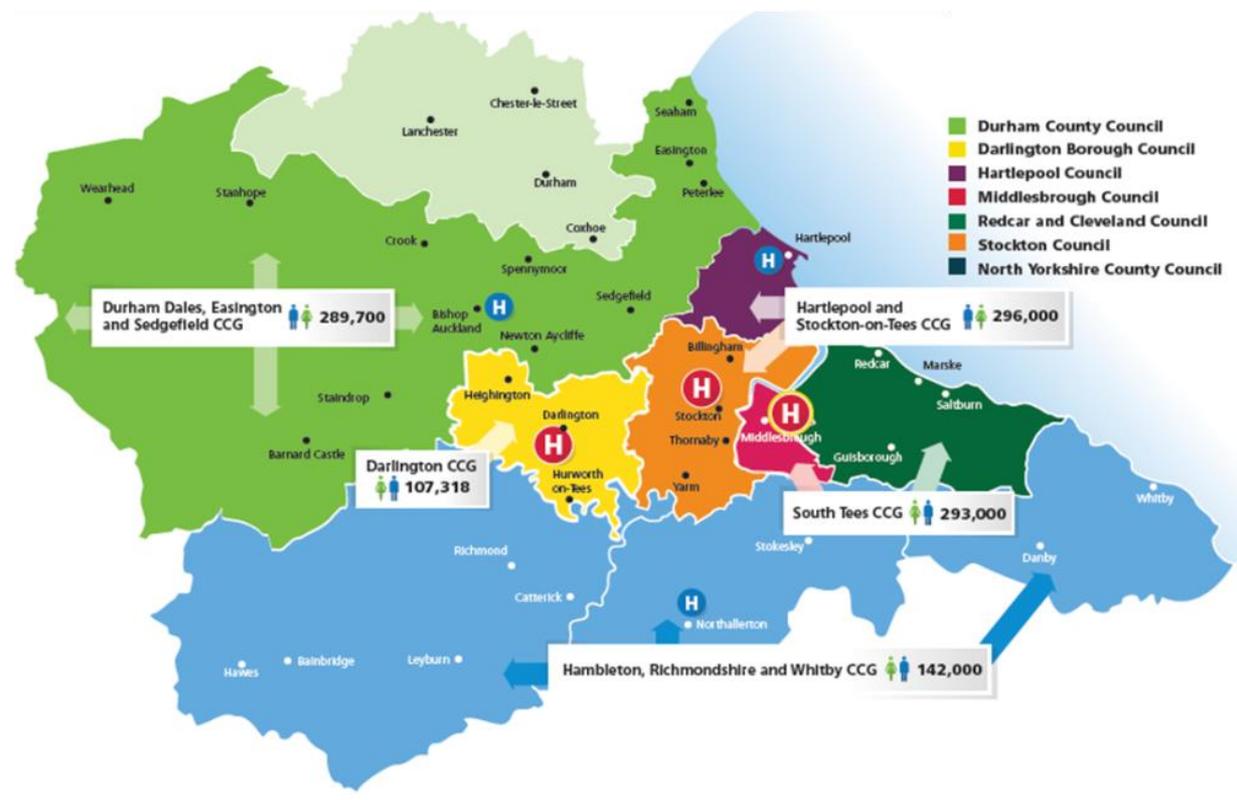


Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby Sustainability Transformation Plan (STP) October 2016

Footprint (CNE02) - Region: Cumbria and the North East
 Designated lead : Alan Foster, Chief Executive, North Tees & Hartlepool NHS Foundation Trust



- 5** Clinical Commissioning Groups
- 2** Acute providers
- 2** Ambulance providers
- 1** Acute provider across DDTHRW and NTW
- 1** Mental Health provider
- 7** Councils

“Meeting our communities’ needs now and for future generations with consistently better health and social care delivered in the best place”

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Early intervention and prevention

A step change in prevention and early intervention in priority areas are a key focus in order to build community resilience, self-care.



Improved Integration across Health and social care to ensure a system wide response across our Neighbourhoods and communities



Reconfigure Hospital based services

Reconfigure district general hospitals into specialist hospital services to raise our quality standards and reduce variation in care outcomes across our system



Technology

Rapid progress of implementation of electronic care records and supporting technology

Welcome to our plan

In Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby (DDTHRW), the NHS including specialised commissioning, local Government and the voluntary sector are committed to continuing our system wide working in order to further develop our ambitious plans to prevent ill health, improve health outcomes, improve quality of care and deliver financial sustainability. The footprint is a mix of urban and rural communities which presents specific challenges for the provisions of healthcare.

In June 2016 we set out our vision of “meeting our communities needs now and for future generations, with consistently better health and social care delivered in the best place”. This was supported by a clear articulation of our challenges associated with an overreliance on hospital based services.

This iteration of our plan articulates how we will deliver transformation at scale and pace in order to deliver the requirements of the ‘Five Year Forward View’. Building on the feedback we received in July, this plan focuses on the following areas;

- Detailing the year on year benefits of the transformation programmes we plan to deliver including expected outcomes.
- Giving a clear indication of the engagement activities required to deliver the transformational changes required.
- Continuing to make connections with neighbouring STPs in order to understand the shared opportunities and wide impact of our respective plans. Including the development of a regional blueprint for an ambitious vision for future services with Northumberland, Tyne & Wear. To make this vision a success, North Durham is now part of the NTW STP reflecting patient flows and population centres around the three rivers. Further more, alignment with Humber, Coast and Vale and West Yorkshire STPs is currently being developed through formal engagement in our STP governance arrangements.

We are building on a long history of working in partnership to drive improvements in the health and wellbeing of our local population. Where we have collaborated with others either outside of our boundaries (e.g. Urgent and Emergency Care Vanguard) or within our footprint, the results have been positive and far greater than any individual organisation could have achieved alone. This is most evident with the Better Health Programme and also Fit for the Future which are providing a strong platform for delivering system wide change.

Transformation across the STP footprint will deliver a shift towards improving ‘population health’ - moving from fragmentation to integration in care delivery, but also tackling the wider determinants of the health and wellbeing of our population. Working together as a Health and Care system enables us to focus on early intervention and prevention, integration, reconfiguration of hospital based services, and technology.

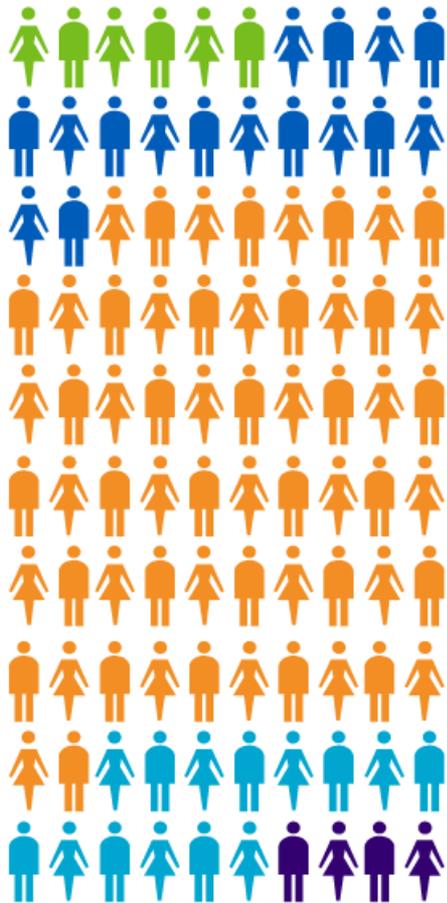
To do nothing is not an option. Our plan is ambitious, and will deliver a transformed system for our workforce and local population, delivering robust clinical rotas with access to a full range of specialists, delivery of community hubs, speedy diagnostics and integrated teams. This will lead to better patient outcomes with shorter hospital stays, improved access to GPs in a financially sustainable system.



Alan Foster
STP Lead

STP Population

If the DDTHRW STP was a Village of 100 people*...



Under 5s Aged 5-18 Aged 19-65
 Aged 66-80 Over 80

Actual population: 1,091,710



*All indicators are an aggregate of the CCG level positions for the following CCGs: Darlington, DDES, HRW, HAST and ST

Triple aim gaps - local STP context

HEALTH and wellbeing



3.3 to 16.6
years range

Inequalities in male life expectancy

4.0 to 12.2
years range

Inequalities in female life expectancy

48 deaths
per 100,000 population

Premature mortality rate due to CHD

13.5 deaths
per 100,000 population

Premature mortality rate due to stroke

28.1 deaths
per 100,000 population

Premature mortality rate due to respiratory

19.6%

Estimated smoking prevalence

11.9%
Obesity prevalence

for people 16+ years old

21.9%
Excess weight (overweight and obese)

for Reception year (4-5 years old)

22.3%
Excess weight (overweight and obese)

for Year 6 (10-11 years old)

CARE and quality



Only 68% of acute clinical standards met by hospitals trusts as defined by the Royal Colleges.

Unwarranted variation

across service delivery and quality, spend and outcomes in cancer, mental health, MSK, CVD, respiratory, maternity and early years, neurology.

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.

Sustainable services

whilst maintaining high levels of care and quality.

Capacity and resilience

to ensure service delivery in communities and neighbourhoods.

Infrastructure and workforce

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

FUNDING and finance



System efficiency and finance challenges:

£281m
gap across health by 2021

if we do nothing this represents 12.4% of the total NHS allocation across the footprint

£281m
gap is driven by increasing demand

on a range of services as a result of an ageing population with multiple and complex care needs.

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

DDTHRW VISION 2020

“Meeting our communities needs now and for future generations with consistently better health and social care delivered in the best place”

DDTHRW Vision 2020

An ambitious system wide care strategy has been developed with full engagement of clinicians and wider stakeholders to provide better quality of care and outcomes for patients in the longer term. This is a rare example of a whole system approach underpinned by strong collective leadership by both a Joint CCG Committee and a Joint NHS FT Committee to steer and direct the plan and implementation. In order to deliver our vision we have clearly described our delivery plan. In order to ensure the realisation of our plan we are reliant on a number of interdependencies across our whole health and care system i.e. Primary Care, Local Authorities, Public Health, Voluntary Sector and all providers.

It is clear that services we provide cannot continue in their present form. They are unable to address the key challenges of health and wellbeing, care and quality, and finance and efficiency which we are currently facing. The clinical strategy is a system wide solution, (Figure 1) – from effective screening and prevention to more integrated community models of care and finally hospital based services transformed so that more local services are provided closer to home but access to specialist Consultants is enhanced (Figure 2). Less variation, with an associated improvement in quality, would be a key outcome at every stage of a patient’s pathway with services delivered in an extended day, 7 days per week.

Figure 1.

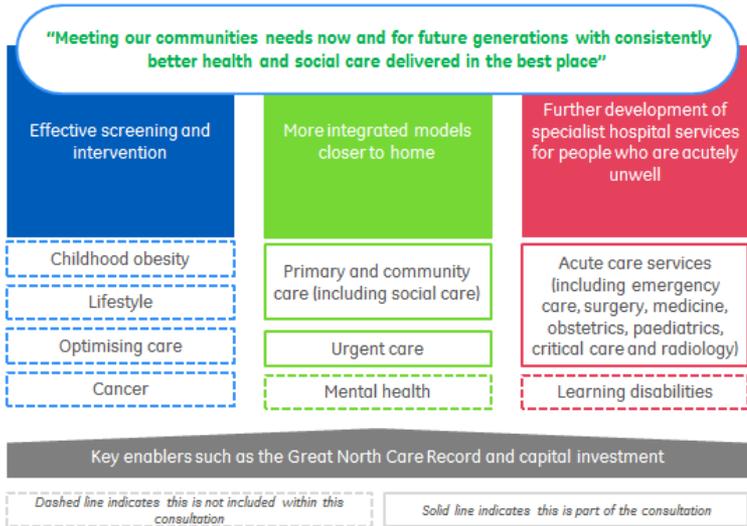
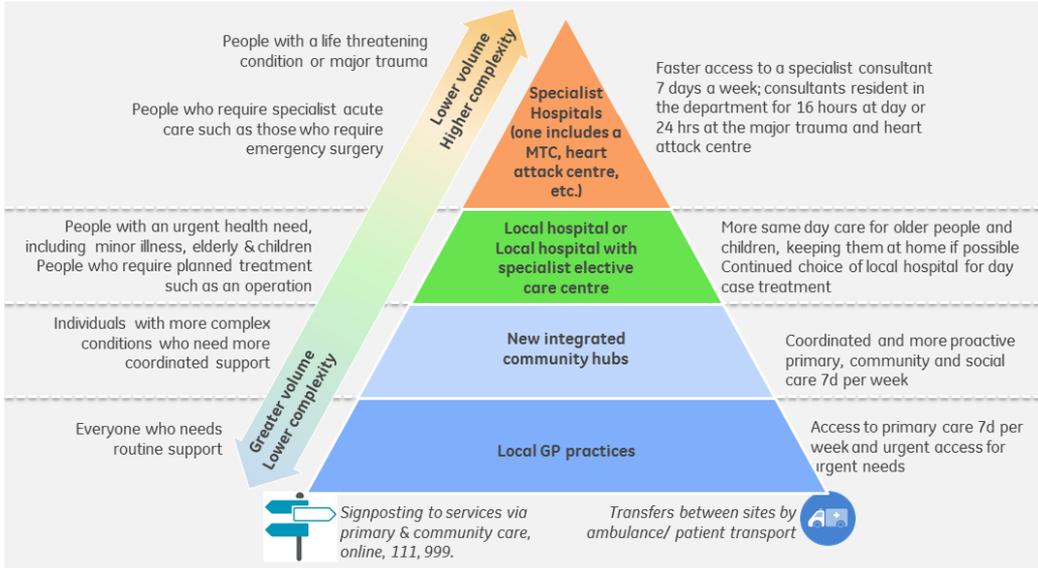


Figure 2.



