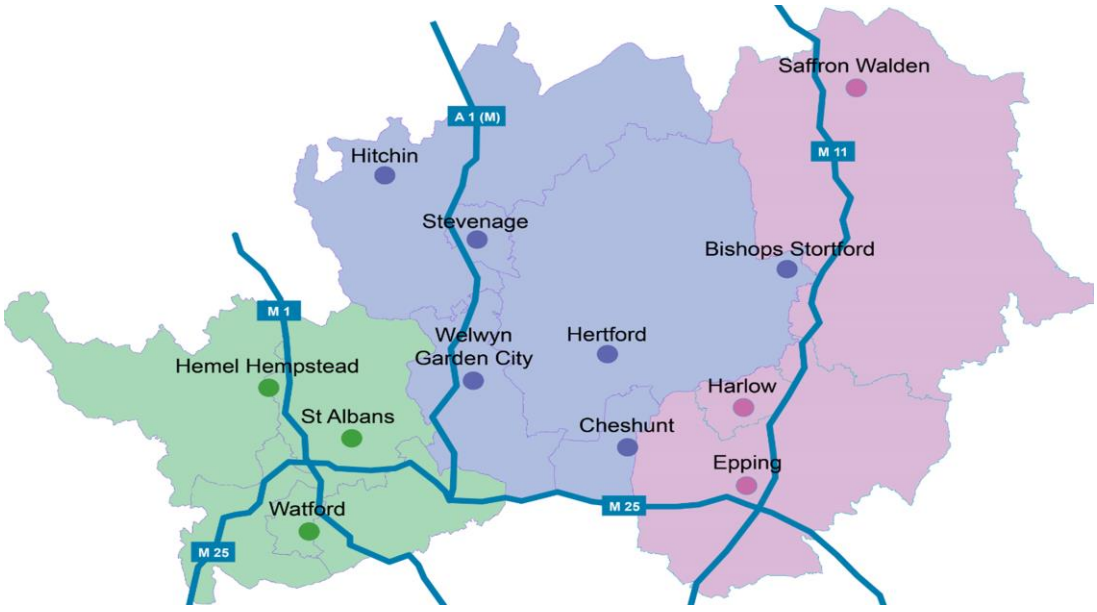
Since this time we have redoubled our efforts to enhance and maintain relationships across our footprint, and these have developed alongside the ambitious plans set out within this document. These plans will support the transformational change required to deliver services differently, improving patient experience and returning the local health economy to financial balance by 2020/21.

We now have in place a robust and rigorous governance structure. The planning and development of our STP plan has been overseen by Chief Executive Officers from partner organisations, who also lead the key workstreams. We have also increased the resourcing of a Programme Management Office dedicated to supporting the development and implementation of the STP, and have engaged analytical experts to support us in the development of our plans to change the way that patients use services in the local health economy.

Our challenges

The main challenge we face results from the increasing demand for services, particularly in the urgent and emergency care system, including mental health, which puts significant pressure on our hospitals and GPs. Our population is growing (a 10% increase forecast in the 10 years 2011-2021) and ageing (45% increase in people aged over 85 from 2011 to 2021) and we need to ensure that our health and social care workforce can meet these challenge in ways that make the most of all of the resources available to us.

Through extensive engagement and consultation processes, such as 'Your Care, Your Future' in the Herts Valleys CCG area and 'My Health, My Future, My Say' in West Essex, residents have made it clear that we need to transform the way we deliver health and care services. By listening and responding to our communities and providing integrated services, we can meet residents' needs by treating the whole person in a location that best meets their needs and the needs of their families and carers.



This document will outline the ambitious proposals that we believe are necessary to create a healthier future for us all.

Delivering National Policy
This plan fully recognises into the wider national NHS Five Year Forward View, and will play a major part in delivering the objectives of this over-arching plan in our area. The NHS has a series of public commitments to maintain and improve standards in a range of areas and this plan will demonstrate how, as a health and care system, we will achieve the following commitments:

1. To create a healthier future for Hertfordshire and west Essex residents in a secure and affordable health and social system by 2020/21.
2. To deliver improvements in the standards of urgent and emergency care our patients experience.
3. To ensure that patients receive the care they need within best practice timescales. To deliver improved care and health outcomes for patients with cancer or suspected cancer.
4. To ensure that people's mental health needs are treated with the same priority as their physical needs.
5. To deliver services to people with learning disabilities which support them from childhood to adult, meeting their health and care needs.
6. To improve the quality of care that all of our residents experience, ensuring safer, sustainable and productive services.

2. Our ambitions

By 2021, we want our residents of all ages to live as healthily and independently as possible, encouraged and empowered by health, social care, community and voluntary services, all working together.

We will make the best use of the funding available to deliver the right care at the right time and in the right place – with a focus on promoting good health and wellbeing.

To create a healthier future for residents, we will place a higher priority on giving people and communities the practical support and confidence they need to manage their own health and wellbeing. To help all of us to make the best use of our time and the resources available to us, we will provide services in people's homes or in their communities wherever possible. Specialist treatment which cannot be delivered at home will take place in specialist centres, such as the area's acute hospitals.

For local people, this will mean:

- Having the advice and support which will enable them to make lifestyle choices to improve their health and wellbeing and prevent ill health, with the opportunity to engage in activities designed to improve their health;
- People at risk of developing avoidable long term conditions will be supported to make changes to their lifestyles, to reduce those risks and stay well;

- Where someone has developed a long term condition, we will support them to successfully manage that condition as far as they are able, using information, advice and technology;
- Care will be provided whenever possible in people's own homes and community settings, based on a single care plan delivered by an integrated, multidisciplinary team. Mental health and learning disability services will be part of the integrated teams, ensuring that an individual's all-round health and care needs are met;
- When someone becomes ill and needs to go to hospital, they will be seen in hospital or admitted only if that is the most appropriate option for them to receive the care and treatment they require;
- People will be returned to their home or a community setting, with the appropriate health and care support and rehabilitation for their individual needs, as soon as they no longer require specialist hospital services.

For our staff, this will mean:

- Different and more productive ways of working in and with the community, with practitioners in primary care, community health, mental health, ambulance and social care services working together in integrated teams based in localities/neighbourhoods, supported by acute care specialists;
- There will be more flexibility in the way that staff deploy their skills, using their expertise to treat patients in a variety of settings, either in hospital, the community or at home, depending on which stage of their treatment the patient is at.

In the integrated community teams and in other areas too, there will be greater flexibility in the way that teams respond to individual patients and clients. There will be more of an emphasis on providing people with consistent contact with practitioners they know and who know them, rather than tasks being allocated to specific professional groups.

On the next page you will see our 'Plan on a Page'. This is a high level distillation of our intentions for the STP. We identified the four key areas for priority action (known as 'workstreams'**)** that we felt were necessary to support our services to transition into the vision we have for health and social care across Hertfordshire and west Essex. Analysis, based on specialist modelling work, has helped us to identify the pathways with the greatest potential gains for patients, providers and commissioners.

Our key workstream areas for priority action, together with input from the national 'Sustainability Transformation Fund', should save at least £452 million pounds, bringing the health system back into financial balance by 2020/21

3. Plan on a Page

Plan on a Page

To achieve our ambitions we will build on some of the excellent examples of integrated services, partnership and innovation across Hertfordshire and West Essex to build a new way of delivering these services to people in our local communities.

