Sustainability & Transformation Plan (STP) submission Wider Devon 30 June 2016

Name of Footprint and number: **Wider Devon (37)**
Region: **South**
Nominated lead of the footprint: **Angela Pedder, Chief Executive, Royal Devon and Exeter NHS Trust**

Contact details
angela.pedder@nhs.net
l.nicholas@nhs.net

Organisations within footprint

NEW Devon CCG, South Devon and Torbay CCG, Plymouth Hospitals NHS Trust, Royal Devon and Exeter NHS Trust, Northern Devon Healthcare NHS Trust, Torbay and South Devon NHS Trust, South West Ambulance Service Trust, Devon Partnership NHS Trust, NHS England, Circa 160 GP practices, Virgin Care, Devon County Council, Plymouth City Council, Torbay Council, Living Well (formerly PCH) (CIC), Devon Doctors, Healthwatch (Devon, Plymouth and Torbay) and Care UK.

The NHS in Devon understands its need to meet all relevant statutory obligations when undertaking a change programme and nothing in this report should be taken to commit the NHS to a particular decision without proper consideration of those obligations.

Content

Introduction

Welcome to the Wider Devon Sustainability & Transformation plan (STP) submission June 2016

Our aspiration is to achieve, by 2021, a fully aligned sense of place linking the benefit of health , education, housing and employment to economic and social wellbeing for our communities through joint working of statutory partners and the voluntary and charitable sectors.

This plan provides the overarching strategic framework within which people residing in wider Devon will experience sustainable, integrated, place-based support by 2021. It will drive delivery of a major programme of transformational change and improvement across wider Devon starting from 2016/17.

The challenges we face are significant and will require a transformational mindset, courage and support from national bodies to ensure our health and care system is truly clinically and financially sustainable and with the capability to deliver exemplary 21st century support to the people and communities of wider Devon.

These ambitious plans will respond to the growing physical and mental health needs of people in their communities to ensure a future integrated network of support that is safe, sustainable and affordable and that enables people to live their lives well.

Case for Change

Services in Devon must change in order to become clinically and financially sustainable, and the key reasons for this are highlighted in the case for change:

- People are living longer and will require more support from the health and care system. In excess of 280,000 local people, including 13,000 children, are living with one or more long term condition.
- The system needs to respond better to the high levels of need and complexity in some parts of the population
- Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across the system
- There is a difference of 15 years in life expectancy across wider Devon and differences in health outcomes – or 'health inequalities' – between some areas, particularly Plymouth
- Spending per person on health and social care differs markedly between the locality areas and is 10% less in the most deprived areas
- Mental health services are not as accessible and available as they need to be, driving people to access other forms of care with limited value from the intervention received . People with a mental health condition have poorer health outcomes than other groups
- There is an over reliance on bed based care - every day over 500 people in Wider Devon are medically fit to leave hospital but can't for a variety of reasons
- The care home sector is struggling to meet increasing demand and complexity of need
- Almost a quarter of local GPs plan to leave the NHS in 5 years and there are significant pressures on primary care services. Some other services are particularly fragile due to high levels of consultant, nursing, social work or therapy vacancies
- Local health and social care services are under severe financial pressure, and health services alone are likely to be **£572m** in deficit in 2020/21 if nothing changes

Plan on a page

Our commitment

Partners across the wider Devon health and care community are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve.

Clinical and financial performance, and outcomes improvement

2016/17

2017/18

2018/19

2019/20

2020/21

Drive delivery of 16/17 recovery plan

Engage, design and consult of new models of care to address inequalities and reduce reliance on bed based care

Deliver further financial improvement

Engage, design and consult on reconfigured new models of care for acute and specialist services to secure clinically sustainable services, reduce duplication and variation and improve user experience

Promote prevention and early intervention

Implement primary care strategy

- Build equitable mental health and emotional well being capacity
- Mobilise new model of fully integrated health and social care placed-based community support in all localities
- Reduce bed stock
- Commence specialist and acute reconfigurations implementation

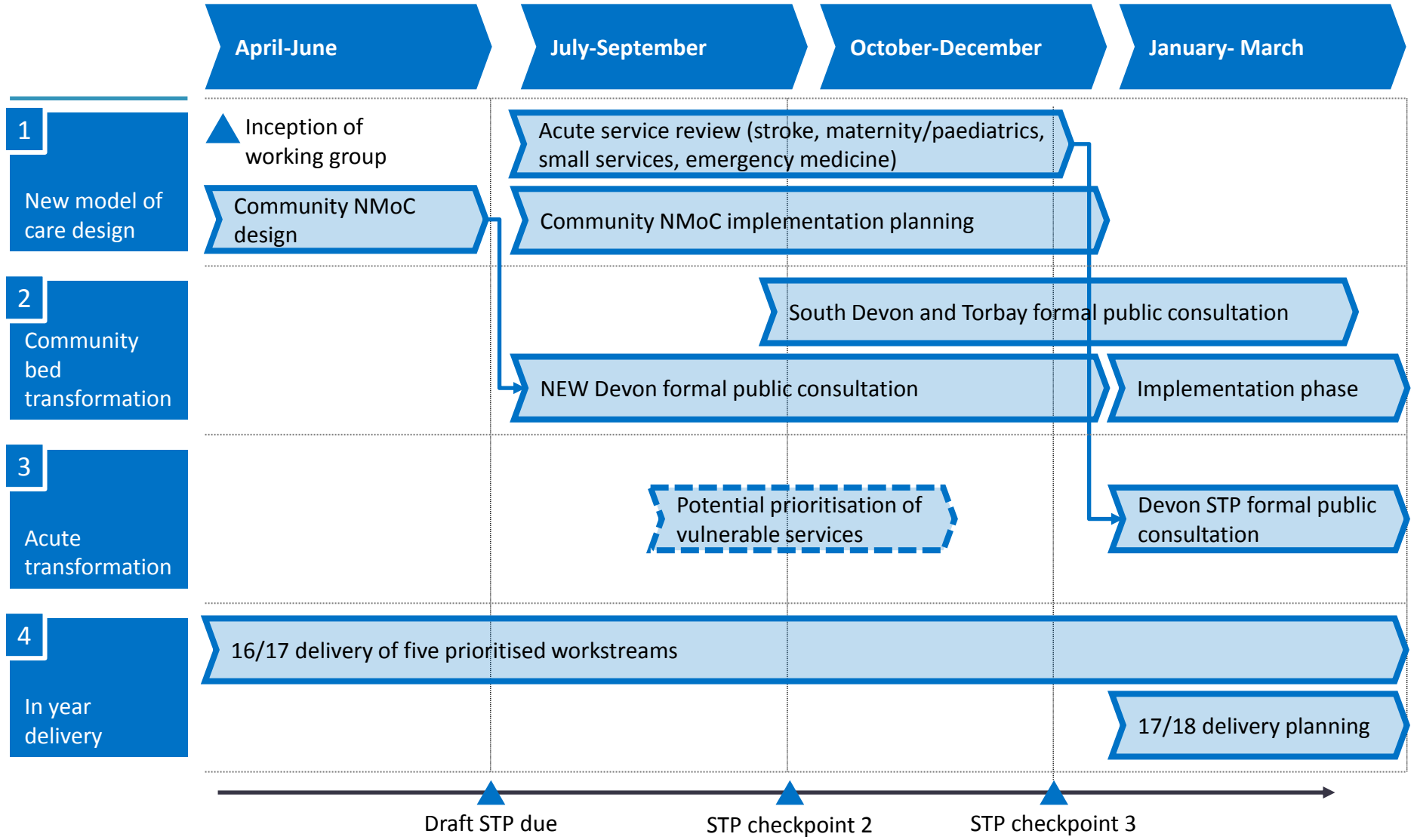
Realise benefits in reduction in variation and reduction in excess demand access and improved outcomes

Clinical and financial sustainability secured

Improvements in health/patient experience outcomes demonstrated

Key priorities	Prevention & early intervention	New Models of Care	Mental Health	Primary Care	Acute & specialist services	Children & Young People	Bridging the financial gap

A number of large scale transformations are scheduled for review and implementation throughout 2016/17



Our Shared Vision

Aim and Statement of Purpose

We will operate as an aligned health and care system, to be a major force and trustworthy partners for the continual improvement of health and care for people living in Devon, Plymouth and Torbay.

The Challenge for Wider Devon

Deliver better and more equal outcomes for more people, sustainably delivered in a more integrated way, maximising the gain that can be achieved within the financial resources available to our collective

MISSION	VALUES	STRATEGIC OBJECTIVES
We will focus everything we do on improving: • Population Health • Experience of Care • Cost effectiveness per head of population	**We will act, behave and be held to account for**: • Operating without boundaries • Working with speed and agility • Strong teamwork • Embracing innovation • Relentless focus on population benefit and user experience	**We will deliver:** • Excellence in service delivery • Improved health and well being for populations and communities • Integrated care for people • Improved care for people • Empowered users who are experts in managing their care needs

Public Engagement in developing our shared vision

Our plans are designed to deliver on a series of "I" statements developed by local people:

- I will take responsibility to stay well and independent as long as possible in my community
- I can plan my own care with people who work together to understand me and my family
- The team supporting me allow me control and bring services together for outcomes important to me
- I can get help at an early stage to avoid a crisis at a later time
- I tell my story once and I always know who is coordinating my care
- I have the information and help I need to use it, to make decisions about my care and support
- I know what resources are available for my care and support, and I can determine how they are used
- I receive high quality services that meet my needs, fit around my circumstances and keep me safe
- I experience joined up and seamless care – across organisational and team boundaries
- I can expect my services to be based on the best available evidence to achieve the best outcomes for me

From where we are	To where we want to be
From patients…	To people
From care settings…	To places and communities
From organisations…	To networks of care and support
From what's the matter with you…	To what matters to you
From illness management…	To wellness support

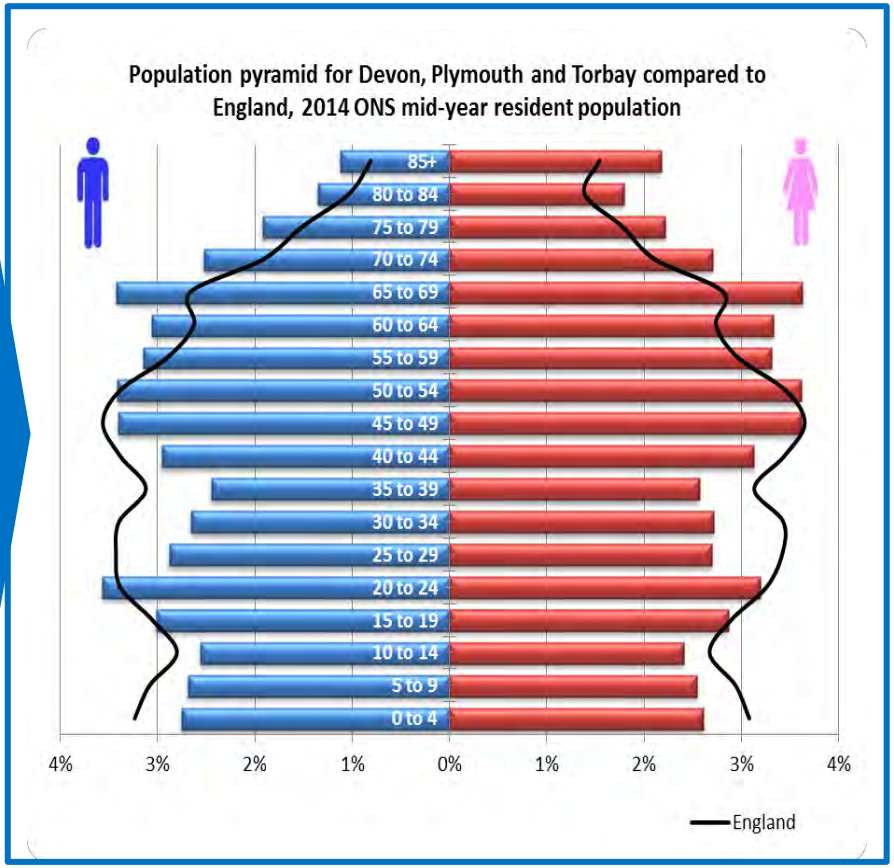
Demography, Geography and Deprivation

There is a real opportunity to make significant improvement in physical and mental health, wellbeing and care for the population and communities. Wider Devon has a significantly older population than the rest of England and delivering its STP can help create the evidence base to inform other areas as we plan for the changing demands associated with an ageing demographic. We plan to share our learning to benefit communities beyond wider Devon.

Wider Devon has a resident population of around 1,160,000, with just over half living in urban communities, and just under half living in rural communities within the 3 local authority areas of Devon County Council, Plymouth City Council and Torbay Council

Wider Devon has an aged and ageing population with the number of those aged 85 and over forecast to more than double over the next twenty years; we are facing challenges now that other parts of the country will face in decades to come

There are significant areas of inequality and deprivation within wider Devon, with around 152,000 residents living in the top 20% most deprived in England.



