

Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan - Summary Plan 21st October 2016

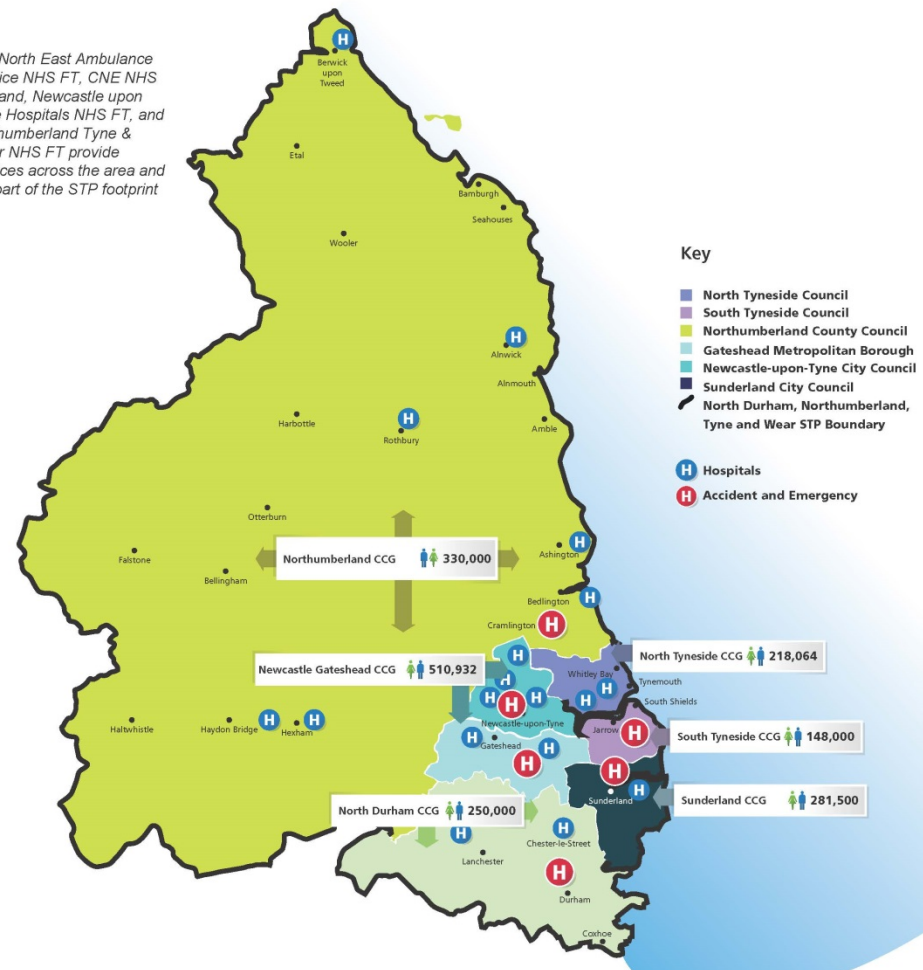
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The Northumberland Tyne and Wear and North Durham (NTWND) STP footprint is a new collaboration covering a total population of 1.7 million residents across three Local Health Economies (LHEs):

- **Newcastle Gateshead**
- **Northumberland and North Tyneside**
- **South Tyneside, Sunderland and North Durham**

Organisations delivering Health and Social Care within the STP footprint are detailed on the map

The North East Ambulance Service NHS FT, CNE NHS England, Newcastle upon Tyne Hospitals NHS FT, and Northumberland Tyne & Wear NHS FT provide services across the area and are part of the STP footprint



Foreword from Mark Adams - Sustainability and Transformation Plan (STP) Lead

The Northumberland, Tyne and Wear and North Durham STP footprint, is largely coterminous with the North East Combined Authority (NECA) area. The area has strong health and care services and has experienced the fastest increase in life expectancy of any region of the UK. But the health and wellbeing gap compared to the rest of the UK and health inequalities within the region remain stubbornly high. Poor population health leads to overuse of intensive health services and pressures on primary and social care, resulting in a system over-focussed on the treatment of ill health at the expense of preventing it. It also reduces productivity and hampers economic growth, entrenching income inequalities which contribute to poor health.

We are building on a long history of partnership working and through that collaboration the results have been positive and greater than any individual organisation could have achieved alone. As a footprint, NHS and Local Authority organisations in Northumberland Tyne and Wear and North Durham (NTWND) have come together to work in collaboration on closing the three gaps of health and wellbeing, care and quality and financial sustainability. We do so working at scale across the STP footprint and as distinct Local Health Economy (LHE) Areas: Northumberland and North Tyneside, Newcastle and Gateshead, South Tyneside, Sunderland and North Durham.

Our STP is built upon established programmes of work within each of our Local Health Economies as well as additional new proposals for transformation over the next 5 years with common priorities being delivered at an STP level. The NTWND health and social care system is one of the strongest in England. We have some of the highest performing providers in the country (consistently delivering NHS Constitutional Standards) and we have 6 Five Year Forward View 'Vanguard' and pioneer programmes. Through the implementation of our programmes of work at all levels, our STP indicates how we propose to deliver financial stability.

Looking forward to 2021, by doing nothing we will see the current gaps in our Health and Wellbeing and Care and Quality outcomes against the rest of the country widen. Our local NHS financial gap coupled with that of our local authorities' financial constraints, if left unaddressed, will cause a decline in our local services resulting in an unsustainable health and care system.

On that basis, our STP plan will focus on a number of key **Transformational Areas** that will:

- **Scale up Prevention, Health and Wellbeing** to improve the health and wellbeing of our public and patients utilising an industrialised approach designed by the Directors of Public Health from each of the local authorities.
- Improve the quality and experience of care through **Out of Hospital Collaboration** and **the Optimal Use of the Acute Sector** by:
 - Scaling up of the New Care Models from our Vanguards and development of a resilient and robust primary care sector.
 - Ongoing acute service changes underway in our LHEs. For example, the ACO in Northumberland and opening of a new hospital in Northumberland, NSECC, and more recently, South Tyneside FT and Sunderland FT coming together to be managed under a single management team. Further speciality level review is underway to meet the emerging challenges around workforce pressures required to deliver clinical standards within a 7-day service.
- Close the financial gap, which by 2021, if we did nothing to resolve the situation would be, £641million.

While our financial sustainability is based upon a modelling of the NHS budgetary gaps, it should be noted that work continues with our local authority colleagues to understand and reflect the continuing expected impact of austerity and the specific impacts on the NHS.

In this way the STP not only provides an overarching route map for the future direction of travel across the NTWND area, but also provides summary level implementation plans which will be reflected in greater detail in the 2 year operational plans of each of our constituent NHS organisations.

Robust mechanisms of involvement, consultation and scrutiny based on existing partnerships exist, but clearly 'fresh conversations' continue to take place around the scale and pace of our STP proposals. Consequentially, there is recognition that a significant amount of work and support continues to be required to operationalise and refine our STP proposals to ensure delivery.

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1.1 OUR NTWND STP VISION

Northumberland, Tyne and Wear and North Durham STP Vision for 2021

“A place-based system ensuring that Northumberland, Tyne and Wear and North Durham is the best place for health and social care”

Our **collective vision** for NTWND is simple yet effective:

- **Builds upon Health and Well Being Strategies** in each of our Local Authority areas
- **Safe and sustainable health and care services** that are joined up, closer to home and economically viable
- **Empowered and supported people** who can play a role in improving their own health and well being

Our vision builds upon existing work underway within each of our Local Health Economy areas (LHEs) and enables us to take a transformative approach to addressing the key challenges we face across the system.

Our **key aims for Health and Care by 2021** are to:

- Experience levels of health and wellbeing **outcomes comparable to the rest of the country** and **reduce inequalities** across the NTWND STP footprint area
- Ensure a **vibrant Out of Hospital Sector** that wraps itself around the needs of their registered patients and attracts and retains the workforce it needs
- **Maintain and improve the quality hospital and specialist care** across our entire provider sector- delivering highest levels of quality on a **7-day basis**

As a system we will be moving:

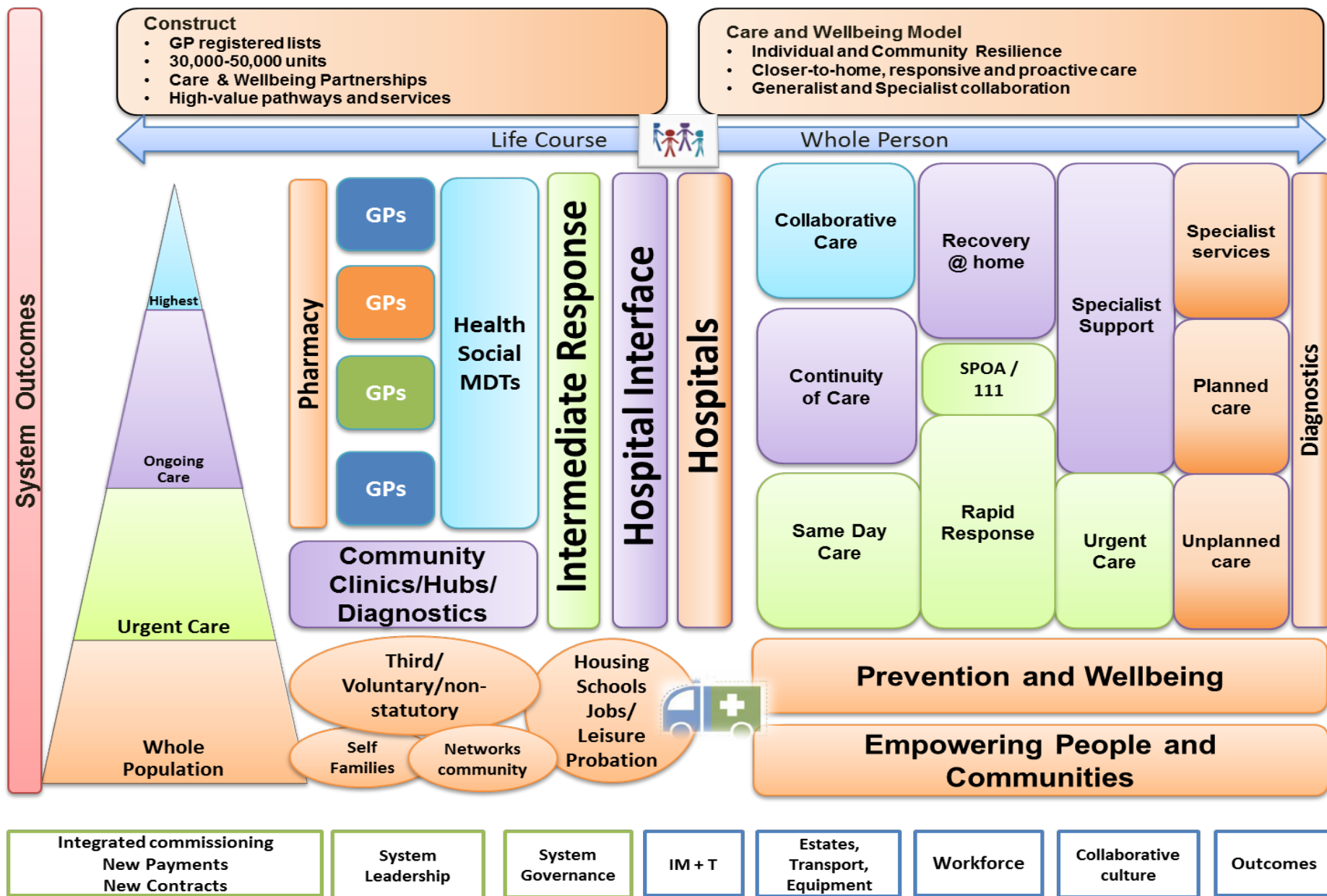
From	To
Fragmented Payment	Unified Budgets
Hospitals at the centre	Home as the hub
Excellent soloists	High performing teams
Moving people	Moving knowledge
‘What is the matter with you?’	‘What matters to you?’
A sense of scarcity	A sense of abundance

1.2 OUR EVOLVING HEALTH AND CARE MODEL

To address the challenges we have established an NTWND STP wide framework for a future health and care model. This work is based on an assessment of current re-design programmes within each LHE including the North East Wide Vanguard Programmes. Our framework provides a 'blue-print' for the spread of population based new models of care.

Our framework is illustrated on the following slide.

NTWND STP – our evolving Health and Care Model



1.3 UNDERSTANDING OUR THREE GAPS

Our understanding of the current position against the three gaps set out within the *NHS Five Year Forward View* has been developed through a process of robust analysis and modelling utilising for example JSNAs, scrutiny of clinical quality and safety data, patient and carer feedback, evaluations and organisational financial information.

We continue to refine our understanding of the challenges facing the NTWND Health and Care System to ensure our plans are focused on delivering the right and most effective changes.

Understanding our three gaps

GAPS

HEALTH and wellbeing



27%
of population live
among 20% most
disadvantaged areas
in England

Deprivation and
broader social
determinants set the
foundation for poor
health across the STP

16%
women smoking at
time of delivery
(11% in England)

Children are not
always given the
'Best Start in Life'

68%
obese or overweight
adults (65% in England)

High prevalence of
risk factors that lead to
potentially preventable
illness, eg smoking

6.7%
of adults on a diabetes
register, (6.4% in England)

attributable hospital
admissions over 50% higher
than across England - nearly
25,000 admissions per year.

20% higher
early death rate in
NTWND due to cancer
than across England

High levels of early
mortality from cancer,
respiratory disease, and
cardiovascular disease

59.6 years
Healthy life expectancy
in NTWND
(64 years in England)

Growing older population
with associated increases
in frailty and multiple
morbidity

CARE and quality



Unwarranted variation

Cancer, mental health, learning disabilities, maternity services, dementia care. MSK, urgent and emergency care, provision of specialised services.

Variation

in quality, safety and experience of people using health and care services.

Inconsistency

of pathway between local and specialised services.

Increasing demand

for hospital and bed-based services: 20% higher in the North East than across England as a whole.

Clinically sustainable

services whilst maintaining high levels of care and quality.

Capacity and resilience

of community care and community service.

Infrastructure and workforce

required to deliver fully integrated health and care services outside of hospital.

7

Availability of seven day services and mental health advice.

FUNDING and finance



System efficiency and finance challenges:

£641m

gap across health by 2021

a figure as high as

£904m

Indicates the joint health and social financial gap
from work to date with local authorities

The above figures require risk assessment
and validation as the plan evolves

* Ref: JSNA(s), CCG Outcomes, PH Outcomes

1.4 PLAN ON A PAGE

Our NTWND STP plan on a page sets out how we will achieve our vision for health and social care over the next five years.

It outlines the key actions and activities for the STP as embodied within our plan. These actions and activities have been developed through a clear understanding of the challenges we face in respect of Health and Wellbeing, Care and Quality and Finance and Efficiency and will support us to achieve our ambition for improvements within the new financial envelope.

The plan describes the 3 LHE areas which make up the STP footprint and their direction of travel in relation to New Care Models, the key areas for delivery across the STP and how the efficiencies accruing from the implementation of those changes are expected to deliver financial balance.

Northumberland Tyne and Wear and North Durham – Plan on a Page

“A place-based system ensuring that Northumberland, Tyne and Wear and North Durham is the best place for health and social care”


STP Transformation Areas



Scaling up prevention, health and well being to improve the physical and mental health of our population and reduce inequity



Out of hospital collaboration to develop alternative service models, reduce variation and raise quality of care in community settings



Optimal use of the acute sector to improve experience of care, achieve better outcomes and create a sustainable model

STP Delivery Areas



LHEs

Northumberland and North Tyneside

Newcastle Gateshead

South Tyneside, Sunderland and North Durham

Collaboration/ NCM

NSECH
PACS / ACO

GHFT and NUTH collaboration
EHCH and MCP/PACS

STFT and CHSFT partnership UHND
MCP

Cross cutting themes

Learning Disability services – TLP (Adults and Children)

Cancer Alliance and Strategic Delivery

Mental Health 5YFV (Adults and Children)

Women (LMS and Better Births and Children’s (0-19 years)

Closing the financial gap

Size of residual financial challenge by 2021



Summary Solutions

Out of hospital £89m	Acute consolidation £39m	Provider efficiencies £241m
Shared back office £31m	CCG efficiencies £105m	Prevention £18m
STF funding £65m	Specialised services £44m	Pathology £9m

Workforce

Information Technology – Great North Care Record

Estates – One Public Estate

Accountable and outcome-based systems

1.5 IMPACT OF OUR PLAN – WHAT WILL IT DELIVER?

NTWND STP impact - Health and Well being

Measurable benefits through improving the health of the population, targeting high risk cohorts and promoting 'healthy behaviours.'

Better Health impact by 2021

Citizens

- ✓ Lifestyle improvements – less people overweight, less people smoking and reduced use of excess alcohol
- ✓ All children will have the best start in life
- ✓ Well being improvements – less social isolation and loneliness
- ✓ Reduced burden of disease with fewer complications

System

- ✓ Transformed service landscape – easy and simplified system
- ✓ Improved access to preventative services
- ✓ Reduced demands on health and social care services
- ✓ Sustainable service provision through harnessing opportunities arising from greater links with the third sector example

Workforce

- ✓ Healthy workforce – improved employment opportunities by building self confidence and harnessing volunteers
- ✓ Increased productivity / effectiveness of organisations

Communities

- ✓ Sustainable and connected communities -Improved social networks

Shifting to a new system

OLD SYSTEM

- Deals with the presenting issue
- Clinical decisions made for patients and based on historical practice
- A person's care is the responsibility of the NHS
- People receive mixed messages on health and wellbeing from health and care professionals and organisations
- Rehabilitation and recovery from disease is based in the hospital and limited in its duration and impact
- Mothers receive ad hoc support to stop smoking during pregnancy. Smoking in pregnancy is also viewed as a lifestyle issue rather than a significant risk to the pregnancy
- Breast feeding is viewed as a "nice thing to achieve" in maternity services
- People attending healthcare (both primary, acute and elective) with substance misuse, alcohol and/ or mental health problems have their presenting physical need managed
- Healthcare delivery is disconnected from the community



NEW SYSTEM

- Addresses the root causes of the presenting issues
- Clinical decisions made with patients and based on a clear understanding of the evidence-based options, including non-medical options
- A person's care is their responsibility with help and support from the health and care system, the community and their family
- People receive clear, positive health and wellbeing messages from professionals, in health promoting environments
- Systematic, community-based and integrated (with community provision) secondary prevention pathways are in place for key disease areas
- Smoking in pregnancy is seen as a key clinical risk to the pregnancy and systematic and intensive support is provided to help mother quit
- Breast feeding is a primary objective of maternity services
- People with substance misuse, alcohol and/ or mental health problems receive immediate support from liaison services and are integrated into community support options
- Healthcare services are truly integrated with communities

NTWND STP impact- Care and Quality

Measurable benefits through having a healthier population, integrated preventative service provision and empowered, resilient individuals and communities

**Better Care
impact by 2021**

Citizens

- ✓ In control
- ✓ Self Care
- ✓ Less hospital use (if needed)
- ✓ Alternative options (care placement)

System

- ✓ Access, choice, navigation and flow of care will be simplified
- ✓ Responsive to need
- ✓ High value and preferable closer to home care

Workforce

- ✓ Well trained, satisfied, collaborative working to manage need
- ✓ Less reliance on agency staff
- ✓ **Clear tariff based prevention pathways**

Digital / innovation

- ✓ Solutions will provide choice and operate 7 days
- ✓ Creating opportunities of 'excellence'

Shifting to a new system

OLD SYSTEM

- Hospital-based care has more pathways than closer to home care - poor choice
- Reactive provision leading to crisis
- siloed working arrangements meaning duplication and having to 'say' you story many times
- Numerous contacts at home poorly coordinated
- Poor communication and poor information sharing - care planning
- Delayed transfers of care from hospital to home
- Variation in services (including weekdays to weekends)
- Variation in standards of care
- Workforce, recruitment and retention issues.
- Workforce skills and capabilities not meeting current and future population needs
- Delays in specialist care - planned and emergency
- Urgent and emergency care confusing and fragmented

NEW SYSTEM

- Provide services closer to home, reducing need for hospital care, allowing people to recover at home, live as independently as possible and achieve their wishes within their community
- Proactive care planning - reducing crisis
- MDT working together - reducing duplication and improving coordination
- Clinical standards are applied in a uniform manner across NTWND with provider CQC ratings will be rated good or above
- Patients are able to receive care in the setting most appropriate to their needs
- Health and Care workforce has increased its capacity through building recruitment, developing its skill mix and collaborative working
- Patients are able to receive the most appropriate care every day of the week
- Specialism provided in hospital with appropriate expertise, skills and capacity
- Urgent and Emergency care streamlined and easy to navigate

NTWND STP impact– Finance and efficiency

The STP has identified a financial shortfall across its providers and commissioners of c. £641m in 2020/21. This financial challenge is driven by an increasing demand for healthcare services and a healthcare budget primarily covering inflationary pressures going forward. In order to close this gap, the system has developed a range of solutions that will make more efficient use of the resources available and ensure that patients are managed and treated in the right care setting at the right time.

The specific areas of focus are:

Efficiencies. These incorporate both provider and commissioner efficiencies, and are assumed to close c. £385m (c. 60%) of the 2020/21 funding gap.

Out-of-Hospital model. The NTWND STP is currently in the process of developing a system-wide offering for out-of-hospital care which will allow services to be delivered closer to home, reducing pressure on the acute sector and unwarranted variation in care. Top-down benchmarking identifies an opportunity of up to 15% reduction in non-elective admissions which the system is seeking to achieve by 2020/21.

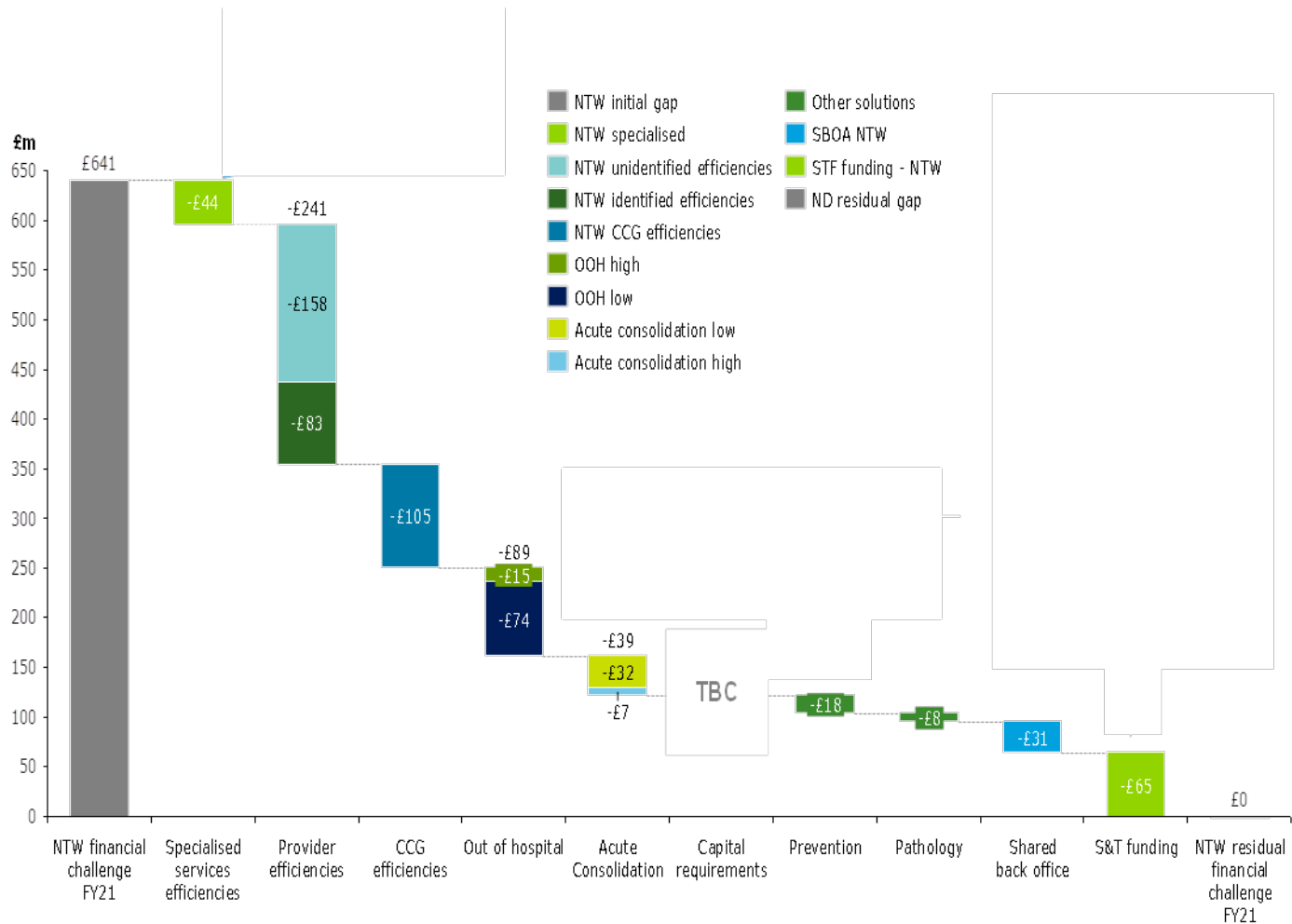
Acute reconfiguration. There are currently seven acute sites operating in the footprint, and the system is looking actively into options for consolidation of services across sites to make better use of available resources and ease workforce pressures. The collaboration between City Hospitals Sunderland and South Tyneside FT exemplifies the opportunities for cooperation that the STP is looking to exploit.