We have identified:

Four Key Workstreams

- **Prevention**
- **Primary and Community Care**
- **Acute**
- **Finance and Activity**

Five Priority Pathways

- **Frailty**
- **Diabetes**
- **Stroke**
- **COPD**
- **Admission prevention**

Five Supporting Workstreams

- **Collaborative Commissioning**
- **Workforce**
- **Technology**
- **Estates and Infrastructure**
- **Communications and Engagement**

We will deliver:

- The Prevention strategy plan, reducing acute hospital demand for patients with a range of conditions, from diabetes to alcohol dependency
- Redesigned community-based health and social care services, working more closely together than ever before to improve clinical quality, patient experience and affordability, and give equal priority to physical and mental health needs
- Reduced demand for acute hospital services, based on work across targeted care pathways including Frailty and Diabetes
- The next phase of planning to modernise the acute hospital sites in west Hertfordshire and Harlow
- Increased funding to General Practice, and expanded Primary Care workforce. We will also develop GP estates and technology, helping to release time to support clinical work
- Meet or exceed STP system control totals on a sustainable long term basis
- Meet the national requirements of the Five Year Forward View, NHS Constitution and improvements in services such as Mental Health and Cancer care.

Why we need to change how we organise healthcare services in our STP footprint:

- The rising demand on services from an increasing and ageing population are putting services as they are currently structured under pressure
- The current spend on Health and Social Care in our STP footprint for 2016/17 is £3.1bn, forecast to be £90 million overspent
- Without corrective action this is expected to increase to approximately £552 million by 2020/21
- Our key work streams, alongside STF monies, will save at least £452 million pounds to bring the system back into financial balance by 2020/21

4. Bridging the financial gap

The financial plans for Hertfordshire and west Essex are based on the need to manage the demand on the health and care system and introduce efficiencies to prevent an overspend that, if no action is taken, is calculated to rise to £548M by the end of 2020/21. Of this, £397M is attributed to the NHS, and £151M to social care.

NHS Financial Plans

NHS organisations within the STP footprint have been financially challenged for a number of years with all three acute providers recording deficits in 2014/15. These worsened in aggregate in 2015/16 but improved in 2016/17 through use of non-recurrent measures and receipt of STF allocations. On a normalised basis the provider deficits were almost identical in 2015/16 and 2016/17 at £106M and £104M.

The position for commissioners has been significantly better; with all three CCGs reporting underspends since their inception. These have increased over the years with each achieving all of the business rules in 2016/17 including a cumulative underspend of at least 1%.

The 'do nothing' position to 2020/21 sees a dramatic deterioration in the position of all organisations, with the total deficit potentially reaching £548M. The table below shows the aggregate impact on income and expenditure for NHS providers and commissioners. The deficit is caused by: higher growth in expenditure necessary to meet increasing demographic demand, funding required to achieve performance standards and new requirements in the various 'forward views'. At the same time the rate of growth in funding is slowing.

Aggregate Impact - 'do nothing' (NHS only)	2016/17	2020/21	Change	
	£M	£M	£M	%
Provider Income	1,384	1,560	176	12.7%
Provider Expenditure	1,481	1,826	345	23.3%
Provider surplus/(deficit)	(97)	(266)	(169)	
Commissioner Income	2,342	2,699	357	15.5%
Commissioner Expenditure	2,346	2,830	484	21.7%
Commissioner under/(overspend)	(4)	(131)	(127)	
STP Footprint surplus/(deficit)	**(101)**	**(397)**	**(296)**	

*the above figures are exclusive of identified social care solutions of £49.7m and cost pressures of £151m, which are included in the overall financial bridge

To address this forecast deterioration, the STP footprint has identified a number of opportunities to improve the cost effectiveness of the local NHS. These range from internal organisation efficiencies, cross organisational efficiencies through to transformational changes to better meet the needs of our population at lower cost. The latter opportunities require investment in community and primary care services alongside transformation of these services to increase the collaboration between providers, improve the co-ordination of care and target the population at risk of

requiring further expensive NHS services in the near future. The aim of all the solutions identified is to improve patients' health and wellbeing at a lower cost. The value of the solutions identified, along with the Sustainability and Transformation Fund (STF) allocation to the STP footprint, enables the achievement of financial balance across the NHS organisations. The table below shows the 'do nothing' and 'do something' position by year.

Aggregate Impact - 'do something'	2016/17 £M	2017/18 £M	2018/19 £M	2019/2020 £M	2020/21 £M
Aggregate 'do nothing'	(101)	(183)	(249)	(313)	(397)
Value of Solutions		90	153	224	302
Value of STF		31	31		100
Forecast surplus/(deficit)	**(101)**	**(62)**	**(65)**	**(90)**	**5**

*the above figures are exclusive of identified social care solutions of £49.7m and cost pressures of £151m, which are included in the overall financial bridge

During September and October, NHS Improvement and NHS England wrote to providers and CCGs respectively, setting out control totals and, where applicable, STF allocations for both 2017/18 and 2018/19.

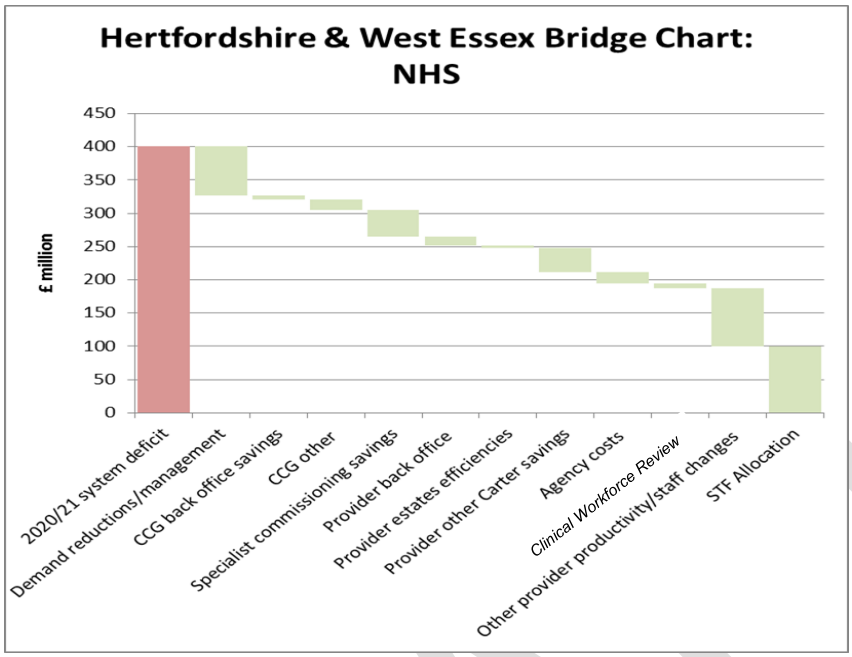
The aggregate control totals required significant improvement of over £30M compared to the normalised 2016/17 position, and the provider STF allocation has reduced slightly for the same period. Whilst the current solutions identified would deliver financial balance by 2020/21 they will not be delivered with such an aggressive profile across the years. There remains a gap to achieving the aggregate control total as set out in the table below. This means that not all organisations are currently in a position to accept the control totals.

Aggregate Control Totals vs. Plans	2017/18 £M	2018/19 £M
Gross Provider Control Total	(71.8)	(56.6)
STF Allocation	30.5	30.5
CCG Control Total	(0.1)	0.3
Aggregate Control Total	(41.4)	(25.8)
Aggregate 'do something'	(113.9)	(107.3)
STF Allocation	30.5	30.5
Aggregate of Plans	(83.4)	(76.8)
Current Gap	**(42.0)**	**(51.0)**

Further work is taking place including:

- reviewing all planned investments to establish opportunities to defer these, although this could impact on delivery of some of the national requirements
- reviewing cost pressures identified in the 'do nothing' scenario to seek alternatives ways to reduce or defer these

- reviewing current savings for further opportunities or ability to be more aggressive on the timing of delivery
- reviewing non-recurrent opportunities to reduce or offset costs.
- identifying further cost reduction initiatives in years two and three.



