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

Section 2
Annex to summary plan

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2.1 EMERGING CHALLENGES

Emerging challenges

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

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

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

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

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

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

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

2.2 LHE DELIVERY PLANS 2016/17 – 2018/19

	Northumberland and North Tyneside LHE Plans for 2016/17 -2017/18	Plans for 2018/19
Scaling up prevention, health and well being	• Deliver the 0-19 & 0-2 Agenda • Work with partners in health and social care, public health, housing, leisure, policing and the Charitable and Voluntary sector, where possible and appropriate, to signpost people into services to support them with issues relating to the wider determinants of health • Implement evidence based smoking, alcohol and obesity treatment and prevention plans, promoting better prevention, detection, treatment, and education. • Establish Alcohol Assertive Outreach Teams (AAOT) to reduce repeat users of hospital and other services such as police and social services, if these are not already included in the Balance NE plans • Support the Mayor's pledge to address inequalities • Secondary/primary prevention considered in all acute contacts • Develop Community Health and Well Being Hubs • Agree potential for material shift in investment and focus towards long term prevention • Healthy Place programme • Integrated H&SC prevention and early intervention for all adult age groups	• Shift in financial levers through capitation and ACO in shadow form. • Ensuring secondary and primary prevention is considered in all acute contacts, with plans in place for audit to ensure follow through. • Development of robust approach to interventions, including social prescribing and health improvement services in health, social care and CVS sectors • Continue development of Asset-based and community-centred approaches to health and wellbeing that will lead to increased *capacity* of individuals to change behaviours
Out of hospital collaboration	• New Models of Care implemented to support most vulnerable frail elderly population through targeted support • Pathways for Frailty developed • LTC management strategy developed • Develop innovative workforce strategy to allow movement across care settings. • Primary care engagement and support GPs to develop capacity and workforce	• Greater hospital collaboration • One Estate priorities progressed • Continued implementation of workforce strategy • Review of scope for increased role for domiciliary and residential staff supported by telecare/tele-monitoring • Training designed for all health staff to identify mental health needs in patients being seen for physical health concerns and to support mental wellbeing e.g. social prescribing
Optimal use of the acute sector	• Development of the PACS / ACO model • Develop ACO Strategic commissioning functions, financial modelling/due diligence, capitated budget/, schemes of delegation and business case submission. • Implementation of Northumberland ACO during 17/18 • Formal NTW wide risk and escalation arrangements for 'at risk' services • Progress 'One Estate' strategy • Right Care - MSK, CVD, Respiratory & Gastroenterology • LTC strategy incl. New Models to support frail elderly population (targeted support) • Prioritise service collaboration based on sustainability risks and workforce gaps • Targeted evidence based work between acute providers, primary care and commissioners to manage demand.	• Implementation of increased collaboration and shared services amongst acute, primary, community and MH providers as appropriate to streamline pathways • Continue to broaden and develop Northumbria's Acute Collaboration Model.
Mental Health	• MH well-being and promotion activity occurring across NL and NT • Sustained improvements to access to mental health services at all tiers	• Training for mental health staff to identify physical health needs, and to offer advice on lifestyle factors such as smoking and weight reduction, including social prescribing and community assets.

	Newcastle Gateshead LHE plans for 2016/17 -2017/18	Plans for 2018/19
Scaling up prevention, health and well being	• Enhance approach to secondary preventative lifestyle support extending access by 2021 to a minimum of 20,000 people per year • Develop opportunity for people to access social prescribing using learning from 'Ways to Wellness' / 'Live Well Gateshead ' and other local initiatives • Work with Northumbria University to embed outcomes from the Health Champions and Care Navigator pilots • Embed an asset based approach through our 'Connected People Connected Communities' / 'Achieving More Together' programmes' • Work with Northumbria University design school using a proof of concept methodology to develop community led approaches to health and well being • Continue to influence environmental and housing development proposals and decisions to support primary prevention and positive well being • Design our approach to positive health and well being for children and young people 'Enhancing Minds, Improving Lives and Amazing Start' • Focused tobacco quits and harm reduction in vulnerable populations	
Out of hospital collaboration	**Intermediate Care** • Undertake comprehensive review of Intermediate Care Pathway • Review focuses upon the four key areas of a and what model might deliver against the '2 day wait indicator' proposed within the National Audit of Intermediate Care (NAIC) & support local implementation to meet priority gaps. • Reviewing how the Better Care Fund (BCF) and New Models of Care agendas (NHS 5 Year Forward View) locally **Community Services** • Roll out of the Gateshead Community Service Framework + Transformation Implementation plan • Engagement + Involvement in co-design of community services in Newcastle based around the NuTH strategic framework **General Practice** • Undertake a review of OOH Primary Care provision in Walk-in Centres • PEP scheme, All NGCCG 16/17 practices with form on LTC, Planned Care, urgent in house PC. • Develop and test innovative Primary Care workforce roles including Practice Nurse Career Start, Navigator and GP fellowship schemes • Support implementation of the 10 high impact actions for General Practice	**Intermediate Care** • Establish integrated services at an operational level aligned to the new models of care. Explore single management structure. • Possessing a Single Point of Access, assessment process, patient record and performance management framework • Established joint induction and training programmes with staff working across services • Apply new funding models which better incentivise a whole system approach i.e. capitated budgets? • Introduce greater emphasis in Mental Health within the intermediate care system to achieve parity of esteem ambitions by having mental health practitioners as part of the integrated team function • Demand and capacity investment agreed with commissioners for step up and step down requirements across the 4 key areas and delivered through a pooled budget **General Practice** • Support and grow the PC workforce – PC Nurse and navigator roles, GP fellowships, HEE practice training hubs roll out. • Improve access to GP in and out of hours - Seamless out of hours provision, GP OOH, WIC, Community/cluster of practices provides extended "in-hours" • IT deployment and Utilities - Patient empowerment – telehealth/ Practice and Community IT systems unified access/ On line booking and consultation • Workload – 10' high impact actions fully embedded/effective federations supporting practice/ NHSE pilot site GPFV early adopter
Optimal use of the acute sector	• Review clinical services to identify outliers in care and quality • Discuss and agree clinical pathways ripe for collaboration. Areas identified to date include Hyper-acute stroke, Vascular, Interventional Radiology, ENT, MSK/Orthopaedics, Paediatrics, Diagnostics and Community Services. • Ensure clinical engagement and ownership of service provision to develop implementation / change plans. This will include details of 'what will be different for patients'.	• Strive for continuous improvement and delivery of the key requirements around access, quality, safety and patient experience. Putting patients at the heart of all that we do • Develop plans to address any identified care and quality outliers • Look to extend the scope and scale of services for collaboration. This may include looking beyond health. • Maximise opportunities for partnership working recognising the strength and assets of both Trusts • Engage and consult with stakeholders about any potential changes to clinical pathways as necessary and appropriate
Mental Health	• Deciding Together (adults) - develop the agreed inpatient bed configuration alongside enhancement of the community service model, urgent care response system and a more responsive IAPT service with a focus on supporting recovery. • Expanding Minds Improving Lives (children) - develop a responsive CAMHS model with improved access across a range of locations	