In addition to these focus areas, a range of additional solutions will help to bring the system into overall financial balance by 2020/21. These include **pathology consolidation, shared back office arrangements, greater efforts on prevention, QIPP schemes for specialised services, and Sustainability and Transformation funding made available by NHS England.**

The impact of each of these solution areas on the 2020/21 financial challenge is summarised in the waterfall on the next slide.

NTWND STP impact– Finance and efficiency

NTWND Waterfall diagram



1.6 HIGH LEVEL TIMELINE FOR DELIVERY

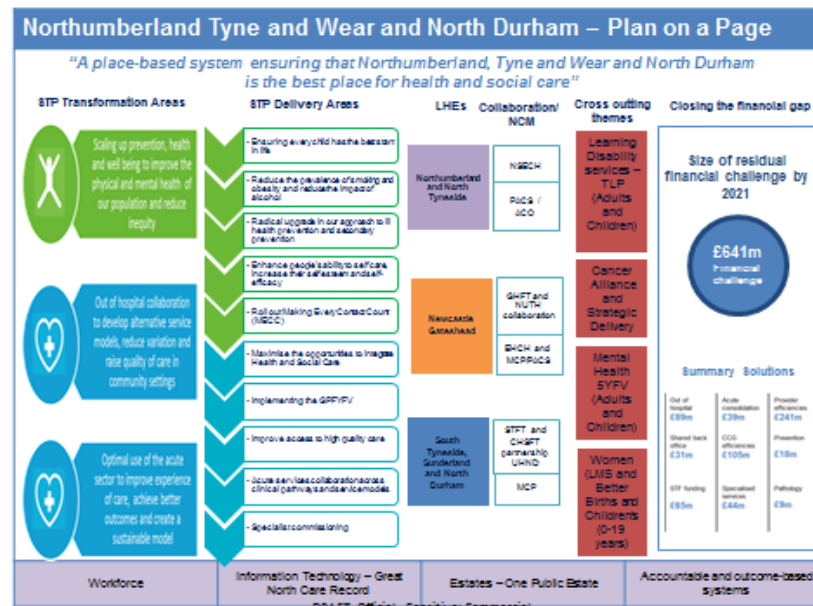
NTWND STP high level timeline

The following table provides a high level timeline of delivery of the three key transformational areas

		16/17	17/18	18/19	19/20	20/21
SCALING UP PREVENTION & WELLBEING	Best start	Develop	Develop	Develop	Implement	Spread
	Prevention Services	Develop	Develop	Develop	Implement	Spread
	Healthy behaviours	Implement	Implement	Implement	Implement	Spread
	Unemployment	Develop	Develop	Implement	Implement	Spread
	Selfcare	Develop	Develop	Implement	Implement	Spread
	Community Assets	Implement	Implement	Implement	Implement	Spread
	Workforce & MECC	Develop	Develop	Implement	Implement	Spread
Out of hospital collaboration	Nortumberland & North Tyneside	Implement	Implement	Spread	Spread	Spread
	Newcastle Gateshead	Implement	Implement	Implement	Implement	Spread
	South Tyneside Sunderland & North Durham	Implement	Implement	Implement	Spread	Spread
Optimal use of the acute sector	Nortumberland & North Tyneside	Develop	Develop	Implement	Implement	Implement
	Newcastle Gateshead	Develop	Develop	Develop	Implement	Implement
	South Tyneside Sunderland & North Durham	Develop	Develop	Implement	Implement	Implement

Develop
Implement
Spread

1.7 HOW OUR PLAN ON A PAGE IS BROKEN DOWN



1.7A STP TRANSFORMATION AREAS AND DELIVERY PRIORITIES

OVERVIEW OF STP DELIVERY PRIORITIES FOR OUR 3 TRANSFORMATIONAL AREAS

Upscaling Prevention, Health and Wellbeing

- **Reduce the prevalence** of smoking and obesity, and reduce the impact of alcohol
- Support **Fresh and Balance, and a region-wide approach to obesity, NICE smoke free standards** across all NHS and local authority health and care services and contracts and Implement a **stop before your op pathway** for elective surgery,
- Radical upgrade in our approach to **ill health prevention and secondary prevention**
- Implement **hospital-based stop smoking services and alcohol brief advice**, Roll out the **diabetes prevention programme**, Develop and resource clear **exercise-based recovery, rehabilitation and maintenance** model, Increase **flu immunisation** rates across the STP, particularly ensuring high uptake in frontline health and care staff, pregnant women and high risk groups,
- Collaborate across the system to ensure the **best start in life**
- Create a network approach to support **community asset-based approaches**, including social prescribing, working closely with the third sector – for example, ensuring that exercise and community connectedness are a first line treatments for conditions such as depression and pain,
- **Collaborate with NECA partners** to support the long-term unemployed back into work
- Enhance people's **ability to self-care**, increase their independence, self-esteem and self-efficacy
- Roll out **Making Every Contact Count (MECC)** as an integral part of our workforce strategy with HENE

Out of Hospital Collaboration

- **Maximise the opportunities within each LHE to integrate Health and Social Care** - aligning with the emerging NECA Health and Social Care Commission, Better Care Fund programmes and National Network and Health and Wellbeing priorities
- **Implement the General Practice Five Year Forward View** to ensure a vibrant and sustainable sector including clustering and workforce development
- Develop optimum evidence based **pathways of care** to improve outcomes and reduce variation working alongside academic bodies (e.g. NICE), Clinical Networks and Senates. Use analytical and modelling tools such as Right Care
- **Clear tariff based prevention pathways (primary and secondary)**
- **Improving access to high quality care.** Working collaboratively across the system to support all our providers achieve CQC rating of good or outstanding. Continue to use Regional Value Based Commissioning process

Optimal use of the acute sector

- Ensure **New Care Models and Pioneers can** improve experience and quality. Formalise learning and sharing of best practice from new models of care programmes. Harness research and innovation working with AHSN.
- Work in partnership with **Specialised Commissioning** to develop whole system, change.
- Provide **Mental Health** care that is 'closer to home' and easily accessible, coordinated and supported by appropriate specialist input implemented through the MH5FV
- Implement the North East and Cumbria **Learning Disability Transformation plan** to reduce reliance on inpatient admissions and develop community support approaches whilst promoting prevention and early intervention
- Work to date has been to understand existing **hospital work programmes** in each of our LHEs and explore opportunities for STP-wide alignment across care pathways, services lines, back office sharing, pathology to improve the quality and experience of care and maintain sustainability within a future hospital system
- The newly created '**Local Maternity System**' (**LMS**) will co-ordinate and oversee a programme of work to develop this new, innovative, and transformative service model

Upscaling prevention, health and well being

Across the STP we will be taking forward our shared ambitions in relation to prevention. Our approach is to ensure that prevention is embedded in the system, not seen as a separate issue. We have created our governance arrangements in a way that reflects prevention as a key priority.

Using population intelligence we have defined the following four gaps:

- Poor early years outcomes as a result of child poverty and deprivation
- Potentially preventable illness
- Excess premature mortality (Cancer, Cardiovascular and Respiratory disease)
- An ageing population with multiple social and health challenges

Our priorities are based on what we feel we can achieve as a health and care system in support of the broader aspirations of the NECA proposals:

- Reduce the prevalence of smoking and obesity, and reduce the impact of alcohol,
- Radical upgrade in our approach to ill health prevention and secondary prevention,
- Collaborate across the system to ensure the best start in life,
- Create a network approach to support community asset-based approaches to support people to be healthy and well at home, including social prescribing, working closely with the third sector
- Collaborate with NECA partners to support the long term unemployed back into work,
- Enhance people's ability to self-care, increase their independence, self-esteem and self-efficacy - roll out Making Every Contact Count (MECC) as an integral part of our workforce strategy with HENE,

We have calculated that if healthy life expectancy among all NECA constituent local authority populations was to rise over the next 10 years to reach the national average healthy life expectancy, this would mean that there would be an additional 400,000 healthy life years lived across the 10 year period. Therefore, by 2020/21 we aim to:

- Give every child the best start in life by having the best maternity outcomes in the country,
- Support the long term unemployed back into work, particularly targeting those with mental health and MSK problems
- Reduce the prevalence of lifestyle and behavioural risks, reduce preventable ill health, and upgrade our approach to primary and secondary prevention
- Enhance people's ability to self-care, increase their independence, self-esteem and self-efficacy
- Improve workplace health and support a health promoting workforce in health and social care

Out of Hospital Collaboration – GPFV and New Care Models

- The quality of our general practice, community health and social care services has been high, but the pressures on these services are increasing and workforce recruitment and retention is challenging.
- We will drive change to the Out of Hospital system through recognised LHE programmes (New Care Models, GPFV) under our overarching Out of Hospital framework and link directly with secondary prevention approaches.
- We will explore and develop alternative closer to home service models that improve productivity and create value by working with communities to provide need based support and reduce the reliance on hospitals and care homes. In doing so, we will optimise:
 - The opportunities to integrate Health and Social Care – NECA and Better Care
 - Implement the General Practice Five Year Forward View.
 - Develop evidence based pathways of care (e.g. Rightcare) to improve outcomes, reduce variation and improve quality (achieve CQC rating of good or outstanding) to identify opportunities for more efficient service delivery (Regional Value Based Commissioning process) releasing opportunities for investment in 7 day services.
 - Ensure New Care Models can improve experience and quality. Formalise learning and sharing and harness research and innovation working with AHSN, clinical senates etc.
- By 2021, our STP footprint will aim to achieve the outcomes set out by National Bodies (NHSE, NHSI, CQC) as well as close NTWND's 7 gaps recognised across care and quality.
- To implement the General Practice Forward View each LHE in partnership with NHSE have started conversations at multiple levels resulting in the identification of the following priority areas for the GPFV – Care re-design, workload, workforce, voice for General Practice, Quality and Investment and co-commissioning.
- Ensure spread of New Care Models (Multispecialty Community Provider [MCP] and Primary and Acute Care System [PACS]):
 - NTWND STP and DDTHRW STP with partners have set out a plan to roll out New Care Models, as one of the key delivery mechanisms for our STP, in particular, as part of our Out of Hospital Framework. Our Out of Hospital Framework uses the MCP and PACS models as a critical underpinning philosophy.
 - For the entirety of the North East, we would anticipate that the MCP and PACS models will become the key delivery mechanism for the majority of sites. The thinking, philosophy and underpinning frameworks behind the MCP and PACS New Care Models are absolutely in line with the direction of travel for the delivery of the STP.
- Vanguard case studies and success to date are detailed in Section 2

Optimal use of the Acute Sector

The aim of this transformation programme is to improve experience of care, achieve better outcomes and create a sustainable model. In the NTWND footprint we have high quality services with 5 out of our 7 Foundation Trust Providers rated good or outstanding.

Our future state and ambition is to :

- Explore and develop alternative service models that improve productivity and reduce the demand burden by working together as health and care systems that will allow us to build upon transformation and sustainability plans underway in each LHE
- Shape services based on need and opportunity and reduce organisational silos and barriers
- Support all Foundation Trust Providers to achieve a rating of outstanding by 2021

However, In order to deliver safe, high-quality care for patients, the same standards of care, seven days a week we know there are a number of challenges facing acute hospitals as a whole, and in terms of the workforce currently available to provide the level of service that is required.

Our work to date has been to understand existing hospital work programmes in each of our LHEs and explore opportunities for STP-wide alignment across care pathways, services lines, back office sharing, pathology to improve the quality and experience of care and maintain sustainability within a future hospital system. The collaboration between City Hospitals Sunderland and South Tyneside FT exemplifies the opportunities for cooperation across other LHEs

The next priority is the modelling work is to agree a range of clinical options for the future delivery of 7-day clinical services across the NTWND STP footprint. The proposed models of delivery will be consistent with clinically recognised good practice as described by national guidance (NICE, Royal College, National Reviews and Strategies); they are clinically sustainable including addressing workforce considerations; not be driven by existing organisational boundaries, but with the best interests of patients and support the delivery of a financially viable STP across the NTWND footprint.

The Chief Executives and Medical Directors across the NTWND STP footprint have agreed that the services to be used as the drivers for change and therefore modelled and assessed will be those listed in the table below:

A&E	Critical care (levels 2&3)	Consultant led obstetrics
Acute medicine	Interventional radiology	SCBU
Hyper-acute stroke	Inpatient paediatrics	Neonates
Acute surgery	SSPAU	Midwifery led (co-located)
Specialist vascular surgery	Elective care (linked to critical care)	Midwifery led (stand alone)

Further details on Optimal Use of Acute Sector in Sections 2 and 3

Transforming Mental Health – MH5YFV

- As an STP footprint we are aware of the clear gaps across health and wellbeing and care and quality in relation to mental health. For example, 75% of people with mental health problems receive no support and people with SMI are at risk of dying on average 15-20 years earlier than the general population with large variation in the numbers of hospital admissions, length of stay and readmissions etc.
- The core ambition of the STP is to ensure “no health without mental health”. This will involve the development of an integrated life span approach to the integrated support of mental health, physical health and social need which wraps around the person, from enabling self- management, care and support systems within communities, through to access to effective, consistent and evidence based support for the management of complex mental health conditions. Following outcomes and benefits have been identified:
 - Delivery of milestones in MH5YFV and reduction in demand for secondary and tertiary children and young people’s services, reduction in waiting times, and delivery and monitoring of successful outcomes
 - Reductions in admissions and length of stay due to more effective integrated management of co-existing physical and mental health conditions through improved support of primary care, access to housing and employment and wider options in crisis support, and development of the recovery college approach
 - Reduction in inappropriate A and E attendances supporting delivery of 4 hour wait target and admissions from care homes arising from poor management of mental health in older people
 - Consistent access to and delivery of effective evidence based treatment and support for people with more complex needs, leading to measurable outcome improvement.
 - Completion of re-design of mental health in-patient care, which is affordable, high quality, 7 day and consistent
- In terms of delivering the core objectives of the Mental Health Five Year Forward View, the table below gives the planned trajectories for improvement over the next two years:

Objective	Trajectory for Improvement
By 2020/21 at least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH services	30% in 2017/18 32% in 2018/19
By 2020/21 at least 25% of people with common NH conditions access psychological therapies each year	16.8% in 2017/18 19% in 2018/19
By 2020/21 at least 60% of people experiencing a 1 st episode of psychosis receive treatment within 2 weeks	50% in 2017/18 53% in 2018/19
% of acute hospitals with an all-age MH liaison service achieving Core 24 service standard	20% - 2017/18 40% - 2018/19

1.7B LHE KEY DELIVERABLES FOR OUT OF HOSPITAL COLLABORATION AND OPTIMAL USE OF THE ACUTE SECTOR

Further detail on LHE Operational Plans is provided within Section 2

Northumberland and North Tyneside LHE – key deliverables

Our focus in years 2017/18 and 2018/19 in our Northumberland and North Tyneside LHE will be to:

- Continue the development of the Northumberland ACO to allow the proof of concept of a PACS model supported by a new commissioning arrangement with the local authority to be fully tested and evaluated.
- The development of the ACO vanguard is hugely important for the NTWND STP and for colleagues looking at similar models across the country.
- It is important for this to continue to develop so that the benefits can be properly measured and the knowledge needed to spread the model wider learned.
- Explore how Newcastle Gateshead CCG might support North Tyneside CCG with a joint management team across both CCGs, to give consistent and strong leadership whilst focusing on immediate financial recovery.
- Continue to support Northumbria Healthcare NHS FT and Northumberland, Tyne and Wear NHS FT to deliver Outstanding care whilst ensuring the former can deliver 7 day services as a key part of acute care provision for the wider North of Tyne population centre

From 2019/20 onwards we will:

- Look to identify the most appropriate care model for North Tyneside by assessing the options presented by a mature ACO arrangement in Northumberland and the model of care identified for the population

Newcastle Gateshead LHE – key deliverables

Our focus in years 2017/18 and 2018/19 in Newcastle Gateshead LHE will be to:

- Continue the development of the work following the successful re-procurement of community services and the development of the Teams Around Practices concept.
- Complete the proof of concept testing around the Enhanced Care in Care Homes Vanguard to enable the model to be spread across Newcastle Gateshead, and the wider NTWND STP area, whilst contributing to national learning.
- Work with Newcastle Upon Tyne Hospitals NHS FT, Newcastle City Council and the primary care and voluntary/third sectors to identify the most appropriate model for the provision of integrated care in Newcastle.
- Continue to support Newcastle Upon Tyne Hospitals NHS FT and Northumberland, Tyne and Wear NHS FT to deliver Outstanding care whilst ensuring the former can deliver 7 day services as a key part of acute care provision for the wider North of Tyne population centre
- Support Newcastle Upon Tyne Hospitals NHS FT and Gateshead Health NHS FT to collaborate on the provision of acute services to explore the most effective methods of delivery for the patients and public of the two populations.

From 2019/20 onwards we will:

- Implement the preferred model for integration of services in Newcastle
- Continue the collaboration on acute service provision across Newcastle Gateshead

Sunderland, South Tyneside and North Durham LHE – key deliverables

Our focus in years 2017/18 and 2018/19 in our Sunderland, South Tyneside and North Durham LHE will be to:

- Focus on the development and proof of concept testing of the Sunderland multi-specialty community provider Vanguard and the South Tyneside Integrated Pioneer work to ensure the benefits are realised and lessons learned with a view to having a viable alternative for a PACS model for other areas to adopt.
- Whilst South Tyneside and Sunderland hospitals recognise the importance and value of having a local hospital providing a range of services, they equally recognise the urgent need to rebalance services across both organisations as it is no longer safe or sustainable for either organisation to duplicate the provision of services in each location.
- The Path to Excellence programme will continue to work to develop plans to deliver better quality care across the local populations and enable the delivery of 7 day services so that key quality standards can be achieved, which will ultimately allow financial stability for both organisations.
- Undertake a clinically led service review programme to look at the best service configuration to make the service the highest quality it can be within existing resources.

Clinical services reviews

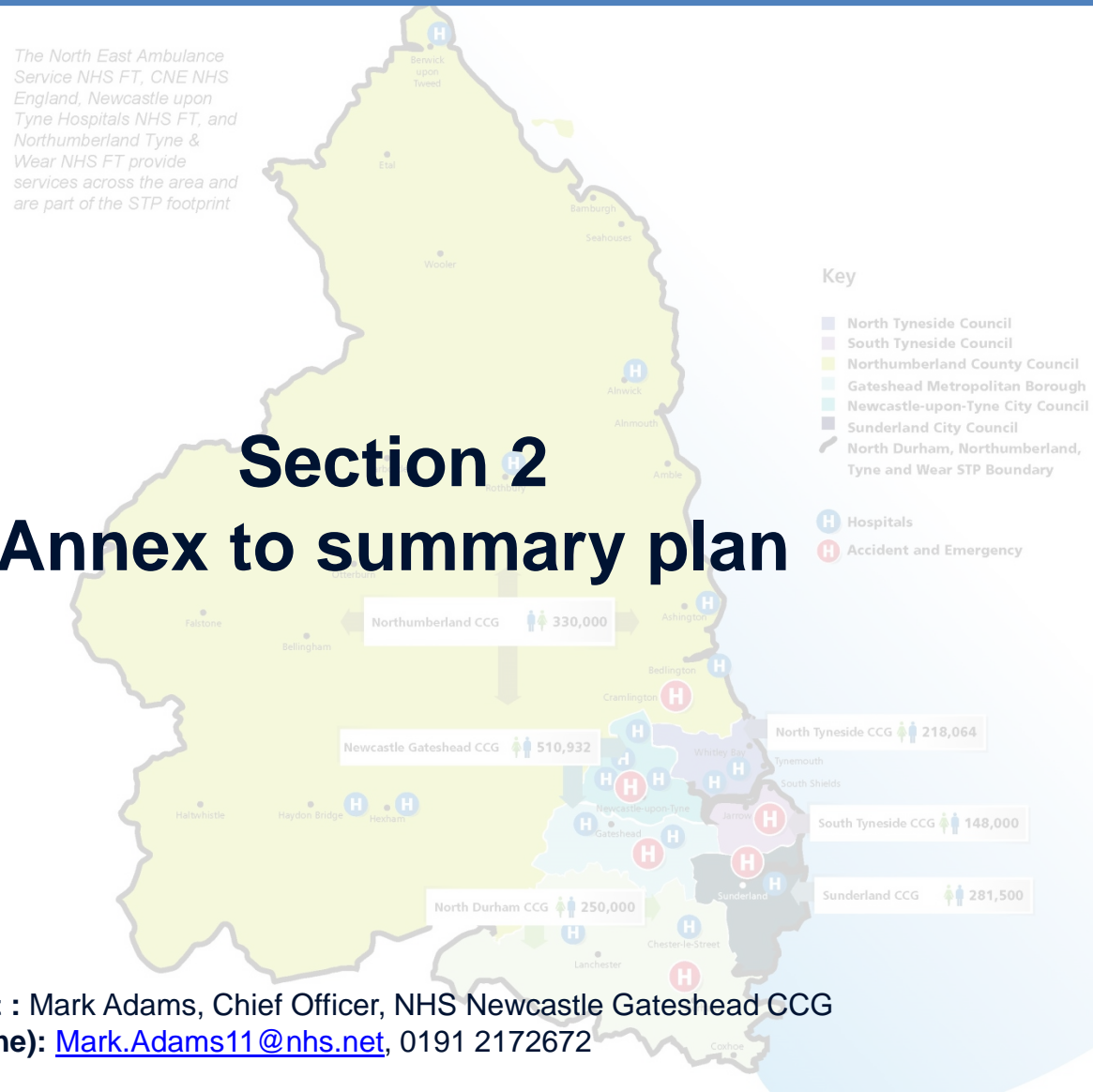
- All clinical services will be reviewed as part of the Clinical Service Review programme over the next two years through a number of defined phases shown in the diagram below.

Phase 1 Underway	Phase 2 October 2016 - March 2017	Phase 3 April 17 - September 2017
Stroke	Pharmacy	Emergency Care
Trauma & Orthopaedics - including Ortho-geriatrics	Anaesthetics & Theatres	Critical Care
Obstetrics & Gynaecology	Cardiology	Acute Medicine
General Surgery – including endoscopy	Gastroenterology	Therapy Services
Paediatrics	Respiratory	Diagnostics
Increasing delivery of elective work at STFT	Diabetes	
	Care of the Elderly	
	Specialist Rehabilitation	

From 2019/20 onwards we will:

- Develop collaborative arrangements with the acute provision in University Hospital of North Durham and the South Tyneside and Sunderland Healthcare Group to make best use of specialist workforce, noting that this will be done in conjunction with both Gateshead Hospitals Foundation Trust and the Newcastle upon Tyne Hospitals Foundation Trust who cater for patients from the North Durham area.

Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan



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2.1 EMERGING CHALLENGES

Emerging challenges

Having modelled various scenarios we know that a radical hospital reconfiguration will not deliver the financial outcomes we require for a safe and sustainable system .