Managing social care finances

The social care funding gap across the STP by 2020/21 is calculated to rise to £151m for this footprint if no action is taken. Savings of £50M have been identified.

The scale of the potential gap (£101M) means a combination of the following is required:

- a continuation of current savings initiatives – (£16.2m of these appear as solutions in the bridge). It will prove difficult to maintain the demand mitigation strategies over the full five-year period countering the impact of demand and demography. The fragility of the care market will also impact on the ability to continue to make procurement and cost savings
- reductions in service - The extent of this will largely depend on the scale and success of other options listed here
- the impact of political decisions on any future Council Tax rises
- the continuation of political acceptance of implementing the Social Care precept (shown as £33m in bridge)

The impact of the above variables cannot be predicted at this point and will require political approval by the Councils at each budget preparation stage during the five year period.

Having outlined the current position relative to the financial bridge, the table below provides a breakdown of the impact assigned to each category and mapped to specific initiatives.

Solution(s)	Impact £M
Demand reductions/management	59.8
CCG QIPP requirements - estimated activity reduction	3.4
Social Care Savings	49.7
CCG 20% running cost savings	6.8
CCG other	10.2
Specialist commissioning savings	39.5
Provider back office	19.9
Provider estates efficiencies	4.3
Provider other Carter savings	24.1
Agency costs	16.7
Clinical staff review	8.3
Other provider productivity/staff changes	109.0
SUBTOTAL	**351.7**
NHS STF Allocation	100
Total Solutions	**452**

This leaves a total system gap of c.£101M which is attributable directly to social care inputs.

2020/21	Prevention	Primary and Community	Acute	Finance Inc. Back Office	Collaborative Commissioning	Estates	Organisations	Social Care	Specialist Commissioning	Total
Demand Reductions and Management	17,500	42,280								59,780
CCG QIPP	2,000	1,404								3,404
CCG Back Office					6,773					6,773
CCG Other							10,232			10,232
Provider Back Office				19,947						19,947
Provider Estates Efficiencies						4,310				4,310
Provider 'Other Carter'							24,052			24,052
Agency Costs		3,500	13,193							16,693
Clinical Staff Review		1,500	6,768							8,268
Provider Productivity			109,045							109,045
Specialist Commissioning									39,456	39,456
Social Care								49,732		49,732
STF							100,000			100,000
Totals	19,500	48,684	128,906	19,947	6,773	4,310	134,284	49,732	39,456	451,692

For the Health system (excluding social care) the bridge analysis is balanced as follows:

Financial Breakdown by workstream

Annualised plans have been developed to support the implementation of schemes related to the STP, each of which operates on the basis of improving the quality and affordability of care for our population. The table above summarises, at a workstream level, the proposed efficiencies attached to each of these workstreams between the 2017/18 and 2020/21.

The figures in the table are based on work carried out on our behalf by management consultancy firms KPMG and Deloitte to model changes in activity and manage demand for services differently.

Capital requirement

The following capital costs have at this stage been identified by partners at West Hertfordshire NHS Trust Hospitals (WHHT) and Princess Alexandra NHS Trust Hospital (PAH) as essential to supporting the maintenance and redevelopment of acute hospital infrastructure within the STP footprint over the STP planning period. These costs have been agreed by regulators as within the scope of the STP.

Capital requirement (WHHT)	Capital requirement (PAH)
£178M	£ 150M

Each trust has significant issues with the quality of their estate including large areas of the clinical environment. The STP therefore includes the need for capital funding from each of the Trusts to mitigate the current problems and ensure the continued provision of clinical services on the existing sites into the future.

The STP is working to apply key learning from the successful delivery of the 'Our Changing Hospitals' Programme in the east and north of Hertfordshire, to support the development of estates solutions in West Hertfordshire and Harlow.

The capital funding breakdown for both trusts relates to backlog maintenance, estate development and infrastructure funding. Further details are provided below.

West Hertfordshire NHS Trust Hospitals (WHHT)

The Trust has a requirement for £178M. Additional opportunities to identify additional capital may be explored.

WHHT capital requirements over the period fall into three categories:

- Critical backlog maintenance, equipment replacement and loan repayments (c £52M)

The overall condition of the WHHT estate is extremely poor and investment will be required over the STP period to address critical safety and business continuity risks (including power, water safety, asbestos removal, water ingress)

- Urgent capacity, compliance, clinical and information management and technology (IM&T) priorities (c £51M)

Priorities under this heading including theatre compliance and capacity at Watford General (an outline business case is in development), improvements to the Accident and Emergency environment and capacity, improvements to maternity services compliance. Additionally, approximately half of this funding relates to IM&T investment to support the Trust to upgrade clinical systems and implement digital records.

- Longer term strategic redevelopment including the redevelopment of Hemel Hempstead Hospital and strategic estate development (c £109M)

The acute transformation workstream of the *Your Care, Your Future* programme is currently developing a strategic outline case (SOC) for the future configuration and redevelopment of acute hospital services in west Hertfordshire. This will confirm the preferred configuration and capital investment requirement to make the hospital infrastructure fit for purpose and is due to complete by March 2017. The SOC sets out a range of options for these developments.

Longer term strategic development includes the development of the outline and full business case's for the long term redevelopment of the Trust's estate, car parking and enabling works. It also includes the potential redevelopment of Hemel Hempstead Hospital into a community hub / local hospital facility in the final year of the STP period. Should this occur, the trust will draw on learning from the development of the New QEII in Welwyn Garden City in order to inform robust planning and delivery

Princess Alexandra NHS Trust Hospital (PAH)
The capital funding request for Princess Alexandra Hospital is based on an evaluation of estates options by KPMG. Problems with the current estate are well documented and any viable strategy for meeting the needs of the growing population will require significant capital investment.

There is wide support for system reconfiguration of services in order to reduce pressure on PAH admissions, in community settings away from the PAH site. However, the area's strategic housing growth plan and demographic change will increase the catchment population substantially, so plans for capital investment in PAH must consider the need for PAH to be capable of serving this increased population in the long term

KPMG have recommended that, given the high expected population growth and the need for transformational change in the way that care is provided (both to improve patient care and to achieve the kind of efficiencies that will enable financial sustainability), the system should be seeking a long term sustainable solution to acute provision in the area and that subject to funding (circa. £450m) the system should seek to deliver an entirely new hospital on a new site.

However, given the current capital constraints the STP capital requirement for PAH of £150m aims to deliver the minimum new build and refurbishment required on site to create a functioning hospital in the short term. This option is described as medium term and involves the phased renewal of the existing site to address critical backlog maintenance and urgent capacity requirements.

- Fracture clinic
- New ward block (60 beds)
- Rebuild EAU
- Refurbishment of 8 wards to address mechanical infrastructure
- Refurbish and extend ED
- Refurbish maternity theatre and build second maternity theatre
- Endoscopy suite
- Expand day surgery; refurbish SMH theatres
- Refurbishment of Pharmacy
- Expansion/ refurbishment of ophthalmology
- Refurb SMH outpatients
- Bed storage
- Replace theatres 8 & 9
- Multi- storey car park (assumed funding not required for this as can be achieved with a private car park partner)
- Short term additional bed capacity rented
- Urgent backlog maintenance cost existing site

The current capital request of £150 m is factored into the STP financial bridge. It is important to note that these figures include planning contingency of 5% and optimism bias of 10%.This is lower than such contingencies often used for capital business cases for large capital projects that are a number of years away. At this point and in this case the lower numbers are considered sufficient a) because they are consistent with other recent cases; and b) because there is less uncertainty due to time as these works will take place in the next year or two. If higher contingencies were used (15% for planning and 25% for optimism) the total figure would be £175m rather than £146m.