	South Tyneside, Sunderland and North Durham LHE Plans for 2016/17 -2017/18 (South Tyneside, Sunderland)	Plans for 2018/19
Scaling up prevention, health and well being	• Strong focus on the best start in life – through reviewing maternity services and 0-19 services • Self care and prevention programme, "making every contact count" and "A Better U" • Embedding an asset based approach to self care – including developing resources to support prevention and self care • Enhancing support to workplaces to promote a healthy and active workforce – through development of the Workplace Health Alliance • Exploring locality-based approaches to tobacco control, alcohol and healthy weight • NHS Rightcare - pathway transformation for respiratory disease, cancer and CVD – from prevention (including Change4Life), secondary prevention & self care to end of life • To enhance long term condition management, through proactive self care (secondary prevention)	• Embed locality based approaches to tobacco control, alcohol and healthy weight • To continue NHS Rightcare pathway transformation
Out of hospital collaboration	• Continuation of out hospital and integrated care models including sharing of learning and exploring model alignment • Deliver the GPFV with a focus on addressing the resilience of general practice including workforce developments; developing general practice at scale and improving access to general practice. • Redesign pathways across primary and secondary care in light of learning from Right Care and productivity opportunities	• Take the best for the 2 models to develop a "blended" out of hospital model • Review progress and continue to implement the GPFV to support the sustainability and transformation of general practice. • Review and further implement the new pathways across primary and secondary care
Optimal use of the acute sector	• Single Clinical operating model created • Full service reviews completed across a number of pathways including Stroke • Options for service delivery consultation	• Full service reviews completed across every service across the two hospital sites • Options for service delivery consultation • To share assets and workforce
Mental Health	• Community Mental health service - easier access to low level interventions for adults and children • Mental health reconfiguration programme largely complete	• Sustain improvements to Mental Health Services at all tiers taking account of the MH 5YFV

	South Tyneside, Sunderland and North Durham LHE Plans for 2016/17 -2017/18 (North Durham)	Plans for 2018/19
Scaling up prevention, health and well being	Whilst Public Health partners have local priorities and initiatives key initiatives and priorities have been identified that entail close working across all partners to deliver a 'scaled up' approach based on best practices already in place across parts of the footprint s including the voluntary and community sector. • Best start in life • Prevention pathways in acute contracts - adhering to nice guidance for nicotine addiction, alcohol addiction, obesity • Prevention pathways in maternity contracts - including perinatal mental health and lifestyle interventions • 0-19 but specific focus on 1001 critical days • Scaling up wellbeing community interventions as part of push for self care to become system default • Prevention and earlier identification of dementia - wellbeing evidence - what's good for your heart is good for your head- physical activity, diet, alcohol • Worklessness interventions in primary care – e.g. IAPT • Alignment of Wellbeing service to the community hub development • Diabetes prevention programme	
Out of hospital collaboration	Agree an MCP model of care which ensures the sustainability of primary and community care now and in the future. To deliver high quality care which is person centred, irrespective of organisational boundaries. People will receive continuity of care that is effectively co-ordinated and delivered where possible close to home. Place based community hub model • Discharge to assess • Develop frail elderly rapid access clinics. • Intermediate care plus • MSK community service • Accountable Care Network development • Implementation of extended access to primary care for vulnerable adults • Development and implementation of community hub model and place based budgets	Progress the North Durham MCP Health and Social Care Integration delivery programme . Further development and implementation of community hub model as part of an accountable care network. Further implementation of extended primary care aligned to community hubs and urgent care pathways. Review progress and continue to implement the GPFV to support the sustainability and transformation of general practice. Continue to roll out career start.
Optimal use of the acute sector	• Optimal Use of Acute Sector through collaboration across clinical pathways. • Shape services based on need and clinical standards and elective pathway redesign in conjunction with Newcastle/Gateshead	Integrated urgent and emergency care centre (UHND site)
Mental Health	• Delivery of the mental health prevention as part of the Five Year Forward View. • Implementation of Children and Young Peoples Mental Health and Wellbeing Plan • Implementation of the Mental Health Five year Forward View • Alignment of mental health and talking therapies to community hubs	