DDTHRW Vision 2020

To date we have relied more on hospital based care than other parts of the country. We want to strengthen care outside of hospital so that neighbourhoods, communities and individuals are able to take more control of their health and maintain independence for longer whilst preventing or delaying the need for more services in acute and community care.

We have ambitious plans to strengthen services delivered in primary care, attracting more GPs to the area and growing the work force. Developing new roles that can support the primary care team to manage their workload, improve integration with social care and expand services that were previously provided in a hospital setting. The new model will enhance proactive care planning and delivery for patients at risk of hospital admission that require wider service support.

We will increase the number of services that are delivered outside of hospital settings. We will be developing health and social care hubs each covering a population of 30,000 to 50,000 people. Health and care organisations will work together in developing new models of care taking responsibility for the health and care of the population budget. This new way of working will enable us to reduce the number of people that require admission to hospital. When people require hospital admission they can often stay in hospital longer than is necessary so we are working closely as health and social care partners to improve support for patients leaving hospital, so that they can be discharged quickly when it is medically safe to do so. We recognise that we need a strong focus on creating sustainable nursing and residential care provision.

We plan to strengthen links between health and social care commissioners. Plans are being developed to integrate commissioning functions where it makes sense to do so and we want to build and encourage the development of the voluntary sector so they can support patient care in the community, ensuring health and social care services are used effectively.

We will increase the number of patients and service users who have access to a Personal Health Budget enabling greater choice and control over their healthcare and the support they receive.

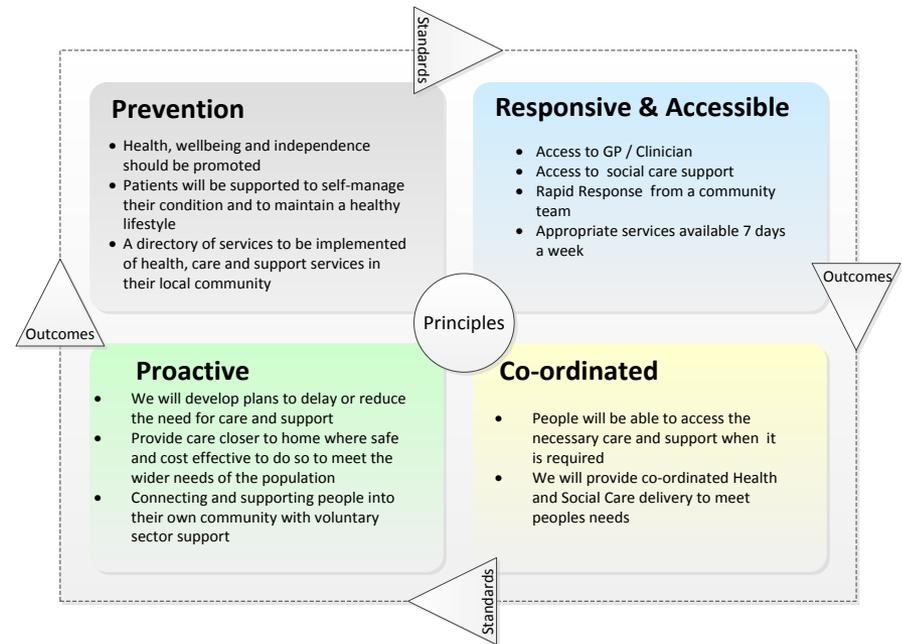
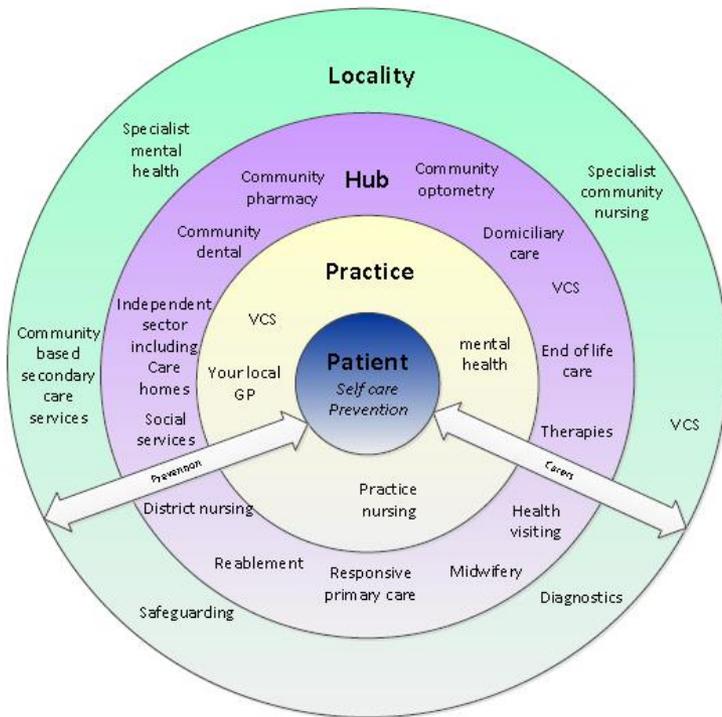
These principles apply for both physical and mental health and service users with a learning disability.

The improvements in services in our neighbourhoods and communities will impact on the way that our hospital based services will be delivered.

DDTHRW Vision 2020

Stakeholders across the STP geography have approved a strategy and a set of quality standards which set out the ambition to deliver person-centred outcomes based on four key principles within our neighbourhoods and communities;

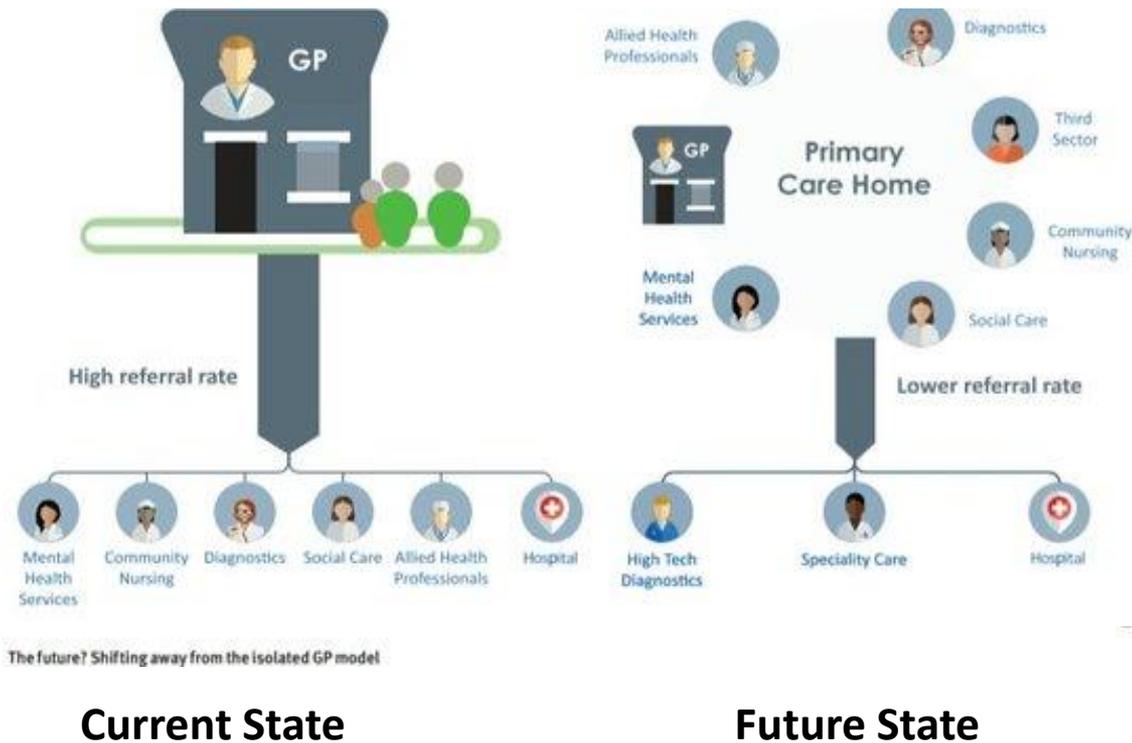
- Prevention
- Proactive care
- Responsive and accessible care
- Co-ordinated approach



DDTHRW Vision 2020

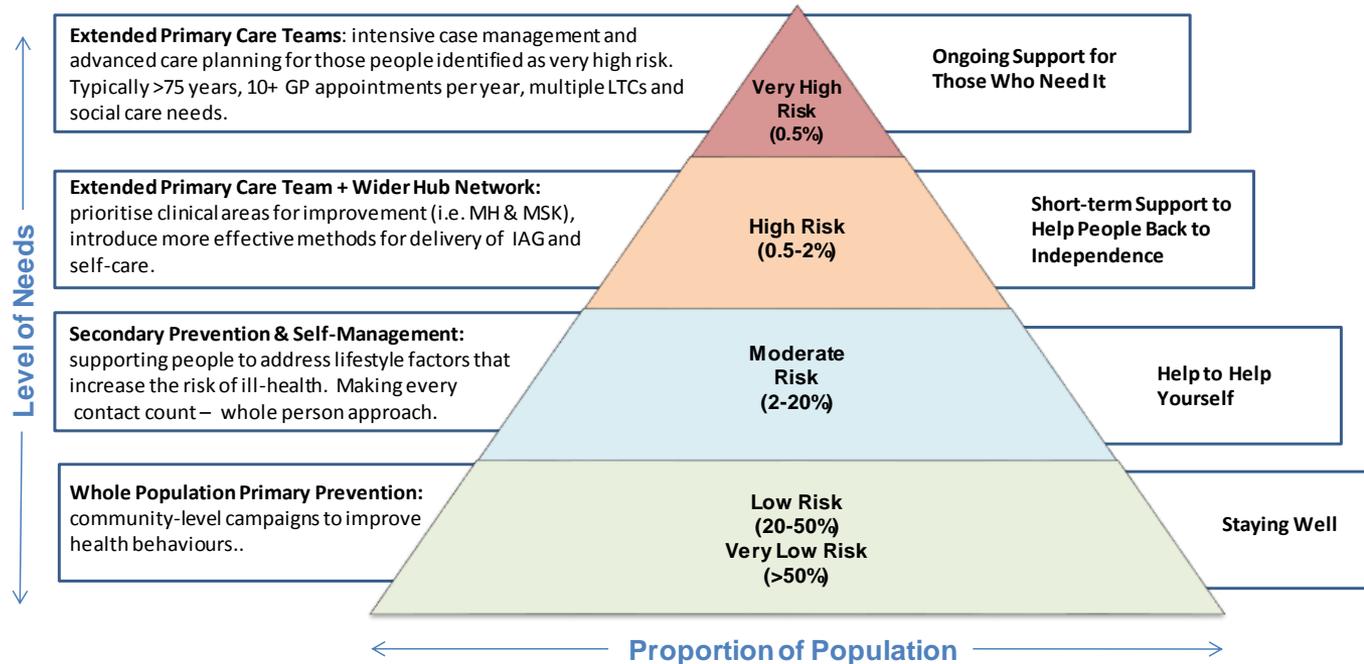
The implementation of community hub models will allow us to provide more services in the community. The community hub will deliver core components and achieve agreed standards across our footprint however each hub is expected to be tailored to meet the needs of local neighbourhoods and communities, in recognition of health inequalities and rurality within our STP geography.