Health and Wellbeing challenges we must address

The Public Health and JSNA key considerations underpinning the plan

- An ageing and growing population
- Balancing access to services in both urban and rural localities
- Complex patterns of deprivation linked to earlier onset of health problems in more deprived areas (10-15 year gap)
- Housing issues (low incomes / high costs/ poor quality in private rental sector)
- Giving every child the best start in life and ensuring children are ready for school
- Poor mental health and wellbeing, contributed to by social isolation and loneliness
- Poor health outcomes caused by modifiable behaviours
- Pressures on services (especially unplanned care) caused by increasing long-term conditions, multi-morbidity, mental health and frailty.
- Unpaid care and associated health outcomes
- Shifting to a prevention and early intervention focus

Health and wellbeing opportunities are based on our understanding of targeted population segments

Health and care segmentation 2014/15

Population, k | Total spend, £m | Spend per head

	Mostly Healthy	Chronic conditions	SEMI	Dementia	Cancer	High needs	
Children 0-16	Mostly healthy children 550 128.9 70.9	Children with chronic conditions 1,384 13.0 18.0	Children with SEMI 3,815 1.2 4.5	- - -	Children with cancer 11,199 0.1 1.2	Children with PD/LD[1] 11,526 2.3 26.0	Vulnerable children 22,922 2.9 66.8
Adults 16-69	Mostly healthy adults 569 372.6 212.1	Adults with chronic conditions 1,379 194.4 268.0	Adults with SEMI 7,052 7.8 55.1	Adults with dementia 6,539 0.4 2.8	Adults with cancer 2,764 18.8 51.9	Adults with phys. disability 12,422 3.1 38.9	Adults with learn. disability 29,767 2.7 80.9
Elderly 70+	Mostly healthy elderly 1,679 15.4 25.8	Elderly with chronic conditions 3,193 74.1 236.,7	Elderly with SEMI 13,465 1.0 13.5	Elderly with dementia 15,264 5.6 84.7	Elderly with cancer 4,089 20.7 84.5	Elderly with phys. disability 18,595 12.2 226.8	Elderly with learn. disability 32,717 0.30 9.8

Source: Monitor Ready Reckoner, Carnall Farrar analysis

1. Children with LD/PD figure does not include spend on education

20 segmented analysis improvement opportunities have been identified to address the health and wellbeing gaps and public health and JSNA priorities (We are updating this to include South Devon & Torbay data– it is unlikely to change the key findings)

The care and quality challenges we have to address

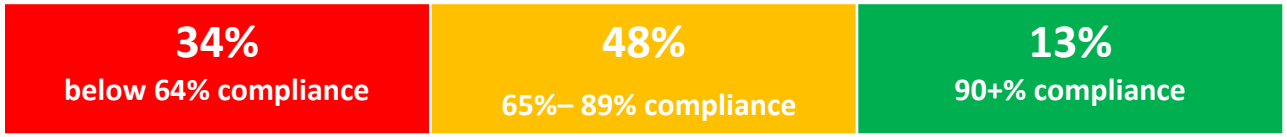
The principles and design features in the STP will drive improvement in an integrated manner, delivering benefits of standardisation to reduce variation but tailored to the clinical needs of individuals and communities. This will drive improved achievement of national performance standards, patient and staff experience, safety, service line resilience and clinical effectiveness and outcomes.

The key care and quality considerations underpinning the plan are:

- Creating a whole system culture of continuous quality improvement and evaluation across the footprint, sharing best practice , learning and spreading the use of recognised improvement methodologies
- To support a culture of safety for people who use our services and staff who provide them, keeping people safe by:
  - Supporting the whole system to reduce avoidable mortality, morbidity and harm
  - Safeguarding adults, young people and children through joined up safeguarding teams and processes
  - Raising awareness and early identification of sepsis at all clinical interfaces
  - Ensuring that people who are cared for in hospitals and residential settings are safeguarded, have personalised care plans and live in places where standards are high, and regularly monitored
  - Systematically learning from mistakes and sharing best practice
  - Creating a positive culture of antibiotic guardianship in primary and secondary care, helping to reduce antimicrobial resistance and improve infection control wherever care is provided.
- Ensuring parity of esteem and equality of access for people with learning disability, mental ill health and looked after children
- Meeting national standards for primary, acute and specialist care (including mental health)
- Achieving a minimum of good in CQC assessments in all services and making sure that services assessed by the CQC as inadequate or requires improvement are supported to improve rapidly and sustainably.
- Reduce harm associated with delayed discharge from bed based care.

Key areas for care and quality improvement

A rigorous self-assessment of performance against quality and performance standards of 13 acute specialties has been completed which demonstrate gaps in consistent, equitable and high quality access to care across all 4 acute providers. There is a significant level of variation in performance across the footprint. However the overall position is summarised here:



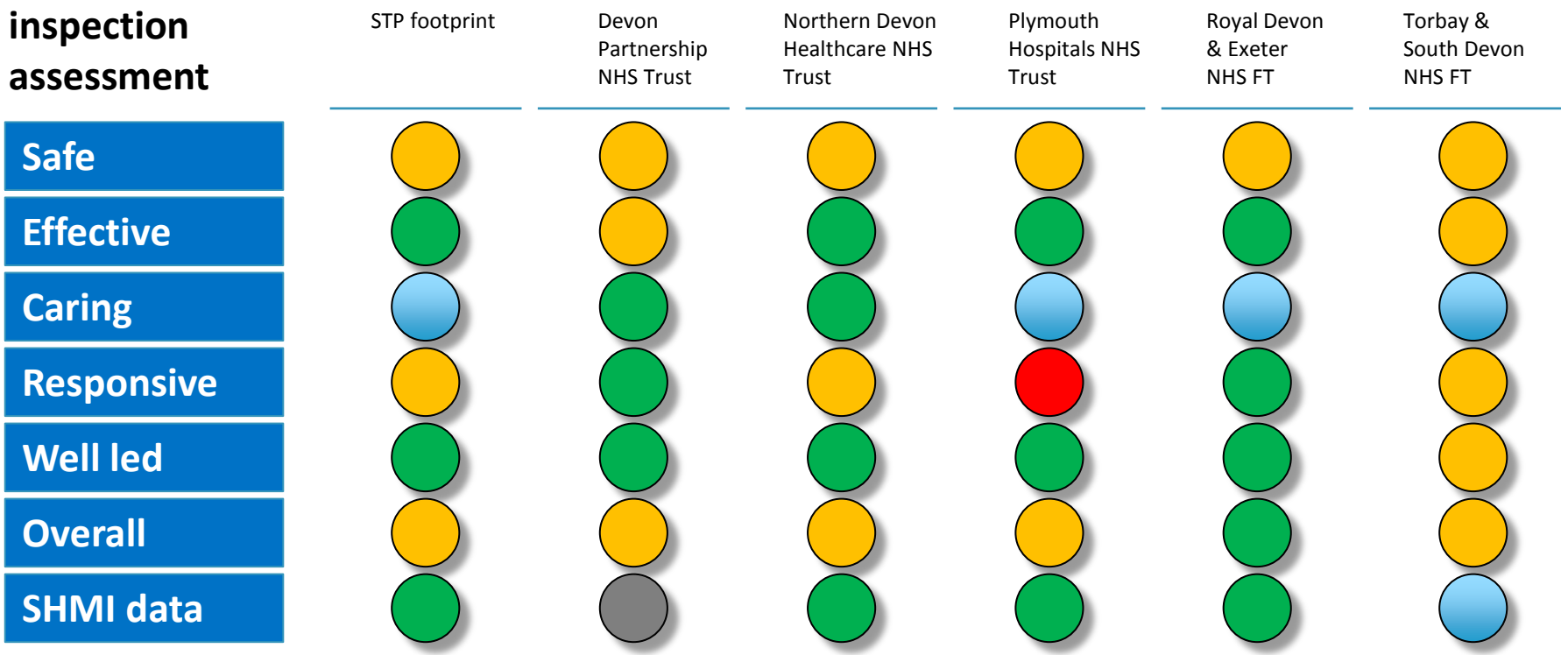
- There are also gaps in consistent, equitable and high quality access to specialist mental health services for adults and children and for those who present to physical acute services but where it would be more beneficial to access:
  - Psychological therapy for those with long term conditions
  - Psychiatric liaison support
  - An integrated psychological medicine service
- There is a system wide, health and social care, over reliance on bed based care the harm associated with non mobilisation for frail elderly people is well documented
- The quality of primary care is generally good but increasing demand and recruitment difficulties will require action to be taken to secure a sustainable service capable of supporting the emergent new model of care.
- Building on innovative approaches in parts of the system a transformational new model of care is in development to address the over reliance on bed based care, ensuring comprehensive integration of mental and physical health and social care
- Reconfiguration of specialist and acute mental and physical health services will be required to achieve sustainability, equitable access and national standards. The following services are priorities for action:
  - Mental Health secure services (cross STP collaborative approach)
  - Urgent and emergency care (A&E)
  - Cardiovascular (stroke and interventional cardiology)
  - Maternity and Obstetrics
  - Paediatrics and Neonatology

Key areas for care and quality improvement – comparative performance and the improvement opportunity

Care and quality gaps in the wider Devon heath and social care system will be addressed over the period of this plan. Current performance is variable across the system ranging from inadequate to outstanding. Our aim is to reduce variation.

- Inadequate
- Requires improvement
- Good
- Outstanding
- Not assessed

CQC full inspection assessment



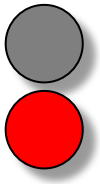
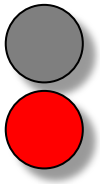
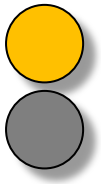
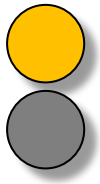
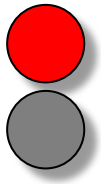
NB :SWAST Livewell and Virgincare Childrens Services CQC assessment not available

Key areas for care and quality improvement – comparative performance of assessments and improvement opportunities

CCG & Local Authority Assessments

OFSTED children's services

CCG assurance framework

NEW Devon CCG	South Devon & Torbay CCG	Devon County Council	Plymouth City Council	Torbay Council
				

Provider performance	RD&E	NDHT	TSDHT	PHT	DPT	England
Friends and Family Test (inpatient)	96	98	97	97	-	96
Friends and Family Test (A&E)	95	86	98	95	-	86
Friends and Family Test (Mental Health)	-	-	-	-	93	87
Harm free care	96%	95%	96%	96%	97%	-
Staff survey score out of 4 Overall engagement increased in all areas	3.85	3.93	3.87	3.68	3.75	3.79

The financial challenges we have to address – drivers of the deficit

Whilst improving health, we also have to close a significant potential funding gap in health and social care funding over the next 5 years. For the wider Devon STP footprint this amounts to £572m in a do nothing scenario by 2020/21 across the health system. This includes any social care gap as part of the integrated organisations in South Devon and Plymouth but excludes any Local Authority spend where not integrated in the wider Devon footprint.

Deficit Drivers

- Continuing health care, which is significantly higher than peer group median spending across the STP footprint
- Elective care, intervention rates - We treat more people than other systems with similar populations
- High levels of community services spending compared to peers
- Excess length of stay in an acute setting and non-elective admissions that are amenable to ambulatory care or alternative community based models of care
- Trust level productivity analysis confirms opportunities across staffing, procurement and agency spend.

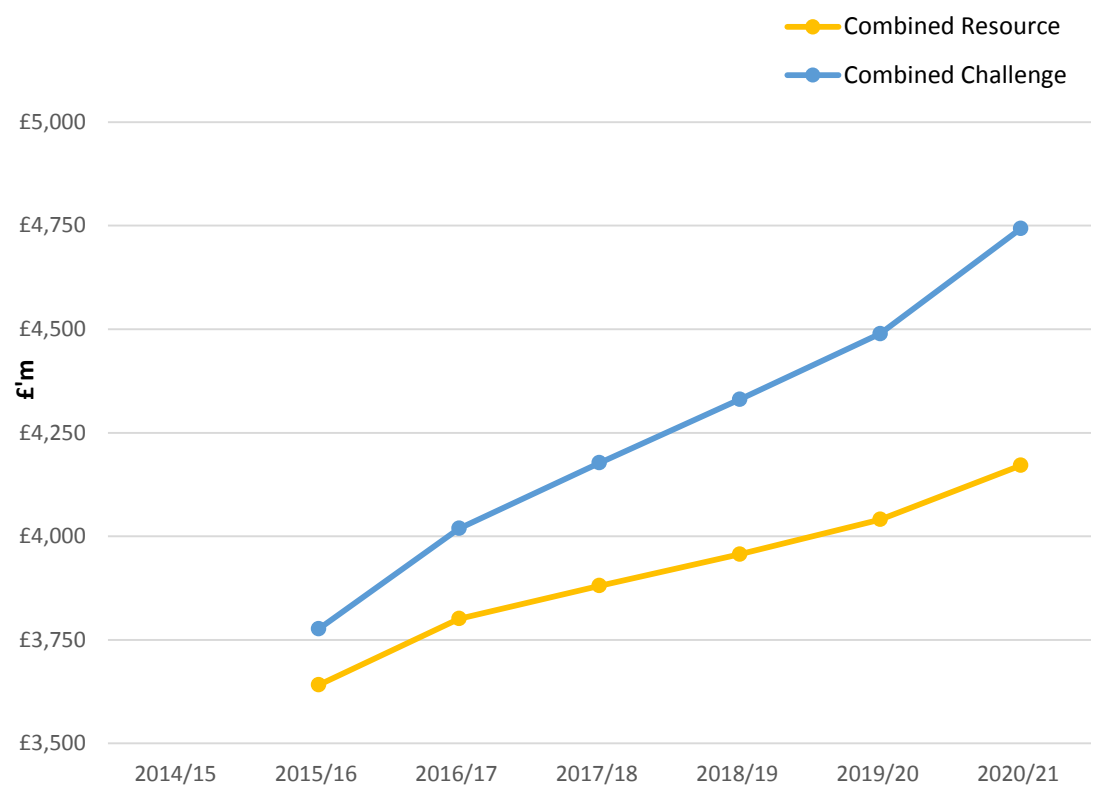
This means responding to what people need through reallocating resources to better meet the greatest needs of the population e.g through reducing the amount spent on expensive bed based care, improving efficiency and reinvesting in less expensive, more innovative, integrated care models including investing in community assets that do more to prevent ill health, keep people out of hospital, treat them effectively when needed and enable them to recover rapidly and to stay in their own homes for as long as possible.