This option will only keep the site going for the next 10 years and there is an acknowledgement that a long term site solution would need to be pursued concurrently. Given the expectation that the local population will continue to grow in line with the Strategic Growth Corridor objectives for the London Stansted Cambridge sub-region, the service will need to address the longer term future of PAH and consider whether it should invest further in its current location and satisfy short and medium term requirements, or invest in new facilities in a new location, satisfying longer term requirements.

In relation to this the system has agreed to proceed to the development of a Strategic Outline Case (SOC) building on the KPMG estates evaluation and testing the feasibility and potential for Local Authority support. This support may be available in a number of ways (PWLB Loan application, subsidised land acquisition and use of Community Infrastructure levy) and could, together with potential land sales, enable a longer term solution (new site option) to be progressed earlier. The development of a SOC will test a range of options around new build as well as refurbishment and development of the existing site.

WORKSTREAMS, ACTIONS AND ENABLING CHANGE

5. Prevention Workstream

Efficiency Requirement: £19.5M

"People should take more responsibility for their own health, which means having the right information and 'tools'" (response to 'My Health, My Future, My Say' public engagement, ***West Essex CCG****)*

Our Ambition: We want to support our residents, patients and population to live well, and stay well, for as long as they can. Where they do have healthcare requirements, our aim is to provide them with the tools to manage their own health and wellbeing independently.

The basis of the Prevention and Wellbeing workstream is a population-based strategy (using the locality/neighbourhoods that the integrated primary and community services are formed around) to tackle the key health issues and improve overall health and wellbeing. Using demand management modelling, prevention interventions are being targeted at areas which will have greatest beneficial impact for the population, while reducing demand on health and care services.

In the STP, our main focus will be to support people to improve their health and wellbeing, and to live well with long-term conditions, including initiatives to prevent the consequences of some conditions, such as diabetes-related amputations and falls.

Critical Success Factors

We will put in place the four critical success factors below, which are vital to the success of a prevention programme.

1. Clinical leadership and accountability for a programme approach – including a lead accountable clinician
2. Clinical practice that supports people with long term conditions to fully realise prevention/self-management/social prescribing potential, in primary and secondary care
3. Prevention to be systematically written into contracts, service level agreements and business plans
4. CCG/system additional investment in prevention projects where there is an identified cost benefit

There are three enabling approaches to prevention that the STP has recognised as having the potential to change our culture and help deliver our approach - social prescribing, personalisation and self-management.

Social Prescribing/Community First

We will engage with communities and individuals to enable them to be more proactive in making choices and taking part in activities to improve health and

wellbeing, and to be more engaged in planning and managing their own care plans. We will work more closely with our districts, communities and voluntary sector partners to support this approach. For example, 30-50% of patients don't take their prescription medication as directed in the first week and compliance declines significantly thereafter. Social prescribing is clearly an important part of supporting the other STP priority conditions (cardio/stroke/respiratory) as they could be exacerbated by the need to address living conditions, such as poor heating and insulation in their homes.

We will continue to work with our District Council colleagues to work with private landlords to ensure they provide safe housing and housing advice. We have a strong partnership with the Voluntary Sector across the STP footprint that can help with social isolation, benefits, insulation and other offers that can help people stay healthy in ways that medication can't. This will offer the following benefits:

- helps clinicians to get patients to people who ***can*** help them (not routinely part of training or current culture)
- patients get non-clinical resources to enable them to improve their health and wellbeing (deal with the non-clinical determinants)
- social prescribing offers patients the opportunity and, crucially, the **time** to talk about their issues in an informal and often non-clinical setting

Self-management and supporting people to live well with their long term conditions.

People who manage their own health, wellbeing and care have better experience of care and reduced demand for high-intensity acute services. Yet from nationally published research we know that 40% 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.

There are six principles to the self-management strategy:

1. Develop a culture of supporting self-management amongst the Hertfordshire & West Essex population and all who work with patients with long term conditions, which is led by effective and strong clinical leadership.
2. Provide a collaborative, integrated and personalised approach to self-management services to support all patients and encourage shared decision making.
3. Use a whole system approach to implementing and commissioning services.
4. Ensure information regarding self-management services is widely promoted and easily accessible.
5. Establish consistent and effective support of the workforce.
6. Regular evaluation which is feasible, and with active improvement of services.

Personalisation

The Integrated Personal Commissioning (IPC) programme in Hertfordshire has the following objectives:

- people will be supported by an integrated direct care workforce who have the flexibility and skills to deliver personalised health and social care tasks (personal assistant market)

- people will have a single point of contact and support for Personal Budget care and support planning
- people will be supported to connect with their community to live an independent life, their way
- we will introduce integrated datasets that serve to promote better performance monitoring, risk stratification and allocation of resources

The Prevention Agenda cuts across all our work. For example, our Maternity Transformation Plan includes actions to improve women's underlying health, both in the preconception period and during and after pregnancy, since pregnancy is a window of opportunity to encourage women to live healthier lifestyles. The work focuses on the 'Saving Babies Lives' care bundle, reducing levels of risk factors known to influence poor outcomes, including rates of stillbirths, neonatal deaths and maternal deaths.

There are a number of interventions that are being developed by colleagues in Public Health, with a selection of interventions that will contribute to our overall efficiency requirement being detailed bel

Diabetes*:* The aim of this element of the workstream is to reduce 10% of the population at risk of developing diabetes. Those with pre diabetes will be targeted with the aim of reducing the risk of them developing diabetes by 25%. Year one will see the roll out of the National Diabetes Prevention Programme, with the aim of reaching 1,500 – 2,500 people over two years. Self-management and strategies to support an increase in this will also play a major role in this workstream.

Smoking*:* This section of the workstream aims to deliver a 10% reduction in the number of current smokers over the period of the STP. It will do so in part by focussing on the traditionally 'hard to reach' parts of the population, who have less contact with medical services, but where some of the greatest gains can be made. A variety of interventions will be launched in year one, from working with employers to increase awareness of smoking cessation services and working with specific workplaces to introduce Smoke Free Toolkits, to increasing the role of community pharmacies and working more closely with key risk groups.

Weight management interventions: Weight management interventions aim to ensure that 10% of obese patients are enrolled in evidence based weight reduction services by the end of 2019/20. Through the development and roll out of "raising the issue" training for primary care on raising the issue of obesity with patients and acting on it – drawing on models with good evidence, as well as other interventions, such as further developing weight reduction pathways for patients referred for elective surgery under general anaesthesia – the STP footprint aims to make significant efficiency savings.

Alcohol management: This section of the workstream aims to reduce the number of 'increasing risk' drinkers by 10% over the period of the STP. This will be achieved through a number of specific, targeted interventions including extending access to 'Identification and Brief Advice' in NHS Provider settings, increasing access to alcohol needs assessments for older people, improving identification in primary care and Accident and Emergency through nurse liaison.

Atrial fibrillation: The aim of this element of the workstream is to reduce stroke through reducing blood pressure from above 140/90 in 10% of hypertensive patients. Improved management of atrial fibrillation will also play a significant contributory factor in efficiencies derived from this scheme.