Below is an example of how this could work;



DDTHRW Vision 2020

We will move away from a traditional model to a new model of care for chronic disease management, where self-management support, early intervention and diagnosis is the responsibility and an integral part of the Community Hub. Care will be delivered by a proactive workforce across seven days and an extended day, enabling patients to move away from being passive recipients of care to informed and activated to self-manage with an appropriate response in the event of escalation (identify, integrate and co-manage).



DDTHRW Vision 2020

A proposed outcomes framework has been developed which takes a whole (hub) population approach and attempts to align different outcomes with each sector of a Community Hub's segmented population (very high risk, high risk, moderate risk, low risk groups).

Hub Inputs	Hub Processes	Target Population	Example Indicators / Measures	Outcome
1. Extended Primary Care Team	Regular risk stratification of population Regular MDT & Advanced Care Planning Intensive Case Management	Very High Risk (0.5%)	People dying in preferred place of death	Ongoing Support for Those Who Need It Most
			Reducing number of people admitted to hospital from a care home	
			Emergency Admissions - reduction of inter-practice variance	
2. Primary Care Team + Wider Community Network	Introducing more effective methods for communication, advice & guidance, and self-help Prioritising clinical areas for improvement, e.g. mental health, musculoskeletal	High Risk (0.5-2%)	% who know how to contact an out-of-hours GP service	Short-term Support to Help You Return to Independence
			Reducing avoidable emergency admissions (BCF Composite)	
			Delayed transfers of care attributable to adult social care per 100,000 aged 18	
3. Secondary prevention & self-management	Supporting people to address lifestyle factors that increase the risk of ill health Making Every Contact Count – taking a whole person approach in every interaction	Moderate Risk (2%-20%)	Patients (75+ yrs.) with a fragility fracture treated with bone-sparing agent	Help to help yourself
			Smokers (15+ yrs.) with a record of an offer of support and treatment (last 24 months)	
			Newly diagnosed patients w. diabetes referred to education programme within 9 months	
4. Whole Population Primary Prevention	Community-level campaigns to improve health behaviours	Low Risk (20-50%) Very Low Risk (>50%)	People taking up an NHS Health Check Invite	Staying Well
			% of all infants due a 6 to 8-week check that are totally or partially breastfed	
			Prevalence of overweight (including obese) among children in Reception	

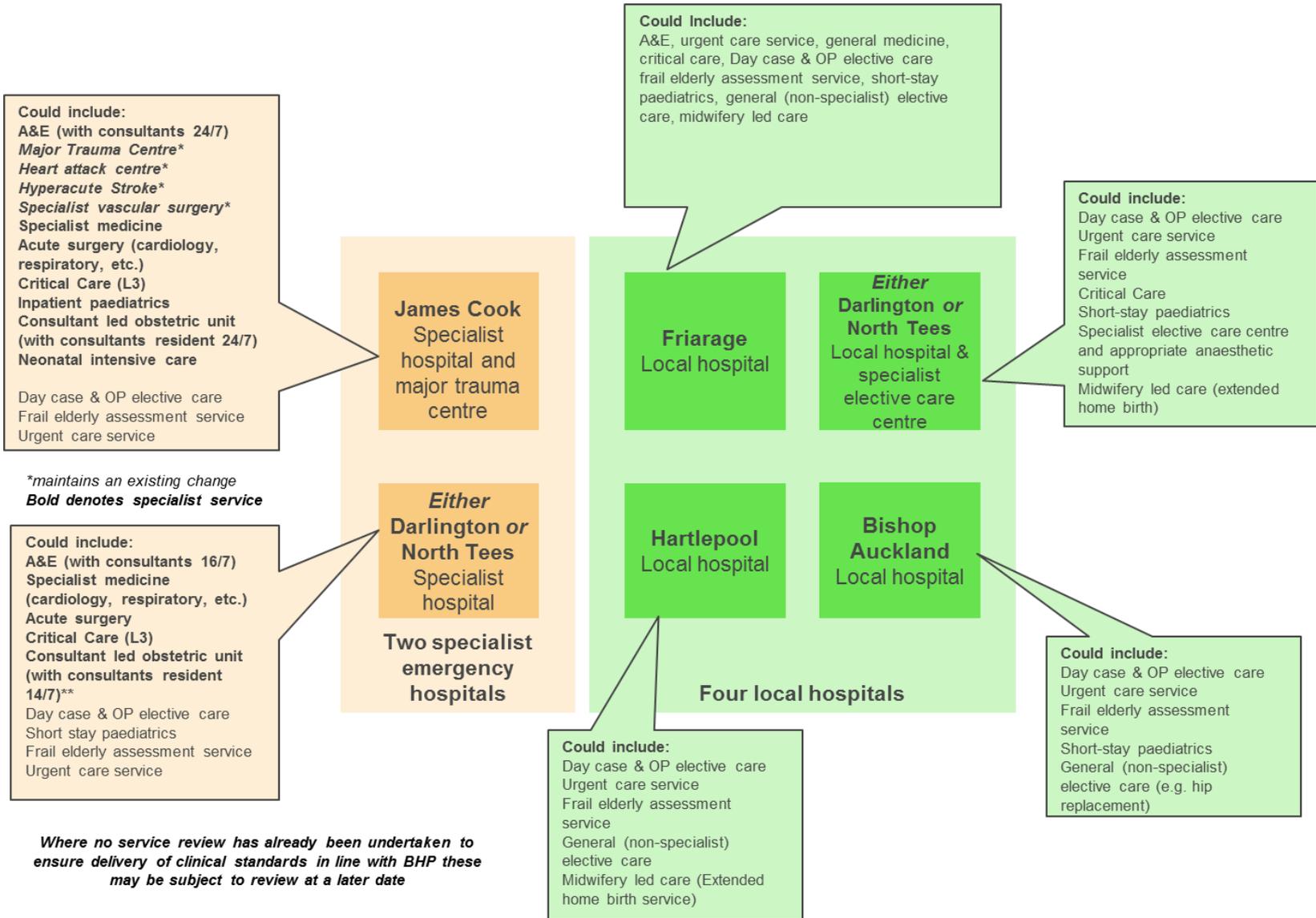
DDTHRW Vision 2020

Changes to services outside of hospital will impact on the way that our hospital based services will be delivered. At the 'front of house' of each of our hospitals would be a resilient interface with the community and neighbourhood services to provide:

- Urgent care services
- Frail elderly assessment
- Short stay paediatric assessment
- Ambulatory care services
- Fast access to diagnostic services
- Signposting and transfer to the specialist hospitals, where appropriate

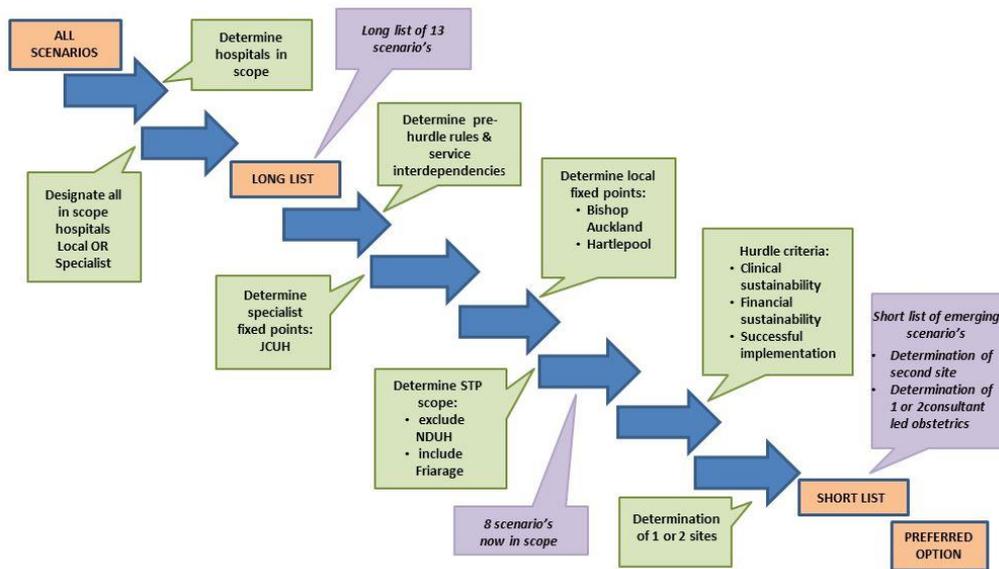
The potential reconfiguration of the specialist hospital based emergency services is best described by the illustration on the next page, it demonstrates a system wide approach underpinned by a clinical network of services with local care provided by the local hospitals (this is under development and subject to consultation).

DDTHRW Vision 2020



DDTHRW Vision 2020

Decision Making Process



Results

A methodology to fully consider the long list of scenarios against the decision making criteria was agreed, based on:

- Long term clinical sustainability
- Long term financial sustainability
- Successful implementation

The original long list of scenarios was reduced following the change to the STP footprint in August. The criteria to date concludes that four scenarios do not meet our strategic aim of better care and outcomes for patients and these are:

- Retaining two district general hospitals and one Specialist Hospital including a major trauma centre
- One single site for all emergency care services
- Three site and two site inpatient paediatric services.

The next stage is to apply the decision making evaluation (next slide) to determine the preferred option for:

- a. The second specialist emergency hospital
- b. The preferred scenario for inpatient paediatrics and local short stay paediatric assessment.
- c. The preferred scenario for consultant lead obstetric care

These are summarised on the next slide. Hospitals would work in partnership to deliver a new model of clinical networks and single services across the system, where appropriate.

A recommendation to the NHS statutory bodies and the Joint CCG Committee is planned.

DDTHRW Vision 2020

Potential Service Scenarios

Scenario	James Cook University Hospital	Darlington Memorial Hospital	North Tees University hospital	Maternity & Paediatric Services
1b	Specialist	Specialist	Local / Elective	1 paediatric inpatient unit and 1 consultant led obstetrics - both at James Cook.
1c	Specialist	Specialist	Local / Elective	1 paediatric inpatient unit at James Cook. Consultant led obstetrics at both specialist sites
2b	Specialist	Local / Elective	Specialist	1 paediatric inpatient unit and 1 consultant led obstetrics - both at James Cook.
2c	Specialist	Local / Elective	Specialist	1 paediatric inpatient unit at James Cook. Consultant led obstetrics at both specialist sites

The evaluation criteria needs continued refinement and professional judgement to determine the second emergency hospital site and determine the preferred option for consultant led obstetrics and paediatric services.

EVALUATION CRITERIA	
Long Term Clinical Sustainability	
1b.	Scenario's will demonstrate the potential improvement to deliver less variation and best in class in overall outcomes by 2021. CLG will make a professional clinical judgement matching the scenario's to the quality outcomes.
1d.*	Scenario must evidence a resilient & sustainable clinical workforce within 2 and 5 years.
1e.	The likely ability to attract and retain doctors in training (professional judgement).
1f.	The scenario needs to demonstrate a vibrant north east research & development contribution to attract and retain our workforce and to contribute to better outcomes
Long Term Financial Sustainability	
2a*	The scenario maximises the net positive contribution achieved over and above the net positive contribution.
2b.	The scenario should maximise the available capacity of theatres and beds in PF sites.
Successful Implementation	
3a.	There is evidence in the past 2 years that core targets have been achieved (4 out of 8 quarterly periods).
3b.	Specialist services can be accessed by 99% of the DDT public within 75 minutes by car/public transport.
3c.*	Population size and density affects the transfer of the minimum number of people seeking emergency care. Total population attending the sites.
3d.	The Health Inequalities of all affected areas will be reviewed and analysed against others within the region and against England averages.
3e.*	The scale of patient movement has minimal impact on the number of people seeking emergency care.
3g.	How long do the capital plans for scenario's take to implement
3h.	Scenario must evidence a resilient & sustainable clinical workforce from Day 1.

* The key criteria highlighted above should enable a decision to be made for the preferred second site. However, a compelling difference between sites has not yet been identified. Therefore further clinical guidance has been sought.

Please refer to appendix 1 which sets out in detail our financial assumptions made in order to deliver our vision.