The financial challenges we have to address

- The options recommended in this report need to achieve both clinical and financial sustainability of services in Devon
- The size of the financial challenge has been updated using the latest available information, including 2016/17 planning guidance, CCG place based allocations and revised assumptions following agreement with the finance working group, consisting of all DOFs and CFOs in the STP footprint
- The STP has adopted the latest national planning assumptions on inflation but have reverted to the 5YFV assumptions (set out as part of the Success Regime) for growth. This is due to the level of local analysis that has been undertaken on assessing and understanding activity growth rates and represents a collective commissioner and provider view of future growth
- To meet business rules there is a do-nothing gap of £572m for the STP up to 2020/21. This represents the wider Devon footprint of the STP and the adoption of the national planning assumptions on inflation
- The Sustainability and Transformation Funding (STF) of £81m has been included in 2020/21 as per the guidance offset by investment to the same value to deliver clinical sustainability for meeting 7 day working / national standards. This is phased in as per the STF funding and further work is required on the likely phasing of the investment to deliver these service requirements.

The financial challenges we have to address

A system-wide challenge of £572m is forecast by the year 2020/21



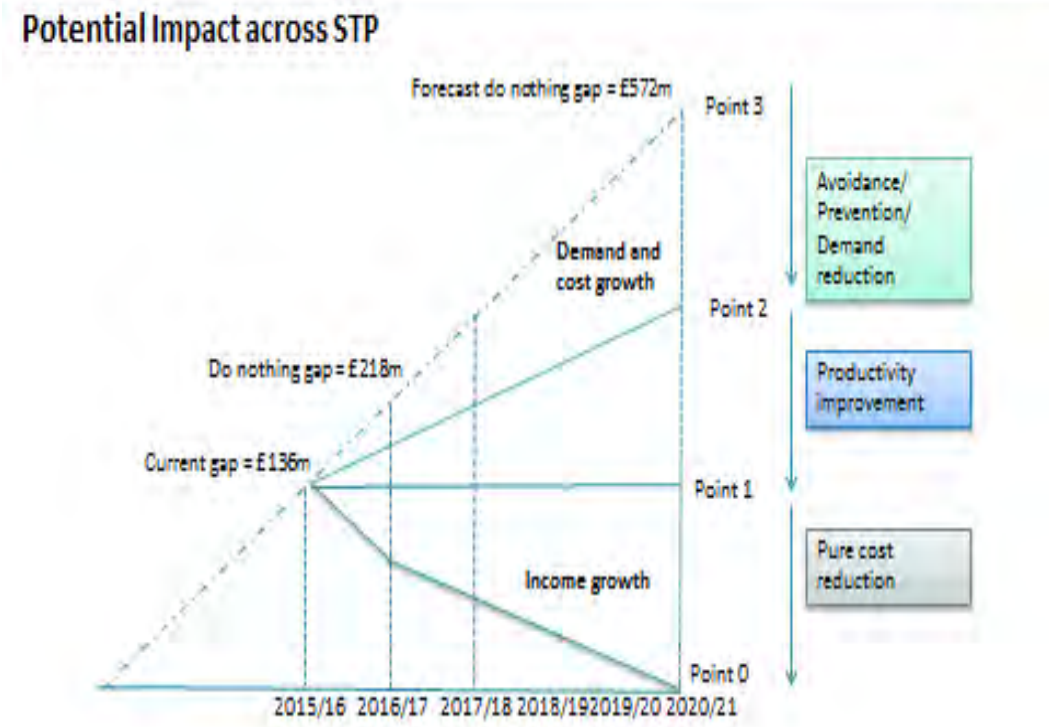
By 2021, without transformational change there will be a system deficit of £572m

NOTE: When the RAB effect is included, the total challenge amounts to £744m.

The financial challenges we have to address – opportunities for improvement

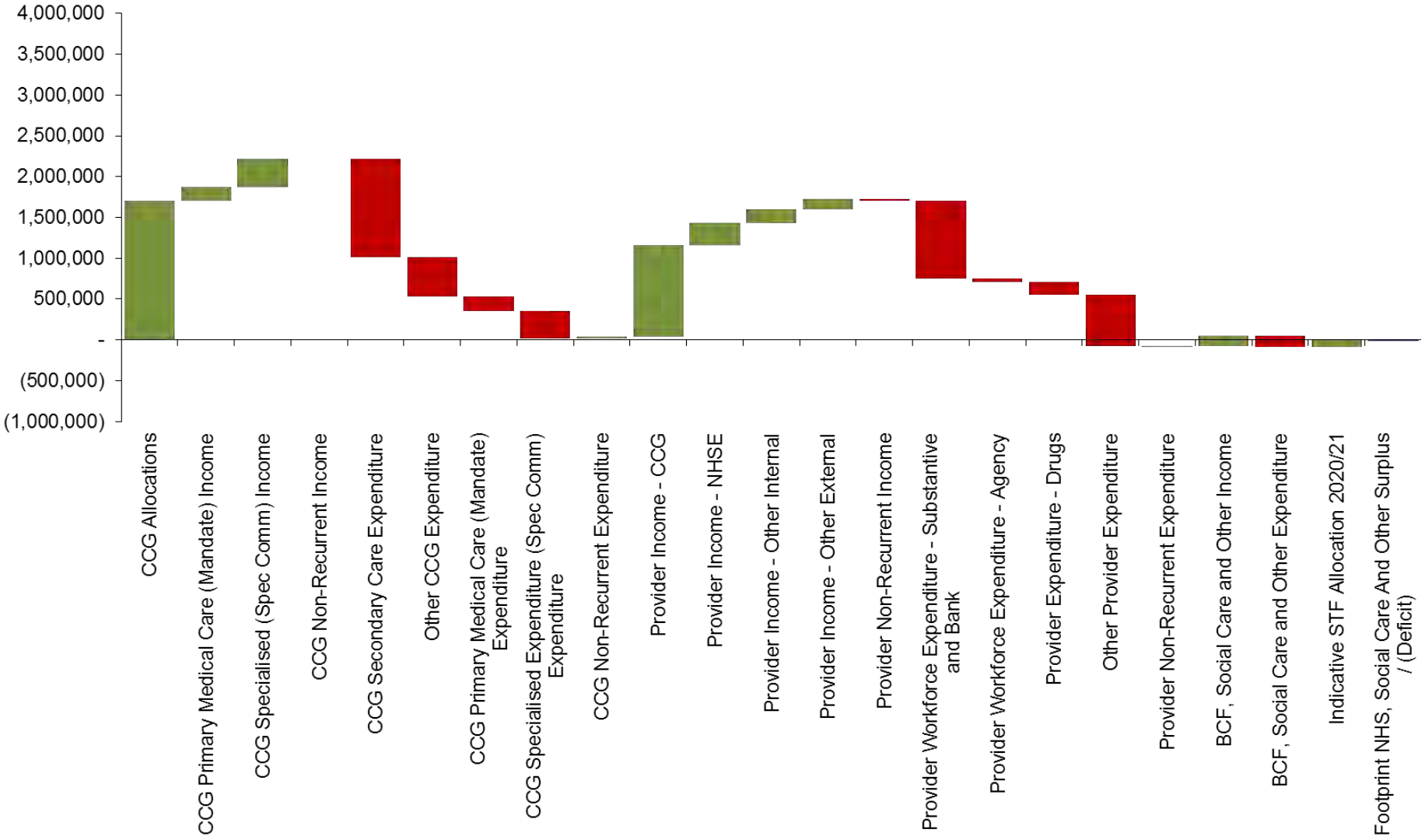
Closing this financial gap will rely on five things:

1. Implementation of the five 2016/17 priority opportunities: the system is planning to deliver savings in the region of £85m next year including Business as Usual efficiencies across providers and commissioners, the NEW Devon footprint system wide savings plan and South Devon reduced cost of care initiatives.
2. Delivering excellent care and shifting activity from acute settings: an assessment of investment in new and enhanced services and the expected impact on activity has been carried out
3. Productivity efficiencies in providers
4. Financial benefit from options for changing the configuration of services: this is evaluated at a high level but will be calculated in detail as part of the success regime phase 2b economic modelling .
5. Delivering benefits across the Torbay and South Devon Integrated Care Organisation and new models of care.



If the STF were phased in as per the success regime, the system would achieve financial balance in 2018/19

The financial challenges we have to address – The 16/17 to 20/21 bridge



Opportunities for transforming care

Prevention and early intervention	• Healthy start for children – Promoting healthy lifestyles • Supporting vulnerable children and families - targeting early support for the most deprived and in need • Living well – promoting healthier lifestyles to support mental and physical well being and intervening earlier when needed • Ageing well – supporting people to live independently and rehabilitating after illness • Proactive care and support planning linking risk stratification to Experion data
Excellent Care	Develop new models of care to: • Support sustainable primary care at scale • Support people with dementia and multiple comorbidities • Secure equality of access for populations and optimise elective pathways for all mental and physical health care • Reduce reliance on bed based care – reducing length of stay and system failure emergency admissions • Provide better access to a full range of services locally for patients who experience mental ill health and reducing out of area placements; providing for the mental health needs of patients during physical illness and in the management of their long term conditions • Enable people to die in their place of choice • Provide fair and equitable access to continuing health care and reduce spend • Exploit the gains from research and the application of personalise medicine associated with the genomics

Service Configuration	Delivery of the new models of care and securing clinical and financial sustainability will require some reconfiguration of services the priority changes are:
	• Securing sustainable & accessible:
	  • emergency services and urgent care services (delivering the urgent & emergency care review)
	  • maternity obstetric and paediatric inpatient services
	  • smaller specialist services eg vascular & ENT surgery
	  • cancer pathways to improve prevention and survival rates
	• Reduce system bed numbers by circa 590 by 20/21- this will be a combination of community hospitals and acute beds
	• Improving cancer pathways to improve prevention and survival rates

Effectiveness & Productivity	Through collaborative effort and the application of evidence based best practice ensure provider productivity(Carter) and clinically effective care (NICE) is secured. Dealing with potential increases in costs through improved models of care and management of demand

Translating opportunities into priorities for action

1 Prevention and early intervention	Health promotion and disease prevention need to be a common element of all services, helping to optimise health and decrease the long term burden of disease. Maximisation of social capital and building healthy communities to develop a multiagency risk stratified prevention plan which will be supported by new models of care. Exploring the use of Experion data to target preventive interventions at an earlier point
2 Bridging the financial gap	Delivery of the actions required and the supporting financial plan will secure system financial balance by 2021.
3 New models of care	Transformation of provision will significantly change where health and care is delivered in the future. Greater integration across health and social care will mean that more care will be delivered closer to peoples' homes, preventing avoidable admissions and clinically unnecessary long stays in hospital. Bed-based activity will decrease and fewer beds will be needed in acute hospitals or community hospitals. This will require a recurrent investment in integrated services of around £60m to deliver new models of care and will reduce unnecessary recurrent costs by £180m. Ensuring that integrated care services are connected to local communities and meeting the needs of the people they serve, is fundamental to their success.
4 Mental Health	A shared cross Devon plan for Mental Health which supports transformative new models of delivering care, promotes mental health and wellbeing and is ambitious in improving outcomes, addressing inequalities and achieving national standards
5 Primary Care	Primary care will be a key and integral part of the emergent new model of care. The footprint will learn from experience of developing strategy in SD+T to produce a NEW Devon primary care strategy.
6 Acute and specialist care	Secure a system of clinically sustainable mental health, acute and specialist services to ensure that the population is served with safe, sustainable, quality services which meet national standards. The initial focus will be on services which are most "at risk" in terms of sustainability. For more specialised services wider Devon will work closely with the Somerset and Cornwall STP footprints
7 Children	Targeted plans around addressing the key issues in health and social care for children and families especially children's emotional health and wellbeing and early help offer

Translating opportunities into priorities for action – the scale of change and level of ambition (NEW Devon)

	Key change	Implications
Emergency & urgent care	• 15% reduction in EL • 20% reduction in NEL	• Allows for delivery of non-elective care closer to home
Excellent care - New models of care	• Reduce the 40% of acute bed days accounted for by 70 year olds staying >10 days • Reduce the 86% of bed days accounted for by 70 year olds staying 10 days or more • Secure equality of access for populations and optimise elective pathways for all mental and physical health care • Address low spending on MH per capita	• 400+ acute beds could be reduced based on today's activity level, with reprovision in new models of care • In addition, acute activity reduction suggests a further 10% reduction which would further reduce beds • Current investment in community beds should be cut with reinvestment in alternative provision. • Redistribution of resource between localities and from acute to mental health services. This will require reductions in service access for some populations
Service Configurations	• Reduce duplication of services: e.g., internal medicine 26 of 32 services have 2+ providers, cancer (7 of 12 services have 2+) and blood (4 of 5 services have 2+). • Less than 65% of the standards are being met for stroke, emergency medicine and older persons care by each of the three Trusts	• New models of care will drive acute changes and reconfigurations • Reduction in the number of sites offering current pattern of acute and specialist service -consolidation at Plymouth and RD&E for some services. • To address population access need and travelling times networked solutions likely to ne required . • Need to consider wider scope of specialised service in conjunction with Somerset and Cornwall STP areas
Effectiveness & Productivity	• Implementation of Carter proposals rationalisation of estate and back office functions enabled and supported by new models of care and management of demand	• Major savings required • Opportunity to ensure services are high quality and high value for money.