Year One Targeted Savings	Year Two Targeted Savings	Year Four Cumulative Savings
£ 3,5M	£3.5M	£ 19.5M

6. Primary and Community Care Workstream

Efficiency Requirement: £48.7M

"Through HomeFirst, the physiotherapist came to my house and showed me exercises I can do at home, and the nurse visited to check my blood pressure and my pulse. It also means that my wife and carer Audrey doesn't need to travel in and out of hospital to visit me." (Ernest, 85, Cheshunt)

Our Ambition: To support more people to live their lives as independently as possible in the community. In turn this will support the reduction in demand on health and social care. This means supporting individuals and their families to manage their own health and wellbeing, providing the information and advice they need to do this. Our focus will be on developing active communities with strong local networks of support, whilst delivering care and support in a flexible integrated way. We will also be seeking to increase the use of personalised budgets to help individuals feel in control of their health and wellbeing.

Building on work that has been undertaken to date; we are focusing on the further development of integrated services wrapped around GP practices, developing place based care in neighbourhoods/localities. In doing so we will increase collaboration across services, reduce duplication, and will ensure that people only need to go to hospital when it is absolutely necessary.

Through the detailed modelling we have undertaken across the STP with KPMG, a number of pathways have been identified that, by adopting best practice, will have a demonstrable impact on reducing demand into the acute hospitals:

- frailty services
- the prevention and effective management of diabetes
- the prevention and effective management of chronic obstructive pulmonary disease (COPD)
- preventing stroke and rehabilitating patients after stroke
- ensuring that mental and physical health are given equal priority

Development of pathways and models of care to achieve best practice will be agreed across the STP footprint, with local delivery aligned with the Clinical Commissioning Group geographical areas. This reflects and builds on the work that began prior to the formation of the STP footprint.

- The Accountable Care Partnership (ACP) in west Essex – this is a natural progression of the West Essex Integration Programme that has been running for two years which has established neighbourhood teams, a new patient at home model and an integrated discharge model. The ACP includes elements of both the Multispecialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) models of care and will inform the future ambition of an Accountable Care Organisation (ACO) in West Essex
- In Hertfordshire, Integrated Care Programme Boards have existed for over two years delivering a range of integrated services including HomeFirst and Multi-Speciality Teams. These have been further developed to become the Herts Valleys Primary and Community Services Delivery Board (PCSB) and the East and North Hertfordshire Primary and Community Services Delivery Board (PCSB).

The planned changes in activity are detailed below

	3 years		5 years	
	ACTIVITY	REDUCED BED DAYS	ACTIVITY	REDUCED BED DAYS
In patients				
Frailty	11231	13584	24451	28222
Respiratory	1578	4263	3730	8637
CVD	1677	2544	3923	5228
Diabetes	164	205	386	407
MSK	282	418	674	856
Elective	1093	3520	2884	8524
	0	0	0	0
TOTAL	16025	24534	36048	51874
A&E attendances				
Well adults	44888	0	113050	0
Outpatients	140959	0	343095	0
TOTAL	**185847**	**0**	**456145**	
GRAND TOTAL	**201872**	**24534**	**492193**	**51874**

The modelling data detailed above has been translated into locality level plans, which will provide primary care and community-based colleagues with an understanding of the practical changes that they will need to make on the ground to achieve the overall aims of the workstream. The tables below provide an example of this locality level modelling, for the Lower Lea Valley locality.

PER MONTH

3 years		5 years	
ACTIVITY	REDUCED BED DAYS	ACTIVITY	REDUCED BED DAYS
5.5	8.1	8.7	10.4
1.4	4.5	2.2	5.5
1.4	1.5	2.2	2.0
0.1	0.1	0.2	0.1
0.3	0.3	0.4	0.4
1.8	5.9	2.9	8.5
10.5	**20.4**	**16.7**	**27.0**
57.1	0.0	90.4	0.0
173.9	0.0	275.3	0.0
231.0	**0.0**	**365.8**	**0.0**
241.5	**20.4**	**382.4**	**27.0**

PER WEEK

3 years		5 years	
ACTIVITY	REDUCED BED DAYS	ACTIVITY	REDUCED BED DAYS
1.3	1.9	2.0	2.4
0.3	1.0	0.5	1.3
0.3	0.4	0.5	0.5
0.0	0.0	0.1	0.0
0.1	0.1	0.1	0.1
0.4	1.4	0.7	2.0
2.4	**4.7**	**3.9**	**6.2**
13.2	0.0	20.9	0.0
40.1	0.0	63.5	0.0
53.3	**0.0**	**84.4**	**0.0**
55.7	**4.7**	**88.3**	**6.2**

Through reducing the volume of referrals into secondary care, we will also support colleagues working to transform acute service to release capacity and ‘right size’ their overall bed base to the changing demands of our population.

Year One Targeted Savings	**Year Two Targeted Savings**	**Year Four Cumulative Savings**
10.9M	13.7M	48.7M

Mental Health and Learning Disability

Our Ambition: We aim to dramatically improve outcomes and life expectancy for people who have a mental illness and those with a learning disability. We will do this by providing outstanding care and services which make a positive difference to the lives of service users and their carers. To help achieve this, we have committed across the STP that mental health and learning disability services will be given the same emphasis as physical health in local care planning and delivery.

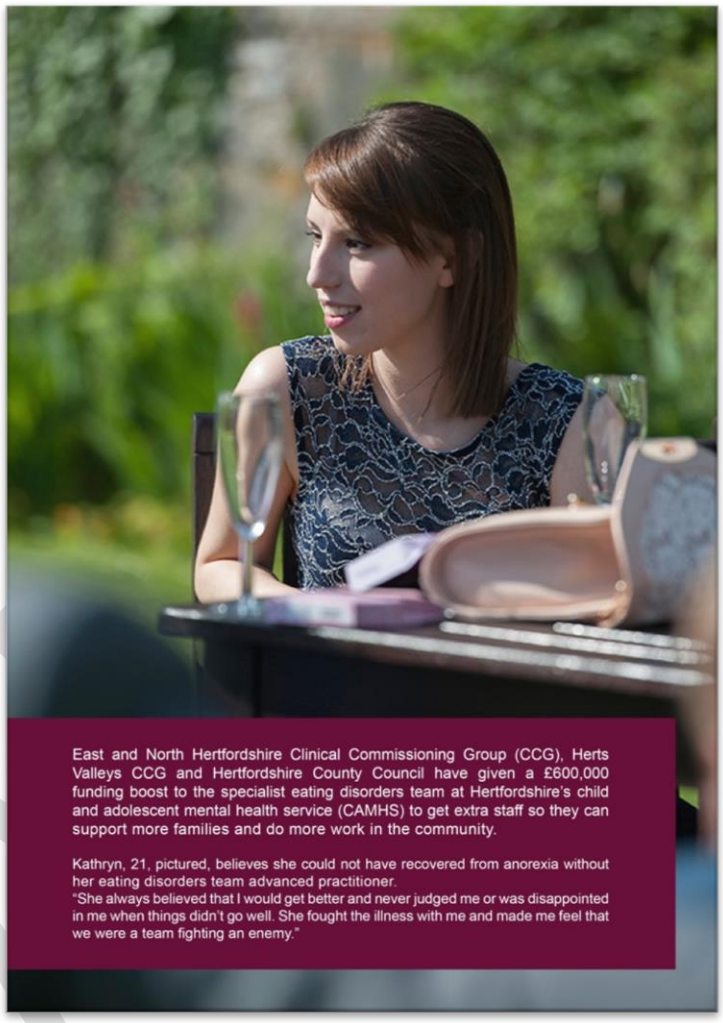
Our ambitions for mental health and learning disability services are framed within the context of the Five Year Forward View for Mental Health and the national Transforming Care agenda. Everything we plan to do is aimed at providing consistently high quality, joined up care, support and treatment that empowers individuals to manage their mental and physical wellbeing as close to home as possible, whilst keeping them safe from avoidable harm.