OUR DELIVERY PLAN

The nine must do's

'Must dos'	Requirements of the STP	STP Commitment
1. STPs	Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.	✓
	Achieve agreed trajectories against the STP core metrics set for 2017-19.	
2. Finance	Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals.	✓
	Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.	
	Delivery of demand reduction measures.	
	Delivery of Provider efficiency measures.	
3. Primary care	Implementation of the General Practice Forward View.	✓
	Ensure local investment meets or exceeds minimum required levels.	
	Tackle workforce and workload issues.	
	Improve access by no later than March 2019.	
	Support general practice at scale, the expansion of MCPs or PACS, and improving health in care homes.	
4. Urgent and emergency care	Deliver the four hour A&E and Ambulance response standard	✓
	Meet the four priority standards for seven-day hospital services for all urgent network specialist services.	
	Implement the Urgent and Emergency Care Review.	
	Deliver a reduction in the 999 calls that result in avoidable transportation to an A&E department.	
	Prepare for waiting time standard for urgent care for those in a mental health crisis.	

'Must dos'	Requirements of the STP	STP Commitment
5. Referral to treatment times and elective care	Deliver the 18 weeks from referral to treatment (RTT)	✓
	Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals	
	Streamline elective care pathways	
	Implement the national maternity services review, Better Births, through local maternity systems	
6. Cancer	Implement the cancer taskforce report.	✓
	Deliver the 62 day cancer standard	
	Make progress in improving one-year survival rates	
	Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.	
7. Mental health	Ensure all elements of the Recovery Package are commissioned.	✓
	Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:	
	Ensure delivery of the mental health access and quality standards	
	Increase baseline spend on mental health to deliver the Mental Health Investment Standard.	
	Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.	
8. People with learning disabilities	Eliminate out of area placements for non-specialist acute care by 2020/21.	✓
	Deliver Transforming Care Partnership plans	
	Reduce inpatient bed capacity.	
	Improve access to healthcare for people with learning disability.	
9. Improving quality in organisations	Reduce premature mortality	✓
	All organisations should implement plans to improve quality of care, particularly for organisations in special measures.	
	Measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.	
	Participate in the annual publication of findings from reviews of deaths.	✓

Across the STP historical performance in relation to constitutional standards has been good.

Recognising there will be individual variances which will be addressed through local plans and performance recovery measures, where necessary, there is a commitment across the STP to ensure delivery.

In particular addressing our challenges in relation to;

- Cancer waiting time
- A&E 4 hour standard
- Ambulance response times

Health & Wellbeing Gap	Early Intervention and Prevention	Transformation Scheme	STP Actions	Enablers	Efficiency
		Cancer	Implementing the Cancer Alliance, Matching diagnostic capacity to expected demand, Continuous improvement of all pathways, Increase Cancer awareness on prevention and early identification	Estates	£9.6m
		Lifestyle, Early Intervention and Prevention	Reduce smoking rates, Reduce obesity rate through increased physical activity, Focus on hard to reach communities		
		Giving Every Child the Best Start	Improve perinatal services including mental health and smoking. Reduce childhood obesity rates through increase physical activity, Focus on hard to reach communities		
Quality & Care Gap	Neighbourhoods and Communities	Transformation Scheme	STP Actions	Workforce	£42.9m
		New Models of Care	Engagement and benchmarking of models of care, Design and agree models of care at a local level, Commence implementation phase including 'Discharge to Assess' models		
		Primary Care	CCG investment into developing and supporting Primary Care, Delivery of extended access, Implement new models of care		
		Urgent & Emergency Care Network	Re-procurement of 111 service (including clinical hub), Delivery of IUC standards to support new models of care, Reform payment mechanisms and metrics		
		Mental Health	Implement plans regarding Early Intervention into Psychosis (EIP), psychological therapies (IAPT) and improvements to CAMHS, Develop community based services to support repatriation of 'out of area' placements, Implement enhanced system wide dementia support.		
		Learning Disabilities	Co-production of new service model, Agree and implement bed closures, Agree financial flows	Engagement	£110.7m
		Right Care	Implement a range of clinical thresholds for priority areas, review pathways in line with New Models of Care, reduce variation at practice level.		
Funding & Efficiency Gap	Acute Hospital Reconfiguration	Transformation Scheme	STP Actions		
		Better Health Programme	Finalise options for public engagement, Undertake public consultation, develop implementation plans		
	Digital Care & Technology	Transformation Scheme	STP Actions		
		Digital Care and Technology	Continuation of data sharing and interoperability, Progress the digital maturity of secondary care providers, Implementation of the Local Digital Roadmap with an emphasis on Remote /Self Care and Decision support	19	

EARLY INTERVENTION AND PREVENTION

Lifestyle, early identification and intervention

Must Do's



	16/17	17/18	18/19	19/20	20/21
Smoking		Re-procure Fresh & Balance Develop revitalised programme for obesity, tobacco and alcohol	Implement Smoke Free NHS (Acute and MH) with holistic smoke free pathway and access to smoking cessation services		
Alcohol		Develop holistic alcohol brief intervention and treatment pathways with improved community support services			
Lifestyle		Develop 4 year comprehensive prevention programme for Long Term Condition e.g. Cardiovascular disease prevention programme and COPD pathways(using PHE Programme)			
		Build on Health at Work Award and develop comprehensive workplace health programmes and pathways to work programmes			

The Gap – Why Change is needed

- The majority of Local Authority areas report rates that are significantly worse than the England average for Hospital stays for alcohol related harm and alcohol specific stays for under 18's.
- Alcohol misuse contributes significantly to 48 health conditions, wholly or partially, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time.
- Smoking is the single largest cause of health inequalities and premature death, within the STP, nearly 1 in 5 adult's smoke (19.6%).
- Smoking is the primary reason for the gap in life expectancy between those in the most deprived quintile and those in the least deprived quintile.
- Obesity rates for the STP are 11.9% compared to a national rate of 9.0% and the percentage of physically inactive adults is 31.0% compared to a national rate of 27.7%.
- Poor diet and physical inactivity are causal factors of obesity and obesity disproportionately affects the most deprived communities.
- Key themes have been identified through analysis of right care that has identified key areas such as respiratory, CVD and cancer.
- Themes identified to improve outcomes focus on preventative interventions specifically screening and early diagnosis, lifestyle changes, vaccinations which all require close working between public health and health service providers with a strong focus on primary care as early action and improved primary care models will reduce spend and maximise health gain.

This presentation outlines our proposals to deliver the three gaps. Further refinement will be required as we work through appropriate governance arrangements including public engagement and formal consultation processes

Future State/Ambition for 2020/21

- Improved support services for people admitted with alcohol related admissions along with provision of brief advice in primary and secondary care settings and sustained engagement with high-impact users..
- Refocus of local tobacco control efforts and smoking cessation services on priority groups; the poorest 10% of our community, people with long term conditions including mental health illness and smoking in pregnancy
- Hospital liaison services for drugs and alcohol
- Implement Government Buying Standards for food and catering services (GBSF) across a range of public settings and facilitate the uptake of nutrition policy tools
- Integrate weight management and mental health services
- Greater focus on screening initiatives to improve effective early detection and management of long term conditions
- Care pathways will endure referral to appropriate support services at key trigger points in the patient journey and where possible provide support proactive self management
- Secondary prevention in all acute contracts and audited to monitor delivery
- Extending the use of personal health and social care budgets and supporting people to use and manage these effectively to ensure people will have increased choice and control over all aspects of their life.
- Scaling up wellbeing / wellness programmes in the community and expanding capacity to deliver as part of self care as system default building upon existing programmes with an equal focus on mental health
- Increase the role of physical activity as prevention, early intervention, pre-habilitation and rehabilitation for physical and mental health.

Benefits

- A reduction in alcohol related hospital admissions
- Reduce Alcohol Related Harm
- A reduction in the prevalence of smoking among persons aged 18 years and over
- A reduction in directly standardised rate of smoking attributable admissions in people aged 35 and over
- An increase in successful quitters at 4 weeks per 100,000 smokers
- Reduce Obesity and Promote Healthy Diet
- Increase Physical Activity
- Reduce Premature Deaths
- Reduce Health Inequalities
- Increase in the number of people accessing personal health budgets
- An increase in screening rates
- An increase in vaccination rates
- Support Self Care & Prevention & Making Every Contact Count

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

- A joined up targeted public health response across the STP footprint
- Focused input to identify, and work with, hard to reach groups and deprived communities
- Support for primary care to manage worklessness and support people with LTC back into employment
- A multi disciplinary workforce to ensure that every contact counts underpinned by a long term plan for workforce recruitment to the NE and not based on individual organisations
- Continuous improvement and awareness of pathway developments across the footprint through a robust training and education plan
- Additional resource through working practice and innovation to improve secondary prevention in primary care and secondary care

Providing every child the best start in life



	16/17	17/18	18/19	19/20	20/21
Childhood Obesity		Develop 4 year comprehensive, childhood obesity programme to promote healthy diet, increase physical activity & sport, improve tier two & community support services			
Integrated Services		Develop integrated 0-19 or 0-26 services across HV, SN and Social Care to deliver Healthy Child Programme and reduce LAC			
Breastfeeding		Expand Breastfeeding Initiatives such as Henry, Babyclear and UNICEF Baby Friendly Initiative			
Maternal Smoking		Expand Targeted Smoking Cessation Initiatives such as Henry, Babyclear and UNICEF Baby Friendly Initiative			
Pathways		Develop and support the delivery of improved pathways through existing networks			

The Gap – Why Change is needed

- This remains a priority for all organisations with the majority of Local Authorities reporting above the national average highlighted in the annual National Child Measurement Programme (NCMP) reports.
- Excess weight (overweight and obese) for Reception year (4-5 years) of 21.9% and for Year 6 (10-11 years) of 22.3%
- Data from the NCMP 2012/2013 show us that the most deprived 4-5 year olds and 10-11 year olds are twice as likely to be obese than the least deprived.
- Data from PHE shows that this footprint has significant child poverty and several worsening areas of health e.g. mortality; MMR immunisations uptake ; levels of child development; rise in children in care

Future State/Ambition for 2020/21

- All children and families to be able to access improved services for ; maternal mental health, mental health, breastfeeding, maternal obesity, maternal smoking, parental drug and alcohol issues, parenting programmes, school readiness
- Support organisations to realise the benefits of physical activity is an important component of early brain development and learning. Communication skills depend on well-developed physical skills, such as effective movement and eye contact; parenting programmes; Daily mile – schools; Park runs - communities
- Supporting all children and families to access child health prevention programmes
- All children and families to access - food in settings - hospitals, nurseries, schools, workplaces
- All organisations to Healthy weight declaration or sugar smart city
- Implement prevention pathways in maternity contracts
- Improved poorly child pathways
- Improved public mental health across the life course. This could include a clear offer for all life stages in line with Future Minds/CAMHS transformation

Benefits

- Reduce the prevalence of overweight and obese children at Reception and Year 6
- Reduce the variation of prevalence of overweight and obese children at Reception and Year 6 with the STP footprint
- A reduction in maternal smoking
- Reduce mortality rates
- Reduce mental health of children
- Reduction in the top 10 childhood illnesses
- Increase in child development
- Reduction in children in care
- Reduction in A&E Attendances for children
- Reduction in non-elective activity
- Improve School Readiness
- Improve Childhood Immunisation Rates
- Increase Breastfeeding Rates
- Reduce Teenage Pregnancy
- Improve Maternal Mental Health
- Improve the mental health of children
- A reduction in self harm emergency admissions and suicide rates.

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

- Increase in training and education of primary, community, 3rd sector to be confident in recognising potential problems and being able to signpost proficiently and effectively
- Secondary prevention in primary care and secondary care. E.g. Nicotine addiction to be managed as part of routine care not as an add on. Delivering against NICE guidance

Transforming cancer services

Must Do's

Implement the cancer taskforce report	Deliver the NHS Constitution 62 day cancer standard	Secure adequate diagnostic capacity
Make progress in improving one-year survival rates	Reduce the proportion of cancers diagnosed following an emergency admission	Ensure stratified follow up pathways for breast cancer patients
All patients have a holistic needs assessment and care plan at the point of diagnosis	A treatment summary is sent to the patient's GP at the end of treatment	A cancer care review is completed by the GP within six months of a cancer diagnosis

Future State/Ambition for 2020/21

- Preventing cancer by addressing cancer risk factors – especially smoking; the STP will take steps to reduce local rates by 2021.
- Diagnosing more cancers early, increasing the proportion of cancers diagnosed at stage 1 and 2. The STP will improve all cancer pathways as well as substantially increasing diagnostic capacity (especially imaging/radiology). These actions will result in fewer cancers diagnosed as an emergency, and an increase in one and five-year survival rates.
- By 2020, everyone with a suspected cancer should receive a definitive diagnosis or within 28 days.
- By 2020, all patients will have access to high-quality modern therapeutic services, such as personalised treatment informed by molecular diagnostics. They will be cared for during and after their treatment, benefiting from increased support to live well after treatment.
- Patients will have a better experience of their cancer care, with less variation across the STP.