Translating opportunities into priorities for action – the scale of change and level of ambition (SD+T)

Workstream	Key change	Implications	Lead org.
Activity Reduction	Activity Reduction, elective, Right Care	Elective inpatient changes	CCG
	Demand curtailed in the Emergency system, both acute and community	Growth rates differences between STF rates and 1.4% assumed in ICO business case for Acute and Community contracts	CCG
	MSK Pathways, referral management	Elective inpatient changes	CCG
Acute and Community Bed Reduction	Care Model from Torbay ICO business case: Beds and Outpatients	Bed savings acute and community, change structure of Community hospitals and MIUs, enhance IC and spot bed purchasing. Wellbeing, frailty pathways,OP Innovations	Provider costs
Primary Care	Prescribing		CCG
Commercial Income Generation	Income Generation – commercial income	Pharmacy manufacturing, private treatment and repatriation, shared service provision	Provider Income
Productivity including CHC, Procurement, Agency, Carter Benchmarking, Acute Standards	Provider BAU efficiencies	2% of turnover assumed cost reduction across pay and non-pay	Provider Costs
	Carter Model and Benchmarking Efficiency	11% mandated reduction in cost for the following areas – Procurement, Management and admin, Nursing Workforce, AHP, EFM, Medical Workforce	Provider Costs
	ASC	Voluntary sector utilisation, increased community support to reduce care package costs	Provider costs
	Placed People	Reduce costs to national average benchmark through client numbers and robust procurement and monitoring	Provider costs
	Provider Strategic/ benchmarking	Agency, Social Care cost reductions Council driven. Other	Provider costs
Other	Council ASC, income match to LTFM and Council Tax precepts	Income modelled too low at zero inflation	Provider Income
	Devon Acute Services Plans		CCG

Critical Decisions

- Financial recovery and meeting of future predicted increases in demand is predicated on implementing the new integrated care model that is significantly less reliant on bed based care. The changes we are proposing will result in a reduction in the number of acute and community beds across our system of the order of 590 by 2021.
- To facilitate implementation of the care model and release funding to invest in more ambulatory care provision in community and home based settings, NEW Devon are developing consultation proposals on the overall strategic direction of travel and provision changes, the components of new models of care and specific intentions to close a number of community hospital beds. Consultation is expected to start at the end of July 2016
- In South Devon & Torbay implementation of the care model as set out in the ICO business case is pushing ahead with consultation on community services transformation including proposals for closure of four community hospitals. This is set to commence in September 2016
- Preparations will begin to develop proposals for some changes to the acute care model across the STP footprint. There are a number of specialties that need to change to address future sustainability issues- stroke, vascular services, paediatrics, maternity and ENT. These will also require public consultation and preparations for this will begin in August.
- We anticipate that we can make further progress over the five year period with developing the new care model and this is likely to lead to further formal consultations on changes to community provision including bed closures and material changes to centres of provision

In the next six months we need to:

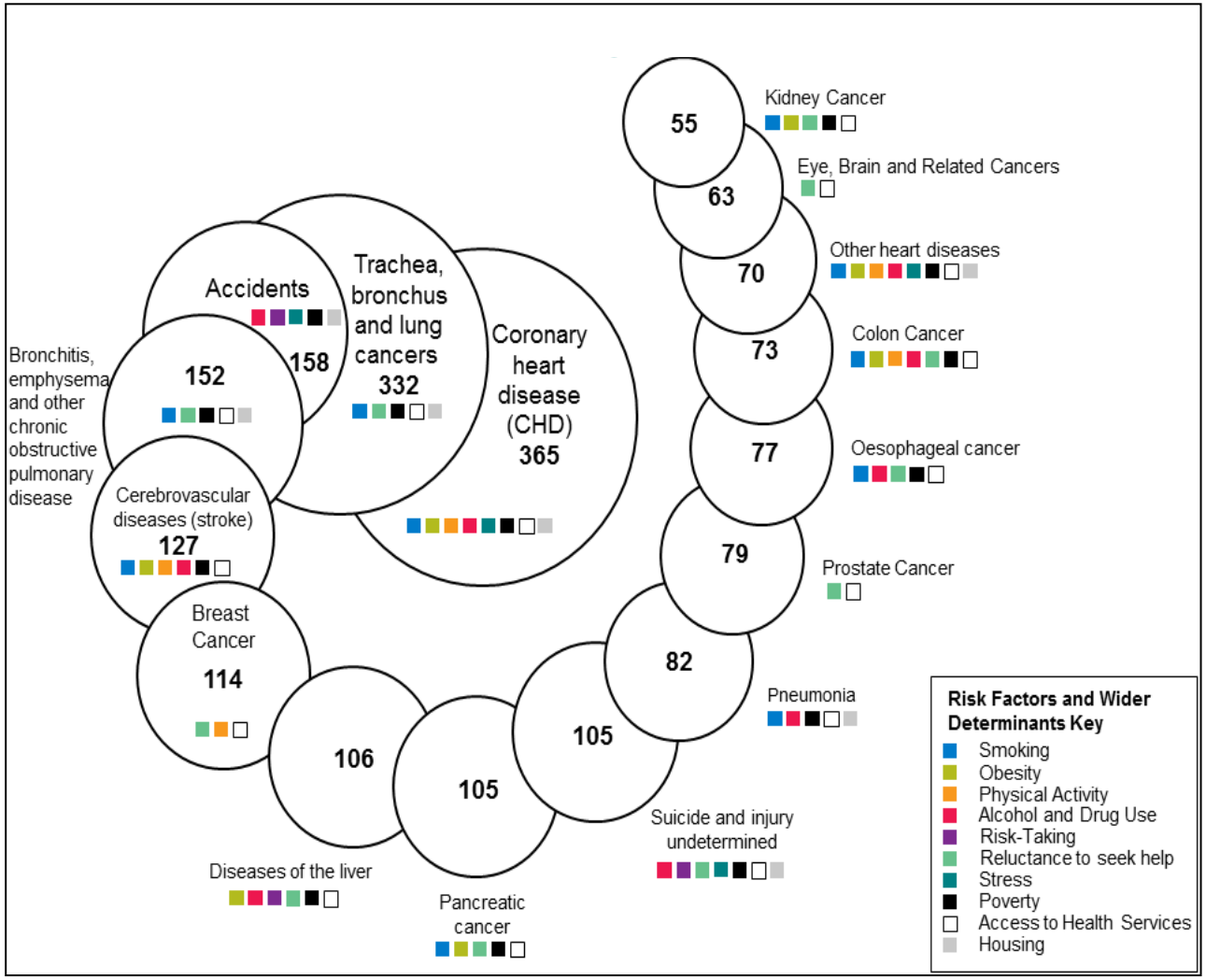
- Engage fully with our stakeholders on future direction of travel and proposed changes to services particularly where this impacts on the number of beds available, community hospital closures, and changes to specific acute services
- Begin to formulate our ideas and agree the future configuration of commissioning and provision functions to best support delivery.
- Ensure that plans rapidly take shape post consultation to ensure we are ready for implementation in 2017/18

Support Required

- Advice and support on consultation proposals particularly on managing to tight timeline and preparation required to facilitate smooth transition through NHSE gateway process
- Support when in engaging with politicians at a senior level to facilitate significant change
- Pragmatic approach support for non- recurrent funding
- Continued emphasis on Success Regime as a positive vehicle within the STP process
- Continued support for ongoing development of collaborative system leadership approach including agreement of a single financial control total, review of organisational forms and consideration of options around an accountable care system
- Integration of regulatory assurance processes and reporting mechanisms.

Priority 1 - Prevention

Causes of death in under 75s by main cause and risk factor – 3,411 Deaths (2014)



Delivered through the new care model, We will bring renewed focus on prevention. Immediate priorities:

- smoking cessation
- alcohol control
- Healthy eating,
- moving more
- social connectedness and combatting loneliness
- mental health gap
- addressing wider social economic, environmental and cultural factors.

Priority 1 - Promoting Health through integration

In order to empower people and communities to take a more active role in their health and wellbeing we plan to:

- Develop Integrated Personal Commissioning (IPC) as a mainstream model of community based care for around 5% of the Devon population, including people with multiple long term conditions, people with severe and enduring mental health problems and children and adults with complex learning disabilities and autism.
- Expand personal health budgets and integrated personal budgets in line with the ambitions of the Five Year Forward View - including exploring the concept for maternity and end-of life. Our ambition in Devon is to use the Integrated Personal Commissioning programme to go further and faster than the national target and we aim to achieve 2,000 individual budgets by 2018. We are already well ahead of other systems in implementing IPC.
- Achieve a step change in patient activation and self-care. The South Devon and Torbay Urgent care vanguard has a focus on this area and a framework in place including social segmentation, a strengths based approach behaviour change and development and integration of directory of services. We also need to build on the Plymouth approach to integration and the East Devon ICE project.
- Continue to work with Peninsula Urgent and Emergency Care network to develop a Peninsula-wide plan, leveraging collaborative opportunities. In parallel, we will develop detailed service models that meet local population needs. Our local delivery timeline is aligned with the emerging plan being developed for the PUECN.
- Continue to develop our Better Care Funds to support our focus on prevention. They are already operating in a way that brings providers and commissioners together to determine how a single pooled fund can best be deployed to support improved flow of patients and how to keep people well and supported at home, or to return their own home as quickly as possible following a period of ill health.

Priority 2 – The financial challenge

- Total system opportunities have been identified using a combination of detailed planning, baseline modelling and benchmarking delivering a net cumulative benefit of £491m by 2020/21 (exc. STF) as set out on the following slide
- Solutions are derived from jointly agreed provider and commissioner projects within the STP footprint as a result of BAU efficiencies and transformational savings
- A significant proportion of the opportunities centre around the provider productivity gains (£124m)
- All the opportunities are in the process of being developed into plans for delivering the level of opportunity identified (i.e. converting the opportunities into deliverable solutions)
- The success regime modelling of baseline data has been undertaken across the NEW Devon footprint only however the underlying analysis undertaken in the South Devon footprint utilises the same methodologies of benchmarking and peer review through utilising Right Care and is fed into the BAU efficiencies and reduced cost of care initiatives
- The South Devon solutions draw on information from the Integrated Care Organisation business case which was supported by Ernst and Young and underwent extensive due diligence by Monitor as part of the approval process.
- The opportunities impact on the sector differentially as follows:

Description	Value (£m)
Net commissioner Expenditure reduction (inc CHC)	242
Provider reduction in Income	-151
Provider Cost Savings	400
Net system savings	491

13 opportunities have been identified across the STP

Solutions	2016/17 £'m	2017/18 £'m	2018/19 £'m	2019/20 £'m	2020/21 £'m
S1 BAU (NEW Devon providers)	21	22	23	25	26
S2 1617 system wide plan (NEW Devon)	48	65	71	73	76
S3a BAU TSD	9	10	11	12	13
S3b South Devon Provider Productivity	0	8	14	21	29
S4 TSD Reduced costs of care	7	8	10	11	12
S5 ICO Care Model	0	4	5	6	6
S6 BAU Commissioner	0	16	23	31	39
S7 CF Prevention	0	9	15	21	41
S8 CF Excellent care	0	0	0	0	24
S9 CF Excellent care Other	0	0	3	8	20
S10 CF Acute Productivity	0	13	33	46	52
S11 CF Mental Health & Community	0	9	48	86	124
S12 TSD Reduce demand	0	7	15	22	29
Total Solutions	85	171	271	362	491

- 2016/17 is focused on delivering the system business as usual savings along with the NEW Devon footprint 16/17 system wide savings plan
- Future years identify the opportunities from the Carnall Farrar success regime outputs which for NEW Devon will enable providers to release their continued BAU expected targets through provider productivities and move towards the transformational delivery in 2018/19 onwards.
- The focus for the South Devon footprint is realising the benefits of the integrated model of health and social care provision in delivering continued provider efficiencies and driving down the cost of care.