Working across health and social care services, together with voluntary organisations, we will seek to break down the artificial divide between mental and physical wellbeing, delivering care that is wrapped around the needs of individuals. In doing so we will reduce the health inequalities gap for people with a learning disability or mental illness. Specifically we will be seeking to deliver effective care that ensures the very best clinical and individual recovery outcomes, and the best possible experience. We will focus on:

- Improving support for people in crisis, increasing access to services and expanding interventions.
- Improving access to high quality personalised mental health and learning disability services
- Improving dementia diagnosis and post diagnostic support
- Supporting people in their local community to manage their mental and physical health better, in partnership with social care, primary care and community support network
- Improving access to services so that individuals receive the right care, in the right place, at the right time, and reduce to a minimum the time spent in hospital when they could be treated outside of an acute setting.
- Investing in appropriate mental health support and interventions for identified priority long term condition pathways (e.g. diabetes, stroke, frailty) to improve outcomes

In addition, as a priority we will be working to deliver the ambitions outlined nationally including;

- Provide access to additional psychological therapies
- Improve access to mental health services for children and young people
- Improving access to packages of care for people experiencing their first episode of psychosis
- Improve access to individual placement support for patients in secondary care
- Increase our community offer to extend to eating disorder services for young people
- Reduce suicide rates by 10%
- Street triage vehicle - the vehicle has a paramedic, mental health practitioner and police officer to help those patients in crisis



7. Acute Workstream

Efficiency Requirement: £129.0M

"People need to understand that Urgent Care does almost exactly what the A&E did, apart from accept ambulances. If you can get to the hospital on your own go to QE2, if you need an ambulance you'll end up in Lister. If you drive to Lister and wait for 4 hours you've only got yourself to blame!"

"Went in with my step son was seen in less than 20 minutes. X-rays etc. all done and out in less than 1 hour. Great Service ☺" *(Welwyn Garden City News Facebook Group)*

Our Ambition: We will support the provision of sustainable acute services across the STP by adopting a patient-centred, quality driven approach to optimising patient outcomes whilst reducing hospital based activity, optimising use of all resources and removing avoidable cost. We will deliver improvements in the standard of urgent and emergency care our patient's experience, and improve access to and outcomes for cancer patients.

Improvements in urgent and emergency care

Performance in urgent and emergency care across our STP footprint requires improvement. We understand that performance as it stands is being driven by a variety of factors, from increasing demand and unsuitable infrastructure, to capacity constraints and care pathways that require redevelopment.

There are a number of interventions referenced within this document that will enable us to materially improve standards in urgent and emergency care, and achieve the nationally mandated requirement of offering an Accident and Emergency appointment to all patients within 4 hours of their arrival at a Unit. Through supporting patients to better manage their own condition we will reduce demand, and through creating a more responsive and integrated offer in primary and community care we will support patients to seek treatment outside of an acute hospital setting.

Across our STP our acute hospitals will focus on key components of urgent and emergency care as part of their recovery plans to improve performance in a sustainable manner. These will include:

The seven priority areas are:

1. Streaming
2. Patient Flow
3. Discharge
4. Workforce
5. Speciality referral
6. A&E Rapid Assessment
7. Operations Management

Specific examples of work already underway across our STP include:

1. **GP in Accident and Emergency – Providing a GP** in the minor injury area to reduce the pressure in this department and increase availability of staff to address pressures in the majors department. This should also contribute to a reduction in the waiting time for assessment.
2. **Frailty team** – Working to reduce unnecessary admissions through the Accident and Emergency department, improve the assessment process and deliver a service six days a week which reduces delays against the 4 hour standard performance target.

Improving care and health outcomes for patients with cancer

Our vision for cancer services is to collaborate with local partners to deliver one-system, patient centred, exceptional care for our patients. We provide a full range of cancer services that meet NICE guidelines, including a full range of diagnostic services, Clinical Nurse Specialist Service, acute oncology service supporting early diagnosis and supporting patients living with and beyond cancer through the Recovery Package. This includes:

- stratified follow up pathways;

- holistic needs assessments;
- end of treatment summaries; and
- access to health and well-being events.

We will continue to develop our core service offering including:

- focusing on patient experience through support, user and focus groups and local and National surveys;
- ensuring our patients have full access to research protocols; and
- ensuring delivery of key access and performance targets supported by information management systems.

Supporting local delivery and integrated care closer to home is a core part of our vision and across the STP our organisations will work closely with a range of key local health and voluntary sector partners to deliver patient centred cancer care close to home. Over the coming years we will:

- continue collaborative working with partners for inter-Trust referrals;
- work with primary care on prevention including GP education and training;
- work with the emerging cancer alliances to co-design optimal pathways to ensure effective integration and address variation;
- work collaboratively with CCGs, Cancer Networks (London, Anglia, East of England);
- work with existing and new screening partners
- deliver comprehensive information in all aspects of cancer care including audit, access and survival data to support delivery of services to achieve better outcomes.

In addition to the improvements that we plan to make in urgent & emergency care, and cancer, there are a number of specific subsections of the workstream which are working to achieve our ambitions, some of which are detailed below.

Reducing Unwarranted Variation: Acute trusts across the STP are working in collaboration with the aim of eliminating unwarranted variation by the appropriate standardisation of integrated clinical pathways across the STP. This work is being designed and led by the three Medical Directors to significantly reduce length of stay for identified pathways. Identified priorities for Year 1 include community acquired pneumonia, chest pain and frailty. By benchmarking against national best in class performance for these pathways, we will be implementing streamlined processes that significantly reduce length of stay. This will benefit patients, who will spend less time away from home, as well as cut costs—both by bringing down cost per patient treated, and by allowing us to repatriate some patients that are currently seen in alternative settings due to lack of capacity.

Clinical Services Consolidation (including fragile services): Good progress is being made to develop pan provider services that will enable fragile clinical services to continue to be provided sustainably and locally, and to avoid future cost increases. Agreement has been reached on priority services to include in the first phase of clinical collaboration across STP partner organisations. The following services have been identified to improve the quality, efficiency and sustainability of each service:

Vascular surgery and interventional radiology: East and North Hertfordshire NHS Trust (ENHT) is working together with Princess Alexandra Hospital Trust to set up a vascular network covering the east of the STP footprint, to improve access to this service and make progress towards full compliance with service specification (subject to agreement with Specialist Commissioners). WHHT are engaged in the East of England vascular review and are in dialogue with ENHT/PAH regarding options to improve sustainability and work in a more networked way, pending a final decision on the location of the vascular hub.

Paediatric Urology: Agreement reached for ENHT to provide one day/week paediatric urology service at PAH to enable the continuity of this service.

Nephrology: Agreement in principle for ENHT to replace Mid Essex as provider of outpatient and in-reach service at PAH. This is expected to deliver improved patient flow, outcomes and experience. WHHT is also reviewing the provision of specialist nephrology outreach and in-reach services and will be exploring potential options with ENHT and / or the Royal Free London NHS Foundation Trust (RFL) group.

Specialist cancer surgery: Agreement in principle for ENHT to become the specialist cancer surgery centre for complex urological cancer surgery referrals from PAH, avoiding the need for patients to travel into London for surgery from 2017/18 (subject to agreement with Specialist Commissioners). WHHT currently provides specialist cancer surgery for gynaecological and upper gastro-intestinal oncology and will be reviewing options to improve the sustainability of these services with specialist commissioners.