2.3 UPSCALING PREVENTION , HEALTH AND WELLBEING

See section 3 for detailed delivery plans

Upscaling prevention health and well being

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

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

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

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

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

NTWND STP impact and ambitions - Health and Wellbeing

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

Better Health impact by 2021

Citizens

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

System

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

Workforce

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

Communities

- ✓ Sustainable and connected communities -Improved social networks

Priorities

Give every child the best start in life

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

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

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

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

Ambitions 2021

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

2.4 OUT OF HOSPITAL COLLABORATION

See section 3 for detailed delivery plans for:

GPFFYFV
Mental health
Learning Disabilities
Urgent and Emergency Care

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

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

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

In 2016/17, we are taking the spread of NCMs forward through the following:
Using the MCP/PACS care model to articulate the out-of-hospital model in the STPs, as a strategic framework.
Resource to support key enablers across the patch e.g. workforce.
Supporting local teams to be the next wave of MCP/PACS.

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

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

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

Vanguard case studies and success to date are detailed in annex

New care models learning and sharing
- Capitalising on existing work within our STP footprint to optimise service provision

Sunderland 'All Together Better' MCP Vanguard

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

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

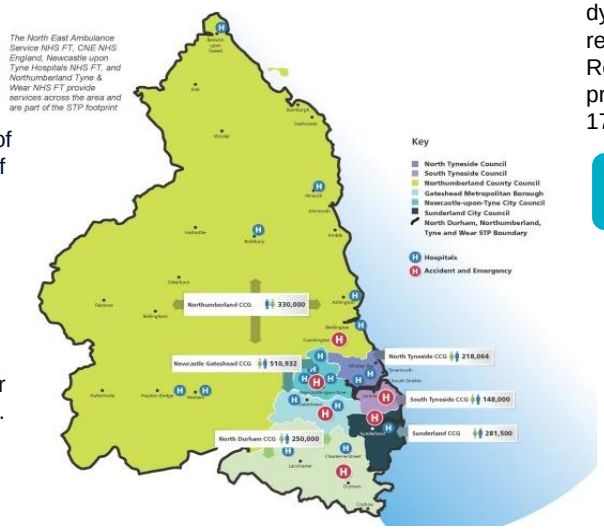
Working across boundaries: Sunderland has 2 GP federations and a city wide NHS contract for engagement avoiding the need for 51 contracts between CCG and each practice. Digital solutions to support the model are a key part of the programme and in the MCP fast follower cohort looking at new contracting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

Newcastle Gateshead Enhanced Healthcare in Care Home Vanguard

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

Impacts on the wider system: 14.5% reduction in care home NEL activity – average length of stay (LOS) has fallen from 13.2 to 11.8 days.
Reduction in LOS for those aged 65 and over – average LOS reduced from 7.79 days in 14/15 to 7.42 for 15/16.
Reduction in no. of patients aged 65 and over dying in hospital –trends suggest a 5.2% reduction from 14/15 to 15/16.
Reduction in Oral Nutritional Supplements prescribed – reduction in prescriptions by 17.9% (Gateshead) and 13.4% in Newcastle.

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



Northumberland PACS Vanguard

Description: The model will move care outside of hospital for primary care based services to proactively manage more complex patients.
Impacts on the wider system: 30% reduction in emergency admissions releasing £8m into the local health economy
Working across boundaries: Moving towards an ACO is underpinned by key stakeholders being committed to demonstrating system leadership to ensure services provided are in best interests of local population rather than restricted by organisational structures.