Benefits

Immediate Actions:

- Achieve cancer waiting time standards
- 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
- Reduction in smoking rates
- Increased uptake in all cancer screening programmes
- A demonstrable improvement in the proportion of cancers diagnosed at stages 1 and 2

Overall 2020 /21 goals:

- Deliver significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (now at 69%) with a reduction in CCG variation
- 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
- Continuous improvement in patient experience with a reduction in variation
- An increase in the proportion of patients participating in research for cancer care
- Continuous improvement in long term quality of life
- A marked reduction in the proportion of diagnosis through emergency presentation

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

The independent cancer task force report sets out how to achieve world class cancer outcomes in England by 2020. In response to this we will utilise the capacity and resources within the Alliance to deliver the following;

- A joined up targeted public health response across the STP footprint
- Focused input to identify, and work with, hard to reach groups and deprived communities
- Increased capacity in cancer support services (including diagnostics, welfare advice, screening etc.) delivered through improved working practice and innovations such as pooling clinical capacity across the system. This will be undertaken in partnership with NHS, Independent Sector and Voluntary Community Sector providers.
- A multi disciplinary workforce to ensure that every contact counts underpinned by a long term plan for workforce recruitment to the NE and not based on individual organisations
- Continuous improvement and awareness of pathway developments across the footprint through a robust training and education plan

	Milestones	16/17	17/18	18/19	19/20	20/21
Key Actions	Implement Cancer alliance	First meeting of Alliance and agreement of priorities				
	Cancer waiting times	Delivery of cancer standards in line with STF plans				
	Diagnostic capacity	Agree increase in diagnostic capacity	Implement 'BHP' to ensure sufficient diagnostic capacity in the right locations			Deliver diagnostic capacity
	Pathways	Continuous improvement of all pathways				
	Stakeholder and Patient Education	Baseline assessment	Implement ongoing programme of education with stakeholders and public			

The Gap – Why Change is needed

- Significant gap between life expectancy across the STP footprint and that of England. Cancer is a significant contributor to this.
- Higher than national average prevalence rates for incidents of smoking, including smoking during pregnancy
- Significant inequality gap within communities across our STP
- We have too many people diagnosed at a late stage
- Too many people die within 12 months of diagnosis

NEIGHBOURHOOD AND COMMUNITIES

New models of care



	Milestones	16/17	17/18	18/19	19/20	20/21
Key Actions	Community Hub Actions:					
	Engagement and benchmarking					
	Design					
	Implementation Phase 1					
	Implementation Phase 2-5					
	D2A					

The Gap – Why Change is needed

- A population with a growing number of older people
- Our current health and care system is not always co-ordinated well
- Many patients have conditions which are not managed as well as they could be and so often go to hospital when they could be better supported in a community setting or at home.
- A growing number of people with complex medical conditions coupled with communities with different needs.
- There are high levels of ill-health and disease prevalence in our area, we need to do more in terms of promoting wellbeing within the community.
- People tell us that services feel fragmented and that information does not follow the individual around the system.
- People tell us they are confused about how to access services in the community, particularly where people have an urgent need.
- Fragile market in relation to care and nursing home provision
- Under use of community assets or voluntary sector capacity

This presentation outlines our proposals to deliver the three gaps. Further refinement will be required as we work through appropriate governance arrangements including public engagement and formal consultation processes.

Future State/Ambition

- A risk assessment based proactive approach to care looking at a whole population model (based on populations of 30k-50k)
- Less reliance on hospital based care through developing new innovative models of care with partners
- Bringing together core primary medical care services with wider community-based NHS services and, potentially, social care (extending beyond primary care at-scale) with a focus on out-of-hospital services based around registered populations through development of community hubs
- Developing multi-specialty community providers all essentially working towards the same goal, quality improvement, cost savings and working together more efficiently.
- Expanded multi-disciplinary community-based teams
- Incorporation of some specialist services or support
- Enabling community activation and well being through neighbourhoods by working collaboratively with Voluntary Community Social Enterprise (VCSE) sector
- New contracting and funding approaches to manage a capitated budget for all out-of-hospital care

Benefits

- Reduce frail elderly bed days by 20% over the next five years
- Reduction in A&E attendances
- Reduction in frail elderly emergency readmissions, particularly focussing on GP admissions
- Reduction in emergency readmissions
- Reduction in permanent admissions to care homes (older adults over 65) per 100,000 population
- Increase in deaths in the usual place of residence
- Reduce delayed transfers of care as a percentage of occupied bed days

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

Implementing Community Hub Model

- Integration of providers within health and social care
- Integration of information systems
- A developed workforce that delivers care as part of a care planning approach
- A care model that is based around a triangle of needs, incorporating:
- Highest needs – Extensivist model supported by strong multidisciplinary team, with risk stratification to identify patients who will benefit most from intensive support
- Ongoing care needs – Integrated primary and community care MDTs, based around population hubs, working closely with specialists, carers, other sectors and with a care co-ordinator. GPs ensuring continuity of responsibility for patients on their list, supported by standardised tools for LTC management.

Implementing Discharge to Assess

- A developed culture which has trust in the system to discharge into the community when medically fit
- An infrastructure able to manage needs within the community

STP support for the New Models of Care

- An application for funds in order to support the spread of new care models to deliver not-in-hospital services

Primary care

Must Do's	Ensure the sustainability of general practice by implementing the Forward View	Ensure local investment meets or exceeds minimum required levels	Tackle workforce and workload issues to increase the number of doctors working in general practice
	Investment in training practice staff and stimulating the use of online consultation systems	Extend and improve access in line with requirements for new national funding	Support general practice at scale

Themes	16/17	17/18	18/19	19/20	20/21
Investment		CCG investment into developing and supporting primary care			
Workforce			Recruitment and retention initiatives	Training care navigators Medical assistant roles	
Workload		Reform OOH/111 Paper free			
Infrastructure		New models of care			
Care Redesign	Fund protected learning		Extended access	Propose MCP contract	

Future State/Ambition

Our vision for the future state of Primary care is that a new style of Primary care intervention is delivered through integrated primary care teams.

- An increase workforce in general practice supported by new roles beyond traditional GP's such as mental health counsellors/therapists, physician associates and clinical pharmacists
- Primary care would be delivered at scale through the development of a seven day access model via primary care 'hubs'. The hubs will need to be slightly different across localities but core components and standards of access will be the same across each with increased access to primary care through the provision of pre-bookable and same day appointments in evenings and weekends
- Use of technology to introduce new ways of accessing primary care services introducing services providing alternatives to face-to-face contact including the use of phone and online consultations.
- Collaborative working between practices work to capture economies of scale, improve quality, reduce variation and improve efficiencies supported by a system wide practice development programme.
- Primary care records shared across the local health economy, including community pharmacy, with the introduction of common standards, paperless transfer of notes and digital summary care records.
- Implementation of a new model of care that integrates provision of primary and community to ensure a whole population health approach to service delivery with the required infrastructure and 'fit for purpose' premises
- Introduction of Care Navigation / Care Co-ordination roles to ensure a seamless patient journey across health and social care, enabling a patient to tell 'their story' only once

Benefits

- Increase in GP numbers and skill mix with healthcare professionals
- Improved access times to primary care
- Increased 111 access to general practice appointment systems
- Improved information sharing and data flows across health services
- Increased scope of services available in primary care
- Improved satisfaction rates for access to primary care
- Increased funding in primary care
- Increase inter practice referrals and greater use of technologies e.g. Skype and telehealth
- Reduction in A&E attendances

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

- Access to and utilisation of Estates and Technology Transformation Funding
- Additional investment to primary care access through the sustainability and transformation package of support from 17/18 to 18/19
- Additional workforce capacity through working practice and innovation and increased recruitment and retention
- Transformation resource to support the implementation of new models of care

The Gap – Why Change is needed

A new style of primary care is required to strengthen the connections between healthcare professionals and the people they care for. Primary care is pivotal in delivery in the NHS and has the ability to ensure early intervention and prevention. There is a high use of services including A&E which could be dealt with through early intervention and improved access to primary care.

Primary care needs to change to meet the challenges of an ageing population and to better serve those living with complex health and care needs. This means providing personalised, proactive care to keep people healthy independent and out of hospital through a risk based approach and reducing variation in approaches to delivering care. There is a need to expand and change the skill mix of the workforce in primary care as within our STP there is an ageing workforce and difficulty in recruiting GPs.

Urgent and emergency care network

Must Do's

Deliver the four hour A&E standard, and standards for ambulance response times	Meet the four priority standards for seven-day hospital services for all urgent network specialist services	Implement the Urgent and Emergency Care Review
Ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020	A reduction in ambulance calls that result in avoidable transportation to an A&E department	Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis

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 the A&E 4 hour standard and delivery of the Ambulance standards (in line with STF requirements)				
Payment reform & metrics	Modelling work undertaken	Shadowing of revised payment mechanism	Implementation of revised payment mechanism and system wide outcome metrics 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				
Develop and deliver new models of crisis care for young people	Test out new models of care and adopt best practice				

The Gap – Why Change is needed

- 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 and is not delivering performance standards.

Future State/Ambition

The NEUCN 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. Our objectives:

- Delivering urgent care centres in community and primary care facilities providing access to urgent care for the local population 24/7 addressing our population health needs, balanced against requirements of personalisation
- Simple to access integrated care pathways, delivered as close to home as possible, provided across a full range of care settings, enabling good choices by patients and clinicians
- Improved patient experience and clinical outcomes delivered through care in the right place, at the right time, provided by those with the right skills
- Ensure people with more serious or life threatening emergency care needs receive treatment in centres with the best expertise and facilities

Benefits

- 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

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

Redesigned and more accessible, enhanced urgent care services, delivering the eight commissioning standards that:

- A single call to get an appointment out-of-hours (OOHs)
- Data can be sent between providers
- The capacity for NHS 111 and OOHs is jointly planned
- The summary care record is available in the clinical hub and elsewhere
- Care plans and patient notes are shared between providers
- Appointments can be made to in-hours GPs
- There is joint governance across local urgent and emergency care providers
- There is a clinical hub containing (physically or virtually) GPs and other health care professionals
- Workforce development will include promoting health, wellbeing, prevention and self-care
- All NHS providers are working towards the better health at work award

Learning disabilities transformation

Must Do's

Deliver Transforming Care Partnership plans with local government partners & enhancing community provision

Reduce over reliance on inpatient bed capacity and inappropriate admissions

Improve access to healthcare for people with learning disability

Reduce premature mortality by improving access to health services, education and training of staff

Key Actions	Milestones	16/17	17/18	18/19	19/20	20/21
	Co-Production					
Bed Closure						
Developing a new service model						
Funding Arrangements						

The Gap – Why Change is needed

- The current experience for people with learning disabilities within the footprint 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.
- 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).
- The pace of transformation in respect of the community infrastructure is paramount in facilitating the safe reduction in inpatient beds across the locality. Without the matched level of investment and resource the demand on inpatient beds will continue to be a pressure. This is further influenced by the changes in commissioning across NHSE Specialised Services, which will see less treatment programmes being delivered in secure settings and more patients being managed in the community. The transfer of patients through the rehabilitation pathway will require the CCG to ensure that the necessary settings are available to safely respond to patients with associated behavioural and forensic needs.

This presentation outlines our proposals to deliver the three gaps. Further refinement will be required as we work through appropriate governance arrangements including public engagement and formal consultation processes

Future State/Ambition

Our ambition is for the footprint is 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 partners and 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 North East and Cumbria Learning Disability Transformation Plan and the Yorkshire Transforming Care Plan aims include less reliance on in-patient admissions, developing community support and alternatives to inpatient admission, prevention and early intervention, avoidance of crisis and better management of crisis when it happens to create better more fulfilled lives.