Support Services (including 'back office'): Significant progress has been made between PAH and ENHT to develop shared back office and clinical support services. Both Trusts have shared high level costs and income for back offices services, with a range of financial opportunities modelled which will vary depending upon the nature of the collaboration. In addition, support is being provided by ENHT across a range of other services including estates management.

Partnership working*:* The Royal Free London NHS Foundation Trust (RFL), as part of the national 5 year forward view Vanguard programme, is developing a group membership model that aims to promote stronger clinical partnership working between hospitals. The model will support the development of more consistent, best practice clinical care models that reduce unwarranted variation in pathways and outcomes. The group model will also look at how the NHS can harness the opportunities provided by new technologies and help secure greater efficiency in back office support services. West Hertfordshire Hospitals NHS Trust is exploring the possibility of becoming a member of the group model to help secure the very best, sustainable clinical services for local residents.

Similarly, East and North Herts NHS Trust Hospital and Princess Alexandra Hospital have formally entered into a Memorandum of Understanding to jointly explore opportunities offered by collaborating to provide clinical and non-clinical services. Examples for clinical collaboration have been identified as above, with others in development.

Year One Targeted Savings	Year Two Targeted Savings	Year Four Cumulative Savings
52.1M	£39.5	129.0M

8. Enabling Workstreams

8.1 Collaborative Commissioning Workstream

Efficiency Requirement: £6.8M

Our Ambition: The three CCGs and two county councils will work together to provide a single standard for commissioning integrated services across Hertfordshire and west Essex; by commissioning health and social care together and collaborating with providers we will deliver more effective and personalised services to patients and service users.

The principles of our commissioning approach will be based on outcomes, best practice and value, and will focus on moving activity from acute to community and primary care. We will focus on the whole person, taking into consideration both their physical and mental health needs.

This will include:

- a common set of commissioning intentions based on STP priorities
- common specifications, threshold criteria, and exclusions
- joint teams, sharing approaches e.g. to contracting with providers, singular leads where practicable
- Committees meeting in common with delegated authority

Common specifications, threshold criteria, and exclusions: Work is already underway to unify commissioning practice across our STP footprint area. There are areas where policies currently differ. These areas will need to be explored and considered in collaboration with clinicians and the public. Two specific examples include the varied approach currently taken within the STP area to the provision of IVF and gluten free foods on prescription. This workstream is projected to achieve the following savings:

Joint teams, sharing approaches: All commissioning organisations within the Hertfordshire and West Essex STP footprint have committed to reducing running costs, reflecting the ambition of partners to work more closely together on running cost functions where cost has been duplicated (such as contracting, business intelligence etc.). Each organisation has committed to a 20% reduction of 2016/17 running costs over the course of the STP period.

Year One Targeted Savings	Year Two Targeted Savings	Year Four Cumulative Savings
TBC	TBC	£6.8M

8.2 Workforce Workstream

Workforce

Our Ambition: The ambitious vision for the transformation of health and care services contained in this plan will be delivered by a workforce providing patient-focused delivery of care pathways, which will often involve more than one care setting. The workforce will be supported in developing the skills to work flexibly – across care settings, in flexible multi-disciplinary teams, flexing with activity and demand shifts, and working in the system rather than for an organisation.

We will therefore model the changes in investment and activity – where and how services will be delivered – and align the plans for workforce development and investment with these. Always maintaining the clear link between finance, activity and workforce, we will articulate a clear case for change and implementation plans. These will include comprehensive organisational development programmes for all staff to embed the different cultures and behaviours required throughout the health and care system.

We will take the following measures to ensure a well-planned process:

- draw up a comprehensive baseline of the current workforce, including identifying issues which require solutions, such as services dependant on high numbers of agency staff, recruitment and retention issues, demographic issues and areas of national shortage.
- develop short term actions and long term strategies to address the issues identified above
- design the workforce for future years based on detailed review of the activity and investment profiles in the STP and the requirements for new approaches and flexibilities in the models of care
- articulate the case for change and set out detailed plans for the transition into the new models of care.

8.3 Estates Workstream

Our ambition: To provide services in locations that are convenient for local people, near to their homes, with local services located close together so that people do not have to make multiple journeys. People should only have to travel to acute hospitals when their treatment can only be provided in such a specialised setting.

We will review the use of community estate, building on work already done across primary care, community and mental health and social care services to ensure we are making the best use of the resources at our disposal. We will also ensure that we have planned for the movement of activity from hospitals to community settings. We will work with partners to find opportunities to maximise the benefit we get from public sector buildings through the ‘One Public Estate’ initiative.

8.4 Technology Workstream

Our ambition: We will use technology to improve the way we work together across agencies to provide a single, joined-up response to individuals' health and social care needs, by allowing easier communication between practitioners, and the creation of single care records. We will become more responsive by being able to track, for example, performance and capacity in urgent and emergency care using real-time information systems. We will place particular emphasis on using technology to assist patients to manage their conditions, remaining as independent as possible. This work will be facilitated by our Local Digital Roadmap (LDR), the underlying digital strategy for our STP.

There is a strong focus on four specific objectives within this workstream that will contribute to the integration of health and social care systems, joining up services between homes, clinics and hospitals:

- interoperability for direct care
- live urgent care dashboards
- integrated intelligence and information governance
- infrastructure and provision

To achieve these specific objectives, we will promote continued collaboration between Hertfordshire and west Essex to align the local digital roadmap to the STP. We will also set up a working group on integrated intelligence and information governance to continue promoting effective information sharing. Finally, we will work towards shared care records to improve integration of services

We anticipate that funding in the region of £120M will be required to deliver the aims of the LDR. A detailed breakdown of this figure will be provided in the next LDR submission, due in November 2016.

Medical interoperability gateway (MIG)

Previously patient information and care records will have been made available via traditional methods such as secure post, fax or email, which can be slow and, at times, unreliable, and possibly prolong diagnosis and treatment.

My Care Record is accessed via the different and secure health and care computer systems, once you have given your permission.

None of the information it collects is stored and the existing information cannot be altered.

Before any information is collected or displayed, you must give your permission. Your permission is recorded in an audit trail, which also keeps all access tracked and logged.

9. Communications and Engagement

The STP communications and engagement strategy builds on well-established foundations of engagement and participation across the footprint area, which has already seen the delivery of significant strategic change.

STP partner organisations in Hertfordshire and west Essex have been working with the public for some time to address a number of challenges and demographic pressures, in order to create a sustainable, high-quality and affordable health and social care system.

Examples of projects which will feed into the STP and which have included significant clinical and public engagement include:

1) **Prevention**

   Diabetes - In partnership with Diabetes UK, East and North Hertfordshire CCG has established eight patient-led peer support groups for adults with Type 2 diabetes across their area. The groups are self-supporting and meet regularly to encourage each other to manage their condition effectively. Patient-led diabetes education pilot events begin later this month, aimed at engaging people to understand and manage their own conditions and signposting them to peer-support groups.

2) **Acute Care**

   Record sharing - Through the 'My Care Record' project, West Essex CCG has engaged extensively with the general public and clinicians in the acute and primary care sector in order to facilitate a GP record-sharing project to improve patient outcomes. The project, which is about to go live, will enable acute and community-based health and social care practitioners to view the records of the patient they are treating, with the express permission of that patient at the point of treatment. Agreement has recently been reached to extend this information sharing agreement across the East and North Hertfordshire CCG area.

