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

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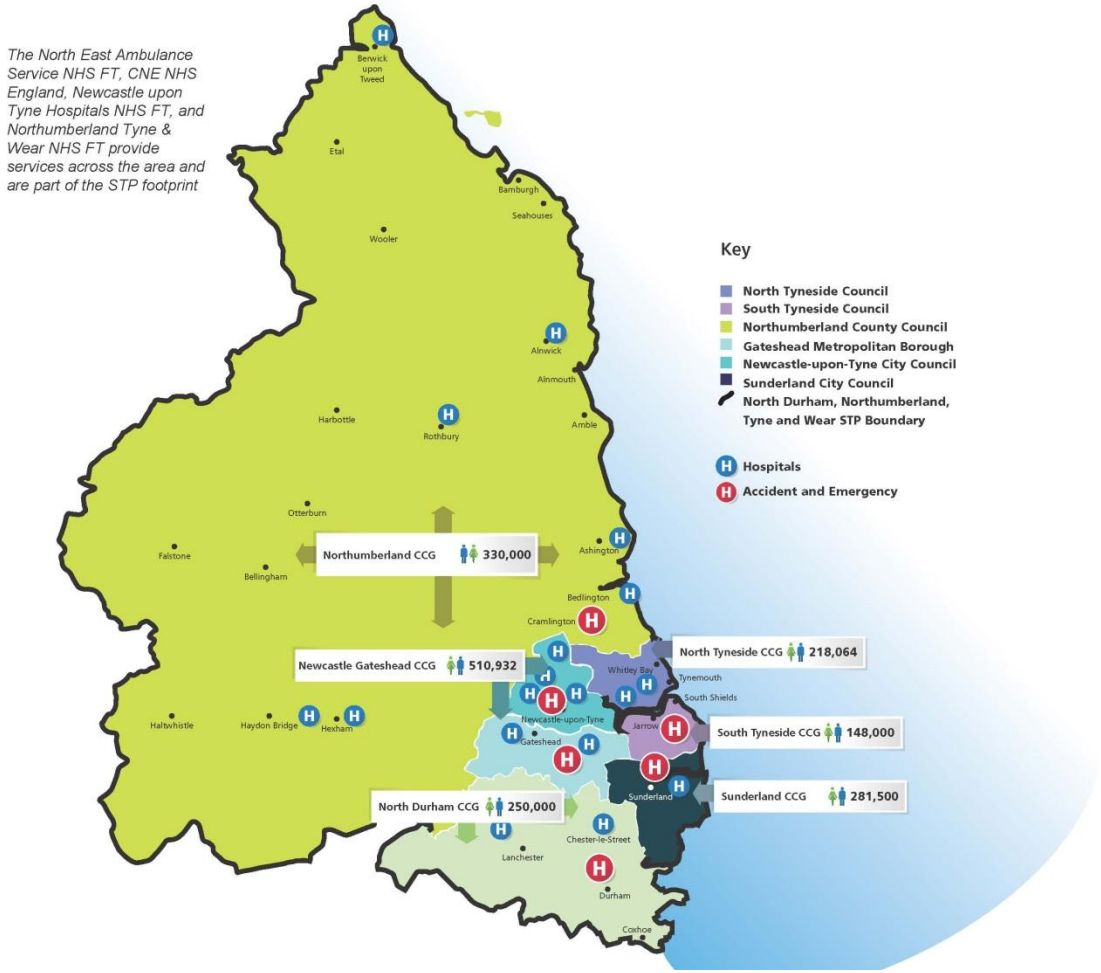
The Northumberland Tyne and Wear and North Durham (NTWND) STP footprint is a new collaboration covering a total population of 1.7 million residents across three Local Health Economies (LHEs):

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

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



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

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

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

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

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

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

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

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

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

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

Contents page

1.1 OUR NTWND STP VISION

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

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

Our c***ollective vision*** for NTWND is simple yet effective:

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

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

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

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

As a system we will be moving:

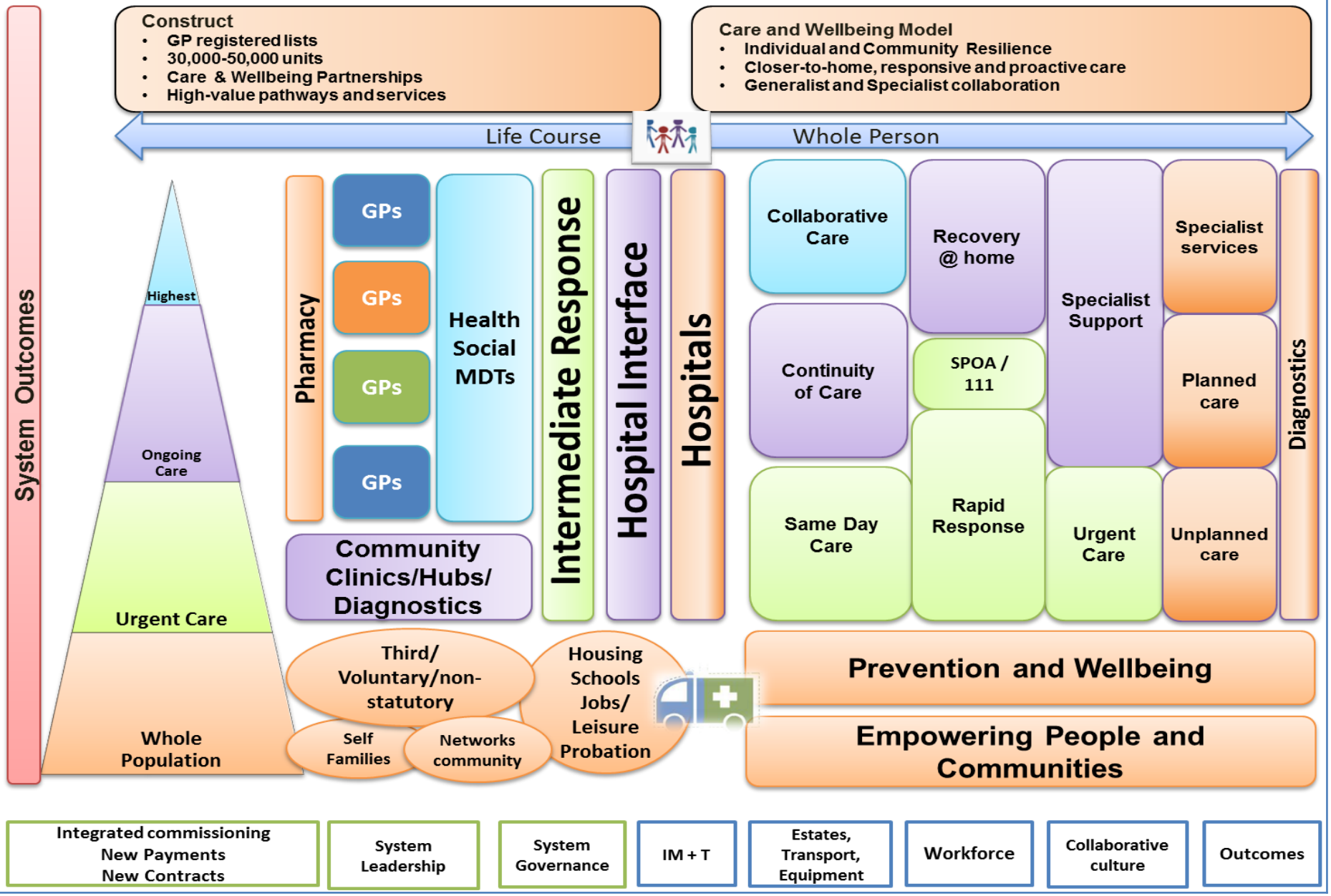
From	To
Fragmented Payment	**Unified Budgets**
Hospitals at the centre	**Home as the hub**
Excellent soloists	**High performing teams**
Moving people	**Moving knowledge**
'What is the matter with you?'	**'What matters to you?'**
A sense of scarcity	**A sense of abundance**

1.2 OUR EVOLVING HEALTH AND CARE MODEL

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

Our framework is illustrated on the following slide.