Benefits

- Less reliance on in-patient admissions, delivering a reduction in avoidable admissions to inpatient learning disability services and delivery of a commissioned bed reduction trajectory by 2020.
- Developing community services and alternatives to inpatient admission
- Prevention, early identification and early intervention
- Increasing the number of annual health checks and health promotion/prevention programmes
- Avoidance of crisis and better management of crisis when it happens
- Better more fulfilled lives.
- Improved quality of life
- Improved service user experience

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.
- Closer working between Specialised Commissioners and CCGs to better manage the transition of patients between services
- Joint working with LA partners to increase resilience in the existing provider market and also develop new models of care and support is a priority and will require more detailed and diverse co-commissioning to enable the physical and cultural shift in service delivery. The release of recurrent investment from bed based services is crucial in order to support the development of more robust community services, dowries, and the delivery of health and social care community.

Transforming mental health services

Must Do's

At least 25% of people with common mental health conditions will get access to psychological therapies

35% more children and young people with mental health conditions will receive treatment

Ensure that at least 60% of people experiencing a first episode of psychosis begin treatment within two weeks

Increase access to individual placement support for people with severe mental illness in secondary care services

Ensure that 95% of children and young people with an eating disorder receive treatment within four weeks

Reduce suicide rates by 10% against the 2016/17 baseline

Deliver mental health access and quality standards including 24/7 access to community crisis resolution

Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence

Eliminate out of area placements for non-specialist acute care by 2020/21

	16/17	17/18	18/19	19/20	20/21
60% of people with first episode psychosis treated with NICE concordant therapy within 2 weeks of referral	50%				
95% of children and young people with eating disorders are seen within 4 weeks of referral (1 week for urgent referrals)					
Comprehensive core 24 liaison service in place in acute hospitals (1 hour response in urgent care, 24 hour response to inpatient settings)					
Access to specialist perinatal mental health services both community and in patient					
25% of people with common MH conditions access psychological therapies	15.8%	16.8%	19%	22%	25%
Access to liaison and diversion services across the criminal justice system					
Mental health access standards for crisis care					
CYP transformation plan	Refresh plan				

The Gap – Why Change is needed

Due to the prevalence of disease and long term illnesses coupled with high levels of deprivation individuals are more susceptible to developing mental health problems in our footprint.

Recognising within our footprint there are a significant number of armed forces personnel and veterans and families who may require enhanced mental health support, therefore it is essential more is done to ensure early identification and support to access care is in place.

This presentation outlines our proposals to deliver the three gaps. Further refinement will be required as we work through appropriate governance arrangements including public engagement and formal consultation processes

Future State/Ambition

24/7 urgent and emergency health response, an all-age mental health liaison service in emergency departments and in-patient wards, multi-agency suicide prevention plan in order to reduce suicides by 10%

Mental health is everywhere and the health needs of our population are increasing. We are looking to build high quality services and a highly skilled workforce that not only delivers value for money and are financially sustainable, but that provide more of our population with early interventions and increased access to treatment across all of our communities

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

- To deliver the 60% target for first episode psychosis further workforce development and targeted funding is required to ensure access to the full range of NICE concordant treatment.
- In order that 35% more CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service, further targeted investment in line with NHSE commitment needs to be made available to support CYP IAPT programme, CAMHS crisis and home treatment, specialist eating disorder and tier 2 and 3 CAMHS
- Development of growth and investment plans for workforce development and service capacity so that at least 25% of people with common MH conditions get access to psychological therapies each year by 2020
- Ensure that commitment is sustained so that all of our acute hospitals have in place all-age mental health liaison service achieving Core 24 service standard
- Continued support to community mental health services to eliminate out of area in patient treatment for non-specialist acute mental health care and improve employment support.
- Develop opportunities for collaborative commissioning with partners to deliver new models of care for specialist mental health services and integrated mental and physical health services
- Investment in workforce and services is required to ensure access to specialist perinatal mental health support in the community and in patient settings by 2020/21
- Continued focus on memory clinics and cross system dementia care services to ensure maintenance of diagnosis rate and effective post diagnosis support.
- Work with all agencies to develop and implement a range of routine outcome measures across all services.
- Increased investment in individual placement support in secondary MH services
- Ensure continued multi agency support to suicide task groups to maintain relevance of suicide reduction plans

Benefits

The success of the improvement areas under the Mental Health Five year Forward View will mean that vastly more people, of all ages, will have access to high quality, timely mental health treatment and earlier intervention, specific to their needs and improvements in health and wellbeing to increase opportunities for people affected by mental health and close the mortality gap.

Scheme specific benefits will be seen in terms of service improvements in: (1) Health & Wellbeing, (2) Care & Quality, and (3) Finance & Efficiency.

Reducing variation – Right Care

Must Do's

Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.

	Milestones	16/17	17/18	18/19	19/20	20/21
Key actions	Delivery at STP level	Continued work to further analyse and implement service change to deliver opportunities identified within the RightCare approach.				
	Delivery at local level	Continued work to further analyse and implement service change to deliver opportunities identified within the RightCare approach.				

The Gap – Why Change is needed
 Analysis of the RightCare focus packs (May 2016) at an STP level identifies an unwarranted variation across service delivery and quality, spend and outcomes in cancer, mental health, MSK, CVD, respiratory maternity and early years, and neurology.

In addition to this, more local analysis has been undertaken at a CCG level which has informed Commissioner level RightCare plans which are currently being progressed.

Changes to prevention, delivery of pathways and service integration as set out in the RightCare opportunities are critical to the delivery of the key transformation schemes. The STP recognises the importance of implementing the RightCare approach in order to deliver better patient outcomes and to free up funding to enable further innovation.

- Future State/Ambition for 2020/21**
- **For patients** – better access to excellent care, improved patient experience and greater involvement in decisions about their care.
 - **For commissioners** – a proven approach to unite partners across the health economy and prioritise investment to maximise value, whilst meeting the requirements of the new NHS Improvement and Assessment Framework.
 - **For primary and community care** – opportunities to redesign patient care with a focus on prevention and early intervention.
 - **For secondary care** – active involvement in the redesign of patient journeys across primary and secondary care. Plus, support to meet the requirements of the Carter Review to reduce unwarranted variation.
 - **For local authorities** – a sound, transparent rationale for how limited resources are prioritised, helping meet legal duties under the Health and Social Care Act 2012 to reduce health inequalities.
 - **For professional bodies** – partnership working to develop a common view of what ‘excellent’ looks like and promote opportunities for clinical engagement and reform.
 - **For national programmes** – an opportunity to embed a proven approach that delivers better outcomes and reduces variation within national work.
 - **For special interest groups** – using variation to target health economy support and the opportunity to contribute to the design of optimal patient experience.

- Benefits**
- Cancer and tumours: A reduction in mortality from all cancers: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard
 - Reduction of expenditure cancer programmes of care.
 - Respiratory conditions: A reduction in mortality from respiratory disease: Under 75 Directly age-standardised rates (DSR) per 100,000.
 - Reduction of expenditure on respiratory programmes of care.
 - Reduction of expenditure on CVD programmes of care.
 - Reduction of expenditure on Primary Care prescribing items where identified as appropriate.
 - Musculoskeletal issues: An increase in % of patients aged 75+ years with a fragility fracture treated with an appropriate bone-sparing agent - Excludes Trauma
 - Maternity and reproductive health: A reduction in rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 population aged <5 years
 - Mental Health: Rate of recovery: An increase % of people who are "moving to recovery" of those who have completed IAPT treatment

What resources are required to deliver / what capacity and capability do we need?
 Delivery of RightCare is dependent upon all Providers and Commissioners within the STP footprint being engaged and demonstrating buy-in to the principles. We need to ensure there is sufficient Business Intelligence support to understand at an STP level the possible system opportunities available beyond those already identified.

ACUTE HOSPITAL RECONFIGURATION

Better Health Programme – Acute reconfiguration



Milestones	16/17	17/18	18/19	19/20	20/21
Paediatrics					
Neonates					
Urgent Care					
Obstetrics					
Emergency Surgery					
A&E and acute medicine					
Elective care					
Radiology					
Enabling programmes					

Milestones	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Decision making process													
Investment Committee													
Local Elections													
Public Consultation													
Joint Committee													
Joint OSC													
Joint Committee decision													

The Gap – Why Change is needed

- Hospital Trusts are significantly short (68% met) in meeting over 700 standards set by the Royal Colleges, NCEPOD and Emergency Care Academy.
- As healthcare is becoming increasingly specialised it is becoming more difficult to have that level of expertise available in every hospital for every service.
- The medical evidence shows that where patients are admitted to specialist centres with staff seeing a high volume of patients with similar problems, and meeting high clinical standards, the outcomes for patients are much improved.
- Changing patterns of need; medicine is advancing with revolutionary new treatments saving and transforming lives. As well as living longer, the nature of illness is changing with far more patients with chronic long term conditions rather than a brief acute illness that resolves within days
- Our challenge is the availability of a specialist workforce at consultant and senior doctor level. We need to address this so that to ensure consistent specialist consultant decision making , 7 days a week, 16 hours per day and where this applies to a major trauma centre 24 hours per day.
- Our population and our specialist consultant medical workforce are in balance but spread over too many hospitals to respond to the medical advances now and in the foreseeable future

Benefits

- 100% delivery of the clinical standards
 - 7 day consultant presence
 - 16 hours per day Consultant specialist access
 - Over 75% of patients assessed by a Specialist Consultant on admission and 100% assessed within 12 hours by a Consultant
- Less variation in outcomes across the system, e.g.,
 - Top 3 outcomes for each service agreed by Clinical Leadership Group, for example, hyper acute stroke, 18 weeks, patient cancellations, obstetrics and neonatal services.
 - Operational excellence in contributing to better value for money
 - Better retention and recruitment of highly skills consultant and clinical staff with reduced spend on locum staff.

Future State / Ambition

See Vision 2020 statement

DIGITAL CARE & TECHNOLOGY

Digital care and technology

Must Do's

- A treatment summary is sent to the patient's GP at the end of treatment
- Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups
- Provider efficiency measures include: implementing pathology service and back office rationalisation
- Ensure the sustainability of general practice
- Investment in training practice staff and stimulating the use of online consultation systems
- All patients have a holistic needs assessment and care plan at the point of diagnosis
- Enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes
- Deliver a reduction in the proportion of ambulance calls that result in avoidable transportation to an A&E department
- Measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.

Transformation Programmes	Milestones	16/17	17/18	18/19	19/20	20/21
	Interoperability between care systems					
Infrastructure						
Planning and decision support						
Transfers of care						
Technology enabled care services						
Communications, engagement and consent						
Northern England Clinical Network key priorities						
Analytics						
National Initiatives						

Interdependencies

- Develop **Local Digital Roadmaps** to support delivery 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.
- Leverage the multiple strands of the Regional Informatics Conversation - North East & Cumbria **Digital Care Programme, U&EC Network 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.

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

- More patients treated locally preventing the need for care outside of the local community
- By 2021 we will make a lasting contribution to the health and well-being of our population through the sharing of information securely and effectively. By end 16/17 we will have in place a critical milestone to this – sharing of GP records across all providers.
- The Great North Care Record will make information more widely available and accessible to support frontline care, individual self-management, planning and research.
- Through the use of TECS patients, carers and citizens will use digital technologies to be able to 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.
- A paper free system with information flowing seamlessly between primary, secondary and social care digitally

Benefits and Outcomes

- 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 Record (EPR) Systems
- 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

Digital care and technology

(this is the Local Digital Roadmap 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

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

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

Medicines management and optimisation

Medicines are prescribed electronically

Digital records give a view of all existing medications and prescriptions

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

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 plans



STP joint working



Regional working

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Delivery plan – key outcome measures

Improvement and Assessment Indicator	Early Intervention and Prevention	Neighbourhood and Communities	Acute Reconfiguration	Digital Care and Technology
At least a 5% reduction in A&E attendances		✓	✓	
Delayed transfers of care as a percentage of occupied bed days		✓	✓	
Delivery of 7 Day Standards			✓	✓
Improvement in Smoking quit rates (successful quitters) 16+	✓			
Improvement in urgent GP referral having first definitive treatment for cancer in 62 days		✓		
Improvement of Ambulance waiting times			✓	
Improvement of one year cancer survival	✓			
Improving Access to Psychological Therapies recovery rate		✓		
Increase in estimated diagnosis rate for people with dementia		✓		
Increase in the number of patients waiting 18 weeks or less from referral to hospital treatment			✓	
Increase of patients treated within the 4 hour A&E standard			✓	
Increase Personal Health Budgets per 100,000 population		✓		
Increased cancer diagnosis at an earlier stage	✓			
Injuries from falls in people aged 65 and over per 100,000 population		✓		
People with 1st episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral		✓		
People with a long-term condition feeling supported to manage their condition		✓		✓
People with diabetes diagnosed less than a year who attend a structured education course		✓		
Percentage reduction in permanent admissions to care homes (older adults over 65) per 100,000 population		✓		
Percentage reduction in permanent admissions to care homes (older adults over 65) per 100,000 population			✓	
Proportion of people with a learning disability on the GP register receiving an annual health check		✓		
Reduction in Bed Days		✓	✓	
Reduction in delayed transfers of care attributable to the NHS and Social Care per 100,000			✓	✓
Reduction in emergency admission rates			✓	
Reduction in emergency admissions for alcohol related liver disease	✓			
Reduction in emergency readmissions rates		✓	✓	
Reduction in frail elderly emergency admissions, particularly focussing on GP admissions		✓		
Reduction in frail elderly emergency admissions, particularly focussing on GP admissions			✓	
Reduction in maternal smoking rate at delivery	✓			
Reduction in out of area placements for mental health inpatients		✓		
Reduction in percentage of overweight or obese children at Year 6	✓			
Reduction in the number of emergency bed days per 1,000 population			✓	
Reduction in the percentage of deaths which take place in hospital		✓	✓	
Reduction of neonatal and still births	✓			

ENABLERS

Estates is an enabler for the STP to deliver its service ambitions and close the financial gap. Ensuring delivery of improved Primary and Community Care estate to facilitate care in the local community and respond to population growth and demographic pressures across the STP area is essential. A key component of this will be the delivery of the ETTF programmes in each CCG area, to both transform individual practices and deliver integrated community, primary and social care services at scale. Improved utilisation of core estate and rationalisation and disposal of older not fit for purpose buildings is required to reduce poor quality accommodation; eliminate backlog maintenance, void and excess running costs and facilities. This will allow us to maximise existing identified core sites and buildings through increasing occupancy and utilisation.