   Acute reconfiguration – Through the 'Your Care, Your Future' strategic review, Herts Valleys CCG has conducted more than 50 public meetings, received more than 900 survey responses, held focus groups and engaged clinicians from across their area in a wide-ranging debate about delivering sustainable health and social care, including the future of the areas three hospital sites.

3) **Primary and Community**

   HomeFirst – HomeFirst is a rapid response, case management and supported discharge service which supports older adults and people with multiple long term

or complex conditions such as diabetes, dementia and COPD to remain at home rather than going into hospital or residential care. Developed and driven forward in collaboration between GP locality leads, Hertfordshire Community Trust and Hertfordshire County Council, HomeFirst brings together physical and mental health and social care services to deliver improved access to rapid support, with care from the right professional.

HomeFirst improves the communication between people using the service and those delivering care, with the ultimate aim of reduced accident and emergency attendances, unplanned hospital admissions or placement into residential care. Feedback from patients, GPs, carers and multi-disciplinary staff has been excellent. The service has reduced the number of people being admitted to A&E in its areas of operation and is being extended across the east and north of Hertfordshire.

Child and Adolescent Mental Health Services (CAMHS) – The Hertfordshire CAMHS Transformation plan has secured £2M national funding to improve services over five years, with Hertfordshire's two NHS clinical commissioning groups taking the lead. Key priorities are to: focus on prevention and early intervention, improve access to psychological therapies, bring together education and mental health services, develop community eating disorder services and improve mental health services for women during pregnancy and within the first year of having a baby.

Emerging themes
The following themes have emerged from the engagement and consultation around these projects:

- Professionals and care should be joined up
- Local services need to change
- People should take more responsibility for their own health
- Quality and efficiency comes from caring for people as people
- Unnecessary journeys to hospital can be reduced by providing care closer to home
- Build on existing community services so more people benefit from the care and support of voluntary organisations
- Support the creation of social movements to improve health and wellbeing

Communicating the STP challenge
The high-level challenges facing our STP footprint area and a broad approach to improving health and social care have been articulated at a number of recent events for a range of audiences.

Examples include a number of public events, clinical engagement programmes and stakeholder engagement events.

Next steps
There are well-established existing networks and relationships between communications and engagement staff in Hertfordshire and west Essex. Monthly

joint communications meetings have been taking place for the last two years and winter health and care communications planning (for example) is already undertaken as a joint enterprise with shared key messages and pooled resources. Communications and engagement representatives from all of the Hertfordshire and west Essex STP partner organisations will continue to collaborate and communicate regularly to develop comprehensive localised engagement and communications action plans, in line with the over-arching strategy attached to this document as an appendix. Agreed key messages, presentation materials and other resources will be shared amongst the partner organisations to ensure that consistent messages about the STP are shared.

Both the two Hertfordshire and West Essex CCGs have long-standing formal and informal communications networks with health overview and scrutiny committees (HOSCs), Health and Wellbeing Boards and Healthwatch, which will be fully utilised during the development and delivery of the STP.

Priority actions:
In November and December, we will:

- produce a public-facing document with which to engage our residents about the STP
- begin a series of primary care workshops across STP
- develop a pool of clinical leads and presenters to act as advocates for the STP
- identify where formal consultation processes will be necessary, and the resources needed to deliver these
- brief patient participation groups and Trust membership bodies
- brief key political stakeholders, including MPs, District and County Councillors.

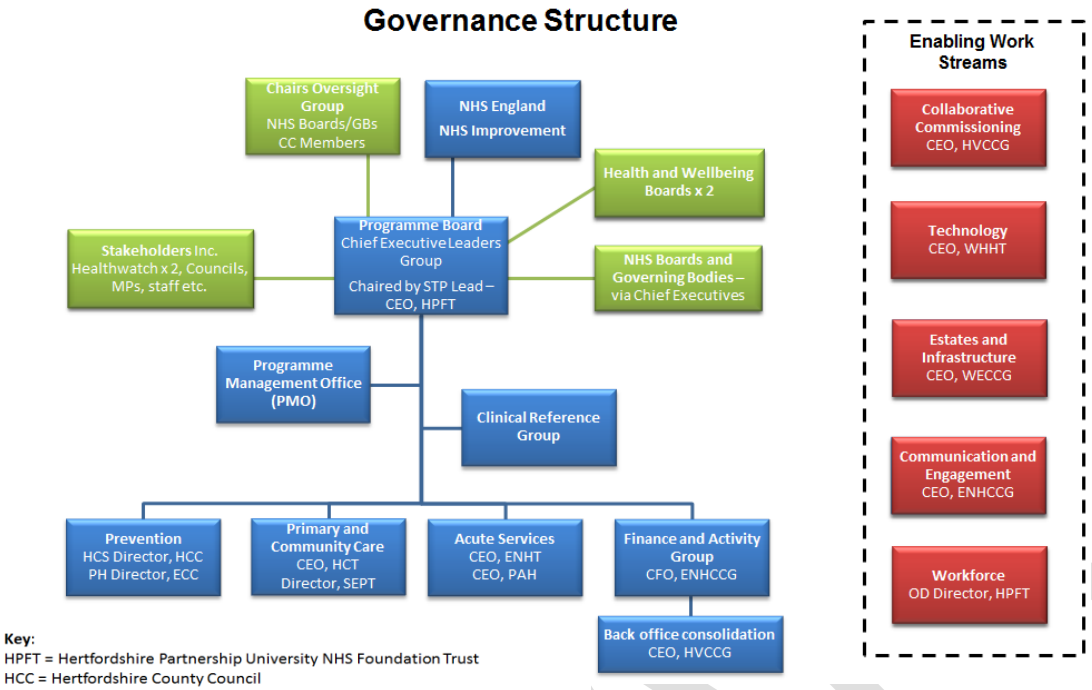
10. Key risks

Risks

This is an ambitious plan, and there are therefore some significant risks associated with its achievement. These are:

- The plans are in development phase and need to be tested to verify viability give scale of challenge
- There is a risk that 2017/18 control totals cannot be achieved by all organisations, as reflected earlier in this submission
- There is significant uncertainty about the ability to maintain the planned year-end financial position for 2016/17
- The capacity and capability in the system is not sufficient to deliver the plan;
- Insufficient engagement and buy-in from clinicians and practitioners which impede delivery
- The priorities of individual organisations may preclude the full commitment of all partners that is needed to achieve the plan.

11. Governance



Key:
HPFT = Hertfordshire Partnership University NHS Foundation Trust
HCC = Hertfordshire County Council
ECC = Essex County Council
HCT = Hertfordshire Community NHS Trust
SEPT = South Essex Partnership University NHS Foundation Trust
ENHT = East and North Hertfordshire NHS Trust
PAH = The Princess Alexandra Hospital Trust
ENHCCG = East and North Hertfordshire Clinical Commissioning Group
HVCCG = Herts Valleys Clinical Commissioning Group
WHHT = West Hertfordshire Hospitals NHS Trust
WECCG = West Essex Clinical Commissioning Group

CEO = Chief Executive Officer
HCS = Health and Community Services
PH = Public Health
CFO = Chief Finance Officer
OD = Organisation Development

12. Programme management

It is acknowledged that given the scale of change and transformation required to effect the STP serious consideration has been given to resourcing programme. This amount will be included within the financial bridge.

In the meantime, partner organisations have committed to supporting the STP process by providing senior personnel to the programme. More detail assessments of requirements will be made in the coming weeks. However, it is envisaged that the programme will be co-ordinated through a relatively small Project Management Office.