However it is important to note that we do have a number of emerging challenges not least in respect to:

- Workforce across health and social care
- Maintaining clinical and quality standards
- The delivery of 7-day services

Equally we have challenges to deliver our overarching STP in respect of:

- Need to industrialise 'best practice' and prevention
- Reducing variation across service provision
- De-risking the plan

We know that an STP wide radical hospital reconfiguration will not deliver what we need, our future work programmes are based on:

- Upscaling prevention, health and well being – STP wide programmes
- Out of Hospital collaboration – identification of best practice in New Care Models and subsequent spread
- Optimal use of the acute sector – driven at the level of LHE and further STP wide specialty service reviews

2.2 LHE DELIVERY PLANS 2016/17 – 2018/19

Northumberland and North Tyneside LHE Plans for 2016/17 -2017/18

Plans for 2018/19

Scaling up prevention, health and well being

- Deliver the 0-19 & 0-2 Agenda
- Work with partners in health and social care, public health, housing, leisure, policing and the Charitable and Voluntary sector, where possible and appropriate, to signpost people into services to support them with issues relating to the wider determinants of health
- Implement evidence based smoking, alcohol and obesity treatment and prevention plans, promoting better prevention, detection, treatment, and education.
- Establish Alcohol Assertive Outreach Teams (AAOT) to reduce repeat users of hospital and other services such as police and social services, if these are not already included in the Balance NE plans
- Support the Mayor's pledge to address inequalities
- Secondary/primary prevention considered in all acute contacts
- Develop Community Health and Well Being Hubs
- Agree potential for material shift in investment and focus towards long term prevention
- Healthy Place programme
- Integrated H&SC prevention and early intervention for all adult age groups

- Shift in financial levers through capitation and ACO in shadow form.
- Ensuring secondary and primary prevention is considered in all acute contacts, with plans in place for audit to ensure follow through.
- Development of robust approach to interventions, including social prescribing and health improvement services in health, social care and CVS sectors
- Continue development of Asset-based and community-centred approaches to health and wellbeing that will lead to increased *capacity* of individuals to change behaviours

Out of hospital collaboration

- New Models of Care implemented to support most vulnerable frail elderly population through targeted support
- Pathways for Frailty developed
- LTC management strategy developed
- Develop innovative workforce strategy to allow movement across care settings.
- Primary care engagement and support GPs to develop capacity and workforce

- Greater hospital collaboration
- One Estate priorities progressed
- Continued implementation of workforce strategy
- Review of scope for increased role for domiciliary and residential staff supported by telecare/tele-monitoring
- Training designed for all health staff to identify mental health needs in patients being seen for physical health concerns and to support mental wellbeing e.g. social prescribing

Optimal use of the acute sector

- Development of the PACS / ACO model
- Develop ACO Strategic commissioning functions, financial modelling/due diligence, capitated budget/, schemes of delegation and business case submission.
- Implementation of Northumberland ACO during 17/18
- Formal NTW wide risk and escalation arrangements for 'at risk' services
- Progress 'One Estate' strategy
- Right Care - MSK, CVD, Respiratory & Gastroenterology
- LTC strategy incl. New Models to support frail elderly population (targeted support)
- Prioritise service collaboration based on sustainability risks and workforce gaps
- Targeted evidence based work between acute providers, primary care and commissioners to manage demand.

- Implementation of increased collaboration and shared services amongst acute, primary, community and MH providers as appropriate to streamline pathways
- Continue to broaden and develop Northumbria's Acute Collaboration Model.

Mental Health

- MH well-being and promotion activity occurring across NL and NT
- Sustained improvements to access to mental health services at all tiers

- Training for mental health staff to identify physical health needs, and to offer advice on lifestyle factors such as smoking and weight reduction, including social prescribing and community assets. 6

Newcastle Gateshead LHE plans for 2016/17 -2017/18

Plans for 2018/19

Scaling up prevention, health and well being

- Enhance approach to secondary preventative lifestyle support extending access by 2021 to a minimum of 20,000 people per year
- Develop opportunity for people to access social prescribing using learning from 'Ways to Wellness' / 'Live Well Gateshead ' and other local initiatives
- Work with Northumbria University to embed outcomes from the Health Champions and Care Navigator pilots
- Embed an asset based approach through our 'Connected People Connected Communities' / 'Achieving More Together' programmes'
- Work with Northumbria University design school using a proof of concept methodology to develop community led approaches to health and well being
- Continue to influence environmental and housing development proposals and decisions to support primary prevention and positive well being
- Design our approach to positive health and well being for children and young people 'Enhancing Minds, Improving Lives and Amazing Start'
- Focused tobacco quits and harm reduction in vulnerable populations

Out of hospital collaboration

Intermediate Care

- Undertake comprehensive review of Intermediate Care Pathway
- Review focuses upon the four key areas of a and what model might deliver against the '2 day wait indicator' proposed within the National Audit of Intermediate Care (NAIC) & support local implementation to meet priority gaps.
- Reviewing how the Better Care Fund (BCF) and New Models of Care agendas (NHS 5 Year Forward View) locally

Community Services

- Roll out of the Gateshead Community Service Framework + Transformation Implementation plan
- Engagement + Involvement in co-design of community services in Newcastle based around the NuTH strategic framework

General Practice

- Undertake a review of OOH Primary Care provision in Walk-in Centres
- PEP scheme, All NGCCG 16/17 practices with form on LTC, Planned Care, urgent in house PC.
- Develop and test innovative Primary Care workforce roles including Practice Nurse Career Start, Navigator and GP fellowship schemes
- Support implementation of the 10 high impact actions for General Practice

Intermediate Care

- Establish integrated services at an operational level aligned to the new models of care. Explore single management structure.
- Possessing a Single Point of Access, assessment process, patient record and performance management framework
- Established joint induction and training programmes with staff working across services
- Apply new funding models which better incentivise a whole system approach i.e. capitated budgets?
- Introduce greater emphasis in Mental Health within the intermediate care system to achieve parity of esteem ambitions by having mental health practitioners as part of the integrated team function
- Demand and capacity investment agreed with commissioners for step up and step down requirements across the 4 key areas and delivered through a pooled budget

General Practice

- Support and grow the PC workforce – PC Nurse and navigator roles, GP fellowships, HEE practice training hubs roll out.
- Improve access to GP in and out of hours - Seamless out of hours provision, GP OOH, WIC, Community/cluster of practices provides extended "in-hours"
- IT deployment and Utilities - Patient empowerment – telehealth/ Practice and Community IT systems unified access/ On line booking and consultation
- Workload – 10' high impact actions fully embedded/effective federations supporting practice/ NHSE pilot site GPFV early adopter

Optimal use of the acute sector

- Review clinical services to identify outliers in care and quality
- Discuss and agree clinical pathways ripe for collaboration. Areas identified to date include Hyper-acute stroke, Vascular, Interventional Radiology, ENT, MSK/Orthopaedics, Paediatrics, Diagnostics and Community Services.
- Ensure clinical engagement and ownership of service provision to develop implementation / change plans. This will include details of 'what will be different for patients'.

- Strive for continuous improvement and delivery of the key requirements around access, quality, safety and patient experience. Putting patients at the heart of all that we do
- Develop plans to address any identified care and quality outliers
- Look to extend the scope and scale of services for collaboration. This may include looking beyond health.
- Maximise opportunities for partnership working recognising the strength and assets of both Trusts
- Engage and consult with stakeholders about any potential changes to clinical pathways as necessary and appropriate

Mental Health

- Deciding Together (adults) - develop the agreed inpatient bed configuration alongside enhancement of the community service model, urgent care response system and a more responsive IAPT service with a focus on supporting recovery.
- Expanding Minds Improving Lives (children) - develop a responsive CAMHS model with improved access across a range of locations

	South Tyneside, Sunderland and North Durham LHE Plans for 2016/17 -2017/18 (South Tyneside, Sunderland)	Plans for 2018/19
Scaling up prevention, health and well being	<ul style="list-style-type: none"> • Strong focus on the best start in life – through reviewing maternity services and 0-19 services • Self care and prevention programme, “making every contact count” and “A Better U” • Embedding an asset based approach to self care – including developing resources to support prevention and self care • Enhancing support to workplaces to promote a healthy and active workforce – through development of the Workplace Health Alliance • Exploring locality-based approaches to tobacco control, alcohol and healthy weight • NHS Rightcare - pathway transformation for respiratory disease, cancer and CVD – from prevention (including Change4Life), secondary prevention & self care to end of life • To enhance long term condition management, through proactive self care (secondary prevention) 	<ul style="list-style-type: none"> • Embed locality based approaches to tobacco control, alcohol and healthy weight • To continue NHS Rightcare pathway transformation
Out of hospital collaboration	<ul style="list-style-type: none"> • Continuation of out hospital and integrated care models including sharing of learning and exploring model alignment • Deliver the GPFV with a focus on addressing the resilience of general practice including workforce developments; developing general practice at scale and improving access to general practice. • Redesign pathways across primary and secondary care in light of learning from Right Care and productivity opportunities 	<ul style="list-style-type: none"> • Take the best for the 2 models to develop a “blended” out of hospital model • Review progress and continue to implement the GPFV to support the sustainability and transformation of general practice. • Review and further implement the new pathways across primary and secondary care
Optimal use of the acute sector	<ul style="list-style-type: none"> • Single Clinical operating model created • Full service reviews completed across a number of pathways including Stroke • Options for service delivery consultation 	<ul style="list-style-type: none"> • Full service reviews completed across every service across the two hospital sites • Options for service delivery consultation • To share assets and workforce
Mental Health	<ul style="list-style-type: none"> • Community Mental health service - easier access to low level interventions for adults and children • Mental health reconfiguration programme largely complete 	<ul style="list-style-type: none"> • Sustain improvements to Mental Health Services at all tiers taking account of the MH 5YFV

**South Tyneside, Sunderland and North Durham LHE Plans
for 2016/17 -2017/18
(North Durham)**

Plans for 2018/19

Scaling up prevention, health and well being

Whilst Public Health partners have local priorities and initiatives key initiatives and priorities have been identified that entail close working across all partners to deliver a 'scaled up' approach based on best practices already in place across parts of the footprint s including the voluntary and community sector.

- Best start in life
- Prevention pathways in acute contracts - adhering to nice guidance for nicotine addiction, alcohol addiction, obesity
- Prevention pathways in maternity contracts - including perinatal mental health and lifestyle interventions
- 0-19 but specific focus on 1001 critical days
- Scaling up wellbeing community interventions as part of push for self care to become system default
- Prevention and earlier identification of dementia - wellbeing evidence - what's good for your heart is good for your head- physical activity, diet, alcohol
- Worklessness interventions in primary care – e.g. IAPT
- Alignment of Wellbeing service to the community hub development
- Diabetes prevention programme

Out of hospital collaboration

Agree an MCP model of care which ensures the sustainability of primary and community care now and in the future.

To deliver high quality care which is person centred, irrespective of organisational boundaries. People will receive continuity of care that is effectively co-ordinated and delivered where possible close to home.

Place based community hub model

- Discharge to assess
- Develop frail elderly rapid access clinics.
- Intermediate care plus
- MSK community service
- Accountable Care Network development
- Implementation of extended access to primary care for vulnerable adults
- Development and implementation of community hub model and place based budgets

Progress the North Durham MCP Health and Social Care Integration delivery programme .

Further development and implementation of community hub model as part of an accountable care network.

Further implementation of extended primary care aligned to community hubs and urgent care pathways.

Review progress and continue to implement the GPFV to support the sustainability and transformation of general practice.

Continue to roll out career start.

Optimal use of the acute sector

- Optimal Use of Acute Sector through collaboration across clinical pathways.
- Shape services based on need and clinical standards and elective pathway redesign in conjunction with Newcastle/Gateshead

Integrated urgent and emergency care centre (UHND site)

Mental Health

- Delivery of the mental health prevention as part of the Five Year Forward View.
- Implementation of Children and Young Peoples Mental Health and Wellbeing Plan
- Implementation of the Mental Health Five year Forward View
- Alignment of mental health and talking therapies to community hubs

2.3 UPSCALING PREVENTION, HEALTH AND WELLBEING

See section 3 for detailed delivery plans

Upscaling prevention health and well being

Across NTWND we have made huge progress in relation to health and wellbeing with life expectancy and healthy life expectancy continuing to rise, unhealthy behaviours (such as smoking prevalence) continuing to fall, and preventable causes of death declining (such as reducing rates of stroke and heart attack).

We recognise that healthcare services have a very limited impact on the overall health of the population. Health and wellbeing is largely determined by social circumstances, the environment, and lifestyle and behaviours. These factors are estimated to account for between 60-85% of an individual's overall health and wellbeing. Therefore our wider challenges are:

- High levels of deprivation, child poverty and older people living in poverty (27% of the population live in areas that are among the 20% most disadvantaged in England).
- High levels of unemployment and long-term unemployment (2.6% of the working age population are claiming benefits while seeking work compared to 1.7% across England).
- Poor early years indicators – smoking in pregnancy (NTW 16%, England 11%), breast feeding (NTW 36%, England 44% at 6 to 8 weeks), child development (NTW 63.5%, England 66.3% at a good level at age 5 years)
- High prevalence of unhealthy behaviours – smoking (adult prevalence NTW 18.5%, England 16.9%), alcohol, poor diets, and low levels of physical activity (NTW 53% physically active, England 57%)

NTWND has a history of supporting prevention however a challenge has always been to do this at scale, putting confidence in prevention's ability to deliver. Our local health and care system is currently serving a large "health and wellbeing debt" and we're continuing to run a "health and wellbeing deficit". Therefore, In order to achieve our ambition our priorities include:

- Reduce the prevalence of smoking and obesity, and reduce the impact of alcohol - support Fresh and Balance, and a region-wide approach to obesity and implement NICE smoke free standards across all NHS and local authority health and care services and contracts and stop before your op pathway for elective surgery,
- Radical upgrade in our approach to ill health prevention and secondary prevention - roll out the diabetes prevention programme, develop and resource clear exercise-based recovery, rehabilitation and maintenance model and increase flu immunisation rates across the STP, particularly ensuring high uptake in frontline health and care staff, pregnant women and high risk groups,
- Collaborate across the system to ensure the best start in life - introduce a STP-wide best practice pathway and standards for smoking and alcohol in pregnancy and breastfeeding initiation through sector-led improvement, all in line with NICE standards and ensure all NHS and LA providers are Breast Feeding Friendly and there is a clear breast feeding workforce development programme led by HENE,
- Create a network approach to support community asset-based approaches, including social prescribing, working closely with the third sector – for example, ensuring that exercise and community connectedness are a first line treatments for conditions such as depression and pain,
- Collaborate with NECA partners to support the long term unemployed back into work
- Enhance people's ability to self-care, increase their independence, self-esteem and self-efficacy
- Roll out Making Every Contact Count (MECC) as an integral part of our workforce strategy with HENE
 - Workforce development will include promoting health, wellbeing, prevention and self-care
 - All NHS providers (including those contracted) are working towards the better health at work award

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NTWND STP impact and ambitions - Health and Wellbeing

Measurable benefits through improving the health of the population, targeting high risk cohorts and promoting 'healthy behaviours.

Better Health impact by 2021

Citizens

- ✓ Lifestyle improvements – less people overweight, less people smoking and reduced use of excess alcohol
- ✓ All children will have the best start in life
- ✓ Well being improvements – less social isolation and loneliness
- ✓ Reduced burden of disease with fewer complications

System

- ✓ Transformed service landscape – easy and simplified system
- ✓ Improved access to preventative services
- ✓ Reduced demands on health and social care services
- ✓ Sustainable service provision through harnessing opportunities arising from greater links with the third sector example

Workforce

- ✓ Healthy workforce – improved employment opportunities by building self confidence and harnessing volunteers
- ✓ Increased productivity / effectiveness of organisations

Communities

- ✓ Sustainable and connected communities -Improved social networks

Priorities

Give every child the best start in life

Support the long term unemployed back into work, particularly targeting those with mental health and MSK problem

Reduce the prevalence of lifestyle and behavioural risks, reduce preventable ill health, and upgrade our approach to primary and secondary prevention

Enhance people's ability to self-care, increase their independence, self-esteem and self-efficacy

Improve workplace health and support a health promoting workforce in health and social care

Ambitions 2021

- Reduce smoking in pregnancy rates from 15% in 2015/16 to 10% in 2020/21 – one percentage point per year, meaning 850 less women per year smoking at the time of delivery by 2021. This is in support of a North East ambition to reduce smoking prevalence to 5% by 2025,
- Increase breast feeding initiation from 63% in 2015/16 to 70% by 2020/21 – halving the current gap between the STP and England. This would mean an extra 1,000 babies per year being supported to have their best start in life by 2021
- Support the longterm unemployed back into work, particularly targeting those with mental health and MSK problems. There are 123,000 people (11.5% of the working age population) that have been claiming any benefit for 12 months or more across the STP. We aim to support partners to reduce this to 10% by 2021 meaning there will be 12,600 fewer adults claiming benefits for 12 months or more compared to the current number
- Increase flu immunisation rates in older people back to over 75%, reversing recent declining uptake - now sitting at 72.6% in 2015/16. This would equate to an additional 13,000 over 65 year olds protect from flu each year,
- Increase flu immunisation rates in at risk populations back to over 55%, reversing recent declining uptake – now sitting at 47% in 2015/16. This would equate to an additional 20,000 people in at risk populations protected from flu each year,
- Reduce the prevalence of excess weight in adults from 68% to 64.6% (the current England average) equating to 50,000 more people being a healthy weight from 2020/21,
- Reduce the rate of smoking attributable hospital admissions for the STP to that of Northumberland (best performing in the STP). This would reduce the gap between the STP and England from 52% to 28%, avoiding 5,000 admissions per year from 2020/ 21,
- Half the current gap between NTW&ND and England for alcohol-related hospital admissions (narrow definition) from 35% to 17.5% - reducing the number of alcohol attributable admissions per year by 2,000 by 2020/21,
- Reduce the premature mortality gaps between NTW&ND and England by half by 2020/21: reducing the number of early cardiovascular disease deaths by 360 per year; reducing the number of early cancer
- increase the proportion of people with a Long term Condition who feel supported to manage their condition from 67% in 2015/16 to 75% in 2020/21 supporting an additional 50,000 people to manage their long term condition
- Have over 50% of frontline NHS staff trained in Making Every Contact Count
- Reduce NHS trust sickness absence rates from 4.4% in 2015/16 to the projected national average of 3.8% by 2020/ 21. This would realise an additional 80,000 working days per year, the equivalent of around 370 full-time staff
- Increase flu immunisation rates to 75%, uptake in health and care staff. As an indicator of progress, our current Acute Trust uptake is 56%. If we increased this to 75% it would equate to an additional 6,800 frontline acute trust staff protected from flu each year.

2.4 OUT OF HOSPITAL COLLABORATION

See section 3 for detailed delivery plans for:
GPFYFV
Mental health
Learning Disabilities
Urgent and Emergency Care

Roll out of new care models – 2016/17 and beyond

The North East has been recognised as a National Transformation Area. This means an investment and support to accelerate transformational change across 5 categories. One of those categories includes accelerating 'spread' of NCM across the region within 2016/17 and beyond.

NTWND STP and DDTHRW STP with partners have set out a plan to roll out New Care Models, as one of the key delivery mechanisms for our STP, in particular, as part of our Out of Hospital Framework. Indeed, the Out of Hospital Framework of this STP uses the Multispecialty Community Provider (MCP) and Primary and Acute Care System (PACS) models as a critical underpinning philosophy.

In 2016/17, we are taking the spread of NCMs forward through the following:

Using the MCP/PACS care model to articulate the out-of-hospital model in the STPs, as a strategic framework.

Resource to support key enablers across the patch e.g. workforce.

Supporting local teams to be the next wave of MCP/PACS.

Our designated Transformation Area status gives us the opportunity to bid for £3m to support the first stage of this spread of NCMs in 2016/17 and we would anticipate a number of our sites progressing to become NCMs in 2017/18. The precise roadmap setting out the staged progression of each site will form part of the bid, for submission in November 2016.

The overarching bid will be built up on the back of a series of "sub-bids", by local site. As part of this, local teams are currently undertaking a gap analysis, using a New Care Model maturity matrix, which will help shape the "sub-bids", identify the timescale of progression for each site and enable us to focus resource on the key enablers identified.

For the entirety of the North East, we would anticipate that the MCP and PACS models will become the key delivery mechanism for the majority of sites, with spread covering the vast majority of the population during 2017/18, assuming a successful bid. The thinking, philosophy and underpinning frameworks behind the MCP and PACS New Care Models are absolutely in line with the direction of travel for the delivery of the STP.

Vanguard case studies and success to date are detailed in Section 2

New care models learning and sharing

- Capitalising on existing work within our STP footprint to optimise service provision

Sunderland 'All Together Better' MCP Vanguard

Description: The vision is to implement a new Out of Hospital model which will enable people to stay independent and living for longer, supported to recover from episodes of ill-health following injury, all within a resilient communities setting.

Impacts on the system: Full redesign of the Out of Hospital model will lead to Reduced non-elective admissions and readmissions; improved quality of patient experience of out of hospital care, Improve health related quality of life for people with long term conditions and reduction in years of life lost, Delayed Transfers of Care and admissions to residential care homes.

Working across boundaries: Sunderland has 2 GP federations and a city wide NHS contract for engagement avoiding the need for 51 contracts between CCG and each practice. Digital solutions to support the model are a key part of the programme and in the MCP fast follower cohort looking at new contracting approaches and organisational form for out of hospital care.

Newcastle Gateshead Enhanced Healthcare in Care Home Vanguard

Description: The vision is One Bed, One Outcome irrespective of Commissioner, provider or person and the aim is to develop a sustainable, high quality model for community beds and home based care with outcome based contract and payment system that supports the Provider Alliance Network (PAN) delivery vehicle.

Impacts on the wider system: 14.5% reduction in care home NEL activity – average length of stay (LOS) has fallen from 13.2 to 11.8 days.

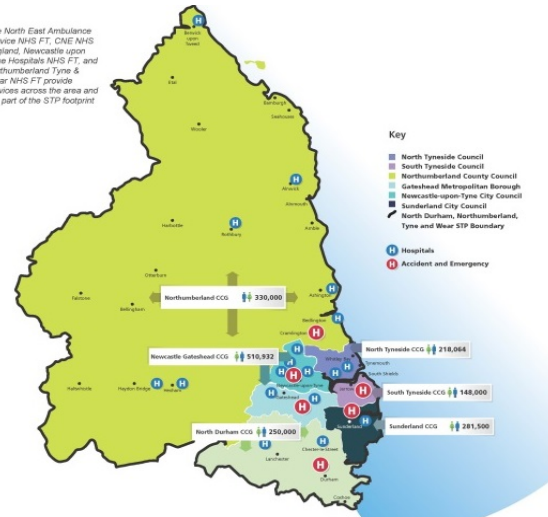
Reduction in LOS for those aged 65 and over – average LOS reduced from 7.79 days in 14/15 to 7.42 for 15/16.

Reduction in no. of patients aged 65 and over dying in hospital – trends suggest a 5.2% reduction from 14/15 to 15/16.

Reduction in Oral Nutritional Supplements prescribed – reduction in prescriptions by 17.9% (Gateshead) and 13.4% in Newcastle.

Working across boundaries: Being a vanguard enabled us to work smarter and to build relationships in the health & social care sector.

The North East Ambulance Service NHS FT, CNE NHS England, Newcastle upon Tyne Hospitals NHS FT, and Northumberland Tyne & Wear NHS FT provide services across the area and are part of the STP footprint



Northumberland PACS Vanguard

Description: The model will move care outside of hospital for primary care based services to proactively manage more complex patients.

Impacts on the wider system: 30% reduction in emergency admissions releasing £8m into the local health economy

Working across boundaries: Moving towards an ACO is underpinned by key stakeholders being committed to demonstrating system leadership to ensure services provided are in best interests of local population rather than restricted by organisational structures.

Northumbria Acute Trust Collaboration Vanguard

Description: Vision to create a high performing Foundation Group to run health organisations and provide shared services across the NHS.

Impacts on the system: Northumbria Healthcare has already operated as a group for some work, can demonstrate replicability across a range of back office services and have a well-established track record including technology, finance, procurement and payroll.

Working across boundaries: Approach focused on inclusivity to support and work with multiple trusts and can flex depending on the needs and requirements of each trust. Membership model provides options to support partnership working across NHS organisations

South Tyneside Integration Pioneer

Description: "A Better U" South Tyneside, connecting with public and staff working across health, social care and the voluntary sector, changing behaviours and culture to ensure local people control their health and wellbeing and are supported to self-care at every opportunity.