Resultant Financial Position – Do Something

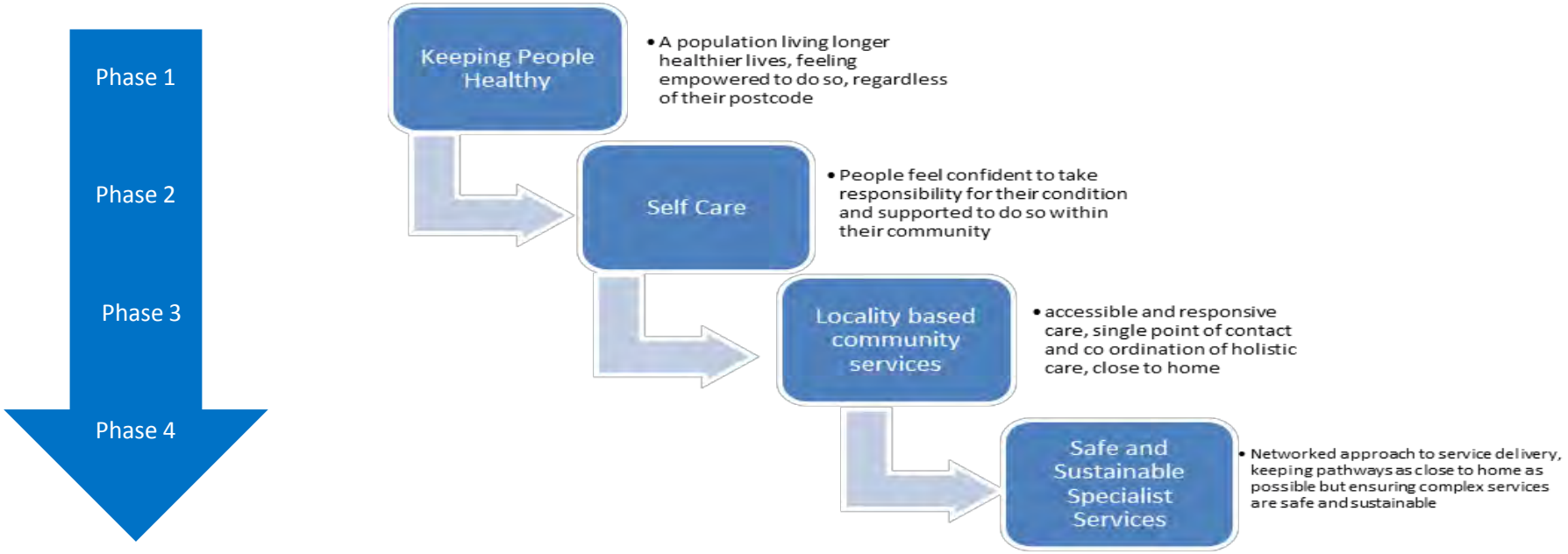
	Do Nothing	Solutions	Do Something
Commissioner Surplus / (Deficit)	(207,372)	242,155	34,783
Provider Surplus / (Deficit)	(355,910)	248,830	(107,080)
Footprint NHS Surplus / (Deficit)	(563,282)	490,985	(72,297)
Indicative STF Allocation 2020/21		81,000	81,000
Footprint NHS Surplus /(Deficit) after STF Allocation	(563,282)	571,985	8,703
Social Care And Other Surplus / (Deficit)	(8,703)	-	(8,703)
Total Footprint NHS Surplus /(Deficit)	(571,985)	571,985	(0)

- At the draft submission stage opportunities have been identified to resolve the total of the modelled do nothing gap across the footprint following receipt of the STF
- The STF has been assumed as a solution in the above table as it offsets the spend assumed in the do nothing scenario to deliver the national must dos against which the STF is predicated
- At this stage, this excludes any gap from local authority spend outside of the integrated organisations within South Devon and Plymouth
- In order to achieve a category 1 robust plan these opportunities now need to be developed into deliverable solutions.

Priority 3 – New models of care

The development and implementation of new models of care is fundamental in delivering the vision based on the drivers for change we have outlined earlier. This transformation work is high profile and will realise a broad range of STP deliverables; upgrade in prevention, financial sustainability and quality of care.

Whilst the vision is consistent across the STP footprint, models will be tailored to meet the needs of localities. Models will maximise the use of non bed based care and support people as individuals, outcomes tailored their specific need. Development is at differing stages currently, in the south a full service model developed underpinned by a full engagement process and planned consultation. In the north there has been a focus on community hospital transformation initially but following this, work has commenced with a range of stakeholders defining the type and level of service required, location, and analysis on both financial benefits and patient benefit. The diagram below supports us to analyse current configurations of service and work with stakeholders around which services and patient outcome should be achieved across the various phases:



Characteristics of the new models of care

1 The best bed is my own bed	We need to make sure that we strengthen out-of-hospital services so that they can both help people to avoid the need to be admitted to hospital and respond swiftly should they experience deterioration in their health. This means investing in more community-based services so that they mirror the availability and reliability of hospital-based care. This includes the provision of high quality End of Life Care.
2 Services closer to home	We also want to make sure that people do not travel further than they need to for treatment and support . The more out-of-hospital services we can provide in or close to people's homes the better.
3 High quality hospital care	Where people need to be admitted to hospital, we want to make sure that they receive the best quality and experience of care, that we have caring and skilled staff to look after them and that we meet national safety standards. New discharge to assess services will ensure people return to their normal place of residence quickly and safely and that care is coordinated around the person and their family.
4 What matters to me	Moving from focusing on 'what is the matter with a person' to what 'matters most to a person' means that we need to adopt an asset based approach to care. This means that we recognise the strengths, networks of support, skills and attributes of every individual and increase people's self-efficacy and confidence to manage their health and care. This approach helps to avoid creating unnecessary dependency on statutory services that take away a person's independence and can sometimes limit their potential to lead a full life.
5 Community centred approach	Adopting a person centred and community centred approach to health and wellbeing helps to build community capacity and resilience which in turn helps reduce social isolation and loneliness and can contribute to reducing health inequalities for individuals and communities. Our voluntary and community partners are at the heart of our new care model. It is through the interaction of statutory services with local voluntary and community groups that we can improve people's health and wellbeing, reduce demand on health and care services and lead to wider social outcomes.
6 Making every contact count	Wellbeing is at the centre of our care model because it reflects the importance and necessity of focussing on prevention and early intervention. 'Making every contact count' encourages conversations based on behaviour change methodologies, ranging from brief advice and intervention, to more advanced behaviour change techniques. The aim is to empower healthier lifestyle choices and exploring the wider social determinants that influence all of our health. Patient activation measures can help us to understand where people are in terms of their level of knowledge and confidence to manage their own health. Activation measures have been linked to improved clinical outcomes and reduced costs of care.

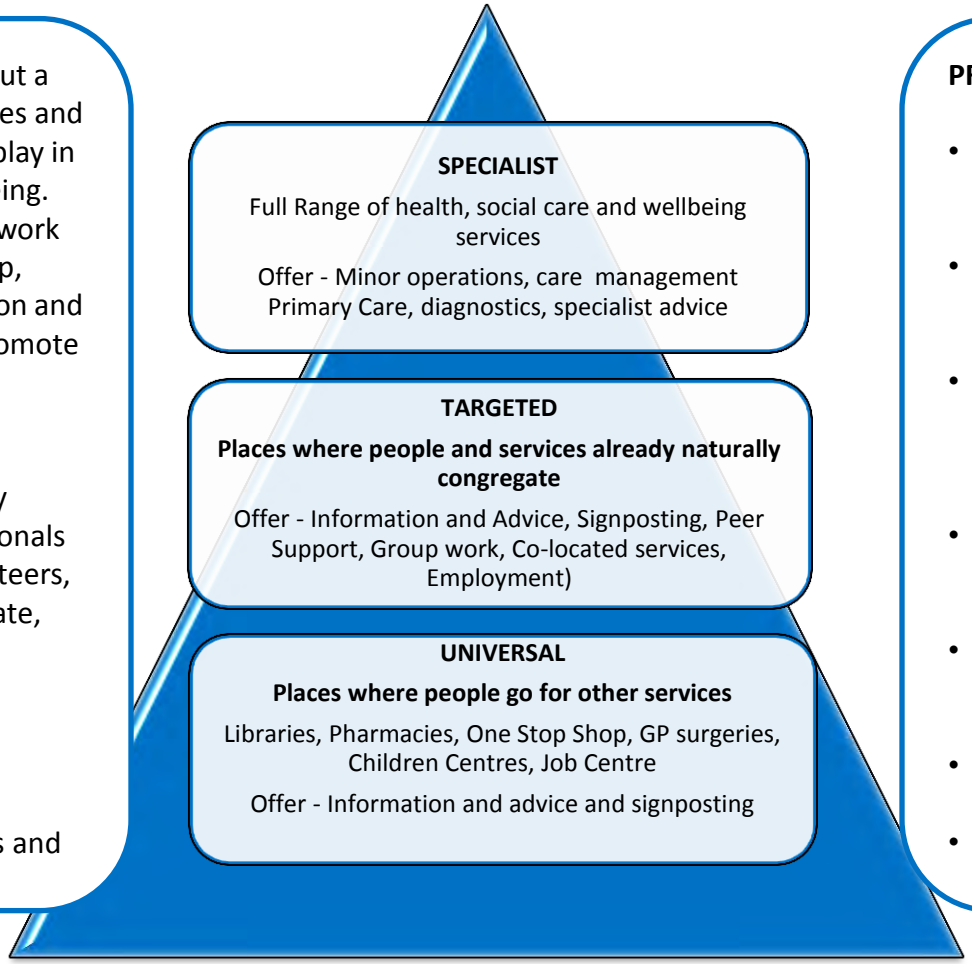
Priority 3 - New Model of Care Delivery - "A Network of Hubs"

Concept: A collaboration of integrated resources working together to inform, enable and support people in the local community to live independently and make life choices that will improve their health and wellbeing and level of activation for self-care

A HUB is not a set building but a network of different resources and services that have a part to play in improving health and wellbeing. They will communicate and work together to provide joined up, quality, consistent information and support for individuals to promote wellbeing, independence, recovery and re-ablement.

Hub services are provided by health & social care professionals community members, volunteers, paid staff across public, private, and community / voluntary sectors

NO one size fits all – each neighbourhood will have a different network that works and makes sense locally



PRINCIPLES

- Cooperative Commissioning Framework
- Community Engagement Framework
- Success Regime – responds to local need, best use of estates, community involvement
- Accessible and Inclusive e.g. Dementia Friendly
- Promote self management and Self help
- Utilise new technology
- Problem solving

Priority 3 – New model of care - Place based approach (1)

- Our new model of care will have a place based approach. In developing this we have considered the work of the King's Fund "Place-based systems of care" (Ham; Alderwick 2015) recognising that systems of care exist on different place based footprints. The level of the STP based on the Wider Devon area has a geographical and economic coherence based on the old shire county. Within this we have recognised material variation in care & quality, health & wellbeing outcomes; productivity, and finance and delivery performance. It is at this STP population level that we want to develop strategic plans including a financial strategy to achieve financial balance. However, these variations and inequalities can only change through action and delivery at the level at which they occur.
- Public and user engagement in our vision is helping shape common design principles that will enable us to prioritise and tackle specific inequalities at the level of 3 local geographies:
  - North & East Devon
  - Western Devon (including Plymouth)
  - South Devon & Torbay
- The needs of these 3 geographies will determine the priorities for improvement; the shaping of health and care provision based on and in consultation with local natural communities as well as considerations for future organisational form, within the context of the STP.

Wider Devon STP
New care model design principles
Resource strategy
Enabling strategies

North & East Devon	South Devon & Torbay 1st ICO	Western inc. Plymouth
RDE+ NDHT Vertical integration One Ilfracombe community "hub"	Established H&SC integration	Whole system fund. Integrated H&SC commissioning

This diagram reflects the current Planning and Delivery Units

Priority 3 – New model of care - Place based approach (2)

- Place based planning will also take account of natural cross boundary flows. Most significant is the East Cornwall population served by PHT. We are working with Kernow CCG to ensure our plans can be adapted to properly serve this population
- There is already an established track record of achievement which we will help to accelerate change:
  - The first established ICO in England in South Devon & Torbay
  - Fully Integrated health & social care commissioning in Plymouth
  - Integrated health and social care community provider in Plymouth
  - A high degree of vertical integration between acute and community services already delivering benefits in North & East Devon, including a HWB hub
  - Significant progress on integrated health & social care provision across Devon County
  - A strong track record of population engagement on community services.