Northumbria Acute Trust Collaboration Vanguard

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

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

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

South Tyneside Integration Pioneer

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

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

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

2.4.1VANGUARD CASE STUDIES

Northumberland

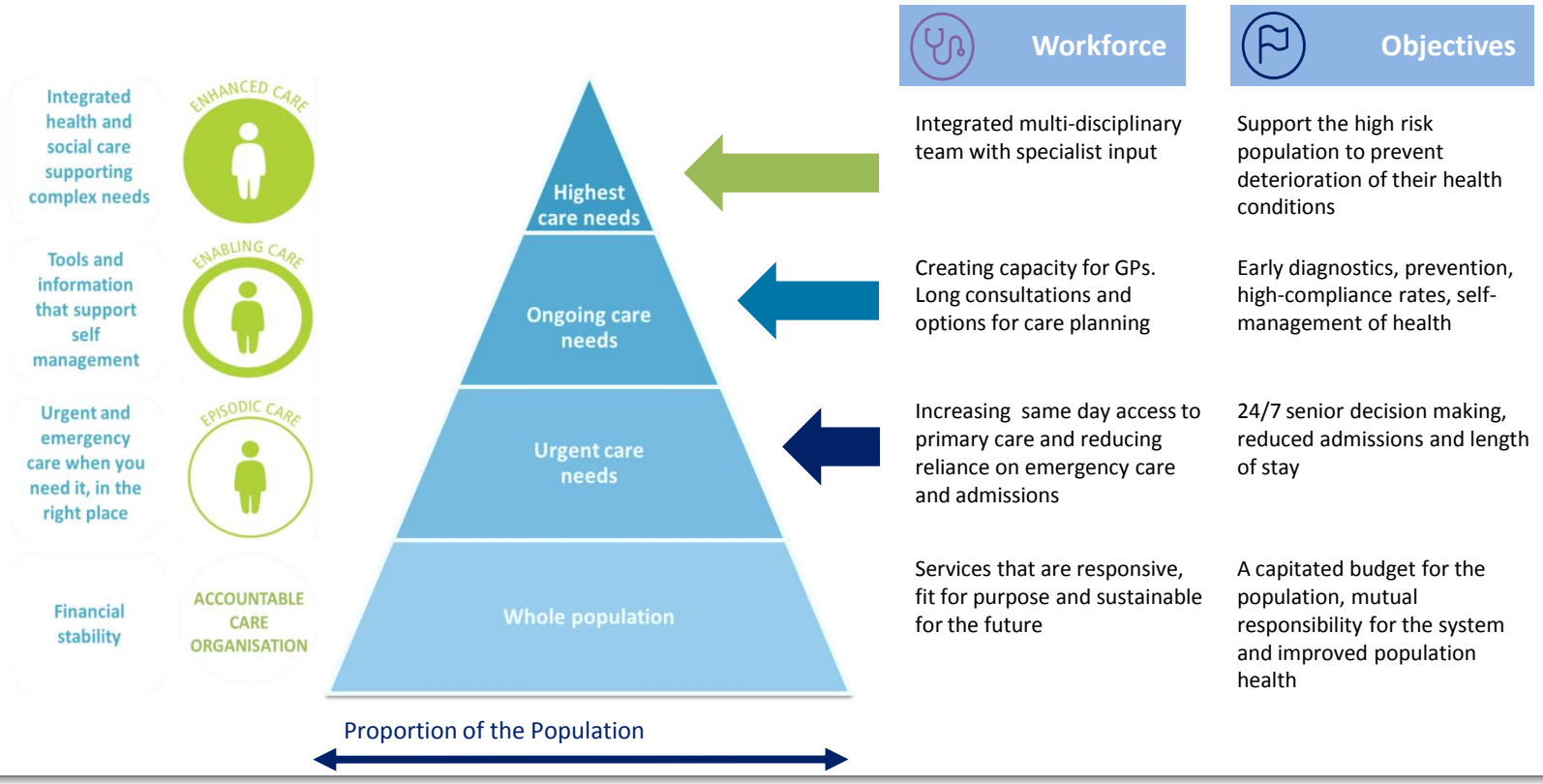
Case Study: Northumberland (1/6)

Overview

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

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

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



Source: Northumberland PACS value proposition

Case Study: Northumberland (2/6)

Key interventions and their expected benefits in each area

	Interventions	Expected Benefits[1]
INTEGRATED SYSTEM FOR URGENT CARE	• **Northumbria Specialist Emergency Care Hospital**: specialist hospital focused exclusively on emergency care, with 24/7 emergency consultants, dedicated diagnostics and 7 day specialty consultant availability • **Urgent care centres**: within district general hospitals, employing GPs alongside the regular clinical personnel	• Reduction in non-elective admissions • Reduce patient time in hospital • Improved clinical outcomes • 7 day access to a GP service
PRIMARY CARE AT SCALE (Episodic and enabling care)	• **Capacity and demand exercise in 44 GP practices** to shape the development of new access models for primary care • **Collaborative working –** practices working closely together to deliver new models of care across localities	• Increased access to primary care with practices aiming to cover 7-9% of their population within a week • Improved access time (weekends, out of hours) – move to same day demand management • No increase in emergency activity
	• **Self-management:** using new technology to empower patients and give access to clinical expertise • **Increase capacity within primary care** to support care planning through longer consultations designed to improve patient experience within a 'what matters to you?' approach	• Proactive care planning • New ways of accessing specialist opinion reducing OPD activity and investigation. • Development of a common integrated approach – prevention through to EOLC
OUT OF HOSPITAL MODEL (Enhanced care)	• **Blyth Acute Visiting Service:** targeted at patients with LTC, frail elders and complex needs (e.g. MH) • **Care home service** introducing pharmacists to review medications • **Locality based teams** working across organisational and professional boundaries.	• Proactive management of those with complex care needs • Rapid response to acute events • Reduce OBDs, ED attends • Reduce unnecessary prescriptions • Planned and responsive care needs met
INTEGRATED HEALTH RECORDS	• **Introduction of MIG** – 44 practices approving system wide access to primary care record • **Integrated health care record:** primary care system of choice programme supporting a large scale change to a single primary care informatics system.	• Improved communication • Integration of primary and community care records including some medical specialties
DEVELOPING OUR WORKFORCE	• **Northumbria nurse training programme:** 18 month programme reshaping the RGN training pathway • **Trainee pharmacist programme** based within GP practice	• Bridge the recruitment gap • Develop a culture of integrated working • A workforce fit for purpose • Extend capacity within primary care to facilitate new care models