Impacts on the wider system: Improved capability, opportunity and motivation of our residents to self-care promoting independence and wellbeing; increased awareness and knowledge of self-care across our staff .

Working across boundaries: Our method for achieving this is the extension of preventative services, engaging staff across all of our services in 'change conversations' working with local people on a 'self-care offer' stimulating cultural and behavioural change across the Borough.

2.4.1 VANGUARD CASE STUDIES

Northumberland

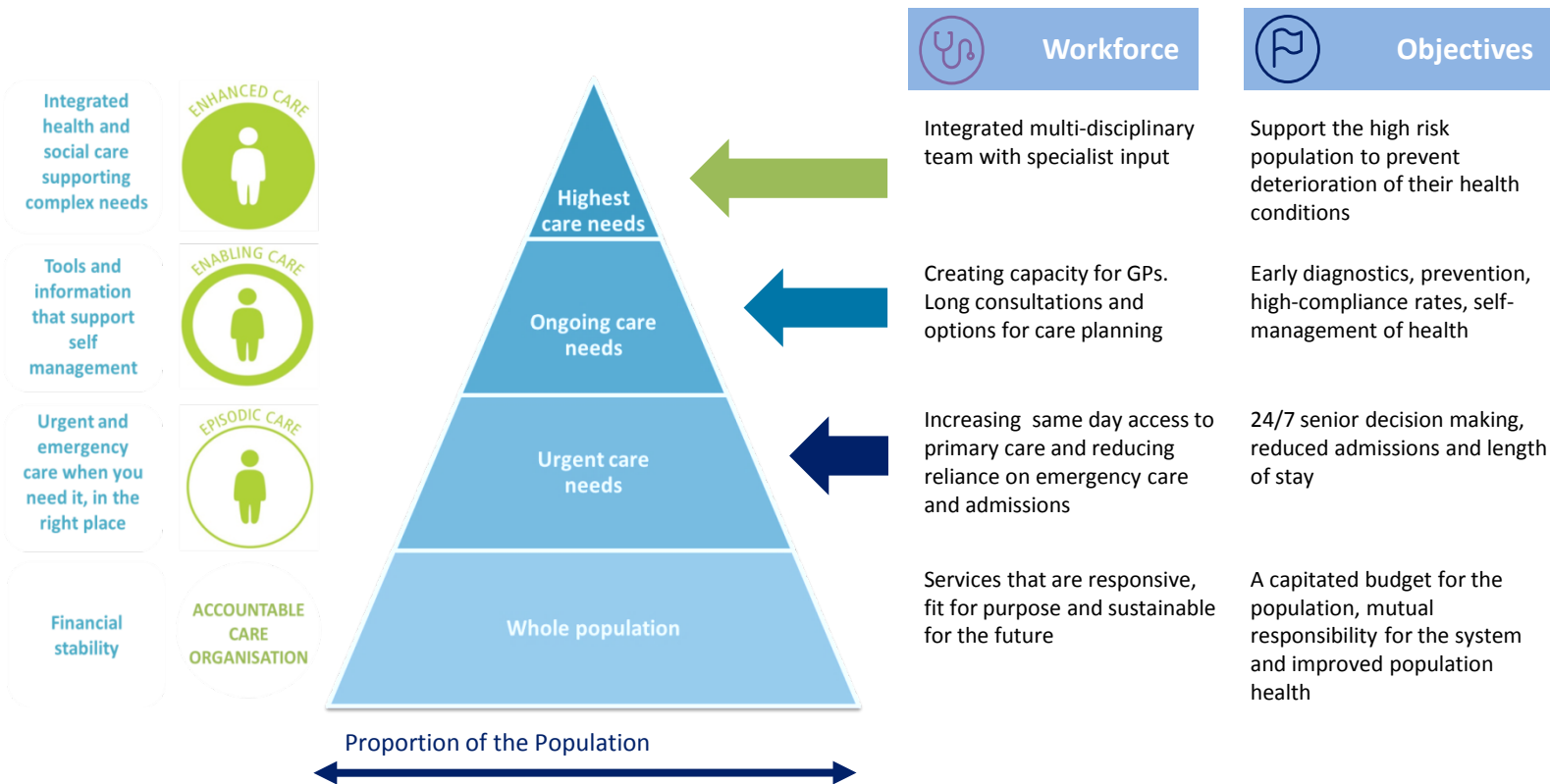
Case Study: Northumberland (1/6)

Overview

Northumbria Healthcare NHS FT, in partnership with Northumberland CCG and Northumberland County Council, aims to develop a **Primary and Acute Care System (PACS)** model in the region in order to move patient care out of acute settings and closer to patients' homes.

The vanguard wants to transform the way health services are delivered by redesigning the emergency care model, enhancing primary and community care, and creating an **Accountable Care Organisation (ACO)** responsible for commissioning and delivering services to the population.

The vanguard is structured around three clinical models: enhanced, enabling, and episodic care.



Case Study: Northumberland (2/6)

Key interventions and their expected benefits in each area

	Interventions	Expected Benefits ¹
INTEGRATED SYSTEM FOR URGENT CARE	<ul style="list-style-type: none"> Northumbria Specialist Emergency Care Hospital: specialist hospital focused exclusively on emergency care, with 24/7 emergency consultants, dedicated diagnostics and 7 day speciality consultant availability Urgent care centres: within district general hospitals, employing GPs alongside the regular clinical personnel 	<ul style="list-style-type: none"> Reduction in non-elective admissions Reduce patient time in hospital Improved clinical outcomes 7 day access to a GP service
PRIMARY CARE AT SCALE (Episodic and enabling care)	<ul style="list-style-type: none"> Capacity and demand exercise in 44 GP practices to shape the development of new access models for primary care Collaborative working – practices working closely together to deliver new models of care across localities 	<ul style="list-style-type: none"> Increased access to primary care with practices aiming to cover 7-9% of their population within a week Improved access time (weekends, out of hours) – move to same day demand management No increase in emergency activity
	<ul style="list-style-type: none"> Self-management: using new technology to empower patients and give access to clinical expertise Increase capacity within primary care to support care planning through longer consultations designed to improve patient experience within a ‘what matters to you?’ approach 	<ul style="list-style-type: none"> Proactive care planning New ways of accessing specialist opinion reducing OPD activity and investigation. Development of a common integrated approach – prevention through to EOLC
OUT OF HOSPITAL MODEL (Enhanced care)	<ul style="list-style-type: none"> Blyth Acute Visiting Service: targeted at patients with LTC, frail elders and complex needs (e.g. MH) Care home service introducing pharmacists to review medications Locality based teams working across organisational and professional boundaries. 	<ul style="list-style-type: none"> Proactive management of those with complex care needs Rapid response to acute events Reduce OBDs, ED attends Reduce unnecessary prescriptions Planned and responsive care needs met
INTEGRATED HEALTH RECORDS	<ul style="list-style-type: none"> Introduction of MIG – 44 practices approving system wide access to primary care record Integrated health care record: primary care system of choice programme supporting a large scale change to a single primary care informatics system. 	<ul style="list-style-type: none"> Improved communication Integration of primary and community care records including some medical specialities
DEVELOPING OUR WORKFORCE	<ul style="list-style-type: none"> Northumbria nurse training programme: 18 month programme reshaping the RGN training pathway Trainee pharmacist programme based within GP practice 	<ul style="list-style-type: none"> Bridge the recruitment gap Develop a culture of integrated working A workforce fit for purpose Extend capacity within primary care to facilitate new care models

¹: All expected benefits sourced from Northumberland PACS value proposition 2016/17

Case Study: Northumberland (3/6)

The new model of care strives to improve outcomes, safety and quality

The vanguard aims to **improve clinical outcomes** with the introduction of integrated working models across hospital, community and primary care settings to move towards a new population health model. Furthermore, integrated patient records and investment in the workforce are expected to improve the **safety and quality of care**.

Improved clinical outcomes

A&E activity



All programme activities across hospital, community and primary care settings are designed to impact on A&E activity. Aim to demonstrate reduce A&E activity (or show no growth) by 3-5%¹, amounting to a reduction in attendance of 325-542 patients p.a.

Length of stay



Integrated working models supported by timely access to specialist advice and appropriate rapid response systems are expected to reduce overall length of stay by reducing the number of patients spending more than 10 days in hospital

Improved safety and quality of care

Avoidable admissions



Investment in workforce capability to increase capacity in conjunction with integrated health care records are expected to reduce avoidable admissions by 10%¹ compared to 2014/15 level, implying a reduction by 65 admissions per month.

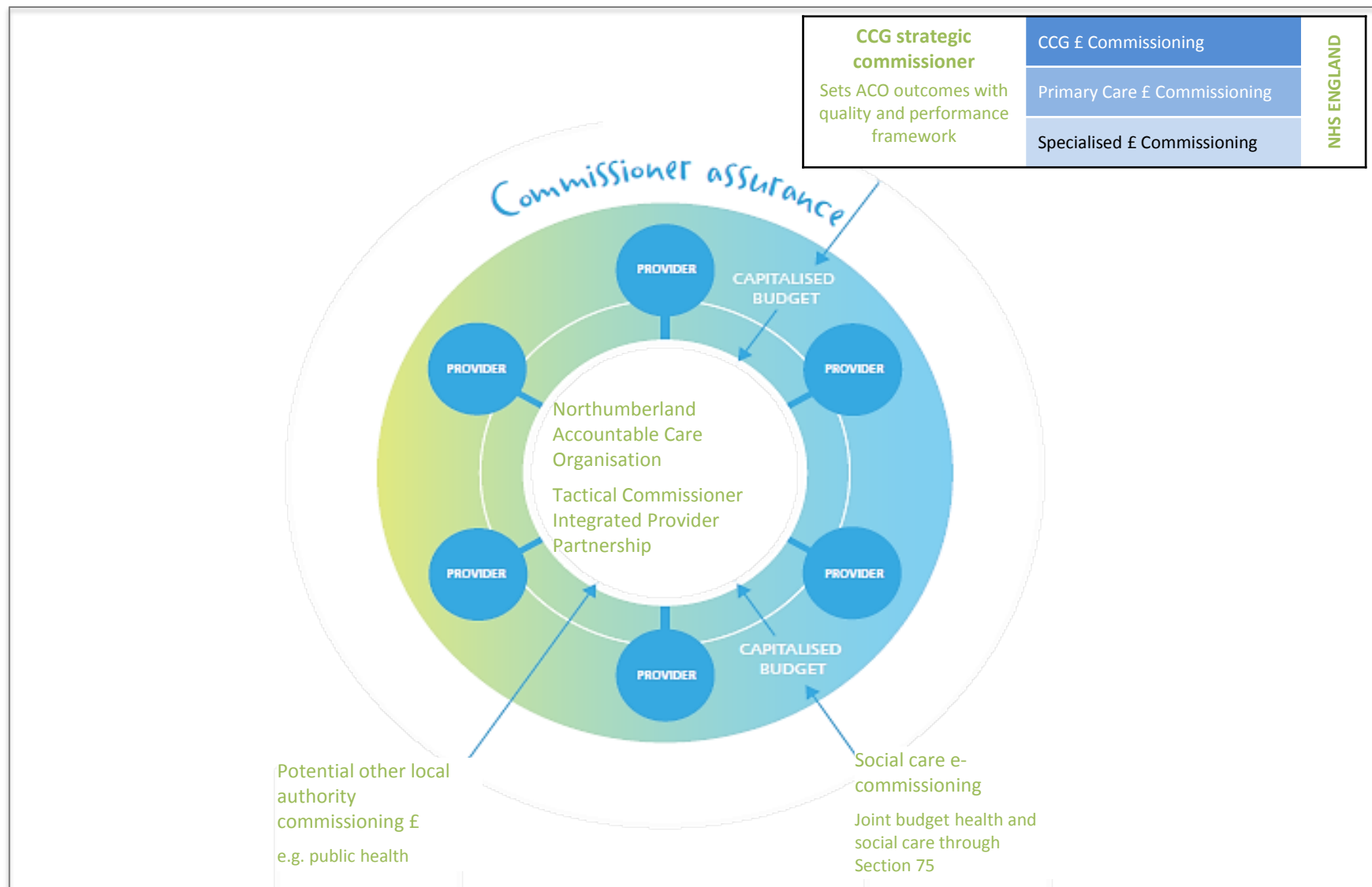
Readmission rates



Integrated health care records and a proactive approach to planned care are expected to at least maintain the readmission rate at the national target of 13%¹. (Oct. 2015 readmission rate was 12.1%)

Case Study: Northumberland (4/6)

Developing an ACO model in Northumberland



Case Study: Northumberland (5/6)

Financial analysis

Summary Financial Analysis – Northumberland PACS/ACO to reflect impact of 2016/17 nominal funding

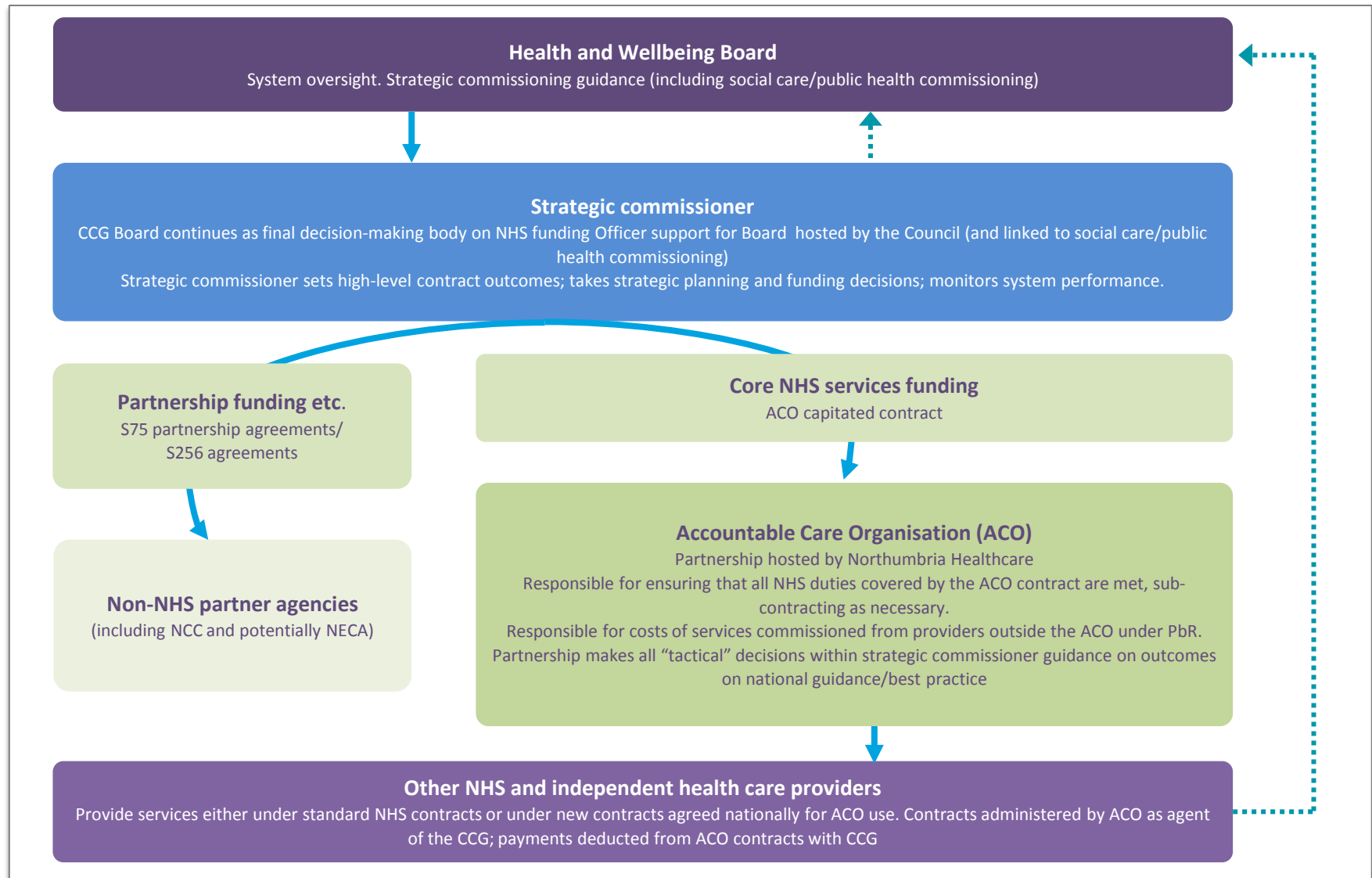
		<i>£m unless stated</i>	2016/17	2017/18	2018/19	2019/20	2020/21
Gross savings			8.3	10	15	15	15
Revenue costs	From vanguard		4.29	8	0	0	0
	From local contribution		8.35	12.5	5.3	5.3	5.3
	Total Revenue costs		12.64	20.5	5.3	5.3	5.3
Net savings			-4.34	-10.5	9.7	9.7	9.7
Capital costs	Other source						
	Total Capital costs		0	0	0	0	0
Population affected ('000)			322	322	322	322	322
Treasury discount rate			103.50%				
Reinvestment rate							35%
5-year average reinvestment rate			77%				

Comparison with wider STP estimates

A 77% 5-year average reinvestment rate has been estimated for the Northumberland new care model. This is higher than the wider STP which assumes that the new models of care could achieve a c.50%. However, the final year reinvestment rate in Northumberland is expected to reach c.35%. This discrepancy represents the investment in training schemes and time taken to develop the models in the early stages of the programme balanced by the lead in timescales for the plans to be fully operational and delivering at optimum levels.

Case Study: Northumberland (6/6)

The proposed system: a diagrammatic overview



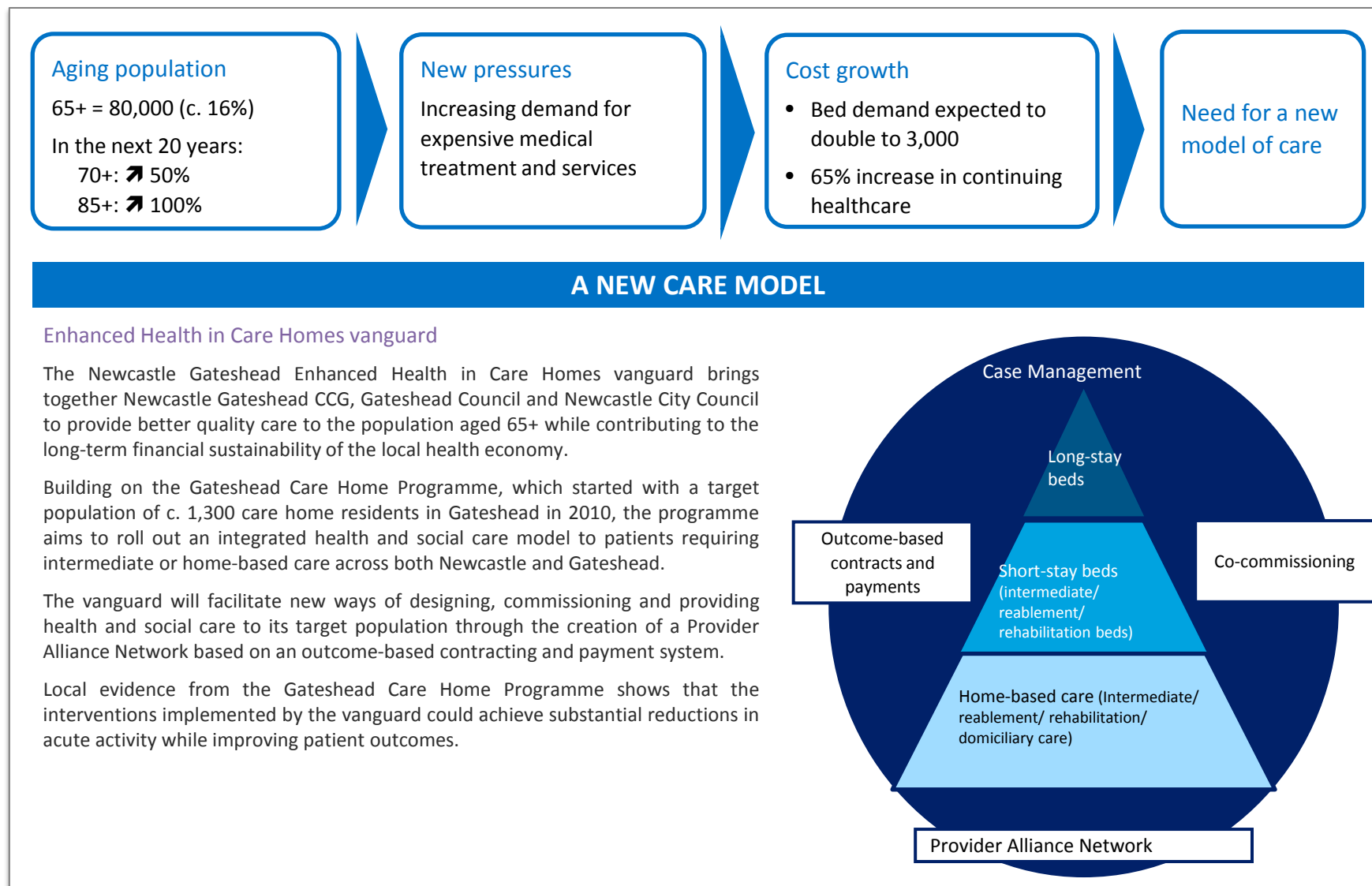
→ Funding flows for NHS budget

⋯→ Advice and guidance

NEWCASTLE GATESHEAD

Case study: Newcastle Gateshead (1/4)

Overview



Case Study: Newcastle Gateshead (2/4)

Key work streams



Case Study: Newcastle Gateshead (3/4)

Expected benefits

Intervention	Target Group	Expected Benefit ¹	Local evidence ²
Enhanced Primary Care	Adults 65+	Reduction in non-elective admissions by 27 % compared to the do nothing scenario	✓
		Reduction of OP appointments for care home patients by 20%	✓
End of Life Care	End of Life patients	Reduction of number of care home residents dying in hospital by 10%	✓
Responsive Care	Adults 65+	Reduction of A&E attendances from care home residents by 10%	✓
		Reduction of 999 calls from care homes which result in see and convey outcome by 10%	✓
Dementia Care	Anti-psychotics	Reduction in use of low dose anti-psychotics by 5%	✓
Hydration and Nutrition Care	Adults 65+	Reduction in admission related to urinary tract infections by 14%	✓
		Reduction in oral nutrition supplement prescription by 10%	✓

1: All numbers sourced from the Newcastle Gateshead 2014/15 vanguard value proposition

2: These ambitions are based on measured outcomes since the start of the Care Home Programme

Case Study: Newcastle Gateshead (4/4)

Financial analysis

Estimates of the potential savings from implementation of the new care model are largely based around the measured impact of the interventions on the target population of the Gateshead Care Home Programme. The table below¹ show the estimated savings achievable from scaling up these impacts to the entire target cohort on the frailty spectrum in Newcastle and Gateshead, estimated to include c. 84,000 patients in 2020/21.

Investments	2016/17	2017/18	2018/19	2019/20	2020/21
Total Investments	-£3.9	-£11.3	-£10.6	-£8.2	-£8.2
Of which vanguard funding	-£1.6	-£7.1	-£4.7	-£0.1	-£0.0
NEL admissions	£0.6	£2.4	£4.9	£7.8	£9.6
Medicines Management	£0.0	£0.8	£0.8	£0.8	£0.8
A&E attendances	-£0.0	£0.1	£0.2	£0.4	£0.4
Nutrition & Hydration	£0.0	£0.2	£0.2	£0.2	£0.2
Other	£0.2	£0.2	£0.2	£0.2	£0.2
Total savings	£0.8	£3.7	£6.3	£9.4	£11.2
Net position each year	-£3.1	-£7.6	-£4.3	£1.2	£3.0
Reinvestment rate					73%

Comparison with wider STP estimates

It is noted that the impacts estimated relate to the 65+ subset of the patient population only. In 2014/15, this population subgroup accounted for 31.5% of non-elective admissions. The vanguard aims to decrease non-elective admissions for this subgroup by 27%², which would result in a population wide reduction in NEL by 8.5%.

A 73% reinvestment rate is derived in this model for the year 2020/21, which is higher than the assumed reinvestment rate in the top-down model.