We also recognise that place includes systems that are wider than the STP. For specialised commissioning, for example, we will work with NHS England across the peninsula, including Cornwall and into Somerset to ensure that there is a coherent commissioning and configuration plan. With Plymouth hospitals Trust (PHT)as a major tertiary centre we expect our STP to have a significant leadership role. Likewise we have established a peninsula wide urgent and emergency care strategic network based around PHT as a major trauma centre.

Priority 4 – Mental Health

National Priorities:

- Seven Day Service
- Integrated Mental and Physical Health Approach
- Promoting Good Mental Health and Preventing Poor Mental Health
- Hard Wiring Mental Health across the NHS

The Devon Priorities	Symbols of the current situation in Devon
Addressing gaps in service provision	• A changing but currently medically- orientated organisational approach. • Lack of capacity / capability to handle some complex conditions e.g. dementia in the community.
Making acute care resilient over 24/7	• Widely different demographics in Devon, driving historically different delivery models.
A life course approach to care	• Problematic segmentation and fragmented transition between age groups, leading to unreliable hand-offs, heavily influenced by the rural landscape.
Equity of access	• Variation in access to mental health services in some areas because of historical configuration of services.
Complex care in Devon for the people of Devon	• No PICU in Devon. • No high intensity rehabilitation. • No older people's speciality services. • large numbers of Devon people cared for Out Of Area (OOA)
Recruiting and retaining the right workforce.	• Ageing workforce • Busy workforce, reducing the opportunity to re-train, develop skills and multi-skill.

A further priority within this work plan is improving care for people with learning disabilities. This includes implementing enhanced community provision, rolling out care and treatment reviews and delivering the immediate and long term ambitions of the Devon Transforming Care Partnership (Detail in Appendices)

Priority 4 – Mental Health

Priorities	Our goal	Examples of our intentions
Addressing gaps in service provision	Removing gaps in service provision by investing in the most appropriate evidence-based pathways in a way that improves patient experience and VFM.	• To adapt the whole workforce to deliver new pathways. • To build community resources. • To adopt new condition care models as part of the overall Devon Model of Care e.g. for dementia. • To build an integrated psychological medicine / IAPT model.
Making acute care resilient over 24/7	A consistent and appropriate Devon approach (balancing bed-based and community-based care appropriately) where people know where to go and where delivered care tends to deescalate.	• To implement a MH Crisis Single Point of Contact, implemented across the Devon public service system, as part of the MH Crisis Concordat Action Plan. • To integrate with 111 and provide seamless pathways ensuring that people receive appropriate and skilled expert care. • Enhanced community crisis and home treatment service.
A life course approach to care	A seamless experience for people who receive an equivalent level of service regardless of age.	• To re-specify services in a way that drives provision of a seamless service. • To identify and close specific gaps. • To Incentivise collaborative working between service providers.

Equity of access	Rebalancing service delivery, while being brave enough to 'over provide' where local needs so-indicate. A full set of services – provided by the full range of provider organisation, including the third sector – that are matched to locality needs, including for Plymouth and Torbay.	• Redesigned and integrated care pathways that achieve the right balance between home treatment community and bedded provision across Devon and that also brings care back into Devon e.g.
		  • A Psychiatric Intensive Care Unit (PICU)
		  • PIMH services, including MBU provision.
		  • Early Intervention Psychosis (EIP)
		  • Eating disorders.
		  • Integrated Psychological Medicine

Complex care in Devon for the people of Devon	To meet local needs locally, building facilities where necessary, in parallel with implementing safe alternatives to in-patient care.	• Upskill the Devon workforce so they can support alternatives to inpatient care • Implement a PICU. • Get better at removing failure demand – right care first time. • Extend clinically led micro commissioning for Individual Patient Placements
Recruiting and retaining workforce.	A balanced and flexible workforce of the right size, with the right skills; that feels well led and appropriately rewarded.	

Priority 5 – Primary Care

- The vision we propose is for consistent, high-quality and sustainable models of primary care, one in which primary care teams are and feel supported and valued in their role. This is not based around the assumption that care is delivered by a GP, or indeed by a member of the General Practice team – rather that care is provided by the person best able to meet the needs of the individual.
- However, we do see GPs as being very much at the centre of patients' care, coordinating and overseeing other clinicians and healthcare providers, as well as providing care directly to patients. Partnership with patients, as well as fellow clinicians, to optimise health and wellbeing will continue to be important, as will pro-active identification and subsequent management of illness, and in particular long-term conditions.
- We will pursue an approach to development that is grounded in genuine multi-agency team approaches. Though the model will vary, principally as a result of variations in factors such as population specific needs and geography, this will increasingly see us realise the benefits of models operating at scale. While in some cases this might result in a reduced number of GP sites and/or fewer contractor entities, we aspire to models that physically bring together as many of those provider groups involved in providing care to the communities they serve as is possible.
- We recognise the need for practices to collaborate more formally than has been typical in the past, and we will provide support to make this happen, including investing in IM&T systems, workforce sustainability and premises where return on investment can satisfactorily be demonstrated. We will continue to commission integrated pathways of care that shift the focus of care from a bed-based model to one that is primary and community focussed, and realign funding to enable this to happen.

Priority 5 – Primary Care

Primary care will be an integral part of our new care model. We need to prioritise broader integration of primary care into the wider care system, in order to address some of their immediate challenges, around workforce sustainability, capacity and scale, 7 day working, IM&T and estate.

The SD&T Primary Care Strategy has been agreed and supported by a Primary Care Stakeholder Survey. This sets out plans to proactively meet the challenges of future development including:

- Access and 7 day a week delivery
- Stakeholders and Professional Reputation
- Collaboration
- IM+T Infrastructure
- Workforce sustainability
- Voluntary and Third Sector
- Education and Leadership development
- Self Care
- Premises
- Patient and Public Participation
- Unplanned Care
- Prescribing and Medicines Optimisation
- Funding flows
- Quality

NEW Devon primary care strategy is in development as part of the success regime transformation work programme. Development of the new care model will need to drive fundamental transformation. First working at scale, getting practices to work together and plan change together, working as part of a transformed multi-disciplinary fully integrated workforce. This will provide a very different offer to patients that protects the core clinical role of the GP and significantly enhances the depth and breadth of support and signposting available to more appropriately meet patients' needs. The CCG has mapped current and planned activity against the requirements of the Planning Guidance and GP Forward View and is commencing engagement with GPs to develop the strategy by October 2016.

Priority 6 – Acute & Specialist Services

Local clinicians have examined the potential options for making changes to the configuration of some services provided in acute settings. These changes are necessary to improve clinical quality, make best use of workforce, or efficient use of resources, or a combination of all three. Consideration has been given to a range of options, including potentially changing the current Major Trauma Centre in the peninsula and the option to build new hospitals. After applying a number of hurdle criteria the above options have been excluded and local clinicians have developed the following recommendations for immediate consideration. A number of other specialty areas will be reviewed.

- Emergency care should be provided networked on the four acute hospital sites in Devon, due mainly to the access requirements for trauma.
- Hyper acute stroke services will be assessed following the publication of the South Western Cardiovascular Strategic Clinical Network review which sets out recommendations for the number of hyper acute stroke services across the region.
- Because of co-dependencies, Derriford Hospital, Plymouth, should be a fixed point for emergency care, paediatrics, neonatology and stroke (and thus consultant-led obstetrics because of co-dependencies) because it is the designated Major Trauma Centre for the region.
- Under a two-site option for maternity, paediatrics and neonatology, Royal Devon and Exeter Hospital would most probably be the second site rather than North Devon District Hospital because an alteration in service provision at Royal Devon and Exeter does not create patient flows that improve the clinical sustainability of services in North Devon Hospital. A similar analysis is being completed for South Devon and Torbay. The outcome will incorporated into the next submission.
- Establish a comprehensive specialist mental health service including improved access to a Mother and Baby Unit for Devon women and the further development of integrated care pathways for people who require secure care– to include pilot on management of tertiary budgets.

Priority 6 Acute and Specialist Services

The leaders within the STP recognise that unifying a commissioning approach to services with Specialised Commissioning is critical to a sustainable plan over the next five years. The CCGs are exploring how specialised services can be commissioned differently to integrate pathways, develop local service alternatives and to crystallise opportunities for consolidation as part of reconfiguration plans. The local priorities are

- To develop PHT as the lead centre for Trauma, Cardiac surgery, Neurosurgery and Level 3 neontology in the STP footprint
- To ensure clinical sustainability for more specialised services there will be a need for further consolidation of provision services under review will include:
  - Cardiovascular
  - Obstetrics and midwifery
  - Vascular surgery
  - Paediatric and neonatal care
- In addition some local acute specialty services will be reviewed to ensure models of care are sustainable tis will include ensuring sustainable emergency surgical services
- Establish a comprehensive specialist mental health service including a Tertiary MH Pilot
- Work at a local and national level to address Neuro and complex spinal capacity

The local STP also seeks permission to develop plans that would reinvest specialised commissioning efficiencies where plans control demand and produce service alternatives that prevent specialised interventions when they are not necessary.

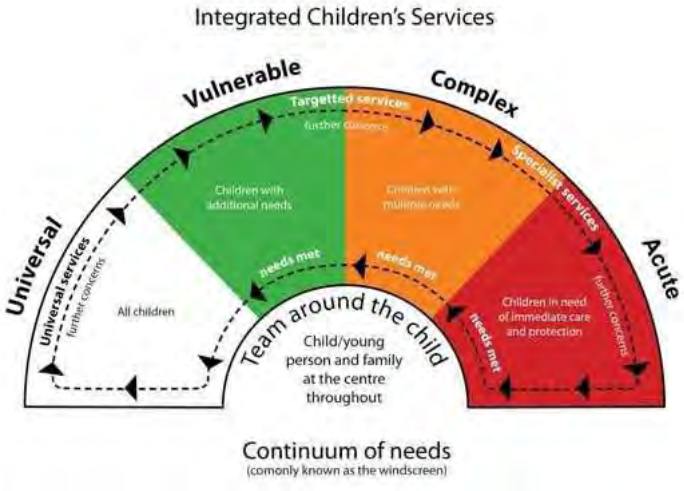
Priority 7 – Children and Families

The Devon CYP programme of system change aims to ensure we are 'doing the right thing at the right time'. Support is area- based, seamless and has an integrated pathway approach that builds resilience and early support to CYP and their families . To do this we need to:

- Help families and practitioners understand and access Early Help in their community.
- Ensure that CYP are able to access whole person support in the right place throughout their journey. This means ensuring that staff have the best skills to help them to thrive and to provide support through key transition points.
- Ensure that CYP stay healthy, with intervention starting earlier, both in terms of access to the right people who have the skills and of expertise to their support needs.
- Commissioners and providers need to work together towards a model of care across universal and specialist services that spans health, social care and education; and that ensures that adults and childrens services work together to prepare young people for adulthood.
- Ensure that mechanisms are in place to enable effective communication, sharing data and enabling timely access to the right pathway.
- Strengthen access to senior paediatric expertise, linked to GP practices, for urgent and non-urgent needs.
- Provide a rapid access clinic for non-emergency cases, led by Paediatricians.
- Triage quickly and effectively to ensure that CYP can access the right care appropriate to their needs and in doing so avoid unnecessary attendances and admissions.

We know that some CYP may need more targeted and specialist support. Therefore we need to:

- Ensure that our consistent arrangements also comply with statutory responsibilities for children with SEND.
- Provide a local offer available for children, under the SEND reforms, that enables them to achieve the outcomes and goals identified through their ECHP. We must support CYP, including those with complex needs and the most vulnerable, with multi-agency co-ordinated care, as close to home as possible.
- Support CYP with emotional well-being and mental health services in supportive communities that can build resilience and that provide access to early help that delivers prevention and early intervention. Transformation of CAMHS will ensure timely crisis responses; specific pathways for eating disorders and self-harm; specific support to children-in-care.
- Evidence effective transition planning for CYO and their families, offering opportunities for more personalised care through the use of Personal Budgets.
- Facilitate access to health assessments for children in care and services which are responsive to their needs; ensuring that we are safeguarding these vulnerable CYP.