Improved utilisation of core estate and rationalisation and disposal of older not fit for purpose buildings to reduce poor quality accommodation; eliminate backlog maintenance; void and excess running costs and facilities. This will allow us to maximise existing identified core sites and buildings through increasing occupancy and utilisation. Through current estates strategies we will ensure the retained estate is energy efficient and properly maintained.

As part the Carter provider efficiencies, we will utilise technology to support reconfiguration of back office functions to maximise available clinical space.

Within the agreed governance framework we will enable greater collaboration across the wider public sector through Cabinet Office's One Public Estate Programme to ensure we respond to housing growth, population and demographic changes across the STP area. Estate Implications of STP Plans:

- Requirement for capital expenditure on acute sites in order to create effective patient flow and service efficiency in line with Better Health Programme proposals. Additional specialist resource requirement for delivery of Acute reconfiguration including substantial capital programme across multiple sites.
- Not in Hospital care model supported by GP community hubs and primary care led urgent care – evaluation of estates implications required.
- Sweat long-term core estate – utilise existing PFI sites such as James Cook University and Bishop Auckland General Hospitals
- Review of Community Hospitals to support Not in Hospital Care – scoping step-up, step down and GP led requirement, may produce medium term consolidation and saving opportunities
- Opportunities to reduce footprint, release capital and contribute to housing targets through previously planned part disposals – business as usual and no impact on service delivery
- Consolidation of pathology at JCUH site, review estate implications and potential for back office consolidation - identify opportunities across the acute and community estate
- Eradicate as much 'not fit for purpose' estate as possible, remove backlog liability across sites
- Address Carter target for non-clinical space proportion 35% or less

The current estate:

Portfolio	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Estate Running costs pa (£m) (rent, s'charge, FM)	Back-log*** Maintenance £m
GP premises	221	-	31,230 [†]	19*	3.5
NHS PS	96	-	85,318	22	
CHP	5	-	17,994	7	0
Provider estate**	7	71.80	377,290	272	70
Mental Health Trusts**	14	30.81	73,809	33	0
Public Health Estate					
Totals	343	102.61	585,641	353	73.5

Performance Measures:

Current	Planned (April 2020)
Estate Running Costs £353m pa (£603 m2)	Reduce 5% -£18m (£573 m2)
Non-Clinical Space 133k sq metres 35 %	Reduce to 30%
Unoccupied Space 22k sq metres 5.65 %	Reduce to 2.5%

Key next steps towards deliver:

Key next step	Challenges	Resources	Indicative timeline	Comments
Acute Reconfiguration	Model options for range of site and service scenarios	Engage estates teams External resource for healthcare planning and modelling	By Nov 2016	Modelling to understand cost and deliverability of change scenarios linked to public consultation requirements
Not in Hospital Care	Understand estates implications of not in hospital proposals	Work with CCGs to understand hub proposals and model cost and delivery options	By March 2017	Modelling to understand cost and deliverability of change scenarios Understand impact of ETTF capital or other capital routes
General	Floor area data on Primary Care estate needs updating	Work with CCG/DV to establish floor areas in HRW	Within 3 months	Better understanding of as-is position required in order to support business case for hubs
Community Estate	Understand the interaction of Community estate with 'not in hospital' plans	Estates input to 'not in hospital' workstream. Model bed numbers and requirements across health economy	By June 2017	Understand long-term requirements across community hospitals and primary care centres, feed into STP plans
Administrative Estate	Detailed proposals for administrative consolidation to reduce costs	Project support to model administrative requirements linked to STP proposals	By June 2017	Understand admin estate requirements and opportunities to consolidate and linked to lease events

The Gap – Why change is needed

- Many challenges relate to the availability of clinical specialist skills and workforce to consistently ensure senior decision making clinicians are available for an extended day, seven days a week, supported by sufficient numbers of junior doctors, nurses, health scientists, etc. For example, for a person using A&E, this does not only mean those doctors who work in A&E, but colleagues in radiology, medicine, surgery, etc. who may also be required to help diagnose and treat the patient.
- At a regional level, some medical specialties are at risk such as Psychiatric workforce, Emergency Medicine, General Internal \ Acute Medicine, Clinical Radiology, Community Sexual and Reproductive Health, Oral and Maxillo Facial Surgery, Immunology, as is general practice
- There are questions about the sustainability of specialty medicine rotas including stroke and cardiology given the smaller number of these consultants.
- Some shortages of middle grades requiring additional consultants to backfill rotas
- Insufficient workforce to safely operate current numbers of sites i.e. maternity
- increasing specialization – which is leading to the main challenge in this area of providing a sustainable workforce.
- There is a high proportion of GPs over the age of 50. This is a risk in terms of the number of GPs expected to retire in the next 10 years; the challenge is in ensuring that there are enough newly qualified GPs to replace this cohort.
- Nursing & midwifery will be effected by recruitment difficulties and high vacancy rates across the nursing profession and specialist nursing roles.; The effect of graduate-entry nursing on the skill mix, attrition and the number undertaking undergraduate courses, which is as yet un-quantified in some areas.

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

Some of the actions to date, and which will continue include:

- Investment in the primary care workforce, this includes increasing the numbers of staff working in primary care in substantive posts and training schemes, by a range of recruitment, retention and education initiatives. This includes developing the entire primary care workforce, including practice nurses, pharmacists, health care assistants, practice management staff
- Investment in the bands 1-4 workforce to reflect their increasingly patient facing role. Including enhancing their competencies to ensure that they can deliver their current roles but also, where appropriate, deliver additional roles traditionally done by other staff.
- Introduce new roles \ change the skill mix and expansion of staff working in different roles, for example advanced practitioners and healthcare scientists taking on roles previously done by medics and physician's associates, working across secondary and primary care in a variety of services.
- Ensuring that the continuing workforce development of staff is reflected in the investment by employers but also by HEE NE.
- Continued work, including via HEE NE, with care homes, hospices and the voluntary sector to understand their education and workforce issues. This includes making education and training available to those working outside of NHS employment.
- Work collectively and individually to reduce turnover and increase retention of the workforce and seek to deliver a more efficient and effective use of bank and agency staff.



Workforce Design Principles

- **Robust, resilient and productive teams** working across organisational boundaries with the same values and behaviours so we have an agile workforce to respond to patient's needs
- **Attract, recruit and retain** the workforce so we can fill vacancies with the people with the right skills and behaviours, reduce agency spend, and increase staff satisfaction to improve patient care
- **Balance specialist skills and generalist skills** both in acute care settings, community and primary care to meet now and future patient needs.
- **Cultural change** and a different philosophy of care at network level (organisations, services and teams) and viewing the workforce differently by using the voluntary sector.

Benefits and impacts

We recognise that the healthcare workforce needs to evolve and change to deliver a more efficient and effective service, in and across a range of different settings. The workforce will have to be redesigned and developed to ensure current gaps are filled, and use of locums reduced. At the same time, the workforce requirements for the communities and neighbourhoods model to be delivered need to be understood and planned for to enable the associated acute reconfiguration.

Some of these changes can and will be with the skill set of the existing workforce, some will be the introduction of new and alternate roles, whilst others will be where and how staff are deployed. Some of these changes will deliver actual financial savings from the pay bill, others will deliver efficiency savings by more appropriate treatment in more appropriate settings.

For greater detail relating to assumptions made on workforce projections please refer to the separately submitted finance and activity template.

Engagement - Progress to Date

Engagement work so far has taken place across the footprint on local plans, the Better Health Programme and Fit 4 the future - transforming our communities. These programmes have undertaken wide-reaching and informative engagement using a variety of inclusive mechanisms and channels where we have aimed to engage with people across the DDTHRW area.

The engagement strategies ensure we have ongoing stakeholder engagement, and enables the consultation process, whilst continuing the information process for stakeholders. Our stakeholder groups have been a crucial part of this strategy, and are fully involved in the approach to public, patient, stakeholder and staff engagement. It is this communication and engagement with a comprehensive range of people which has prepared the path to address the key challenges across the footprint.

Programme	Activity	Engagement Methods
Better Health Programme	Market research	May 2015: including 1,000 telephone interviews and 6 focus groups
	Patient and public pre-engagement	Patient and public engagement events across the footprint <ul style="list-style-type: none"> Phase 1: February 2016 - What can we do better? Phase 2: May 2016 - Future shape of services Phase 3: July 2016 - What's important in decision making Phase 4: October 2016 - care outside hospital, and scenarios Better Health Programme website and digital activities
	Stakeholder engagement	Stakeholder forum events Engagement with: Local Authorities, Voluntary Sector Healthwatch CCG patient participation groups Joint Overview and Scrutiny Committee Health and Wellbeing Boards
Transforming our communities	Voluntary sector groups	100 conversations: Voluntary sector facilitated discussion groups, including a focus on special interest groups and protected characteristics (continuing until October 2016)
	Pre consultation	"Lets have a proper chat" listening events, identifying key issues for the community around care closer to home. Talking to local people about changes to community hospital provision
	Consultation	To engage the local community and provide them with the information in order for them to influence decision making on Fit 4 the future proposals. Formal consultation July 2016 to September 2016

Feedback from our engagement

“People support services outside of hospital but these need to be fully resourced and effectively integrated”

“There are concerns that the transport systems in the County are an issue in being able to access some health care. It was felt that in order to access health care, then transport links would need to be improved and strengthened”

“Concern about impact of increased travel/distance on patient outcomes and on patients, carers and visitors”

“People wanted to be cared for at home when at all possible. On the occasions when it is not possible or practical to offer care at home, people wish to receive treatment as close to home as possible”

Communication and public engagement objectives

Our objectives are to ensure legal duties to engage and consult are met whilst maintaining public confidence in health and social care and supporting safe and robust reconfiguration of services.