The £3m benefits represents c. 0.4% of Newcastle Gateshead CCG's 20/21 allocation. Considering that the care model targets a subpopulation accounting for c. 15.7% of the overall population, this is broadly in line with the estimated STP out-of-hospital benefit of c. 2.9% of 20/21 STP allocation.

1: All numbers sourced from the Newcastle Gateshead 2014/15 vanguard value proposition

2: The vanguard forecasts a 14% reduction compared to 2014/15 baseline, taking into account activity growth until 20/21 this would be a 27% reduction compared to do-nothing

Case Study: Newcastle Gateshead (4/4)

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Sunderland

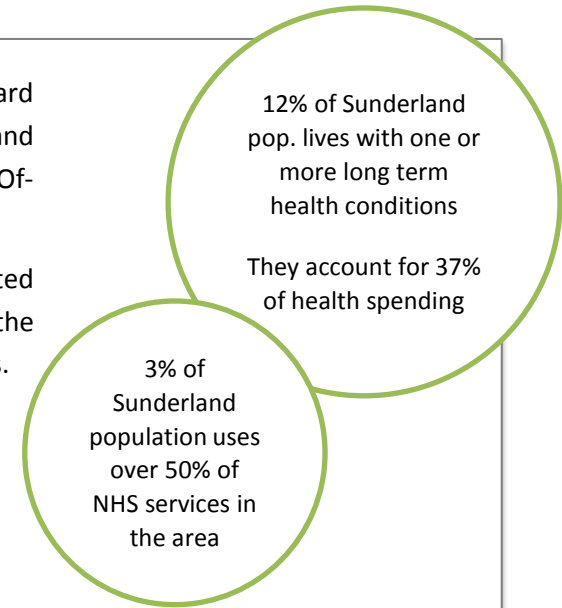
Case Study: Sunderland (1/5)

Overview

Sunderland’s “**All together better**” programme is part of the national New Care Models vanguard programme aimed at achieving the triple aim of closing the health and well-being, care and quality, and financial gaps by 2021 through the integration of services around the patient. It focuses on Out-Of-Hospital solutions as part of an MCP model.

The programme brings together local health and social care professionals, to create a more integrated and accountable model of care, where each practitioner or group of practitioners is responsible for the health of the whole population in the area under this remit. It covers a population of 283,000 patients.

The goal is to reduce avoidable hospital admissions and enable people to continue living independently at home, with all the health care support they require.



The Sunderland MCP model is divided into three main areas:

Recovery at home

A 24/7 service to provide quick support for all adults living at home and at risk of (re-)admission, as well as supporting early and appropriate discharge from hospital. It combines short term health and/or social care, nursing, therapy, and long term care. It is made up of one centralised team, acting as a single point of access to crisis, intermediate care and reablement services

→ Rapid response model (1 to 4 hours)

CITs

Community Integrated Teams

To combine services and create multi-disciplinary CITs (5 in Sunderland) in order to provide co-ordinated effective response to people out of hospital. It is targeted at a frail elderly cohort of patients.

The aims include patient centred, proactive care, avoiding duplication of work and the need for a patient to tell their story more than once.

Enhanced Primary Care

To deliver more sustainable support to people with one or more long term health conditions.

It aims to:

- support patients to better manage their conditions more effectively, including projects around diabetes management.
- support capacity releasing initiatives for general practice, e.g. map of medicine

The programme is led by the Sunderland GP Alliance.

Case Study: Sunderland (2/5)

Main benefits and achievements to date

TARGETS



Activity reduction

- ➔ Reduce non-elective admissions by 12.5% by 2019
- ➔ Reduce admissions to residential and care homes by 4% against 2015/16 baseline
- ➔ Reduce delayed transfers of care by 10% by 2017

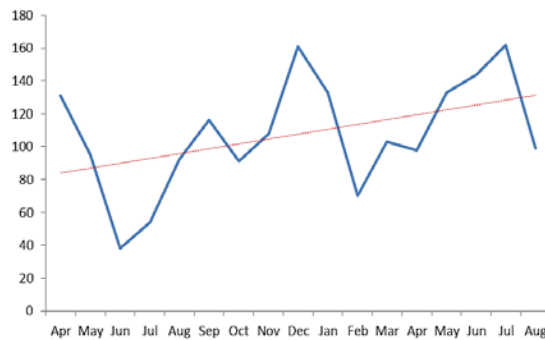


Patients outcomes

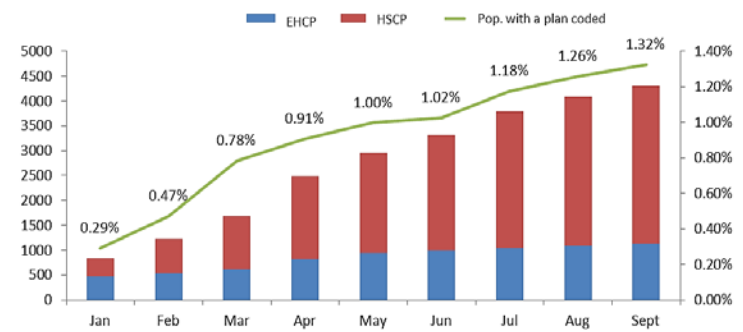
- ➔ Improve quality of patient experience of out-of-hospital care by 8% by 2019
- ➔ Improve health related quality of life for people with LTC by 8.9% by 2019
- ➔ Reduce years of life lost by 15% by 2019

ACHIEVEMENTS TO DATE

Delayed Transfers of Care (Apr 15 - Aug 16)



EHCP / HSCP totals



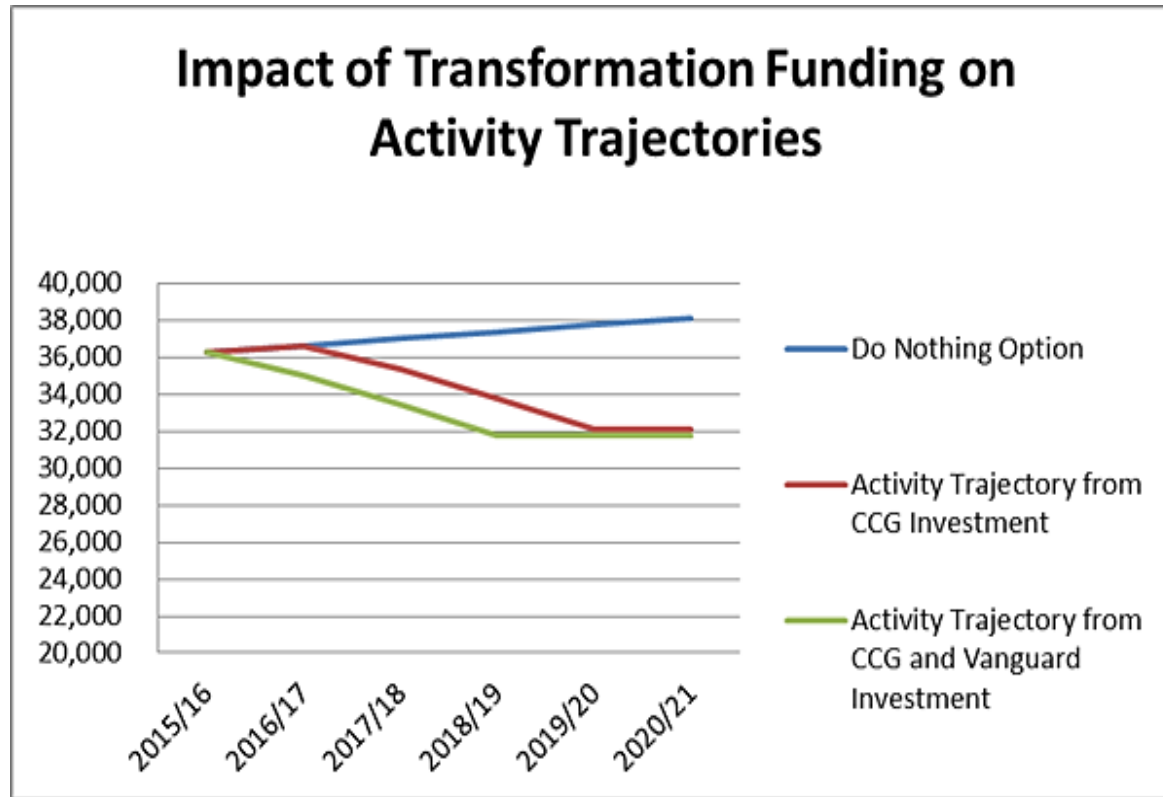
• Case Study: Sunderland (3/5)

Key interventions and their targeted population cohorts

	Target group	Description	Predicted services changes	Benefits
CITS	<p>High-cost segment of the population: 1-3% accounting for 40% of all costs</p> <p>Particularly frail and elderly</p>	<ul style="list-style-type: none"> • A GP provides clinical leadership to the MDT • MDTs meet weekly and use risk stratification tools to identify appropriate patients. • Care Plans are developed to meet patient needs. • Teams work across organisational boundaries. 	<p>Activity shifts expected but still to be modelled:</p> <ul style="list-style-type: none"> • Reductions in NEL for frail elderly population • Reduction in outpatient appointments • Reduction in A&E attendances <p>Latest data shows reductions in A&E attendances and NEL for the majority of patients seen by an MDT.</p>	<ul style="list-style-type: none"> • Improved quality of care • Fewer unplanned admissions • Fewer unplanned readmissions • Reduction in length of stay • Improved coordination of community, social and mental health care
EPC	<p>Patients with at least one long-term condition, across the (not only high-cost):</p> <p>4-12% of the pop.</p>	<ul style="list-style-type: none"> • 5 locality based hubs delivering insulin initiation and Type 2 diabetes management • Care Home alignment with GP practices • Roll out of Map of Medicine across all practices in the city. • Development of post discharge clinics pilot in one locality. 	<p>Activity shifts expected from individual level project pilots contributing to overall aims of the OOH model.</p>	<ul style="list-style-type: none"> • Improved quality of care • Increased capacity within General Practice community • Increased partnership working across General Practice in support of GP 5 Year Forward View.

Case Study: Sunderland (4/5)

Predicted impact on NEL admissions



Description	2016/17	2017/18	2018/19	2019/20	2020/21
Saved Emergency Admissions from Transformation	1,250	2,869	4,519	4,519	4,519

Case Study: Sunderland (5/5)

Financial analysis

Funding Source/assumed savings (£)	2016/17	2017/18	2018/19	2019/20	2020/21
CCG recurrent investments	7,731	7,731	7,731	7,731	7,731
NHS England non recurrent investments	4,799	1,150			
Total investments	12,529	8,881	7,731	7,731	7,731
NEL activity reductions	-1,625	-3,730	-5,875	-5,875	-5,875
Reduction in recurrent investments/ further reductions in NEL activity		-898	-1,795	-1,795	-1,795
Total savings	-1,625	-4,627	-7,670	-7,670	-7,670
Total health commissioning (net cost savings)	10,904	4,253	61	61	61
Total CCG commissioning (net cost savings)	6,106	3,103	61	61	61

Comparison with wider STP estimates

The Sunderland Vanguard is expected to deliver a suite of impacts which are relatively aligned to the ones assumed by the wider STP. In particular, the impact on non-elective activity is assumed to be c.12.5% for this locality whilst the wider STP is assuming a marginally more ambitious target of c.15%

The Sunderland Vanguard is expecting the proposition to balance financially. This is not aligned with the wider STP approach, which assumes that the new models of care will achieve c.50% saving.

However, models of out of hospital care in other localities may not require similar levels of investment as these are conditional on the current state of the community infrastructure. As such, there may be ways of implementing similar approaches in other localities at a with higher levels of return.

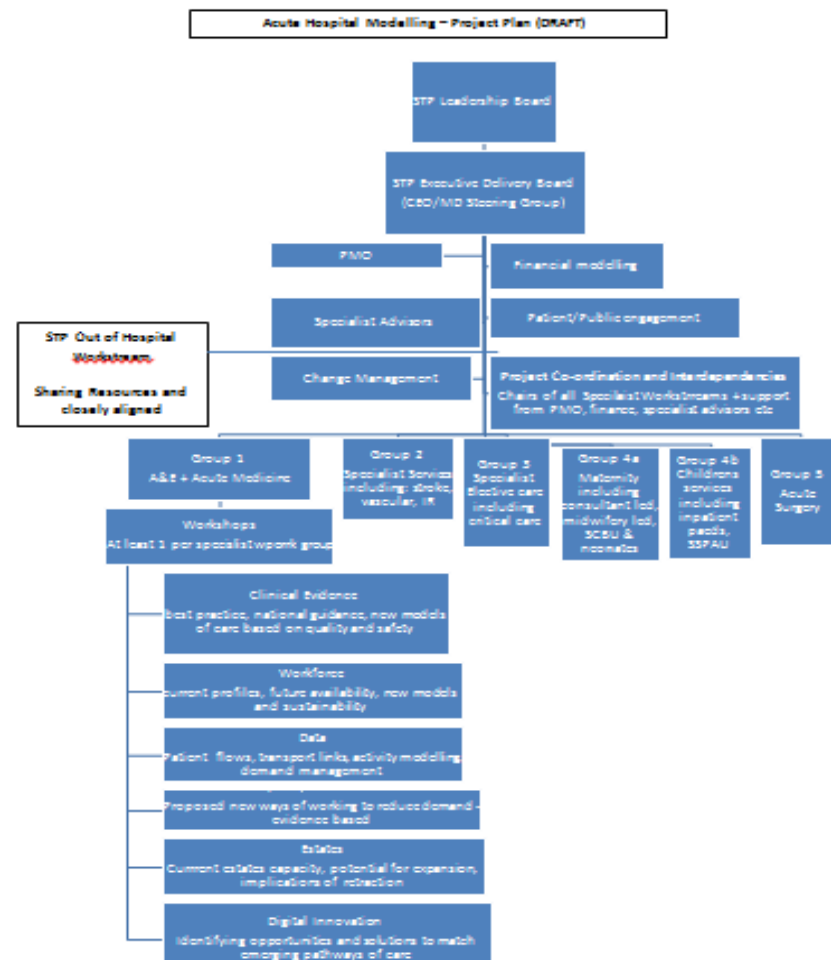
In addition, the proposition is expected to generate a suite of savings for local authorities which are not captured in these estimates. These would generate an additional c.£5m of savings, leading to a reinvestment rate of c.54%

2.5 OPTIMAL USE OF THE ACUTE SECTOR

Optimal use of the Acute Sector – Next Steps

- The next priority is the modelling work for the Optimal Use of the Acute Sector, the purpose of this work is to agree a range of clinical options for the future delivery of 7-day clinical services across the NTWND STP footprint.
- The Chief Executives and Medical Directors across the NTWND STP footprint have agreed that the services to be used as the drivers for change and therefore modelled and assessed will be those listed in the table overleaf:
- It is understood that there may be implications for other services as a result of options considered and these will be considered and developed in the options as they emerge. This work will:
 - be a workstream of the overall NTWND STP project plan and as such will feed in through the agreed STP governance and decision making arrangements
 - build the case for change (clinical and financial) in preparation for public engagement/consultation
 - ensure connectivity between the acute sector evolving model and the other STP workstreams
- Where possible existing networks will be used to form the specialist working groups especially where existing work is in place.
- The Workforce Advisory Group (WAG) will be used to develop approaches to workforce development including new models of delivery that align with the emerging clinical models of delivery.
- To achieve this the work will be concentrated using the principles of rapid improvement (time spent on detailed data collection and presentation with intensive review and development of proposals).
- In addition to these focus areas, footprint organisations are working with NHSI to understand the opportunities for consolidation in Pathology and shared back office.

A&E	Critical care (levels 2&3)	Consultant led obstetrics
Acute medicine	Interventional radiology	SCBU
Hyper-acute stroke	Inpatient paediatrics	Neonates
Acute surgery	SSPAU	Midwifery led (co-located)
Specialist vascular surgery	Elective care (linked to critical care)	Midwifery led (stand alone)



NTWND STP impact and ambitions - Care and Quality

Measurable benefits through having a healthier population, integrated preventative service provision and empowered, resilient individuals and communities

Better Care impact by 2021

Priorities

Ambitions 2021

Citizens

- ✓ In control
- ✓ Self Care
- ✓ Less hospital use (if needed)
- ✓ Alternative options (care placement)

System

- ✓ Access, choice, navigation and flow of care will be simplified
- ✓ Responsive to need
- ✓ High value and preferable closer to home care

Workforce

- ✓ Well trained, satisfied, collaborative working to manage need
- ✓ Less reliance on agency staff
- ✓ **Clear tariff based prevention pathways**

Digital / innovation

- ✓ Solutions will provide choice and operate 7 days
- ✓ Creating opportunities of 'excellence'

Increasing demand for hospital and bed based services

Unwarranted Variation

Variation in quality, safety and experience of people using health and care services

Clinically sustainable services whilst maintaining high levels of care and quality

Infrastructure and workforce required to deliver fully integrated health and care services outside of hospital

Seven day services

- Reduce Accident and Emergency attendances per 1,000 population by 15%
- Reduced Elective Care and Out Patient activity by 10%
- Reduce Emergency hospital admissions per 1,000 population by 15%
- Reduce non-elective admission rates chronic ambulatory care sensitive conditions by 17% by 2020/21, reducing the gap in admission rates between the STP and England by 50%.
- Remove variation in acute sector activity rates for elective MSK by 14.8%, bringing each locality within the STP in line with their Right Care peer group.
- Remove local variation in day case and outpatient procedure ophthalmology activity across the STP, achieving a combined activity reduction of 6.7%.
- Remove variation in and reduce levels of QoF exception rates in key disease areas to the level of the best performing CCG in the STP (Asthma 6%, COPD 11%, Heart Failure 9%, CKD 4%, dementia 4% and SMI 9%)
- 100% of primary care providers rated good or outstanding by 2020/21.
- 100 % of secondary care providers rated good or outstanding by 2020/21.
- All providers of acute stroke services to achieve an overall rating of B or better in the annual SSNAP audit.
- Remove variation in women's experience of maternity services based, achieving a STP score of 84.9 in the 2015 CQC National Maternity Services Survey, matching the best performing CCG within the STP.
- Reduce aggregate Trust sickness absence rates to 3.4% matching the best performing region in the country.
- Diabetes: % of GP practices that participated in the National Diabetes Audit.
- % of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral. (National ambition: 85%)
- Achieve an overall satisfaction rate of with GP services of 89.1%, matching the best performing CCG in the STP and maintaining above average performance above national peers.
- Achieve an overall satisfaction rate of with people feeling supported to manage their LTC of 71.3%, matching the best performing CCG in the STP and maintaining above average performance above national peers.
- Increase the number of weekend and out of hours (18:30 to 20:00) appointments available in primary care to a minimum of 30 minutes per 1,000 population per week and achieve a utilisation rate of at least 75%.
- 100% of referrals to consultant led services to be made electronically.
- 100% of prescriptions and repeat prescriptions to be made electronic
- Increase the number of weekend and out of hours (18:30 to 20:00) appointments available in primary care to a minimum of 30 minutes per 1,000 population per week and achieve a utilisation rate of at least 75%.

2.6 HOW OUR PLANS ARE CLOSING THE FINANCIAL GAP AND LINKING TO OPERATIONAL PLANS

How our plans are closing the finance gap – Out of Hospital Collaboration

The NTWND Health and Care system is planning to provide clinical services through integrated models of care that are significantly more effective and efficient for patients. While work on integrated models of care is well developed in many areas of the footprint through vanguard programmes (such as the All Together Better Sunderland MCP, the Northumberland PACS model and the Newcastle Gateshead Enhanced Health in Care Homes vanguard), the system is currently working to define a unified core offering for out-of-hospital services across the system.

The activity shifts currently assumed by the STP are outlined in the table A. It is noted that while the activity shifts relate to a reduction in acute activity, some of the activity may have to be re-provided within existing or new community and primary care settings.

The financial benefits in table B associated with these activity shifts are then estimated based on the following assumptions:

- The reduction in cost for providers in response to changes in activity is assumed to be 70%; that is for a decrease in activity worth £1, costs are reduced by £0.70
- Re-providing services in the community for patients shifted out of acute settings is assumed to require a re-investment of 50% of the costs taken out of the acute sector

The estimate of net benefits from Out-of-hospital solutions assumes that an equal amount is invested into providing community services. More specifically, the estimated net benefit of c. £89m from the out-of-hospital model are predicated on a recurrent investment into enhanced services outside the acute sector of £89m per annum. It is further assumed that the full benefits of the new care model will only be realised at the end of the planning horizon, with a phasing over the intervening years as shown in table C:

Furthermore, progress towards the establishment of new models of care across the STP will be uneven across the local systems – Sunderland, Northumberland and Newcastle Gateshead – have been developing new care models as part of the national vanguard programme, while other localities are in earlier stages of development.

The case studies in section 2 provide further information on the progress of vanguards within the STP and relate their plans to the high level assumptions on targets for activity reductions and reinvestment requirements which underpin the out-of-hospital analysis. However, it is important to note that the investment aspects of the vanguards may be specific to the locality and may not be required when implementing similar out-of-hospital models elsewhere.

To understand the effects of changes to activity and financial flows on the footprint commissioner and provider organisations, additional assumptions around the payment mechanism have to be made.

Table A – Activity Shifts

	Core	Stretch
Non-elective	-10%	-15%
Elective	-10%	-10%
Outpatients	-10%	-10%
A&E	-15%	-15%

Table B – Financial benefits

	Core	Stretch
NEL	£28.9m	£43.4m
EL/OP	£39.2m	£39.4m
A&E	£5.8m	£5.9m
Total	£73.9m	£88.7m

Table C – Phasing of benefits

2016/17	2017/18	2018/19	2019/20	2020/21
0%	25%	50%	75%	100%

Investment area STF by 2021	Indicative allocation
Sustainability funding	48.0%
GP access	13.2%
Other commitments to GP transformation	3.6%
Paper free, electronic health records	8.6%
Mental health & dementia	5.1%
CAMHS	0.2%
Cancer	4.5%
Maternity	2.0%
Prevention, obesity, diabetes	3.9%
Transformation funding	10.8%

2.7 DELIVERING THE NINE MUST DO'S

'Must Dos' 2017-19	NTWND STP 3 Transformational Areas and Delivery Priorities	
STP	Finances	Out of Hospital Collaboration
		Upscaling Prevention, Health and Wellbeing
		Optimal Use of the Acute Sector
Primary Care		New Care Models – MCP/PACS/EHCH/ACC
		GPFV
Urgent Care		Northeast Urgent and Emergency Care Vanguard
RTT and Elective Care		Local Maternity System & Better Births
Cancer		North East and Cumbria Cancer Alliance & Task Force
Mental Health		MH5YFV
LD and Autism		Transforming Care Partnerships
Quality		Right Care and Value Based Commissioning

2.8 OUR ENABLERS TO SUPPORT ACHIEVEMENT

Enablers to support achievement of our plan

Enabler	Summary
Leadership	NTWND understands that system leadership at all levels is crucial for any change. We will drive accountability and responsibility which is system focused, flexible and multilevel in the current leadership and we will seek to understand the NTWND need for the next generation of leaders based on shared resources and system values
Workforce	NTWND understands the workforce of the future needs to be fundamentally different to the one we have now. We need to develop a workforce strategy to truly reflect the sustainable workforce needed across NTWND. Workforce leads across NTWND have met to discuss opportunities and are linking into the Northern CCG forum
Digital Solutions	Collaboration around technology has been a strong cornerstone of NTWND footprint. Work has been ongoing at a regional level to connect the various programmes with links into other digital programmes across the country. Clinical and managerial leaders across the footprint are coming together to design and implement programmes such as the Great North Care Record. Local Digital Roadmaps are being pulled together in parallel to ensure greatest benefit is achieved
Estates	The principles and learning from 'one public estate' need to be translated across the NTWND footprint and a clear understanding of efficiencies can be achieved by working collectively
Payment and contracts	Integrated provision and commissioning exploration to facilitate new contractual and payment levers that will help drive the change moving away from disincentives of working together

See Section 3 for detailed delivery plans

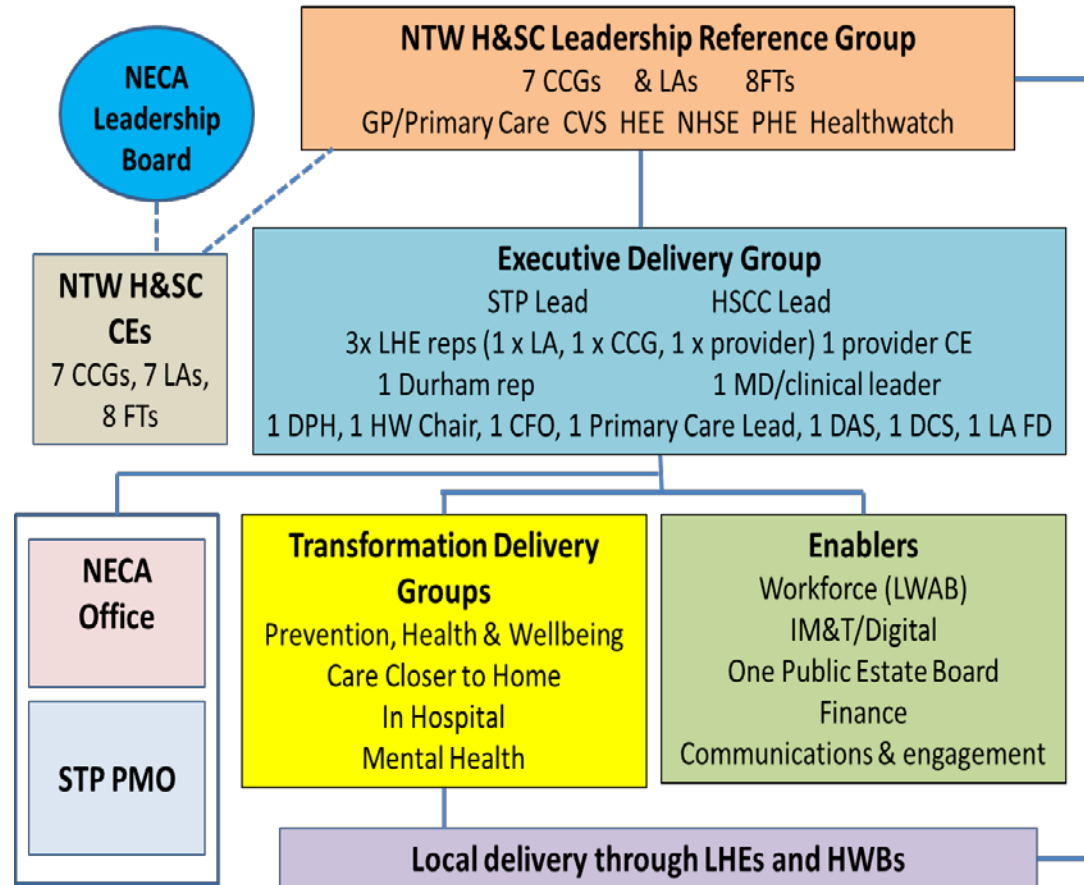
2.9 LEADERSHIP AND GOVERNANCE

NTWND Leadership and Governance

The NTWND footprint embraces leadership as a driver to change. We are shifting from an organisational culture of leadership to one that is systems focused – embracing all the principles of responsible and distributed leadership and including clinical leadership at all levels.