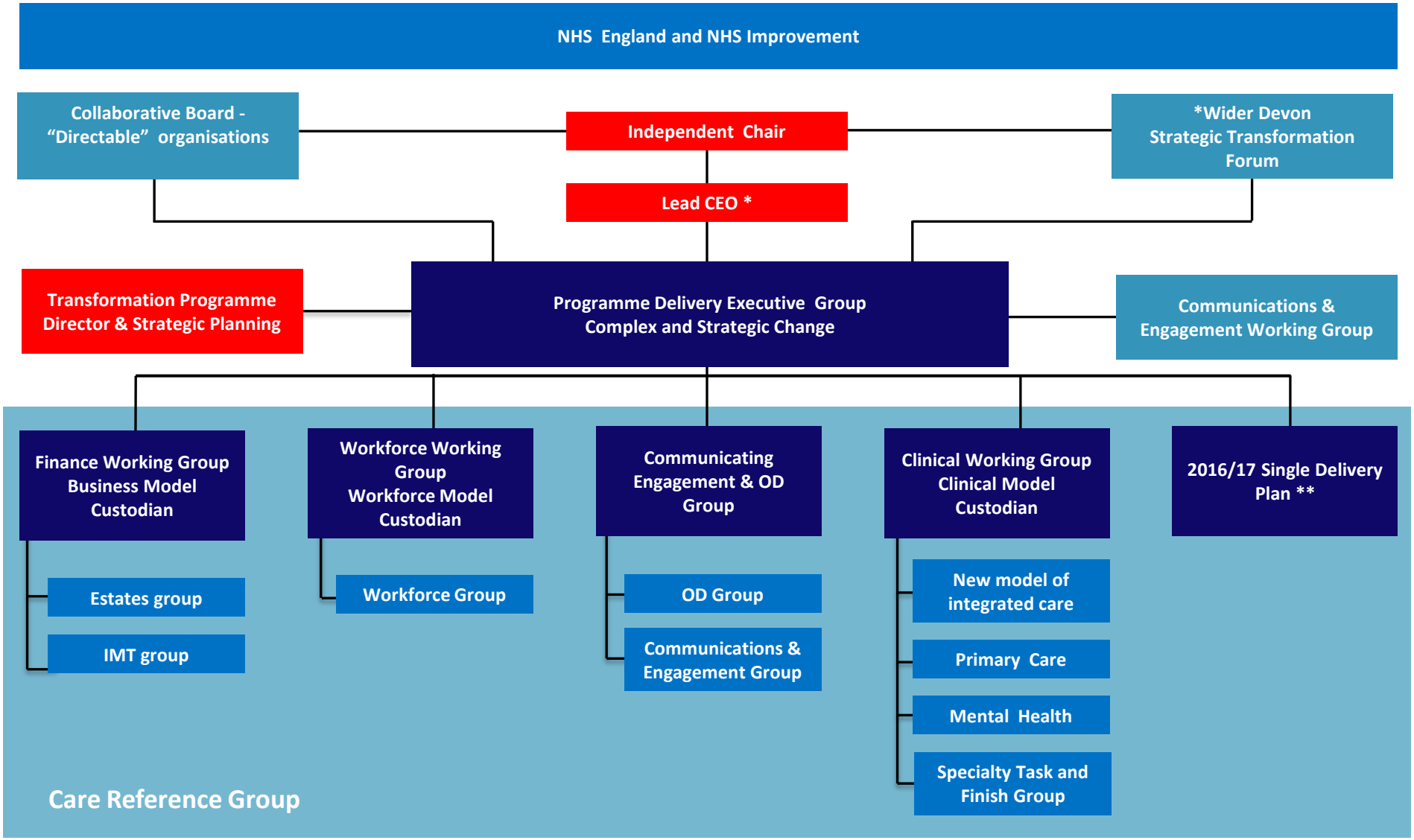


Appendices

Governance arrangements

- The slide on the following page shows the high level, single system wide governance arrangements we are putting in place to oversee the ongoing development and delivery of our STP.
- NEW Devon have recently developed a strong ethos of system wide working with commissioners and providers coming together under our success regime arrangements to agree a single system plan and control total for our 2016/17 plan. We intend to continue our system wide co-design work in developing and implementing our transformational change proposals.
- South Devon & Torbay have a strong track record of working collaboratively across the commissioner /provider axis. Torbay & South Devon Healthcare Trust is the first fully integrated care organisation in England and their local governance arrangements around this were well established in the organisations' previous form.
- The new governance infrastructure as shown, will allow us to work together to extend our collaborative working and decision making across the whole STP footprint, under the leadership of a lead chief executive (Angela Pedder) and an Independent chair (Dame Ruth Carnall)

Governance arrangements



NB: * Lead CEO responsible to NHS England and NHS Improvement Directors for delivery of the Success Regime

** Separate delivery arrangements will be established for NEW Devon and South Devon & Torbay

Membership

Collaborative Board - "Directable" organisations (bi monthly meetings)	Programme Delivery Executive Group (monthly meetings)	Wider Devon Strategic Transformation Forum (bi monthly meetings)
• Independent Chair • Lead Chief Executive • Chair and Chief Executive/Chief Officer all NHS "directable" organisations* • Leader and Chief Executive Devon County Council • Leader and Chief Executive Plymouth City Council • Leader and Chief Executive Torbay Unitary Authority** • CCG Locality Chairs	• Independent Chair • Lead Chief Executive • Chief Executive/Chief Officer all NHS "directable" organisations* • Chief Executive SWAST • Chief Executive or nominated deputy Devon County Council • Chief Executive or nominated deputy Plymouth City Council • Chief Executive or nominated deputy Torbay Unitary Authority** • STP/SR Programme Director • Lead Director of Finance • Lead Medical Director	• Independent Chair • Programme Delivery Executive Group members • DPH x 3 • Healthwatch Devon, Plymouth, Torbay • Livewell, Virgincare Care UK • Primary care provision x 4 • Voluntary Sector x 4 • Health Scrutiny x 3 • Experts by experience x 4 • ALB representation • LMC

- CCGs DPT NDDH PHT RD&E SDFT SWAST

** Phil Norrey leading LA discussion on appropriate elected member attendance

Stakeholder Communication and Engagement (SC&E) embedded within, and integral to the STP Programme

	Current focus	Key achievements to date
Strategic	• Development of a system-wide SC&E plan to support delivery of the STP • Provision of expert SC&E advice to Programme Board informing strategic approach • Representation from three Healthwatches to advise on public engagement at Programme Board • Development of strategic narrative and key messages aligned to, and reinforcing the Devon vision • PPI assurance mechanism in place via NEW Devon Patient and Public Engagement Committee and S D &T Engagement Committee	✓ New Devon case for change launched in February to more than 10,000 staff and public ✓ Widespread and extensive SD&T engagement in developing new model of care for community services ✓ A growing awareness, understanding and acceptance of the need for change by the public and staff ✓ Key stakeholder events held in Plymouth, Torbay, Barnstaple and Exeter – and more planned ✓ Flow of feedback from events influencing the development of STP vision and approach. SD&T survey informing IM&T and wider primary care strategy implementation ✓ OSC/HWB/MP briefing commenced ✓ Public and patient representatives already influencing design of new models of care ✓ Clinicians and SC&E team co-designing/delivering communication and engagement activity ✓ Increased alignment of SC&E across New Devon and South Devon CCG footprints
Tactical	• Embedding SC&E as part of each STP Working Group (eg: the Clinical Cabinet) • Establishing the governance structure to monitor delivery of SC&E Plan (including resourcing) • Development of core SC&E processes, channels and protocols – ensuring consistency, evaluation and use of feedback received • Stakeholder mapping and analysis completed	
Operational	• Patient and public engagement working with clinicians on STP groups • Weekly internal communication established • Media protocol in place with daily calls between commissioners and providers now taking place	

Developing the Workforce Strategy

Implementation of the proposed changes will have a major impact on the existing workforce. Our workforce will be developed with radically different skills and capability. Initial analysis indicated the re-provision of up to £60m per year to deliver the new interventions could provide for between 1,000 and 1,500 new roles, representing 4 - 6% of the current workforce. Initial high level estimates indicated a requirement for 900 staff undertaking different roles (these were based on traditional roles and ways of working, and require development). Many of these roles would be filled by staff relocating their work and expertise from existing services.

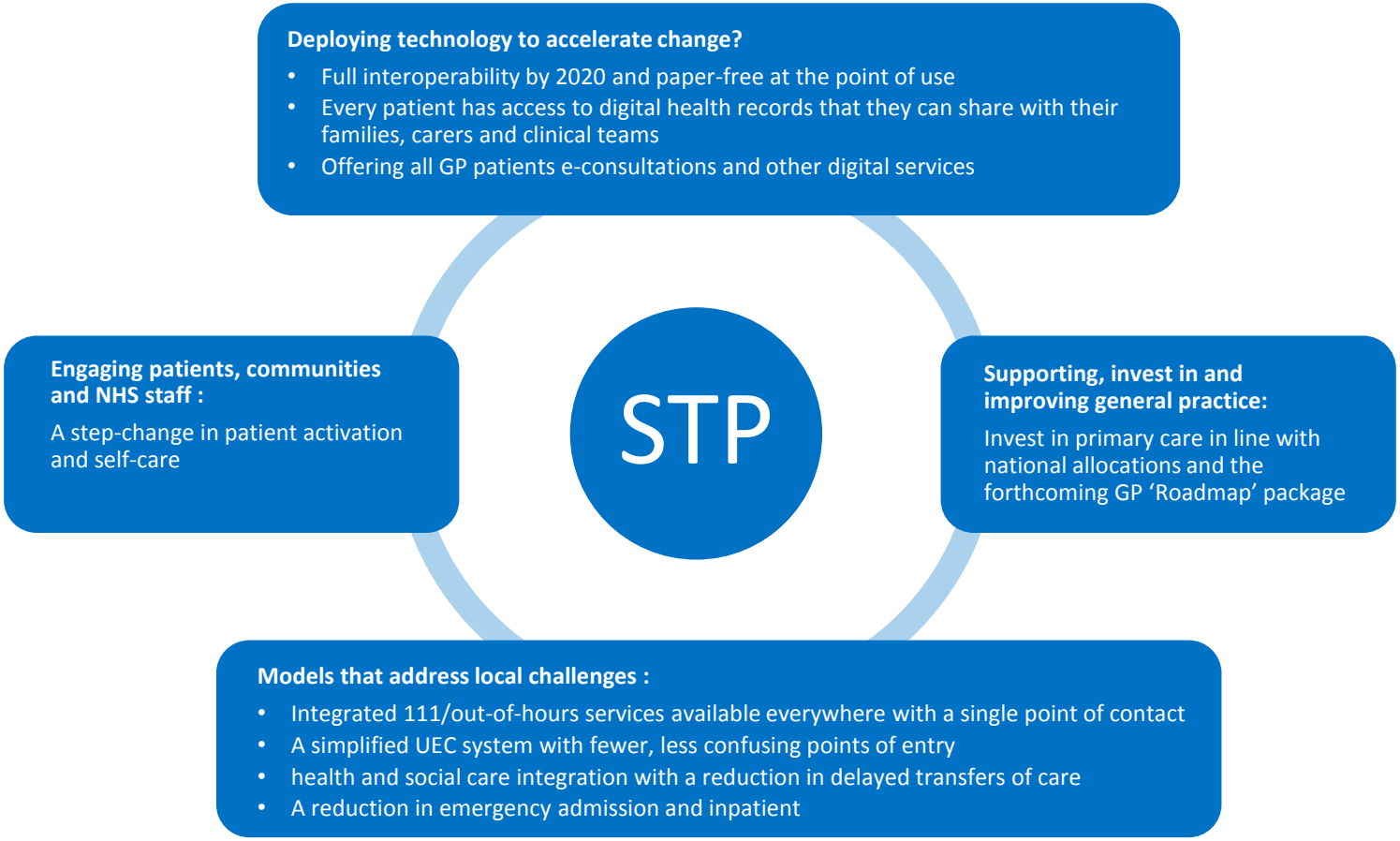
Most significantly, training and support will be needed to as staff move to new roles working in new ways in the new models of care. An extensive OD programme will be established to underpin these changes. There will be challenges in recruitment in several areas such as domiciliary workers , Health Care Assistants, and senior medical staff in small specialties. The Devon GP age profile is also likely to have a significant impact in the near future.

Workforce leads in all the partner organisations in the STP are working together to address these issues and have developed this shared system-wide workplan .