NTWND STP – our evolving Health and Care Model



1.3 UNDERSTANDING OUR THREE GAPS

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

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

Understanding our three gaps

GAPS

HEALTH and wellbeing

27% of population live among 20% most disadvantaged areas in England — Deprivation and broader social determinants set the foundation for poor health across the STP

16% women smoking at time of delivery (11% in England) — Children are not always given the 'Best Start in Life'

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

6.7% of adults on a diabetes register, (6.4% in England) — High prevalence of risk factors that lead to potentially preventable illness, eg smoking attributable hospital admissions over 50% higher than across England - nearly 25,000 admissions per year.

20% higher early death rate in NTWND due to cancer than across England — High levels of early mortality from cancer, respiratory disease, and cardiovascular disease

59.6 years Healthy life expectancy in NTWND (64 years in England) — Growing older population with associated increases in frailty and multiple morbidity

CARE and quality

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

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

Inconsistency
of pathway between local and specialised services.

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

Clinically sustainable
services whilst maintaining high levels of care and quality.

Capacity and resilience
of community care and community service.

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

7 Availability of seven day services and mental health advice.

FUNDING and finance

System efficiency and finance challenges:

£641m
gap across health by 2021

a figure as high as

£904m
Indicates the joint health and social financial gap from work to date with local authorities

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

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

1.4 PLAN ON A PAGE

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

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

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

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

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

STP Transformation Areas

- Scaling up prevention, health and well being to improve the physical and mental health of our population and reduce inequity
- Out of hospital collaboration to develop alternative service models, reduce variation and raise quality of care in community settings
- Optimal use of the acute sector to improve experience of care, achieve better outcomes and create a sustainable model

STP Delivery Areas

- Ensuring every child has the best start in life
- Reduce the prevalence of smoking and obesity and reduce the impact of alcohol
- Radical upgrade in our approach to ill health prevention and secondary prevention
- Enhance people's ability to self care, increase their self esteem and self-efficacy
- Roll out Making Every Contact Count (MECC)
- Maximise the opportunities to integrate Health and Social Care
- Implementing the GPFYFV
- Improve access to high quality care
- Acute services collaboration across clinical pathways and service models
- Specialist commissioning

LHEs / Collaboration/ NCM

LHEs	Collaboration/ NCM
Northumberland and North Tyneside	NSECH
	PACS / ACO
Newcastle Gateshead	GHFT and NUTH collaboration
	EHCH and MCP/PACS
South Tyneside, Sunderland and North Durham	STFT and CHSFT partnership UHND
	MCP

Cross cutting themes

- Learning Disability services – TLP (Adults and Children)
- Cancer Alliance and Strategic Delivery
- Mental Health 5YFV (Adults and Children)
- Women (LMS and Better Births and Children's (0-19 years)

Closing the financial gap

Size of residual financial challenge by 2021

£641m
Financial challenge

Summary Solutions

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

Workforce	Information Technology – Great North Care Record	Estates – One Public Estate	Accountable and outcome-based systems

1.5 IMPACT OF OUR PLAN – WHAT WILL IT DELIVER?

NTWND STP impact - Health and Well being

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

Better Health impact by 2021

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

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

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

Communities
- ✓ Sustainable and connected communities -Improved social networks

Shifting to a new system

OLD SYSTEM

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

NEW SYSTEM

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

NTWND STP impact- Care and Quality

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

Better Care impact by 2021

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

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

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

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

Shifting to a new system

OLD SYSTEM

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

NEW SYSTEM

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

NTWND STP impact– Finance and efficiency

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

The specific areas of focus are:

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

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

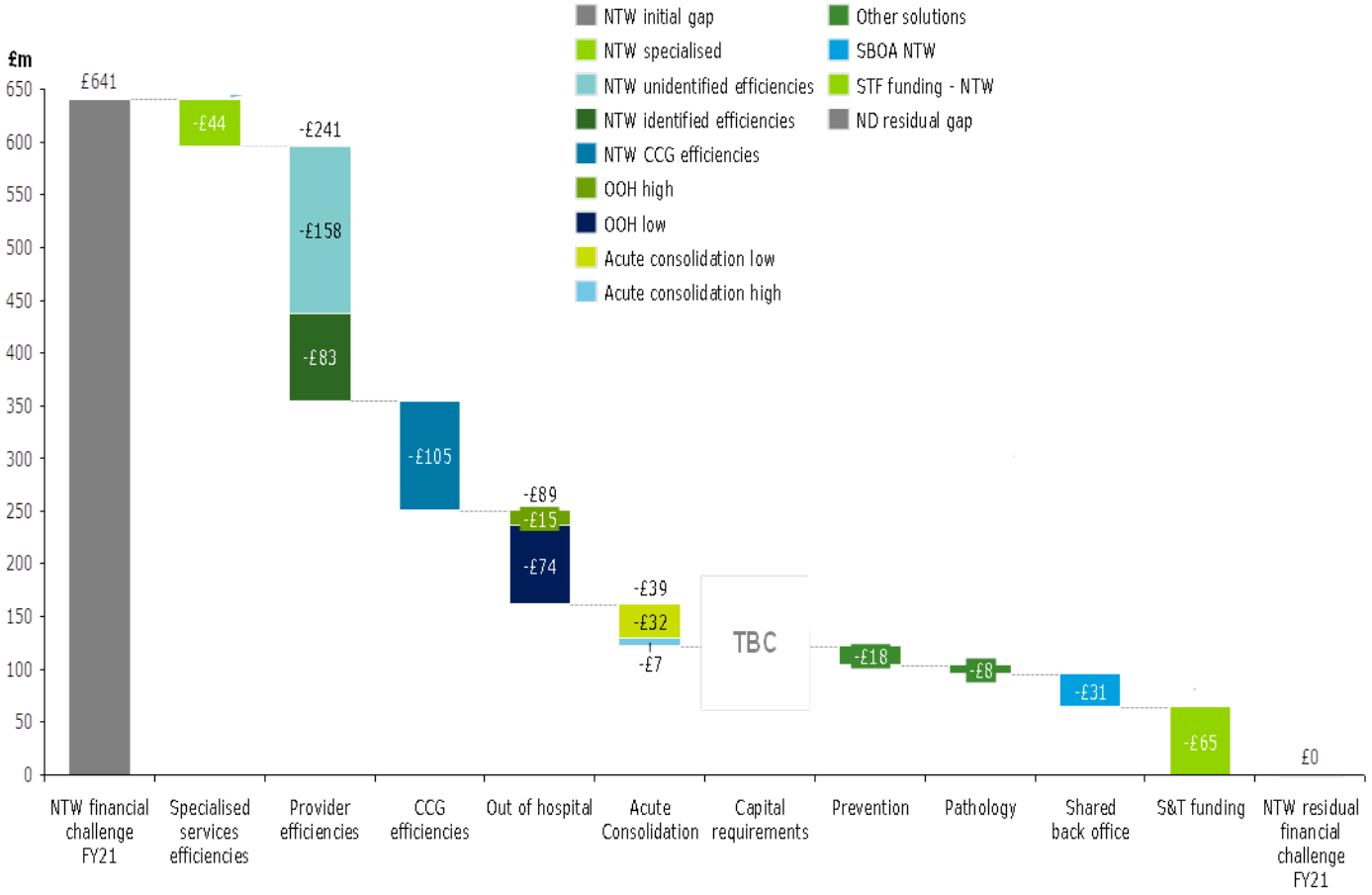
Acute reconfiguration. There are currently seven acute sites operating in the footprint, and the system is looking actively into options for consolidation of services across sites to make better use of available resources and ease workforce pressures. The collaboration between City Hospitals Sunderland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