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

Case Study: Northumberland (3/6)

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

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

Improved clinical outcomes

A&E activity

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

Length of stay

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

mproved safety and quality of care

Avoidable admissions

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

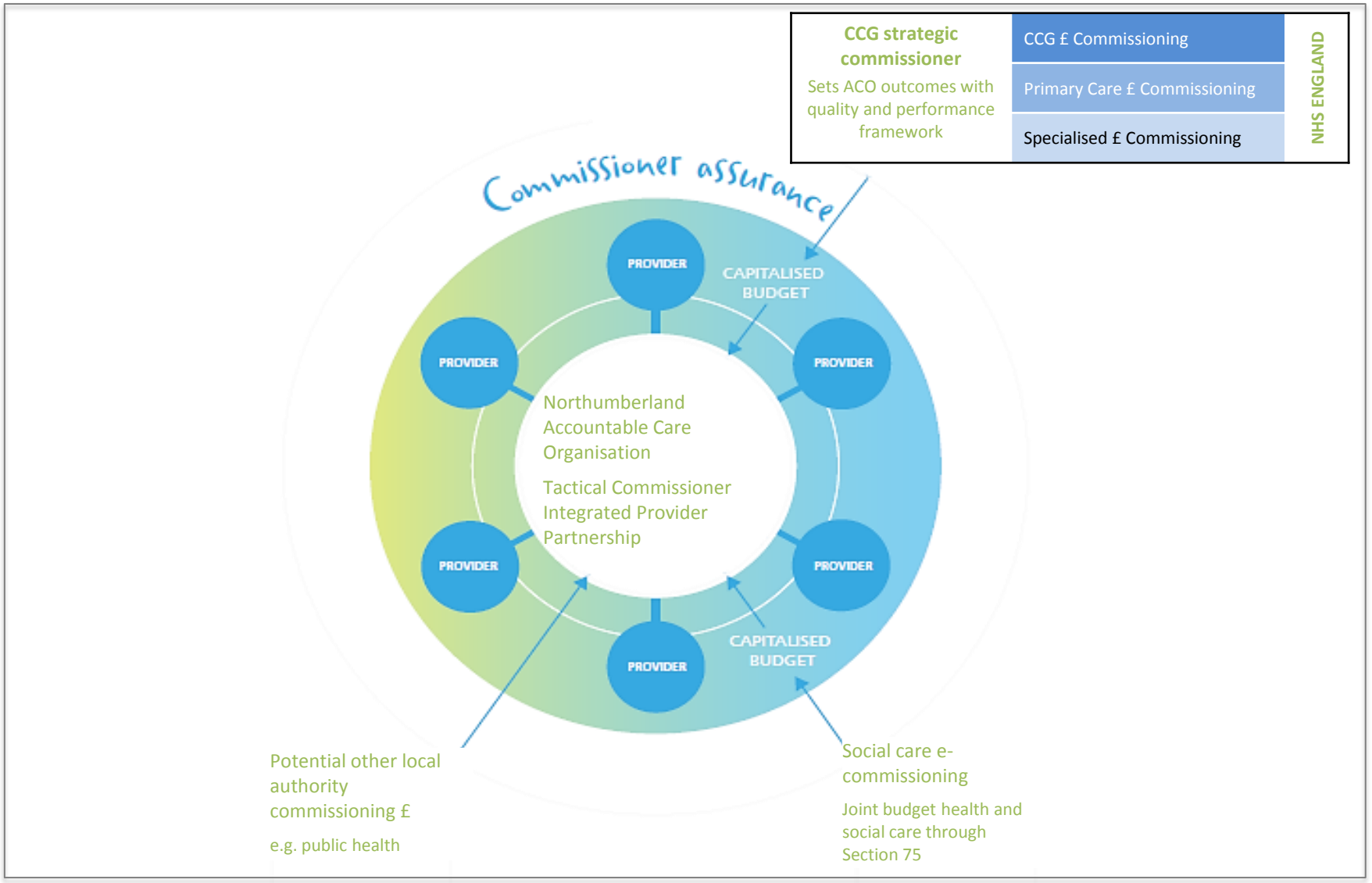
Readmission rates

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

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

Case Study: Northumberland (4/6)

Developing an ACO model in Northumberland



Source: Northumberland PACS value proposition

Case Study: Northumberland (5/6)