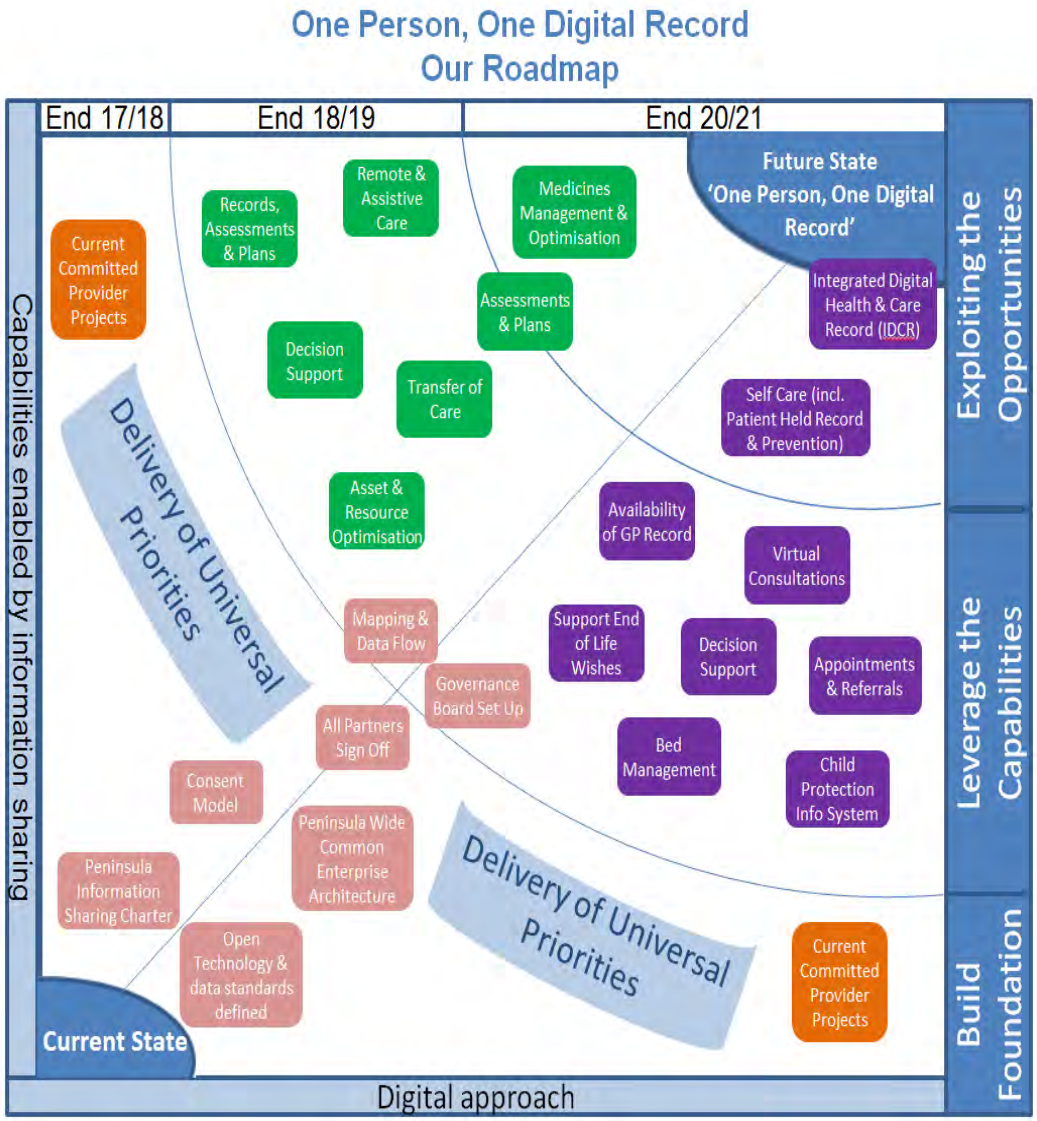
- Build on the agreed workforce representatives from the whole system in an ongoing way ('System-wide awareness / improve knowledge of each other')
- Produce an agreed strategic workforce Sustainability Transformation Plan (STP) which addresses the priorities identified that spans 10 years ahead but focus on the medium to five hear plan.
- Liaise with all systems leaders to ensure sign-up to an implementation plan with clearly identified achievable steps informed and agreed by the models of care and clinical cabinet, tested and assured through agreed modelling.
- Ensure plans encompass the whole system for the long-term with the vision of the future integration landscape described and workforce mapped
- Agree system synergies on workforce, for example, exploring a joint values-based recruitment and retention strategy (one Devon, one workforce) that is inclusive across all parts of the system and all organisations with a focus on utilising the local demographics
- Explore system synergies for flexible education packages and career pathways which enable hybrid roles which rotate within all partner organisations, working as required to support new care models (for example an Integrated Apprenticeship programme)
- Support systems synergy for shared flexible learning interventions and identify quick win areas
- Develop the Community Education Provider Networks (CEPNs) to plan interprofessional learning (with support from AHSN)
- Develop systems that ensure Education/CPD is accessible to the whole workforce
- Consider shared broad based integrated training opportunities that reduce 'wasted free education and includes all sectors'
- Share best practice implementing collective 'quick wins' to enhance the existing workforce to deliver the future
- Establish collective models that deliver new ways of working supported by new employment deal.

Local Digital Roadmap (1)

The IT digital road map is a key strategic deliverable to support the proposed care model. The ability of patients to access and allow sharing of their information is key to catalysing a new compact with service users to take greater responsibility for and involvement in managing personal health & wellbeing. We will be providing digital information and tools to patients to enable them to contribute to their own self-care across pathways. We already know that there are likely to be significant estate implications related to delivering our intended strategy. The first stage of our estate strategy development is complete.



Local Digital Roadmap (2)



Developing the Estates Transformation Strategy

Strategic Aim	Provide a **transformed and innovative estate portfolio** which delivers **excellent, quality, well maintained and economical buildings and facilities** which are **efficient and responsive** to the changing needs of the new model of care population and local communities of Devon.

Strategic Objectives				
	Economical and Efficient Estate	**Transformed and Innovative estate portfolio**	**Well maintained and Responsive**	**Excellent and Quality Environment**
	Support the on-going viability of the NHS by minimising the cost of property and waste and by maximising commercial opportunities for income generation and the use of one public estate.	In collaboration with local communities and partners, deliver changes to the estates portfolio to facilitate the delivery of the integrated service model.	Deliver a safe, statutory compliant and responsive estate by utilising new technologies, innovation and best practice to transform the way Facilities Management (FM) services are delivered.	Invest available resources wisely, delivering an environment of the highest possible quality to maintain the quality of services.

	Drivers for Change	Estates Plans/Solutions
1.	Delivery of the new model of integrated care and reduced need for bed based care. Developing mental health care services, fully integrated with primary and acute care services.	Build on the Local Estates Strategies (LES) by developing a system wide estates strategy. Disposal of poor quality buildings and re-investment in new and re-configured buildings to provide community multi-disciplinary centres and local health and well-being centres. Smaller acute Hospitals
2.	Future population increase and provision of services at the heart of the community.	Locally based affordable rural services with integrated General Practice and community care, provided through multispecialty centres. Partner working and co-ordination between NHS and Local Authorities, to forward plan effectively, and release land to create new opportunities for housing. New Care facilities and building in town centres linked with re-generation.
3.	Pockets of deprivation, levels of high-risk behaviours and multiple conditions.	Re-use of existing estate for preventative and public health services.
4.	Vanguard deliverables.	Development of urgent care centres (and, potentially, new locations).
5.	Ageing population – increased pressure on the whole care system.	Increased private sector care home provision and use of telemedicine to reduce face-to-face appointments. Co-located facilities and partnership working with voluntary services.
6.	Meeting the challenges of the General Practice Forward View (GPFV), the Five Year Forward view (5YFV) and System Transformation Plan (STP). Delivery of the Lord Carter review.	Development of health hubs with GPs operating at scale and within multi-disciplinary centres. Fewer individual GP practices and development of new estate and conversion of existing estate to deliver fit-for-purpose facilities. Partnership working to develop a system wide plan for 'One Public Estate' Reducing the cost of the estate; rationalisation of leases, disposal of buildings in poor condition. Partnership working across all sectors in the region to deliver upper quartile EFM performance, and reduction in running costs. To include new and different funding models and commercial partnership
7.	Reduced Capital resources for investment in the estate	Make use of capital received from disposal of assets for system-wide re-investment in new buildings and facilities to support the re-configured service model.

Outcomes and evaluation framework for STP

Triple aim+ *Domain*	**What we aim to achieve** *Outcomes*	**What we will look at to tell us we are succeeding** *Indicators*
Health & wellbeing	Improved population health	➢ Life expectancy - potential years of life lost ➢ Ill health morbidity ➢ Healthy lifestyle ➢ Mental well being
	Improved quality of life	➢ People able to fulfil their capabilities and their own goals ➢ Social well being
	Reduction in inequalities	➢ Life chances for people living in poverty
Quality of care	Consistent high levels of safety	➢ Bundle of safety indicators
	People always have an excellent experience of care Workforce always has an excellent experience in providing care	➢ Bundle of patient experience indicators with people telling their story once ➢ Services are person centred with empowerment & involvement in care planning & delivery ➢ Bundle of staff experience indicators including resilience, culture & ways of working
	Increased effectiveness & efficiency	➢ Timeliness and access to care ➢ Take up and targeting of services
Value & sustainability	System demonstrating sustainability and resilience, staying within allocated resources	➢ Financial balance across all organisations ➢ System for improving technical and allocative efficiency embedded
	Reduced 'waste' through system efficiencies	➢ Level of re-work within and across pathways/systems
	Shift in resource allocation to achieve the integrated model of care	➢ Shift of financial allocations *Shift to prevention from treatment* *Shift to community and home care from in-patient care* *Shift from physical to mental health*
Transformed services	System where providers and communities are working together as an improving integrated system demonstrating: •*person centred care* •*shared decision making* •*community resourcefulness* •*focus on prevention and early intervention*	➢ Shared health & care records ➢ Workforce readiness for person centred care ➢ Continuous learning & improvement ➢ Continuity of care and a focus on patient activation ➢ Full involvement of community, voluntary and independent sector, working with and building on community assets ➢ Prevention & early intervention prioritisation ➢ Well-led

Framework built on:

- ✓ Triple aim+
- ✓ Integrated care evaluations
- ✓ Multi-organisational input & academia
- ✓ Short & long term measures

STP High Level Risk Summary

Risk	Risk level	Risk description	Mitigating action
1. Pace		Lack of pace in driving change to deliver financial and political imperatives	Programme infrastructure in place including external support to focus initially on preparation for public consultation. Robust delivery arrangements to support 2016/17 plan delivery
2. Governance		Lack of robust governance structure	Rapid implementation of full governance structure for footprint across both CCG areas Fulltime STP lead in place and fulltime from July '16 OD plan in preparation to ensure ongoing development of new partner relationships and ways of working
3. Competing priorities		Balance between focus on 2016/17 delivery and transformation planning	Integration into one set of system-wide clear and robust programme management arrangements
4. Clinical		Insufficient Clinical Leadership & engagement	Clinical cabinet of leaders established to oversee the programme and lead wider engagement. Multi disciplinary clinical working Group leading design work. Extensive funding and backfill available to free up clinical time. Specific staff communications and engagement plan in development
5. Engagement		Stakeholder engagement	Proposed consultations will build on strong track record including, pre-existing and ongoing engagement arrangements and linked to previous community consultation processes. Fully resourced communication and engagement plan including expert external support
6. Finance		Failure to deliver financial targets	STP wide Finance Working Group meeting fortnightly providing oversight of transformation and 16/17 delivery. Robust external analytical support in place to validate financial planning assumptions. STP prioritises financial recovery deliverables Single system savings plan in place in NEW Devon

People who have a Learning disability

Living well with a learning disability is the overarching strategy that has been developed and is well aligned to the STP. http://www.newdevonccg.nhs.uk//your-ccg/learning-disabilities--/100085

Our drivers relate to two key areas of focus;-

1) Tackling health inequalities;- The Confidential Inquiry into the Premature Deaths of People who have Learning Disabilities (CIPOLD) in 2013 showed that on average "women with a learning disability were dying 20 years before women in the general population and men, on average, 13 years earlier."

In order to address this we have developed nursing liaison roles across primary, acute and neurological services, however we need to ensure that as a community of health care providers we have a legal and moral duty to consider the needs of this population **in all our plans and pathways** and make the reasonable adjustments required to help people access the services they need.

2) Transforming care for people who have a learning disability and/or autism who have behaviours that challenge. This aims to bring people placed in hospital back into the community, prevent admissions to hospital, and to make sure that people have every opportunity to live a good life

In order to address this we have developed a new Transforming Care plan that spans the whole STP area and **also includes children and young people**. In order to make sustainable change happen action needs to be undertaken in a number of areas.

Devon - Wide Transforming Care Partnership Plan

Our vision is to create a place where children and adults live in the community of their choice, with the people they want, and with the right support, and are happy, healthy and safe

This plan is for people of all ages living in Devon, Torbay and Plymouth who have a learning disability and / or autism, who display behaviour that challenges, including behaviour from a mental health condition

We are succeeding when:

- All people placed out of the area are returned to their own community
- No-one remains in hospital for longer that they need to be
- People have a better quality of life
- All people on our risk register have been offered a personal budget and have an individually designed service
- There is a lifelong pathway for people
- We have a range of providers offering choice to people who have their own budgets

The current model

People in inpatient care, out of area
Generally people fit into services rather than services being built around them
Long term residential care

The new model

Choice of local housing, care and support
Individually designed services funded through personal budgets
Short term inpatient care

Things to do now

Focus on our vison and refine it with further engagement
Check our data and finance information
Implement our project plan and engage key stakeholders in our working groups
Develop our wider communication plan
Get all the people and organisations involved working together

Things to do in the longer term

A single pathway
In crease the choice of local housing, care and support
Develop co-designed care and support plans
Personal budgets and direct payments
Support for people, parents and carers
Effective short breaks and crisis arrangements

Benefits of our new model of care

People are cared for and supported in the best place for them
Care and support is arranged around people not where they live
People are able to lead active lives in the community