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

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

NTWND STP impact– Finance and efficiency

NTWND Waterfall diagram



1.6 HIGH LEVEL TIMELINE FOR DELIVERY

NTWND STP high level timeline

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

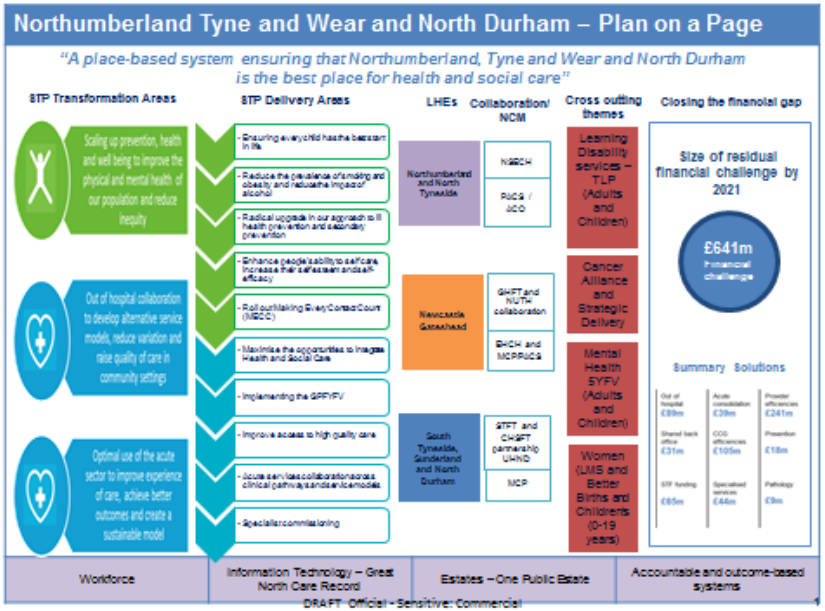
		16/17	17/18	18/19	19/20	20/21
SCALING UP PREVENTION & WELLBEING	Best start					
	Prevention Services					
	Healthy behaviours					
	Unemployment					
	Selfcare					
	Community Assets					
	Workforce & MECC					
Out of hospital collabortaion	Nortumberland & North Tyneside					
	Newcastle Gateshead			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

Develop

Implement

Spread

1.7 HOW OUR PLAN ON A PAGE IS BROKEN DOWN



1.7A STP TRANSFORMATION AREAS AND DELIVERY PRIORITIES

OVERVIEW OF STP DELIVERY PRIORITES FOR OUR 3 TRANSFORMATIONAL AREAS

Upscaling Prevention, Health and Wellbeing	• **Reduce the prevalence** of smoking and obesity, and reduce the impact of alcohol • Support **Fresh and Balance, and a region-wide approach to obesity, NICE smoke free standards** across all NHS and local authority health and care services and contracts and Implement **a stop before your op pathway** for elective surgery, • Radical upgrade in our approach to **ill health prevention and secondary prevention** • Implement **hospital-based stop smoking services and alcohol brief advice**,, Roll out the **diabetes prevention programme**, Develop and resource clear **exercise-based recovery, rehabilitation and maintenance** model, Increase **flu immunisation** rates across the STP, particularly ensuring high uptake in frontline health and care staff, pregnant women and high risk groups, • Collaborate across the system to ensure the **best start in life** • Create a network approach to support **community asset-based approaches,** including social prescribing, working closely with the third sector – for example, ensuring that exercise and community connectedness are a first line treatments for conditions such as depression and pain, • **Collaborate with NECA partners** to support the long-term unemployed back into work • Enhance people's **ability to self-care**, increase their independence, self-esteem and self-efficacy • Roll out **Making Every Contact Count (MECC)** as an integral part of our workforce strategy with HENE
Out of Hospital Collaboration	• **Maximise the opportunities within each LHE to integrate Health and Social Care** - aligning with the emerging NECA Health and Social Care Commission, Better Care Fund programmes and National Network and Health and Wellbeing priorities • **Implement the General Practice Five Year Forward View** to ensure a vibrant and sustainable sector including clustering and workforce development • Develop optimum evidence based **pathways of care** to improve outcomes and reduce variation working alongside academic bodies (e.g. NICE), Clinical Networks and Senates. Use analytical and modelling tools such as Right Care • **Clear tariff based prevention pathways (primary and secondary)** • **Improving access to high quality care**. Working collaboratively across the system to support all our providers achieve CQC rating of good or outstanding. Continue to use Regional Value Based Commissioning process
Optimal use of the acute sector	• Ensure **New Care Models and Pioneers can** improve experience and quality. Formalise learning and sharing of best practice from new models of care programmes. Harness research and innovation working with AHSN. • Work in partnership with **Specialised Commissioning** to develop whole system, change. • Provide **Mental Health** care that is 'closer to home' and easily accessible, coordinated and supported by appropriate specialist input implemented through the MH5FV • Implement the North East and Cumbria **Learning Disability Transformation plan** to reduce reliance on inpatient admissions and develop community support approaches whilst promoting prevention and early intervention • Work to date has been to understand existing **hospital work programmes** in each of our LHEs and explore opportunities for STP-wide alignment across care pathways, services lines, back office sharing, pathology to improve the quality and experience of care and maintain sustainability within a future hospital system • The newly created '**Local Maternity System' (LMS**) will co-ordinate and oversee a programme of work to develop this new, innovative, and transformative service model