A systems-wide Health and Social Care Leadership Board is being developed, linked to the NECA Leadership Board (the seven LA leaders) to ensure strategic oversight of delivery of the STP and the outcomes of the Health and Social Care Commission. This will meet twice a year. An Executive Delivery Group is being formed with senior representation from partners to provide oversight at a more operational level and including programme sponsorship from NHS and LA chief executives.

This will oversee delivery of those transformation areas, including enablers being tackled at a STP / NECA level.



OFFICIAL – SENSITIVE: COMMERCIAL

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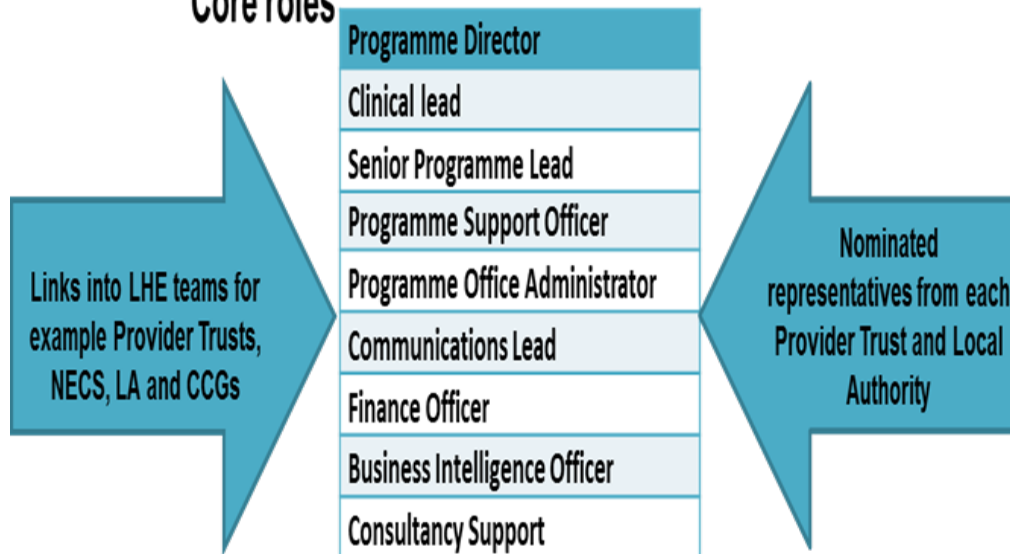
2.10 PROGRAMME MANAGEMENT OFFICE

NTWND programme management office

To support the successful delivery of our plans our Programme Management Office (PMO) is to be further expanded and will ensure close working relationships with neighbouring STP footprints and local Vanguard programmes – identifying opportunities for at scale working and delivering 'once'.

STP PMO

Core roles



2.11 FUTURE COMMISSIONING LANDSCAPE

Future Commissioning Landscape

As we start to change the provision of care and bring together closer collaboration between providers – both formally and informally, this will inevitably change the commissioning landscape across health and across the NHS and Local Authorities.

Future *integrated commissioning* options will clearly be explored on a number of fronts:

- **Financially challenged CCGs.** For example, explore how Newcastle Gateshead CCG might support North Tyneside CCG with a joint management team across both CCGs, to give consistent and strong leadership whilst focusing on immediate financial recovery
- **Sustainability of CCG in the long-term** – small versus larger organisational stability
- **Expertise and Quality** – opportunities to improve the quality of commissioning through consolidating expertise around key commissioning responsibilities

High performing analytical, transformation and business support services are critical if we are to strengthen system leadership, accelerate service transformation and deliver the best possible health outcomes for the people of Cumbria and the North East.

CCG decision-making and our ability to evidence the impact of our interventions depends upon the quality of our commissioning intelligence, as well as safe and accurate data. We want to safeguard our continued access to critical business intelligence applications, further develop the use of these analytical tools to better target our resources and ensure that this valuable insight is integral to our decision-making.

Therefore, to support the delivery of our STP plans, NECS is to transition into a new community interest company owned jointly by its CCG customers. In doing so we want to safeguard NECS's position as a market leader in commissioning support services, whilst further aligning their priorities with ours to drive out greater efficiency, innovation and improvement – as well as cost savings that can be reinvested into frontline care.

We want to channel the energy and expertise of NECS as a catalyst for more integrated, system-wide working across the region. NECS's work will increasingly focus on the shared priorities of CCGs – including commissioning intelligence and the application of Rightcare, programme and project management, communications and engagement and the delivery of whole-region digital care solutions – to help us bridge the quality, performance and financial gaps in our STP.

2.12 PRE ENGAGEMENT AND POST ENGAGEMENT

Engaging local people and stakeholders

Our approach to date has involved utilising the successful communication and engagement methods which are already in place to support existing transformation plans in each of the LHE areas. It has been agreed that these existing mechanisms are to be maximised rather than creating a range of new processes solely to support the STP.

It has been recognised by the STP partners that messages are much more likely to be successfully delivered by existing mechanisms that key stakeholders already trust, rather than from new processes that will take time to establish. However, if a key stakeholder is identified that that at least one of the STP partners does not already communicate with, then methods will need to be developed to plug that gap.

Pre-October
2016

Stakeholder engagement carried out at LHE Level to date, includes:

- Health and Wellbeing board presentations and discussions
- NHS CEOs and LA CEOs meetings and discussions
- Clinical Leaders and CEOs meetings and discussions
- Overview and Scrutiny presentation
- Engagement and discussions with Clinical Networks
- Discussions with Healthwatch chairs
- STP leads actively involved in Health and Social Care Commission meetings

Communication and Public Engagement Objectives

- Ensure legal duties to engage and consult are met
- Maintain public confidence in NHS services
- Support safe reconfiguration of services where needed

Post - October
2016

Communication and Public Engagement strategy includes:

- Stakeholder mapping
- NE&C Comms & PPI network
- LHE engagement plans
- Democratic engagement
- Clinical engagement
- Staff engagement

Public Publication date: 23 November includes:

- Summary doc with clear description of the issues and challenges
- Regional event for key stakeholders
- Arrangements for public involvement
- 5,600 My NHS members

Outline timescale – 5 stage approach

- Stage 1 – publication – engagement and plan
- Stage 2 – update plan with insights from stage 1
- Stage 3 – formal consultation on STP as strategic plan
- Stage 4 – update plan with consultation feedback becomes final plan
- Stage 5 - future various reconfigurations with final consultation process

DRAFT Official - Sensitive: Commercial

2.13 LIMITATIONS AND RISKS

Limitations and risks

- The plan has been developed for the footprint undertaking a top down approach using national indicators, benchmarking and pre application of local intelligence
- Local Authority funding pressures and the potential for additional costs across the health and social care economy with respect to such issues as increases in DTOC have not been modelled in the financial plan
- Simple rules and/or assumptions have been used to define the benchmarks
- The benchmarking undertaken has not been adjusted to take into account differences in delivery models or case mix further than what is controlled for by the retention of the peer group
- The models use indicative values based on local intelligence, top-down literature and benchmarking and as such ranges for both costs and delivery may need to be considered further.
- A simple rules based approach to SF costs has been taken, in line with the functionality in the top-down Solution Model. This does not account for a detailed analysis of sf costs elasticities linked to rota efficiencies, however assumptions drawn from the local system are used instead.
- The STP describes our approach to delivering a balanced financial position in year five of the plan at 2020/21
- The plan also indicates a balanced position in 2017/18 and 2018/19, before investment in national priorities, as per national guidance.
- Noting our intention to deliver financial balance in 2017/18 and 2018/19, and the fact that the STP has been derived at a systems level, circa 1.2% of the required efficiencies to deliver balance in those years remain the subject of further action and detailed determination through the operational and financial planning processes now underway.

Limitations and risks

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The main risks which could destabilise delivery of the major changes we are planning are:

- **Financial Risks**

- Underachievement of the savings planned;
- Under realisation of the savings from reduced national tariffs;
- Unplanned increases in the m of non-elective hospital activity;
- Unplanned increases in either volume or price of the prescribing.
- LA funding reductions and the potential for additional cost pressures for the Health Economy

- **System Risks**

- Primary care engagement and changing clinical behaviours;
- Changing the lifestyles and behaviours of our population;
- Delivering the plan with fewer management staff.

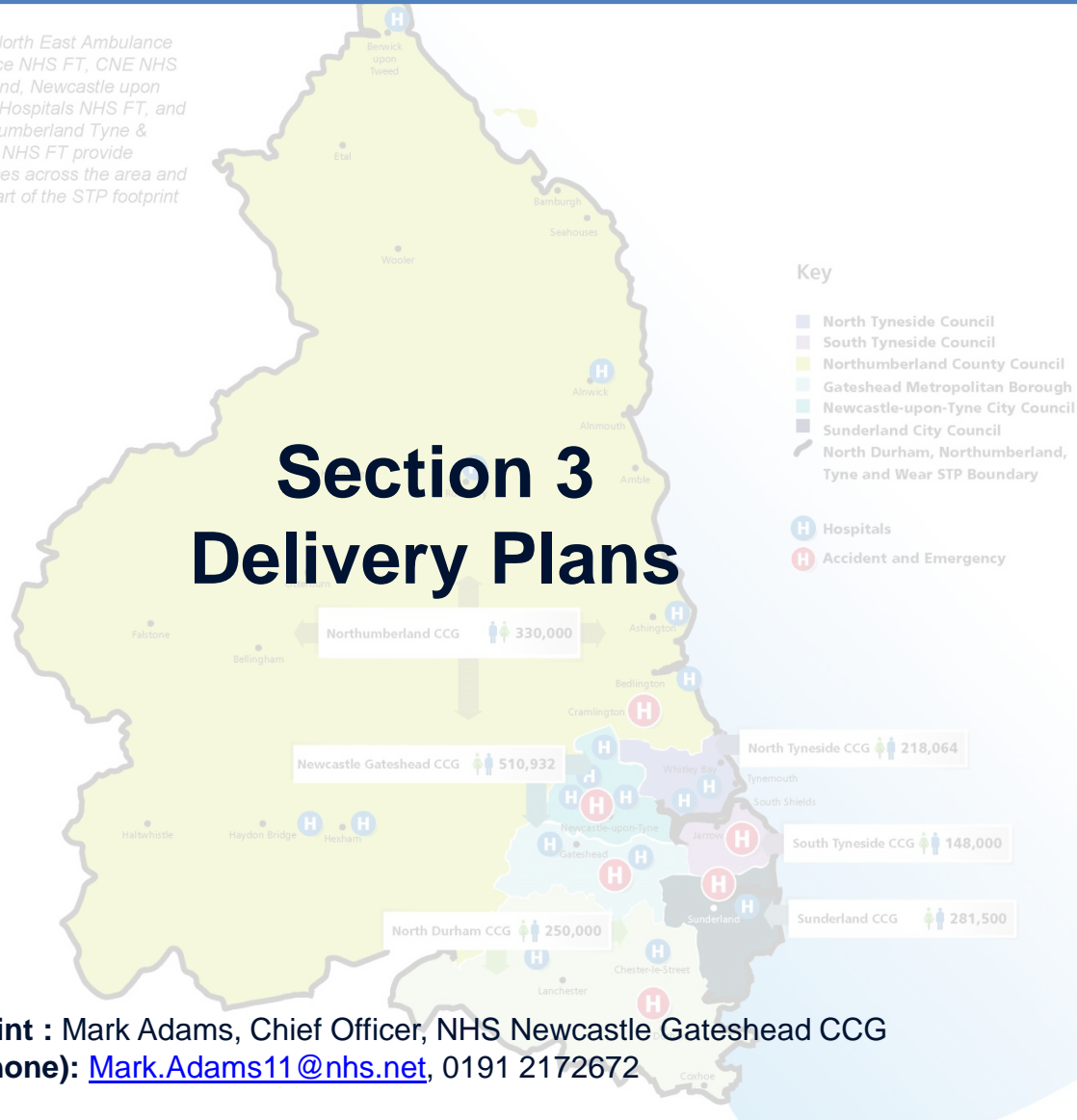
- **Implementation Risks**

- Plans are not executed to the timing, depth and intensity required.

Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan

The North East Ambulance Service NHS FT, CNE NHS England, Newcastle upon Tyne Hospitals NHS FT, and Northumberland Tyne & Wear NHS FT provide services across the area and are part of the STP footprint

Section 3 Delivery Plans



Nominated lead of the footprint : Mark Adams, Chief Officer, NHS Newcastle Gateshead CCG
Contact details (email and phone): Mark.Adams11@nhs.net, 0191 2172672

SCALING UP PREVENTION, HEALTH AND WELL BEING

Overall scheme lead: Amanda Healy – Director of Public Health (South Tyneside Council)



The Gap – Why Change is needed
 Our challenge is that across NTW&ND we provide a comprehensive health and care service to a generally poorer, more unhealthy, and older population with more long term conditions that start earlier in a person's life. Therefore the costs of our health and care system are high and increasing. We must re-orientate our system to be focussed on laying solid health and wellbeing foundations and less focussed on providing specialist and expensive health and care services.

Future State/Ambition
 Our vision is to establish a health and care system in NTW&ND that supports population health and wellbeing as the primary objective. Without tackling the underlying health and wellbeing challenges in NTW&ND we will continue to face higher health and care costs, health inequalities and poor health outcomes.
 We have calculated that if healthy life expectancy among all North East Combined Authority constituent local authority populations was to rise over the next 10 years to reach the national average healthy life expectancy, among both males and females, this would mean that there would be an additional 400,000 healthy life years lived across the 10 year period. Our aim is to work with the NECA to achieve this.

What resources are required to deliver / what capacity and capability do we need?
 The biggest resource required to deliver our health and wellbeing ambition is shared commitment. This means committing to putting prevention first, committing to make small organisational changes that will make a big difference (such as smoke free hospitals), committing to training and supporting our staff to address the underlying causes of ill health not just focus on the presenting disease or condition, and committing to openly and transparently monitoring our progress and outcomes.

Financial implications (ROI)
 In a broad sense we must use all of our collective health and social care spend and focus it on prevention. We will achieve this by undertaking a significant cultural shift across all services and monitoring them on the prevention outcomes they achieve.
 Specifically, the prevention programmes we've identified in this plan will require NHS resources to pump-prime the shift towards prevention.

Benefits (Outcome Measure)
 Indicators include: smoking at the time of delivery, breast feeding initiation, long-term unemployment, flu immunisation rates, prevalence of excess weight, smoking and alcohol attributable hospital admissions, premature mortality rates, people feel supported to manage their long-term condition, sickness/ absence rates across health and care, proportion of health and care staff trained in Making Every Contact Count.

Programmes	16/17	17/18	18/19	19/20	20/21
Best start	Maternity review & training NA	Standards agreed	Perf framework in place	Full implementation	
Prevention Services	Map current prev pathways Flu prog in place	Agree model(s)	Phased roll out	Full implementation	
Healthy behaviours	Fresh & Balance supported	Obesity office created Standards in all contracts			
Unemployment	Engage with NECA on worklessness	Pilot return to work progs	Full implementation		
Selfcare	Evidence Review commissioned	Best practice models and specs	Services commissioned locally		
Community Assets	Community assets website in place	Social prescribing pathways			
Workforce & MECC	HENE workforce dev strategy	All providers working towards BHAWA	All providers gold standard BHAWA	50% staff trained in MECC	

Interdependencies Workforce strategy, GP Forward View, Out of Hospital Model, ICT strategy, Communication and Engagement

TRANSFORMING CANCER SERVICES

Overall scheme lead: Dr Andrew Welch – Medical Director (NUTH NHS FT) – Lead for Cancer Alliance



Implementation Milestones		16/17	17/18	18/19	19/20	20/21
Transformation Programmes	Scheme 1		First meeting of Alliance Board			
	Scheme 2		62-day cancer waiting time as standard			
	Scheme 3		Agree target for diagnostic capacity increase			Meet increase in diagnostic capacity
	Scheme 4					Achieve 28 days to diagnosis

Benefits (Outcome Measure)

2016-17 deliverables:

- Achieve 62-day cancer waiting time standard.
- Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test.
- Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one.

Overall 2020 goals:

- Deliver significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (now at 69%);
- Ensure patients are given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
- Increase diagnostic capacity to meet identified need.

Each CCG will have a local plan that fits with the Cancer Alliance overall objective.

The Gap – Why Change is needed

- Significant gap between life expectancy in the NTWND and that of England.
- Improvements have been seen in coronary heart disease which have reduced the gap but in cancer this has largely remained static nationally and the NE average is higher than this.
- Smoking in deprived communities as being the most significant method of reducing cancer rates
- Sin the least affluent areas is up to 32%.
- Apart from breast cancer incidence and prevalence impacts more on deprived communities. The NE has more of these communities than England as a whole.
- This also impacts on attendance at treatment, a need for additional financial benefits linked to their disease and on survivorship.
- A decline in women attending for screening greater in practices in deprived areas.
- Information sharing and delays in pathways of care as people travel between hospitals impacts on 62 day target and quality of care. Transitions and handoffs are impacting on patients.
- An aging workforce and increasing need for diagnostic service will impact on care.
- The pressure to deliver a 28 day diagnostic response to patients may mean the ability to support patients holistically is lost.
- Increased capacity will cost and some of this (3%) is due to an ageing population with its increased associated cancers.
- All CCG need to expect that their budget for cancer services even with no additional new treatment will need to rise accordingly.

Future State/Ambition for 2020/21

- Fewer people getting preventable cancers improvements in screening including lung;
- More people surviving for longer after a diagnosis, with 57% of patients surviving ten years or more;
- More people having a positive experience of care and support; and,
- More people having a better long-term quality of life including use of third sector in regard to survivorship and in particular benefits advice
- More radical focus on delivering public health improvements at a population scale.
- Commissioning at scale i.e. a n STP level.
- Freeing capacity by stratification of patients in treatment with regard to follow ups starting with breast.
- Viewing cancer as we do long term conditions with key link workers and support

What resources are required to deliver / what capacity and capability do we need?

- A workforce review focused on diagnostics is due next month from which the scale of some of the issues facing the system will be known.
- More targeted public health approaches in more deprived communities is essential to improve uptake in screening and services; and improve survivorship.
- A long term plan for workforce recruitment to the NE and not based on individual FTs.
- Ensure that agreed pathways are embedded in current practice.
- Specifically CCGs are considering lung cancer screening to identify people at stage 1 and 2 to improve treatment options and improve survivorship.

Financial implications (ROI for example)

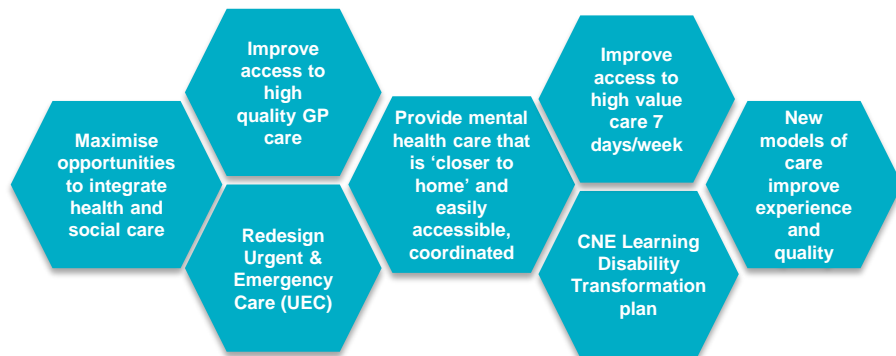
Commissioners and FTs count the investment in different ways. A review of this is to be developed by the Alliance.

Interdependencies:

The North of England Cancer Alliance is already reviewing the dependencies of :Health and social care; Trust to trust; Commissioning bodies. Public patient and carer engagement

OUT OF HOSPITAL COLLABORATION

Overall scheme lead: Dr Dan Cowie – OOH Clinical Lead (Newcastle Gateshead CCG)



Benefits (Outcome Measure)

By 2021, our STP footprint will aim to achieve the outcomes set out by National Bodies including the NHS England's CCG improvement and assessment framework; NHSI Single Operating Framework and CQC's standards. Therefore, the following measures and ambitions are examples of how we will aim to close our 7 Care and Quality gaps by achieving:

- Reduce Accident and Emergency attendances per 1,000 population by 15%
- Reduce Hospital total bed days per 1,000 population by 15%
- Reduced Elective Care and Out Patient activity by 10%
- Reduce Emergency hospital admissions per 1,000 population by 15%
- Reduce non-elective admission rates chronic ambulatory care sensitive conditions by 17% by 2020/21, reducing the gap in admission rates between the STP and England by 50%.
- Remove variation in acute sector activity rates for elective MSK by 14.8%, bringing each locality within the STP in line with their Right Care peer group.
- Remove local variation in day case and outpatient procedure ophthalmology activity across the STP, achieving a combined activity reduction of 6.7%.
- Remove variation in and reduce levels of QoF exception rates in key disease areas to the level of the best performing CCG in the STP (Asthma 6%, COPD 11%, Heart Failure 9%, CKD 4%, dementia 4% and SMI 9%)
- 100% of primary care providers rated good or outstanding by 2020/21.
- 100 % of secondary care providers rated good or outstanding by 2020/21.
- All providers of acute stroke services to achieve an overall rating of B or better in the SSNAP audit.
- Remove variation in women's experience of maternity services based, achieving a STP score of 84.9 in the 2015 CQC National Maternity Services Survey, matching the best performing CCG within the STP.
- Reduce aggregate Trust sickness absence rates to 3.4% matching the best performing region
- Diabetes: % of GP practices that participated in the National Diabetes Audit.
- % of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral. (National ambition: 85%)
- Achieve an overall satisfaction rate of with GP services of 89.1%, matching the best performing CCG in the STP and maintaining above average performance above national peers.
- Achieve an overall satisfaction rate of with people feeling supported to manage their LTC of 71.3%, matching the best performing CCG in the STP
- Increase the number of weekend and out of hours (18:30 to 20:00) appointments available in primary care to a minimum of 30 minutes per 1,000 population per week and achieve a utilisation rate of at least 75%.