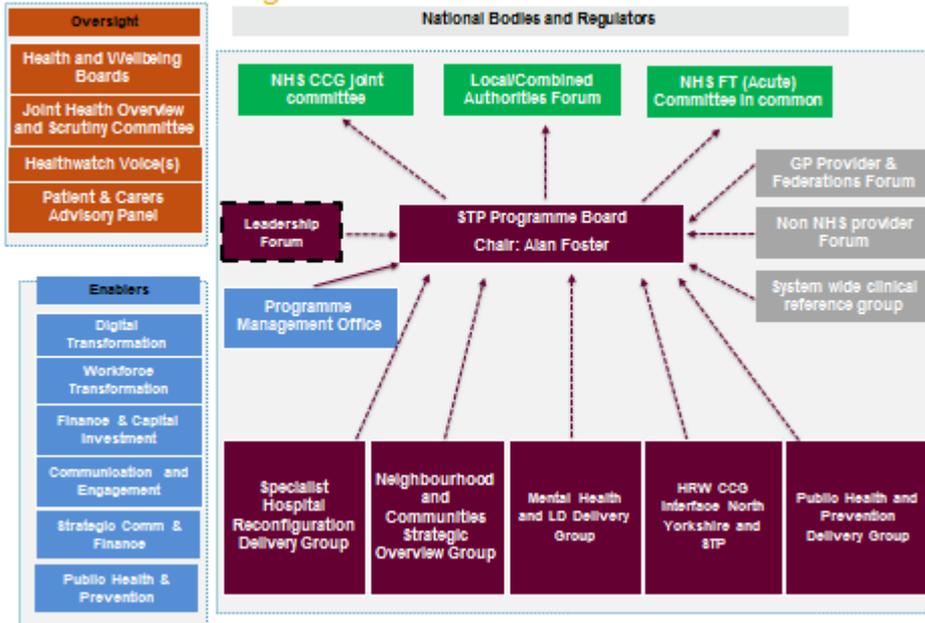
Communications and public engagement strategy includes

- Public engagement
- Clinical engagement
- Staff engagement

Outline approach

- Stage 1 – Publication and engagement on the plan
- Stage 2 – Use insights from stage 1 to inform the consultation
- Stage 3 – Formal consultation
- Stage 4 – Use insights from consultation to inform the decision making

STP - overview of governance structure



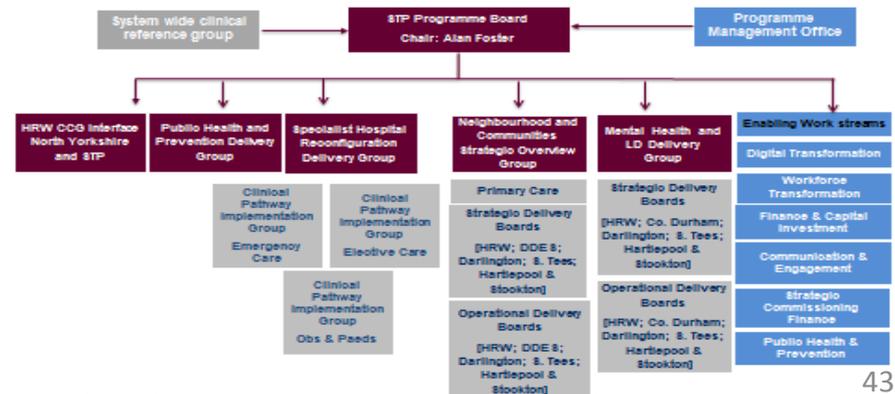
To deliver the key purpose of the STP the Programme Board will have major delivery groups along with enabling work-streams. The emphasis is building on the positive Better Health Programme brand via public engagement over the past two years and ensuring a safe transition into a system wide STP. System owners are in place for each of these Delivery Groups and work-streams.

The development of a “handbook” to set out the clarity of purpose that adds value is the next critical step in the work programme.

The draft governance framework has been developed in partnership with the CCGs, NHS FTs (All Providers) and Local Authorities. It demonstrates a fully engaged and whole system leadership approach. A number of development sessions have been held and this emerging model will continue to develop via a Leadership Forum.

The STP Programme Board has met on several occasions supporting the development of a system wide strategy. The decision making committees are approved. The Joint CCG Committee (Better Health Programme) approved terms of reference are currently being refined as a consequence of the transition from BHP to STP. These are subject to approval at the next CCG Governing Bodies. The NHS FT Committee in Common has agreed terms of reference subject to approval by respective Boards in November. The Local Authority statutory decision making arrangements are clear and will focus on co-design of strategy development in the Programme Board.

STP – Programme Management office and indicative STP work streams



System management – Financial flows, contracting mechanisms and commissioning

Reshaping how care is provided, working through integrated pathways that incentivise the delivery of joined up services, single points of access and system wide clinical provider networks, will require an innovative approach to financial flows that incentivise system outcomes. We envisage the need to streamline the contracting process and reduce transactional activity at individual provider and commissioner level.

Managing financial flows within the STP control total and recognising that there are provider cost reductions that are not picked up in PBR tariffs, we are working towards a capitation based approach across the system. This will require the development of appropriate financial flows and incentives to support delivery across Acute, Community (including Social Care) and Primary Care pathways.

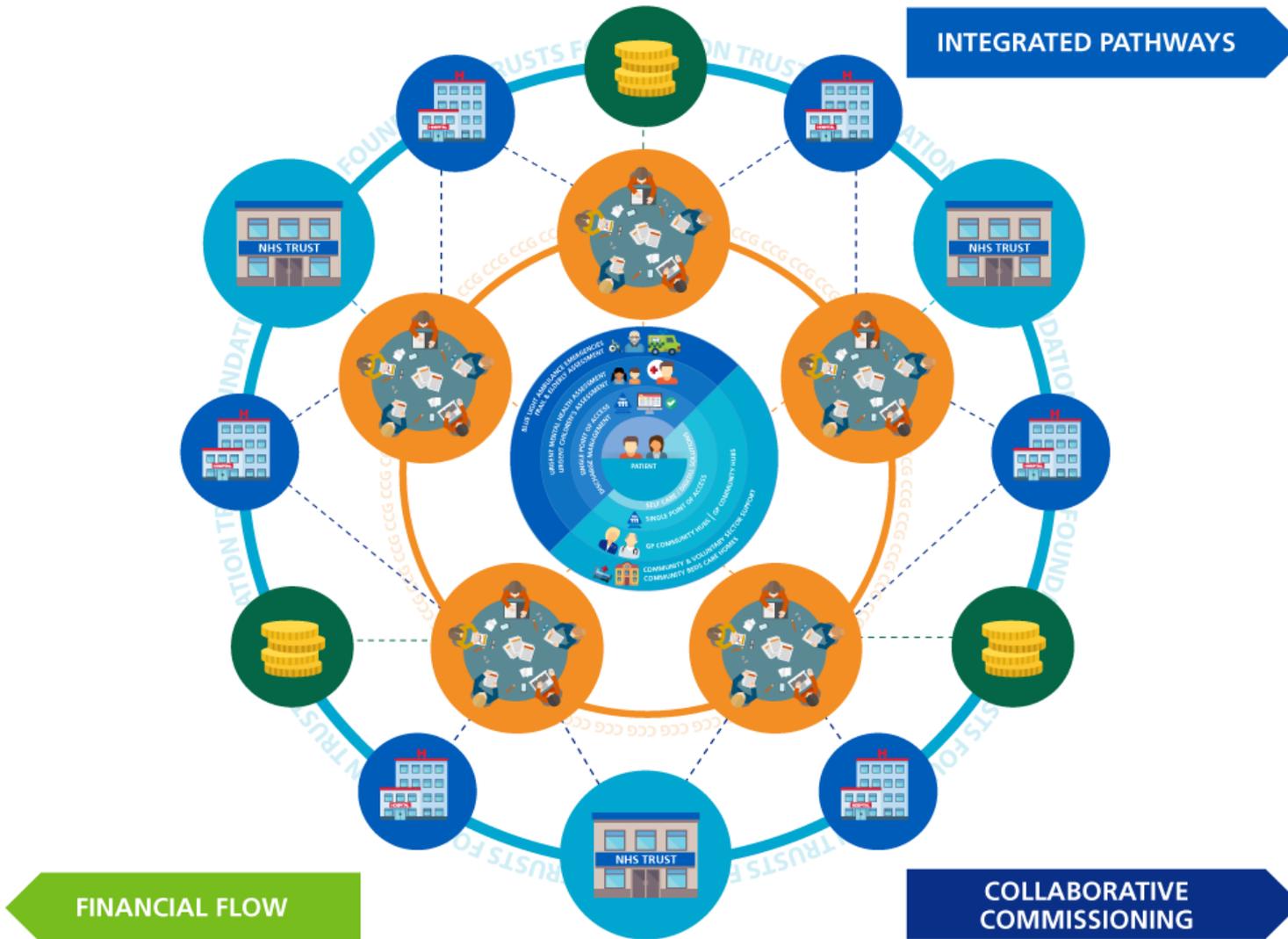
We will continue to explore the use of new contracting models that support the streamlining of our commissioning and provider activities and reduce duplication, including the use of the Prime Contractor, Prime Provider Contract and Alliance contracting models where applicable to the service model being delivered. This approach will also require strong collaborative commissioning arrangements that work across current organisational boundaries.

The CCGs are therefore working on arrangements to strengthen collaborative commissioning processes across our footprint that match proposed changes to the provider landscape and approaches to delivery. These arrangements are intended to deliver better outcomes for patients, maximise the benefits of clinically led commissioning deliver management efficiencies that will contribute to the system wide financial challenges.

Building on longstanding North East wide commissioning arrangements we are determining those activities that will take place at each level of care and across different geographical areas including how we strengthen integration arrangements with social care. These arrangements will be in place in shadow form by the end of the year and will be further developed throughout 2017 so that fully integrated commissioning approaches are in place by the autumn of 2017.

The graphic on the following page represents this work.

System management – Financial flows, contracting mechanisms and commissioning



APPENDIX 1

FINANCIAL & ACTIVITY ASSUMPTIONS

Finance and activity assumptions

Summary Solutions

Neighbourhoods & communities	Acute reconfiguration	Early Intervention & Prevention	Other
£42.9m	£110.7m	£9.6m	£100.8m

Summary Solutions – Activity Reduction

Neighbourhoods and Communities						
	17/18		18/19		19/20	
	Numbers	%	Numbers	%	Numbers	%
Pathway changes						
Consultant led first outpatient			-87,260	-6.83	-261,780	-19.86
Elective			-969	-0.40	-2,907	-1.42
Non Elective			-11,017	-7.80	-33,052	-22.85
Accident and Emergency			-37,150	-7.73	-111,450	-22.46
Rightcare Variation						
Elective	-8,922	-4.97				
Non Elective	-4,347	-3.19				

Our ambitious plan supports a direction of long term clinical and financial sustainability and is based on these strategic assumptions;

- The underlying financial position is based on 2016/17 financial plans
- The cost and tariff inflation used when modelling the financial gap is based on the 5 year planning guidance, covering 2016/17 to 2020/21
- The activity growth included in future years modelling is based on NHS England's growth percentages, issued to individual STP footprints
- Of a significant shift in activity from hospital based services to community based provision
- There will be a shift in frail older people currently admitted for NEL purposes from acute to a community based provision
- Current A&E activity will shift to urgent care centres
- Potential capital investment of £115m

By nature of the complexity of the change this makes delivery high risk. Arrangements are in place through the governance framework to mitigate these risks.

NB Whilst the slide demonstrates the activity shift from acute care (A&E and frail elderly) it does not reflect how the activity into integrated community services (urgent care centres & frailty units) will be counted

Finance assumptions

Triple Aims	STP Priorities	Efficiency
Health & Wellbeing Gap	Early Intervention and Prevention	<p>Early intervention and Prevention £9.6m</p> <p>Consolidation across sites for obstetrics, paediatrics and NICU</p> <ul style="list-style-type: none"> • Consolidation of obstetrics £4.8m • Consolidation of paediatrics services £4.2m • Consolidation on NICU £0.6m
		<p>Neighbourhoods and Communities £42.9m</p> <ul style="list-style-type: none"> • Role substitution £11.0m • Primary care Demand Management £16.5m (Based on CCG RightCare packs, current average of top 5 opportunity) • Not in hospital £15.4m
Quality & Care Gap	Neighbourhoods and Communities	<p>Reconfigure Hospital Services £110.7m</p> <ul style="list-style-type: none"> • Better Health Programme (Consolidation of A&E, Acute Surgery and Acute Medicine) <ul style="list-style-type: none"> ➢ Consolidation of A&E departments on to two sites £2.2m ➢ Consolidation of Acute Medicine onto two site £7.2m ➢ Consolidation of Acute Surgery onto two sites £2.0m • Carter opportunities: Reducing unwarranted variation £36.6m • Pathology Collaboration: Consolidation of pathology services £21.7m • Consolidation of Providers: Reduced corporate costs <ul style="list-style-type: none"> ➢ Consolidation of provider Boards £2.0m ➢ Corporate and Admin reduction £39.1m
		<p>Other Financial Savings £100.8m</p> <ul style="list-style-type: none"> • Business as usual CIP £42.8m • STF Funding £41.5m • Commissioning Efficiencies £5.9m • Medicines management savings £10.6m
Funding & Efficiency Gap	Reconfigure Hospital Based Services	
	Technology	