Upscaling prevention, health and well being

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

Using population intelligence we have defined the following four gaps:

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

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

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

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

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

Out of Hospital Collaboration – GPFV and New Care Models

- The quality of our general practice, community health and social care services has been high, but the pressures on these services are increasing and workforce recruitment and retention is challenging.

- We will drive change to the Out of Hospital system through recognised LHE programmes (New Care Models, GPFV) under our overarching Out of Hospital framework and link directly with secondary prevention approaches.

- We will explore and develop alternative closer to home service models that improve productivity and create value by working with communities to provide need based support and reduce the reliance on hospitals and care homes. In doing so, we will optimise:
  - The opportunities to integrate Health and Social Care – NECA and Better Care
  - Implement the General Practice Five Year Forward View.
  - Develop evidence based pathways of care (e.g. Rightcare) to improve outcomes, reduce variation and improve quality (achieve CQC rating of good or outstanding) to identify opportunities for more efficient service delivery (Regional Value Based Commissioning process) releasing opportunities for investment in 7 day services.
  - Ensure New Care Models can improve experience and quality. Formalise learning and sharing and harness research and innovation working with AHSN, clinical senates etc.

- By 2021, our STP footprint will aim to achieve the outcomes set out by National Bodies (NHSE, NHSI, CQC) as well as close NTWND's 7 gaps recognised across care and quality.

- To implement the General Practice Forward View each LHE in partnership with NHSE have started conversations at multiple levels resulting in the identification of the following priority areas for the GPFV – Care re-design, workload, workforce, voice for General Practice, Quality and Investment and co-commissioning.

- Ensure spread of New Care Models (Multispecialty Community Provider [MCP] and Primary and Acute Care System [PACS]):
  - NTWND STP and DDTHRW STP with partners have set out a plan to roll out New Care Models, as one of the key delivery mechanisms for our STP, in particular, as part of our Out of Hospital Framework. Our Out of Hospital Framework uses the MCP and PACS models as a critical underpinning philosophy.
  - For the entirety of the North East, we would anticipate that the MCP and PACS models will become the key delivery mechanism for the majority of sites. The thinking, philosophy and underpinning frameworks behind the MCP and PACS New Care Models are absolutely in line with the direction of travel for the delivery of the STP.

- Vanguard case studies and success to date are detailed in annex

Optimal use of the Acute Sector

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

Our future state and ambition is to :

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

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

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

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

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

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

Further details on Optimal Use of Acute Sector in annex xx

Transforming Mental Health – MH5YFV

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

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

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

Further detail on LHE Operational Plans is provided within xxxx

Northumberland and North Tyneside LHE – key deliverables

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

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

From 2019/20 onwards we will:

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

Newcastle Gateshead LHE – key deliverables

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

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

From 2019/20 onwards we will:

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

Sunderland, South Tyneside and North Durham LHE – key deliverables

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

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

Clinical services reviews

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

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

From 2019/20 onwards we will:

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