The Gap – Why Change is needed

- We have an over-use of hospital and emergency services and care outside of hospital is not optimally coordinated, leading to delays in hospital discharges and core access standards are not always met, especially for the frail and elderly and people with mental health needs.
- In the care that is provided, we know that variation exists across providers and Right Care modelling has identified opportunities where 'value' could be added through pathway redesign.
- In addition, we understand that some services are not sustainable, for example, ENT, Hyper-acute Stroke, Obstetrics and Gynaecology, Children's services, MSK and General surgery as well as increasing strain on our voluntary and home care services (e.g. domiciliary home care providers and the care home sector).

Future State/Ambition

- Provide services closer to home, reducing need for hospital care, allowing people to recover at home, live as independently as possible and achieve their wishes within their community
- Proactive care planning - reducing crisis
- MDT working together - reducing duplication and improving coordination
- Clinical standards are applied in a uniform manner across NTWND with provider CQC ratings will be rated good or above
- Patients are able to receive care in the setting most appropriate to their needs
- Health + Care workforce has increased its capacity through building recruitment, developing its skill mix and collaborative working
- Patients are able to receive the most appropriate care every day of the week
- Specialism provided in hospital switch appropriate expertise, skills and capacity
- Urgent and Emergency care streamlined and easy to navigate

What resources are required to deliver / what capacity and capability do we need?

- **Workforce** : we need a clear vision and investment plan to future-proof our whole 'out of hospital' workforce, ensuring alignment and integration between primary care and community nursing, social care and the voluntary sector, and doing more to increase the resilience of our communities.
- **Funding**: National Vanguard, Regional Commissioning, Exploration of other sources, GPFV
- **Organisational Leadership**: Individuals from member organisations: New Care Models + Vanguard sites, Strategic Network, Operational Network and Project Boards
- **Knowledge**: Regional, national and international best practice, Sharing learning with other Vanguards, Collaborative working with North East Vanguards

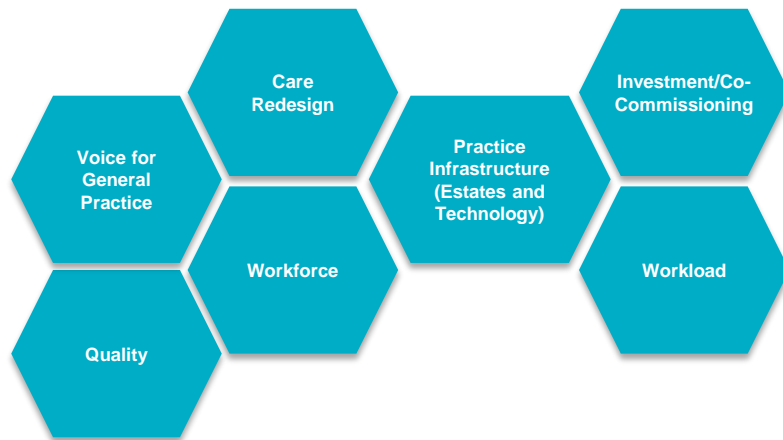
Financial implications (ROI)

- Investment from National Programmes, Allocation of SFT, Local commissioning decisions, Transformation Area status access to early transformation funds for NCM spread
- High level modelling suggests the net benefit estimated for the Out-of-hospital solutions assumes that an equal amount is invested into providing community services for patients seen outside of an acute environment. More specifically, the estimated net benefit of c. £64m from the out-of-hospital model are predicated on a recurrent investment into enhanced services outside the acute sector of £64m per annum.

Interdependencies - Health and social care. integration Delivery GPFV. Roll out of New Care Models. Upscaling Prevention, Health and Wellbeing. Delivery of Acute service consolidation Public patient and carer engagement

TRANSFORMING GENERAL PRACTICE (General Practice Forward View)

Overall scheme lead: Dr Dan Cowie – Primary Care Lead (Newcastle Gateshead CCG)



Implementation

- The national GPFV timeline is driven centrally dependent on release of programmes/funding. Each CCG has submitted readiness assessment tools to NHSE.
- In addition, Health Education England North East are establishing an implementation plan relating to workforce elements such as workforce profiling and practice nurse development. This is in progress.

Benefits (Outcome Measure)

- Overall benefit - the sustainability of general practice and improved patient access through;
- Resilience funding for in-practice and at scale initiatives to improve capacity and capabilities measured through the delivery of the resilience programme
 - Extended and new staff roles – measured through numbers of staff trained and new roles created
 - Improved access through workforce initiatives (as above) and also the 10 high impact actions – the NHSE scheme measured impact
 - Working at scale and new models of care will shift work between secondary and primary care and produce efficiencies in secondary care – measures
 - New work areas delivered by general practice
 - Federation/locality provider viability
 - Development of PACS and MCPs
 - Infrastructure in place to support the above

Interdependencies

- Delivery is dependant on resources actually being made available, both funding and support. For new staffing models and estates in particular recurrent funding is essential
- Transforming general practice will be hindered by lack of investment in estates and technology, therefore ETTF and the IT investment in the GPFV is essential
- The viability and involvement of federations/localities is key to delivering GPFV/5YFV
- Funding must follow the movement of services

The Gap – Why Change is needed

General practice voice

Working at scale and federation/locality group viability as providers as scale

Workforce capability and capacity

Workload – increasing and changing without the skills, capacity and infrastructure to support this

Investment/co-commissioning;

- £3 per head of GPFV transformation funding yet to be secured
- Right place right time right person
- Quality - variation between practices and across the STP

Future State/Ambition What will services look like in 2021 to deliver the 5YFV?

- General practice with a strong voice working along side other key stakeholders
- New models of care - working at scale via PACS, MCP, federations/localities to provide person centred coordinated care closer to home and encourage more self care/preventative care.
- Enhanced primary care services in hubs throughout the LHE footprints, delivering care that was previously provided in hospital
- Less single handed GP practices with more practice networks providing support to each other
- 10 high impact actions adopted across all LHEs
- A resilient workforce with enhanced and new roles working effectively e.g. associates, navigators, pharmacists and mental health practitioners
- General practice viewed as an attractive career option. All North East GP training places are filled with more placements for other health and social care staff in general practice
- Improved patient experience in the GP Survey compared to current baseline

What resources are required to deliver / what capacity and capability do we need?

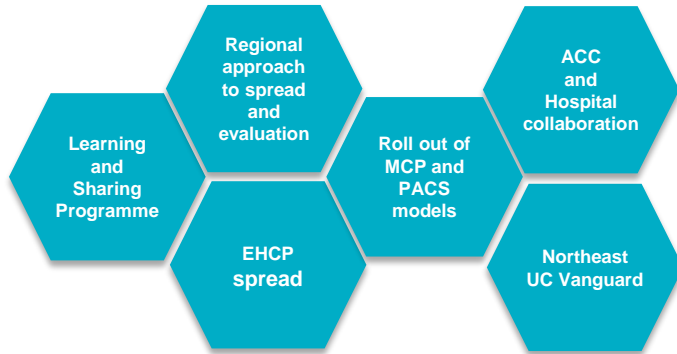
- Pump priming/dual running to enable the establishment of enhanced primary care until the capacity and capability is in place for the care to move from hospital
- Ensure the money follows the movement of care to resource the additional activity recurrently
- OD/business support to developing GP Federations/networks
- Pump priming and access to national support to implement the 10 high impact actions
- Learning hub to enable easy sharing of information/ advice and support on redesigning general practice
- Local Authority and Public Health support to ensure an effective joined up approach to self care and prevention.
- Infrastructure, ETTF and IT investment

Financial implications (ROI)

- Ensure the £3 per head GPFV transformation money is invested into the general practice
- Resources identified above to ensure general practice is able /supported to change
- If the above work to sustain general practice is not progressed costs of health care will continue to rise with increased secondary care activity. There will also be additional costs to the system as whole as people will have less access to general practice and so will rely on other service more, including urgent care, social and community care

SPREAD NEW MODELS OF CARE

Overall scheme lead: Dr Dan Cowie – Primary Care Lead (Newcastle Gateshead CCG)



The Gap – Why Change is needed

- As outlined in the Five Year Forward View, the New Care Models outline a mechanism by which the care and quality gap can be addressed in particular.
- The New Care Models create the opportunity for local teams to innovate and build services that work for their populations, while being consistent with a clear delivery framework for the North East.
- Learning from the existing MCP and PACS sites, such as Sunderland and Northumberland, will enable the spread of best practice in the clinical service structure, relationships, workforce and contractual elements of care delivery.

Future State/Ambition

- The ambition is that in 2020/21, the STP out-of-hospital framework is being delivered across the North East through the implementation of New Care Models, most likely through MCP/PACS.
- This will include healthcare services with a preventative focus, based around centres of General Practice covering roughly 30-50,000 population, with community, mental health and social care services wrapped around them, supported by rapid interface with hospital services.
- Healthcare delivery will be based around a segmented population, with tiered interventions for those with the highest needs, ongoing care needs, urgent care needs and for the whole population.
- Contractual frameworks will be aligned to support integrated service delivery with minimal handoffs for patients.

Milestones	16/17	17/18	18/19	19/20	20/21
Transformation Programmes	Embedding existing NCMs	Delivery of 16/17 objectives	Final NCM delivery	Benefit realisation	
	Evaluation and learning	Local evaluation and review	Harness learning in 2 nd wave	Fully embed learning across STP	
	Next NCM wave rollout	TA bid	NCM rollout initiated		Full rollout of complete MCP/PACS

Benefits (Outcome Measure)

The New Care Models will deliver integration that leads to more patients and citizens being supported to be as independent as they can be.

This will tackle:

1. Increasing demand for hospital and bed based services
2. Unwarranted variation
3. Variation in quality, safety and experience of people using health and care services
4. Clinically sustainable services while maintaining high levels of care and quality
5. Infrastructure and workforce required to deliver fully integrated health and care services outside of hospital
6. Seven day services

Specific outcomes to be worked up through NCM bids for 2016/17 and 2017/18, in line with STP

What resources are required to deliver / what capacity and capability do we need?

- The overarching bid is expected to secure £3m to be used in 2016/17, to support the spread of New Care Models in the North East.
- It is anticipated that this bid would enable a significant number of sites across the North East to be in a position to be part of the next wave of MCP/PACS, with a three-year non-recurrent funding allocation from 2017/18 onwards. Support in terms of capacity and capability to come from that resource and the national & local support offer.

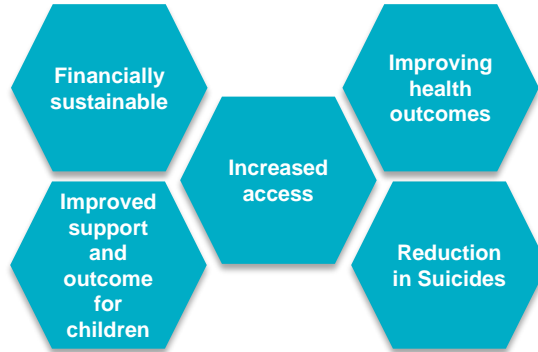
Financial implications (ROI)

It is anticipated that the New Care Model sites will have a clear vision, be able to demonstrate how they will deliver the core components of an MCP or a PACS over 3 – 5 years and have a positive ROI in the region of 50-75% over 5 years.

Interdependencies: Implementation of GPFV, MH5YFV and other programmes. Successful Health and Social Care integration

TRANSFORMING MENTAL HEALTH (MH 5YFV)

Overall scheme lead: John Lawlor - CEO (NTW NHS FT)



The Gap – Why Change is needed

- 10% of children need support or treatment for mental health problems, lack of support leads to further unmet need and increasing burden on more specialist services and waiting times
- People with severe mental health conditions die 10-15 years earlier than the rest of the population, NTWD footprint has higher levels of early mortality than national average, and higher levels of suicide
- High co-morbidity between mental health and long term conditions. LTC account for 50% of all GP appointments, and 70% of days spent in hospital
- 20% of older people in the community and 40% of those living in care homes suffer from depression-key focus group for STP
- Inconsistent access to psychiatric Liaison across the patch-evidence shows it's effectiveness in reducing demand for A and E, and supporting discharge in older people into the community
- 75% of people with mental health problems receive no support, of those that do 90% are supported in primary care
- For those living with severe and complex mental health conditions
 - Variation in numbers of admissions, length of stay and readmissions across patch
 - Variation in access to 7 day services
 - Variation in response to crisis, and timely access to evidence based care leading with associated outcomes

Future State/Ambition

- Integrated life span approach to support of mental health, physical health and social need which wraps around the person, from enabling self management, care and support systems within communities, through to access to effective, consistent and evidence based support for the management of complex mental health conditions.
- Reducing inequalities for those with mental health needs and significantly reducing the impact of mismanagement of mental health support on primary care, A and E, admission to and length of stay in physical healthcare beds. Realising the ambition of the MH5YFV.

What resources are required to deliver / what capacity and capability do we need?

- Increase in investment in CYPS to meet 35% increase in those with a diagnosable MH condition receiving treatment from an NHS-funded community MH service:
- Development of costed plans to achieve increase to at least 25% of people with common MH conditions accessing psychological therapies each year. Focus on support for people with Long term conditions, those in care homes and those needing support into employment. Link investment to savings deliverable from out of hospital programme
- At least 60% of people experiencing a 1st episode of psychosis receive treatment within 2 weeks:
- New investment already in place to achieve 50% target and currently exceeding 60% 2020 deliverable
- Delivery of core 24 psychiatric liaison aligned with acute hospital optimisation, investment linked to planned reduction in demand in A and E and for acute hospital beds through more effective discharge management for those with co-morbid conditions, particularly older people with mental health needs
- Review potential for re-alignment and further rationalisation of in-patient bed model for mental health, enabling increased focus on prevention and community interventions and support, and consistent access to evidence based 7 day high quality safe care that is affordable
- Whole system integrated approach to delivery working across all sectors of delivery ensuring the earliest and most effective forms of interventions and support, smooth transitions and seamless care, and increased emphasis on enabling self management within resilient communities.

Financial implications (ROI)

- The priority will be in creating high quality services that are financially sustainable. With this approach, pump prime funding will be utilised to transform existing services with the expectation that efficiencies gained over the coming years will allow the services to be sustainable once the initial funding ceases to be available.
- Systems to be developed to enable tracking of benefits and savings across the whole system through investment in mental health transformation.
- Expectation is that investment will at least match the increase in growth in overall CCG funding across the patch.
- The expectation is that this will deliver at least 2 to 1 savings across all programmes within the NTWD STP, particularly in supporting the Out of Hospital and Acute Optimisation programmes.

	Milestones	16/17	17/18	18/19	19/20	20/21
Core MH5YFV Deliverables	35% of CYP receiving treatment	28%	30%	32%	34%	35%
	25% of population access therapies	15.8%	16.8%	19%	22%	25%
	60% of 1 st psychosis treatment in 2 weeks	50%	50%	53%	56%	60%
	% of acute hospitals with Core 24 Service	7%	13%	40%	70%	100%

Benefits (Outcome Measure)

- Delivery of milestones in MH5YFV, including co-ordinated drive to reduce suicide across the STP area
- Reduction in demand for secondary and tertiary children and young peoples services, reduction in waiting times, and delivery and monitoring of successful outcomes.
- Reductions in admissions and length of stay due to more effective integrated management of co-existing physical and mental health conditions to support the out of hospital and acute optimisation programmes.
- Development of resilience through improved support of primary care, access to housing and employment, supporting those in employment, wider options in crisis support, and development of the recovery college approach
- Reduction in inappropriate A and E attendances supporting delivery of 4 hour wait target.
- Reduction in admissions from care homes arising from poor management of mental health in older people
- Consistent access to and delivery of effective evidence based treatment and support for people with more complex needs, leading to measurable outcome improvement. Consistent access to 7 day care
- Completion of re-design of mental health in-patient care, which is affordable, high quality, 7 day and consistent
- Measured improvement in experience and outcomes for users and for families.

Interdependencies

Full integration with Scaling up prevention Health and Wellbeing, Out of Hospital and Acute Optimisation Transformation and Delivery Programme. Interdependence with social care delivery, and with all partners across care delivery from 3rd. voluntary and private sector. Requires full engagement and involvement with those with lived experience and their carers and supporters, working together to ensure mutually achievable outcomes

TRANSFORMING LEARNING DISABILITY CARE AND SERVICES

Overall scheme lead: David Hambleton – Chief Executive (South Tyneside CCG)



The Gap – Why Change is needed

- The current experience for people with learning disabilities in the North East and Cumbria is very varied. This is, in part, apparent by looking at the data but also by listening to the stories of service users, families, providers and commissioners. However, there are many challenges in understanding the true picture because of a lack of consistent data across the whole system. We understand pockets of activity such as for patients inpatient settings, but on the whole we have poor visibility of what people's needs are, how they are currently being met (or not), and what issues they are encountering.
- The data shows that although a proportion of patients in specialist learning disability inpatient settings require this type of care, many of them could be managed in the community. The data also shows that people often stay in inpatient settings for longer than necessary, with some people admitted for very long periods of time (up to 25 years).

Future State/Ambition

- Our ambition is for the North East and Cumbria to be as good as anywhere in the world to live for people with a learning disability and / or autism and a mental illness or behaviour that challenges. This vision was developed by all stakeholders, including people with a learning disability, families and carers. By developing community infrastructure, supporting workforce development, avoiding crisis, earlier intervention and prevention the North East and Cumbria will be able to support people in the community so avoiding the need for hospital admission.
- The model of care has been co-produced with people with learning disabilities, families and carers and is based on the principles and evidence base described in the national service model and is developed across the life span taking into consideration the changing needs and requirements of people with learning disabilities

What resources are required to deliver / what capacity and capability do we need?

- Local implementation Groups are active in every locality, leading the delivery of locality plans to implement the new model of care. Regional task and finish groups take forward delivery of the regional strands of work focusing on:
- Resources, capacity and capability are dependant on each specific localities requirements. Focused workforce investment is required to ensure that community based services are resourced with appropriately trained staff.

Financial implications (ROI)

- Financial modelling undertaken and reported to date has included the anticipated revenues and costs for constituent CCGs alongside those for NHS England specialised commissioning. Existing models had to be expanded to include financial and activity information from local authorities.
- Resources released from closure – these are the reductions in inpatient costs to commissioners that arise when providers are able to close wards and beds following patient discharges under TC.
 - Additional community care costs – these are the projected additional costs to the health and social care sectors arising when patients are discharged from hospital under TC.
 - Service development – there is recognition that learning disabilities services in community settings must evolve if they are to be financially sustainable whilst continuing to provide the high quality care required. As work is ongoing to develop the future model of care, current cost projections are based upon CCGs that are better developed and where work on the future model of care is more advanced than elsewhere.
 - Population changes – reflecting children who mature into adults each year, and of mortality among existing patients.
 - Specialised Commissioning – Specialised Commissioning beds are included in the releases, and modelling includes the costs of caring for these patients in the community alongside the service developments required to ensure discharged patients can remain out of hospital and secure bed closures.
 - Marginal inpatient acuity – as learning disabilities inpatient populations decline under TC, the healthcare needs that prevent discharge are expected to increase the 'per patient' costs of care for those remaining in hospital.
 - Future years and system efficiencies – these are based on NHS England assumptions which introduce economies of scale from increased purchase of care packages and improvements in service efficiency over time.

Implementation Milestones

	16/17	17/18	18/19	19/20	20/21
Transformation Programmes	Co-Production	Principles established	Evaluation and QA	Evaluation and QA	Evaluation and QA
	Bed Closures and Transitions	42 bed closures	28 bed closures	7 bed closures	
	Developing a New Service Model	Agree	Implement		
	Funding Arrangements	Develop Strategy	Implement		
	Development of Estate	Milestone 1			

Benefits (Outcome Measure)

North East and Cumbria Learning Disability Transforming Care Partnership is measured by a suite of measures covering patient experience, patient outcomes, quality of life, quality of care and value for money. As result of the transformation programme we expect to see:

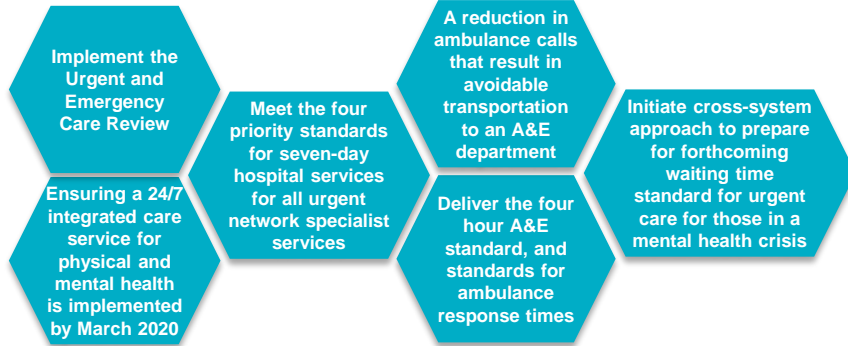
- Less reliance on in-patient admissions, delivering a 51% reduction in admissions to inpatient learning disability services by 2018. (53% reduction in commissioned Specialist Learning Disability beds from 31.03.15 baseline)
- Developing community support and alternatives to inpatient admission
- Prevention, early identification and early intervention
- Avoidance of crisis and better management of crisis when it happens
- Better more fulfilled lives.
- Improved service user experience
- Improved quality of life

Interdependencies

- The key interdependencies relating to the transformation programme relates to the cross-regional bed closure trajectories and implementation of the community model of care in each of the localities.
- There are also interdependencies between Specialised Commissioning and CCG commissioned services.
- There are financial interdependencies between the investment in community services and the closures of in-patient beds. The cost release from closures will need to be reinvested in community provision to ensure the ongoing sustainability of services.

TRANSFORMING URGENT AND EMERGENCY CARE SERVICES

Overall scheme lead: Dr Stewart Findlay – SRO (NE UEC Vanguard)



Milestones	16/17	17/18	18/19	19/20	20/21
Clinical Hub	Clinical hub implemented				
Re-procurement of NHS 111	Start the review of existing service	Continue with procurement			
Directory of Services	Review existing DoS entries to ensure fit for purpose				
Digital in-hours booking	Technical scoping & delivery plan agreed	Technical roll-out across the region			
Behavioural analysis roll-out	Engagement & communication	Learning lessons and continuous improvement			
Constitutional standards	Delivery of A&E 4 hour standard and the Ambulance standards				
Payment reform & metrics	Modelling work undertaken	Shadowing of revised payment mechanism	Implementation to understand how the networked system is performing including channel shift		
Delivery of IUC standards	Implementation of the 8 key elements of integrated IUC standards accessed through 111				
New models of crisis care for young people	Test out new models of care and adopt best practice				

Key Actions

The Gap – Why Change is needed

Context:

The North East Urgent and Emergency Care Network (NEUECN) covers a population of 2.71 million across diverse geographies and incorporating large pockets of both densely populated and dispersed populations, the highest regional unemployment, high levels of deprivation and life expectancy for both men and women is lower than the England average. We have significant performance and financial constraints across both Commissioner and Provider organisations. North East population has an over reliance on hospital based care, at 20% above the national average.

Rationale:

Fragmented urgent care services with multiple points of entry result in patient contact duplication and patient confusions across the region, which is inefficient and does not promote positive patient experience. To ensure that patients receive the 'Right Care, Right Place, First Time' it is essential that we implement a single point of access, improved content and access within the Directory of Services and Clinical Specialists to provide patient and healthcare professional signposting and referral.

Future State/Ambition

- Our vision is of an urgent and emergency care system that provides the right information to enable people to access the right care, provided by the right person in the right place first time.
- The NEUECN aim is to reduce unwarranted variation and improve the quality, safety and equity of urgent and emergency care provision by bringing together A&E Delivery Boards and stakeholders to radically transform the system at scale and pace which could not be delivered by a single A&E Delivery Board alone.