Financial analysis

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

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

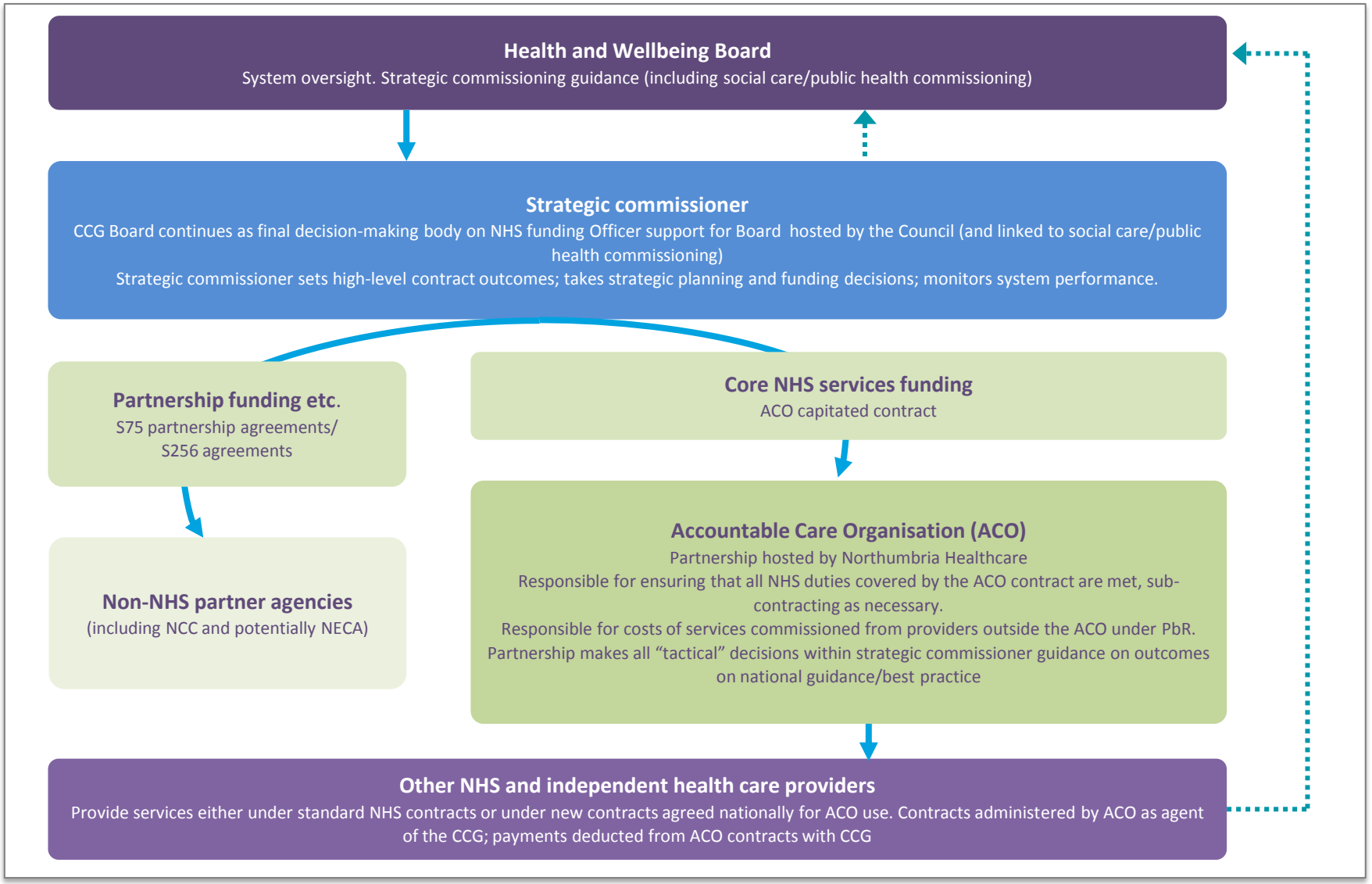
Comparison with wider STP estimates

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

Source: Northumberland PACS value proposition

Case Study: Northumberland (6/6)

The proposed system: a diagrammatic overview



NEWCASTLE GATESHEAD

Case study: Newcastle Gateshead (1/4)

Overview

Aging population

65+ = 80,000 (c. 16%)

In the next 20 years:

70+: ↗ 50%

85+: ↗ 100%

New pressures

Increasing demand for expensive medical treatment and services

Cost growth

- Bed demand expected to double to 3,000
- 65% increase in continuing healthcare

Need for a new model of care

A NEW CARE MODEL

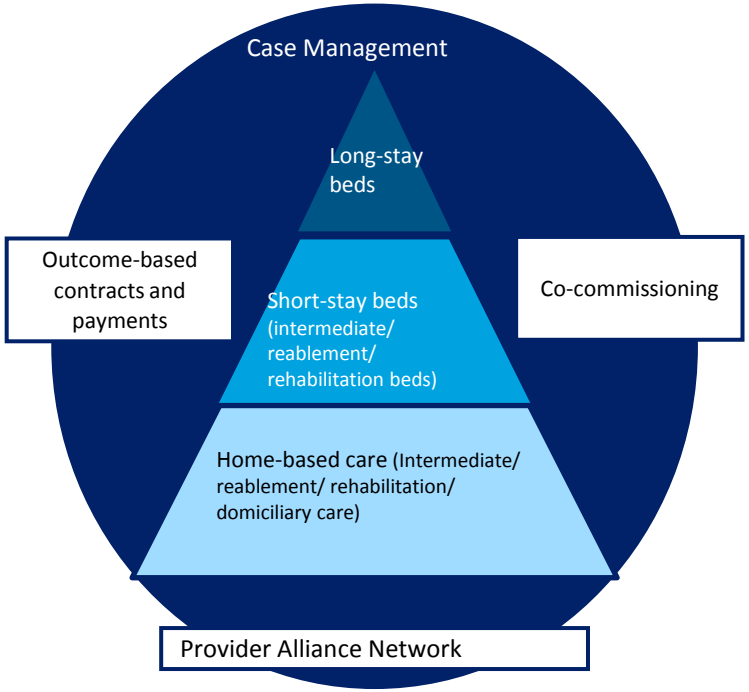
Enhanced Health in Care Homes vanguard

The Newcastle Gateshead Enhanced Health in Care Homes vanguard brings together Newcastle Gateshead CCG, Gateshead Council and Newcastle City Council to provide better quality care to the population aged 65+ while contributing to the long-term financial sustainability of the local health economy.

Building on the Gateshead Care Home Programme, which started with a target population of c. 1,300 care home residents in Gateshead in 2010, the programme aims to roll out an integrated health and social care model to patients requiring intermediate or home-based care across both Newcastle and Gateshead.

The vanguard will facilitate new ways of designing, commissioning and providing health and social care to its target population through the creation of a Provider Alliance Network based on an outcome-based contracting and payment system.

Local evidence from the Gateshead Care Home Programme shows that the interventions implemented by the vanguard could achieve substantial reductions in acute activity while improving patient outcomes.



Source: Newcastle Gateshead vanguard value proposition

Case Study: Newcastle Gateshead (2/4)

Key work streams

CLINICAL

The redesign of the care pathway focuses on 7 key areas:

ENHANCED PRIMARY CARE:
- case management for all those living with frailty,
- practice aligned multidisciplinary teams,
- access to specialists via virtual ward approach

RESPONSIVE CARE:
- rapid response intermediate care nursing and therapy,
- expansion of community intravenous medication administration

MEDICINES MANAGEMENT APPROACH:
- pharmacists as core members of general practice and care home teams
- EoL drug supply service
- Flu vaccination programme
- Improve discharge pathways

END OF LIFE:
- using prognostic indicators to recognise palliative and end of life,
- best practice guidelines for practice palliative care meetings,
- alignment of MacMillan nurses to care homes as well as GP practices

TECHNOLOGY:
- improved data sharing including bespoke transfer of care standards for care home residents,
- enhanced care delivery through telehealth apps

HYDRATION AND NUTRITION CARE:

introduction of technology and facilitation of work based learning through bespoke dietetic support team

DEMENTIA:
- bespoke pathway for dementia diagnosis,
- crisis response to challenging behaviour,
- improving health and wellbeing through meaningful activities

PATIENT EXPERIENCE

person-centred

ENGAGEMENT:
- Development of a Participation and Engagement Programme (incl. self care management)
- 'I' statements, feedback from patients and carers

SAFETY/ QUALITY

EVALUATION:
- Revision of Standard Operation Procedures (SOP) and clinical protocols
- Learning fast: analysis metrics and outcomes of the programme

WORKFORCE

UP-SKILLING:
- Competency framework: covering 3 levels (general, specialist and advance practitioner) to understand potential skill gaps
- Cultural change to implement new ways of working