What resources are required to deliver / what capacity and capability do we need?

Funding:

- National Vanguard, Regional Commissioning, Exploration of other sources

Organisational Leadership:

- Individuals from member organisations: Transformation Board, Clinical Reference Group, Strategic Network, Operational Network and Project Boards

Knowledge:

- Regional, national and international best practice, Sharing learning with other Vanguards, Collaborative working with North East Vanguards

Time:

- Making time available

Benefits (Outcome Measure)

- A reduction in hospital admissions
- A reduction in Accident and Emergency attendances
- A reduction in 999 ambulance dispatches
- Redirection of patients to pharmacies for minor ailments
- Increase see & treat and hear & treat
- Early intervention in care homes
- Ambulance waiting times (including response times & handovers and diverts)
- Delivery of the A&E 4 hour standard
- Patients have equitable access to specialist care in order to maximise their chances of survival and a good recovery
- Reduction in DTOC

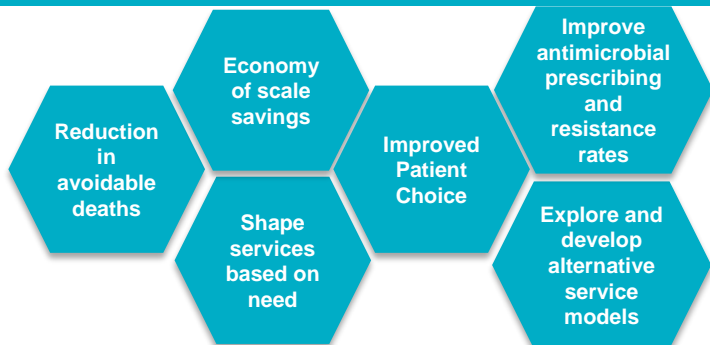
Financial implications

<i>EM unless stated</i>		2016/17	2017/18	2018/19	2019/20	2020/21
	Gross savings	3.62	4.76	4.97	5.00	5.00
Revenue costs	From Vanguard	2.90	1.64	1.22	1.13	1.13
	From Local Contribution	0.27	0.26	0.26	0.26	0.26
	Total Revenue Costs	3.17	1.90	1.48	1.39	1.39
	Net savings	0.45	2.86	3.49	3.61	3.61

Interdependencies: Health and social care. integration Delivery GPFV. Roll out of New Care Models. Upscaling Prevention, Health and Wellbeing. Delivery of Acute service consolidation Public patient and carer engagement

OPTIMAL USE OF THE ACUTE SECTOR

Overall scheme lead(s): Ken Bremner – CEO (CHS/ST/ST NHS FTs), Susan Watson - Director Strategy and Transformation (GH NHS FT)



The Gap – Why Change is needed

- Overall utilisation of acute hospital services is estimated to be 20% higher in the North East than in England as a whole.
- Commissioners within the NTW-ND STP have worked successfully to avoid increases in unplanned hospitalisation with non-elective admission rates in 2015/16 only 2.3% higher than in 208/09 despite an increasingly old and complex population. However, in the same period demand for elective inpatients care has risen by 7.6%, total outpatient attendances by 11.7%.
- National analysis by the Right Care team identifies significant variance in activity rates for all localities within the NTW-ND STP footprint when compared to their peers.
- Local analysis also identifies variation between localities within the NTW-ND footprint (Cancer, Urgent Care, Maternity, Dementia, MSK and Specialist services)
- There are a number of service lines/ pathway of care that appear to not be sustainable across the NTW-ND STP footprint:

Future State/Ambition

Explore and develop alternative service models that improve productivity and reduce the demand burden by working together as health and care systems that will allow us:

- to build upon transformation and sustainability plans underway in each LHE;
- shape services based on need and opportunity and reduce organisational silos and barriers to ensure we are well placed to deliver personalised and high quality care

What resources are required to deliver / what capacity and capability do we need?

Funding

- Capital, infrastructure, technology

Organisational Leadership

- Individuals from member organisations: Transformation Board, Clinical Reference Group, Strategic Network, Operational Network and Project Boards

Knowledge

- Regional, national and international best practice, understanding 'clinical standards, efficiencies'

Workforce

- Modelling to understand future demand and gaps

Time

- Making time available for clinical involvement and co-design

Return on Investment (How much will it cost or save)

The analysis considers a range of scenarios in which either one or two of the six sites would be turned into cold sites by shifting out non-elective procedures and using freed up capacity to shift in elective procedures from the remaining hot sites in the patch..

Cost savings were estimated to be achieved in three ways: Scale economies on shifting activity;/Delivery model savings;/Fix cost release. Analysis below is based on these assumptions:

Scenario	Impact	Total savings
1	Low	£31.4m
	High	£38.8m
2	Low	£37.9m
	High	£39.3m

Milestones	16/17	17/18	18/19	19/20	20/21	
Transformation Programmes	Efficiencies	2-3% improvement	2-3% improvement	2-3% improvement	2-3% improvement	2-3% improvement
	Consolidation	Yr 1 Implementation	Yr 2 Implementation	Yr 3 Implementation	Yr 4 Implementation	Yr 5 Implementation
	Pathology	Yr 1 Implementation	Yr 2 Implementation	Yr 3 Implementation	Yr 4 Implementation	Yr 5 Implementation
	Back Office	Yr 1 Implementation	Yr 2 Implementation	Yr 3 Implementation	Yr 4 Implementation	Yr 5 Implementation

Benefits (Outcome Measure)

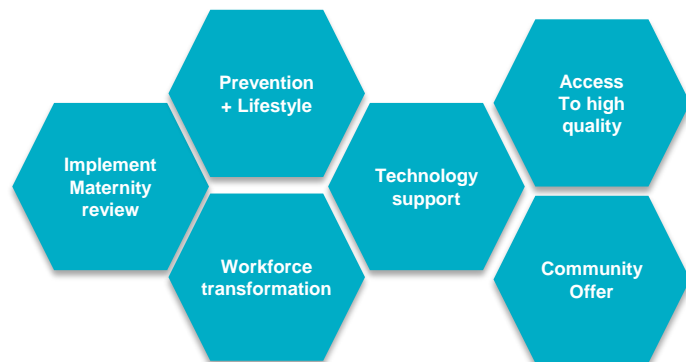
Therefore by 2021, we will aim to:

- With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3% each year), including from reducing growth in activity and maximising cost recovery.
- Roll out of seven day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week.
- Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements.
- Increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures.
- Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes,
- Measurable improvement in antimicrobial prescribing and resistance rates.
- Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96%), and ensure its effectiveness, alongside other sources of feedback to improve services.
- Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.

Interdependencies – Health and social care integration. Delivery GPFV. Roll out of New Care Models. Upscaling Prevention, Health and Wellbeing. Public patient and carer engagement

TRANSFORMING MATERNITY SERVICES – BETTER BIRTHS

Overall scheme lead: Chris Piercy – Executive Director of Nursing (Newcastle Gateshead CCG)



Implementation Milestones		16/17	17/18	18/19	19/20	20/21
Transformation Programmes	Scheme 1	Create LMS		Milestone 2		Milestone 3
	Scheme 2		Co-production of transformative plan	Milestone 2	Milestone 3	

Benefits (Outcome Measure)

What impact will these actions have?

- There will be significant improvements in general maternal health, as well as the maternal and parental experiences of childbirth, in addition to substantial reductions in the numbers of adverse outcomes such as stillbirths, neonatal deaths and significant maternal morbidity. Maternity units will be logistic
- ally and financially sustainable

How will we know what we planned and our actions have the right impact

- The pregnancy outcomes for women in our area will be equal to or better than those anywhere else in the developed world

The Gap – Why Change is needed

- There is an urgent need to improve maternity care in our region – as evidenced by the fact that the numbers of women in our area (and in the UK) who either (a) don't survive their pregnancies, or (b) lose their babies / infants are greater than almost anywhere else in the developed world.
- There are ever increasing demands on local maternity services, as a result (in part) of a more complex caseload resulting from a high prevalence of conditions such as smoking, obesity and alcohol intake. This is at a time when there are major concerns about (a) the resilience and (b) the financial sustainability of the current medical and midwifery workforce model.

Future State/Ambition

What will services look like in 2021 to deliver the 5YFV

- The newly formed Local Maternity System (a collaboration of commissioners, providers, local authorities and public health specialists) will have co-produced and be implementing a new, innovative and transformative service model that will (i) embrace and implement the seven priorities set out in the National Maternity review – adapted to the needs of the population in the area, as well as (ii) maximising the role that prevention and public health have in improving outcomes for maternity care, and (iii) will be sustainable – financially and in relation to projected workforce availability
- A system based on prevention ensuring expert advice and support to reduce smoking and alcohol use in pregnancy and increase breastfeeding

What is distinctive and how will it improve quality through innovation?

- Maternity care across the area will be provided from within a single, coherent service model, characterised by new ways of working across current institutional barriers, using innovative digital solutions (including tele-medicine) to enhance personalised care, improve the general health and well-being of pregnant women, as well as ensuring the timely provision of appropriate expertise and optimal sharing of lessons learnt from more rigorous and networked investigations of adverse events

What resources are required to deliver / what capacity and capability do we need?

This plan will require sufficient project management resource, as well as widespread commitment and 'buy in' from all involved

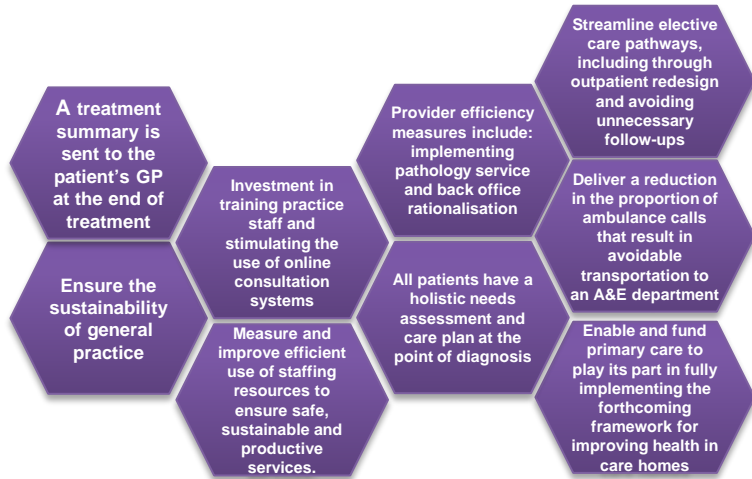
Financial implications (ROI)

The main financial implications of the project – apart from the project management team – are the capital resources needed for developments such as the creation of community maternity hubs, as well as increased capacity at those units likely to experience a greater demand on their services.

Interdependencies: Critical interdependencies include those with neonatal and paediatric services, as well as gynaecology and other acute medical specialties

DIGITAL CARE AND TECHNOLOGY

Overall scheme lead: SRO Dr Mark Dornan, North STP lead Mark Thomas and South STP lead Dr Graham Evans



The Gap – Why Change is needed

- Better use of data and digital technology has the power to support people to live healthier lives and use care services less. It is capable of transforming the cost and quality of services when they are needed.
- It can unlock insights for population health management at scale, and support the development of future medicines and treatments.
- Putting data and technology to work for patients, service users, citizens and the caring professionals who serve them will help ensure that health and care provision in the NHS improves and is sustainable.
- It has a key part to play in helping local leaders across health and care systems meet the efficiency and quality challenges we face.

Future State/Ambition

The regional **vision** is that:

- More patients treated locally preventing the need for care outside of the local community
 - By 2021 the **Great North Care Record** will make a lasting contribution to the health and well-being of our population through the sharing of information securely and effectively.
 - The Great North Care Record will make information more widely available and accessible to support frontline care, individual self-management, planning and research.
 - To work collectively to deliver the regional vision and facilitate a regional conversation so we can have a coordinated approach to expedite plans.
- Enabling professionals and carers to have legitimate access to the right information at the point of need
- Through the use of TECS patients should feel more in control of their condition
 - A significant increase in the level of digital maturity of secondary care providers
 - Digitally enabled health and care system with a move from isolation to integration.
 - Bottom up learning from the City Hospitals Sunderland FT work as a national implementer site
 - A paper free system with information flowing seamlessly between primary, secondary and social care digitally.

Implementation Milestones		16/17	17/18	18/19	19/20	20/21
Transformation Programmes	Interoperability – Great North Care Record					
	Infrastructure					
	Planning and decision support					
	Transfer of care					
	Technology enable care service					
	Technology enabled care service					
	Communications, engagement and consent					
	North England Clinical Networks					
	Analytics					
	National Initiatives					

Benefits (Outcome Measure)

- Reduction in admissions to hospital through more informed clinicians at the point of care
- A reduction in duplicate assessments, investigations and data entry
- Saved time calling other organisations – GP practices
- Saved time and improvements in triage
- A reduction in medications prescribed
- A reduction in unnecessary / inappropriate referrals to another service
- Improved working practices leading to greater efficiencies
- Measured improvement in satisfaction of service provision

What resources are required to deliver / what capacity and capability do we need?

- Installation costs for a single care record (population 3.6 million), plus hosting charges where applicable and annual running costs.
- Replacement and upgrade of Electronic Patient Systems (EPR)
- Funding to invest in infrastructure (Wi-Fi, Virtual Desktop Infrastructure etc.)
- Platform and technological solutions to support Technology Enabled Care Services
- PMO resource to support delivery of the programme

Interdependencies

- Leverage the multiple strands of the Regional Informatics Conversation - North East & Cumbria Digital Care Programme, U&EC Vanguard and Connected Health Cities Programme. Overlay the excellent work being led by clinical and managerial leaders across the footprint to implement the Great North Care Record, resulting in a lasting contribution to the health and well-being of our population through the sharing of information securely and effectively.
- Develop **Local Digital Roadmaps** to support delivery of the 10 universal capabilities, regional priorities and of 'Personalised Health and Care 2020' to drive quality, productivity and patient experience, transforming population health from self-care to value based service when needed.
- Linking with the STP workforce strategy to promote recruitment, retention, role development and the health and wellbeing of staff building upon good practice within the NHS and Local Authorities including **Making Every Contact Count**. This will enable seamless pathways of care that reduce unnecessary reassessment and admission.

DIGITAL CARE AND TECHNOLOGY

(THIS IS THE LOCAL DIGITAL ROADMAP REGIONAL SUMMARY, VISION AND PATHWAY TO DELIVER)

Vision –
addressing
three gaps:

Care and Quality

Care will be safer and more seamless
Care services will be underpinned by access to digital, real time, comprehensive patient information. This will provide care professionals with the information they need to deliver high quality services
Barriers will be broken down with organisations being able to share and collaborate with more connected information and infrastructure

Finance and Efficiency

Professionals will have access to real time information, reducing the need to repeat diagnostic tests
Technology will be used to improve efficiency and allow frontline staff to focus on delivering care
Patients can be tracked through the system, avoiding wasted time on missed appointments
Costs of using paper will be drastically reduced

Health and Wellbeing

Technology will support self care
Information will be connected and analysed to support population health management, planning and research

Becoming paper free at point of care

Records Assessments and Plans

Professionals across care settings will be able to access GP-held information on GP-prescribed medications, patient allergies and adverse reactions.

Patients can access their GP record using online access (50% of the population by March 2018)

Care plans will be developed and shared electronically

Initial focus:

The implementation of the Medical Interoperability Gateway across acute trusts, practices and councils

Next steps:

Developing a regional solution to sharing of records – The Great North Care Record. A single record across health and social care which patients can also view and contribute to. Designed in partnership with councils, commissioners and providers



Transfers of Care

GPs can refer electronically to secondary care, increased use of e-referral system (80% of all referrals to go through e-referral system)

GPs will receive timely electronic discharge summaries and clinic letters from secondary care

Information will be sent in new ways which will allow it to be easily integrated into systems

Social care will receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care

Decision Support

Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly

Professionals across care settings will be made aware of end-of-life preference information
Alerts about patients issues and preferences will be conveyed.

Medicines Management and Optimisation

Medicines are prescribed electronically

Digital records give a view of all existing medications and prescriptions

Remote Care

Patients can book appointments and order repeat prescriptions from their GP practice

Patients can access remote consultations using video conferencing, email, instant messaging

Professionals will communicate with each other in different ways e.g. electronic MDTs
Telehealth solutions will support remote monitoring and motivation of patients to support self care

Asset and Resource Optimisation

Organisations have a good track record of working together and using resources collaboratively. This speeds up implementation and reduces overall resource required so scarce informatics resources can be freed up more quickly to work on the next development. We would plan to share resource by:

- Time and delivery of human resource
- Shared project management system
- Having an agreed shared vision/objective and goals

Orders and Results Management

All requests for consultation and diagnostics will be done electronically.

Test results will be available electronically across all providers at point of care, avoiding need to duplicate tests

Supporting Infrastructure

Mobile working for frontline staff at the point of care

Systems which connect together to support joint working

Connected Information

Information is connected and analysed to support population health management and research

Information Sharing Approach

Single data sharing agreement across all providers

Robust and compliant with Information Governance

Patients informed and able to control who accesses their information

Governance and Delivery

LHE Governance and Delivery



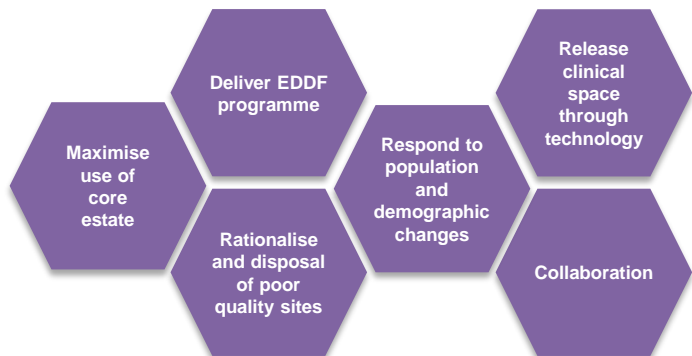
STP Joint Working



Regional Working

DELIVERING THE ESTATES STRATEGY

Overall scheme lead: to be confirmed



Implementation Milestones		16/17	17/18	18/19	19/20	20/21
Transformation Programmes	ETTF Delivery			Complete by 31 Mar		
	Murton Care Village	Feasibility study				Scheme completed
	TVJI site disposal	Options appraisal		Disposal for housing		
	N Durham Comm. Hospital	Options appraisal				Scheme completed

Benefits (Outcome Measure)

- Maximisation of existing identified core sites and buildings through increasing occupancy and utilisation. Ensuring the retained estate is energy efficient and properly maintained.
- Rationalisation and disposal of non-core sites and buildings to reduce poor quality accommodation; eliminate backlog maintenance; void and excess running costs.
- Delivery of the Estates Transformation and Technology Fund (ETTF) schemes by 31 March 2019.
- Delivery of the estates priorities within the individual CCG Strategic Estate Plans for the STP area.
- Responding to housing growth, population and demographic changes across the STP area.
- Utilisation of technology and reconfiguration of back office functions to maximise available clinical space.
- Greater collaboration across the NHS family and with the wider public sector through Cabinet Office's One Public Estate Programme.

Interdependencies Collaboration with wider public sector partners through One Public Estates programme; delivery of ICT innovations; working with GP owners and third party private sector landlords.

The Gap – Why Change is needed

- Estates is an enabler for the STP to deliver its service ambitions and close the financial gap.
- Priorities for change are:
 - Investment in Primary Care Estate to facilitate Out of Hospital patient care and respond to population growth and demographic pressures across the STP area; a key component being the delivery of the ETTF programmes in each CCG area.
 - Improved utilisation of core estate and rationalisation and disposal of older not fit for purpose buildings and facilities.

Future State/ Ambition for 2021

- Delivery of the ETTF programme to both transform individual practices across the STP area and deliver primary care services at scale and enabling services to be brought out of hospital.
- Reconfiguration of community hospital provision in Northumberland and North Durham.
- Delivery of a large care concept village at Murton
- Disposal of surplus land and redundant sites.

What resources are required to deliver/what capacity and capability to we need?

- ETTF Capital Funding:- £53.1M
- NHS Capital Pipeline Funding - £23.4M
- OPE Feasibility Funding:- £95k
- The STP estates programme delivery is supported by CHP and NHSPS.

Financial Implications (ROI)

- The key risk is availability of funding and scarcity of capital.
- Mitigation will come from working with partners including One Public Estate and the use of new models of Public Private Partnerships alongside existing PFI and LIFT options.
- Public consultation. Mitigated through the Governance Model for decision making.

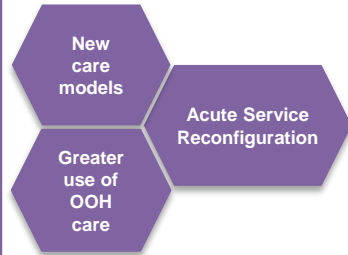
WORKFORCE

Overall scheme lead: Ian Renwick – CEO (Gateshead Health NHS FT)

Working Examples Assumptions

The workforce summary profile shows that we will see a reduction in the overall workforce from 42,057 to 40,386. This is a reduction of 1,671 WTE (4%). This will be largely delivered by removing current vacancies, not replacing staff on a like for like basis when they leave in the future and also by using staff in a revised skill mix but within existing staff groups (e.g. nursing assistants, assistant practitioners, advanced practitioners etc). Therefore the overall skill mix looks largely the same, when comparing the individual staff groups, but will require staff within these staff groups to work differently.

When comparing the reductions in the workforce (4%) to the small reduction in the activity (1%) planned within the hospital setting it is important that we recognise this does not reflect a stand still position on the efficiency of the current staff in post, i.e. via the removal of vacancies. It still requires an efficiency gain within the hospital based workforce of circa 4% to avoid the current reliance on agency staff to fill current vacancies, otherwise the profiled flat line for agency spend will not be achievable and agency costs will continue to rise.



The Gap – Why Change is needed

The NHS provides some of the most comprehensive, cost-effective, high-quality and widely respected primary care services in the world. However the increasing workload and pressure on the workforce, combined with increased numbers of patients with multiple and complex health needs means we need a clear vision and investment plan to future-proof our whole 'out of hospital' workforce, ensuring alignment and integration between primary care and community nursing, social care and the voluntary sector, and doing more to increase the resilience of our communities.

Future State/Ambition

If we succeed in delivering our priorities:

For patients: higher quality relationships with health professionals, reducing unnecessary visits to different specialists, leading to increased patient satisfaction supported to manage their own health, with better outcomes for individuals and better value for money

For staff: Staff will have the training and skills to equip them to care for different individuals increasing their effectiveness and career opportunities

For the system: more effective deployment of the workforce reducing expenditure and reliance on agency staff and increasing productivity. Shift between primary and acute and from formal to home settings will be easier to implement because staff have the skills to provide care wherever the patient is. Example, future OOH workforce:



What resources are required to deliver / what capacity and capability do we need?

Funding

- Capital, infrastructure, technology

Organisational Leadership

- Individuals from member organisations: Transformation Board, Clinical Reference Group, Strategic Network, Operational Network and Project Boards

Knowledge

- Regional, national and international best practice, understanding 'clinical standards, efficiencies'

Workforce

- Modelling to understand future demand and gaps

Time

- Making time available for clinical involvement and co-design

Financial Implications (ROI)

A detailed review of risks is required to identify opportunities for mitigation. This review would be conducted with the support of the workforce action group to identify potential risks and issues, and provide system wide solutions .

Interdependencies : All other Workstreams

Implementation Milestones

	16/17	17/18	18/19	19/20	20/21
Transformation Programmes	Reduce Agency Spend				
	Supply and demand				
	Review skill mix				
	CWD for existing staff				
	Use of new roles (associates)				

Benefits (Outcome Measure)

By 2021, we will aim to contribute to:

- ✓ Reducing the disability employment gap.
- ✓ The Government's goal of increasing the use of Fit for Work.
- ✓ The national aim of 5,000 extra doctors in general practice.
- ✓ The co-funding of an extra 1,500 pharmacists to work in general practice
- ✓ The expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care

Below we set out a high level view of what the service could look like through the eyes of patients, staff and the health system if we succeed in delivering our priorities:

For patients

- Patients will have higher quality relationships with health professionals, reducing unnecessary visits to different specialists, leading to increased patient satisfaction

For staff

- Staff will have a clear understanding of their role in a team, and how their skills can provide the most value to patients, improving job satisfaction and reducing stress levels

For the system

- More effective deployment of the workforce reducing expenditure and reliance on agency staff and increasing productivity