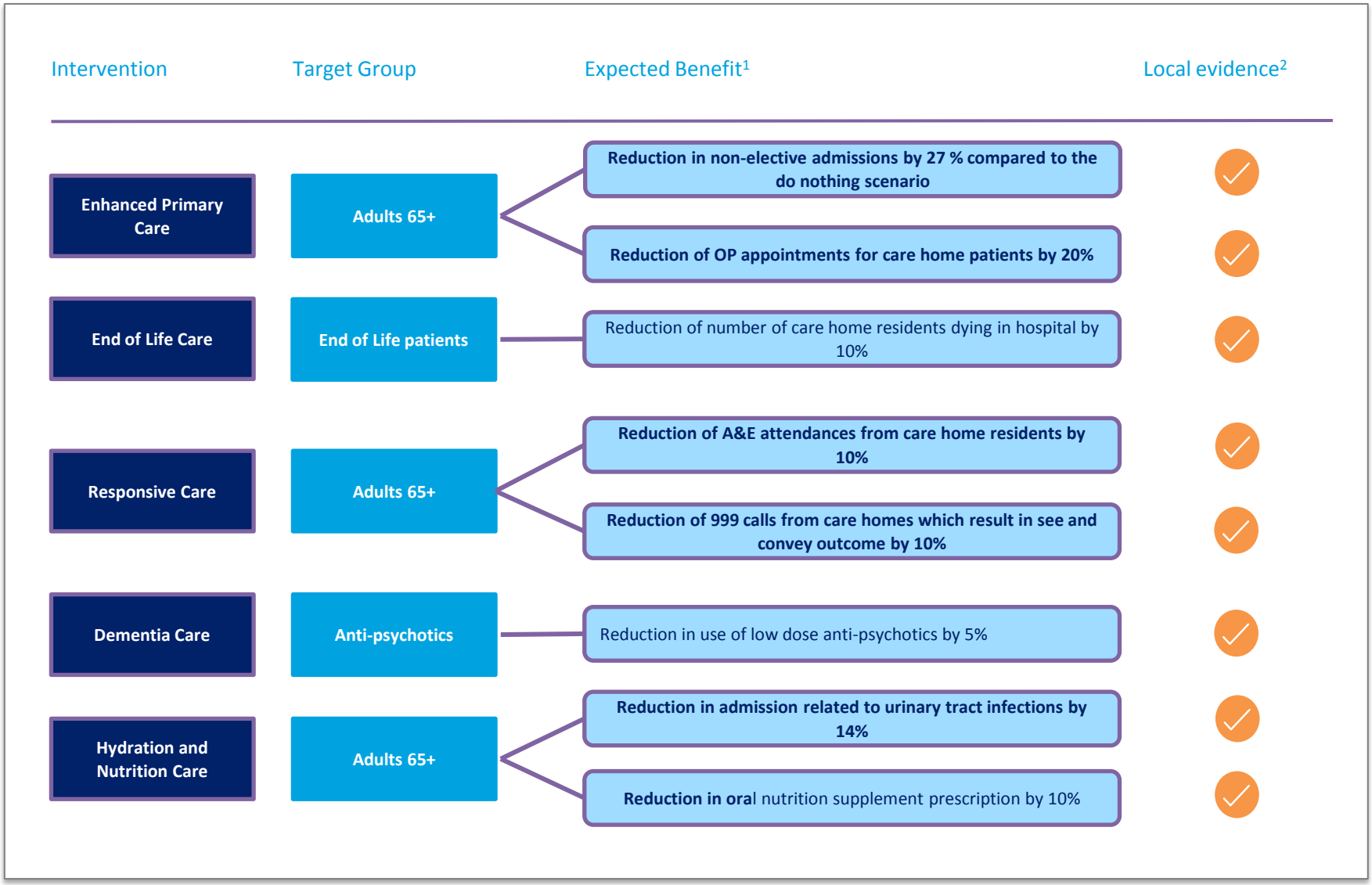
INTEGRATED PROVISION & COMMISSION

- Provider Alliance Network (PAN) to enhance collaboration
- Integrated commissioning: development of a co-commissioned platform for all care home, intermediate and reablement service

Source: Newcastle Gateshead vanguard value proposition

Case Study: Newcastle Gateshead (3/4)

Expected benefits



1: All numbers sourced from the Newcastle Gateshead 2014/15 vanguard value proposition
2: These ambitions are based on measured outcomes since the start of the Care Home Programme

Case Study: Newcastle Gateshead (4/4)

Financial analysis

Estimates of the potential savings from implementation of the new care model are largely based around the measured impact of the interventions on the target population of the Gateshead Care Home Programme. The table below[1] show the estimated savings achievable from scaling up these impacts to the entire target cohort on the frailty spectrum in Newcastle and Gateshead, estimated to include c. 84,000 patients in 2020/21.

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

Comparison with wider STP estimates

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

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

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

1: All numbers sourced from the Newcastle Gateshead 2014/15 vanguard value proposition
2: The vanguard forecasts a 14% reduction compared to 2014/15 baseline, taking into account activity growth until 20/21 this would be a 27% reduction compared to do-nothing

Case Study: Newcastle Gateshead (4/4)

Financial analysis

Estimates of the potential savings from implementation of the new care model are largely based around the measured impact of the interventions on the target population of the Gateshead Care Home Programme. The table below[1] show the estimated savings achievable from scaling up these impacts to the entire target cohort on the frailty spectrum in Newcastle and Gateshead, estimated to include c. 84,000 patients in 2020/21.

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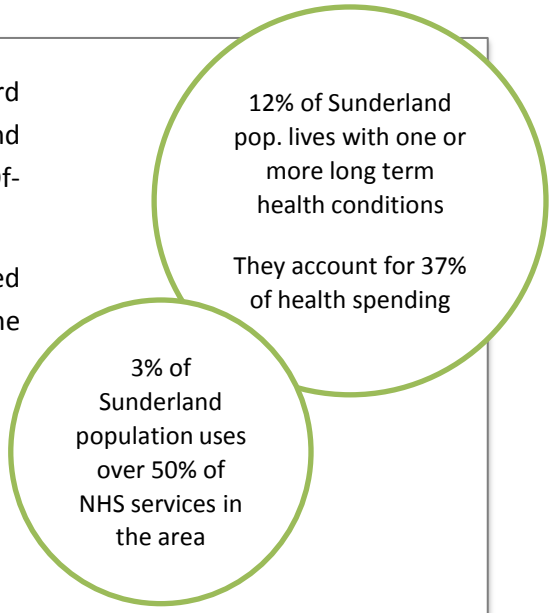
Sunderland

Case Study: Sunderland (1/5)

Overview

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

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



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

The Sunderland MCP model is divided into three main areas:

Recovery at home

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

→ Rapid response model (1 to 4 hours)

CITs

Community Integrated Teams

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

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

Enhanced Primary Care

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

It aims to:

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

The programme is led by the Sunderland GP Alliance.

Source: All Together Better Sunderland value proposition

Case Study: Sunderland (2/5)

Main benefits and achievements to date

TARGETS

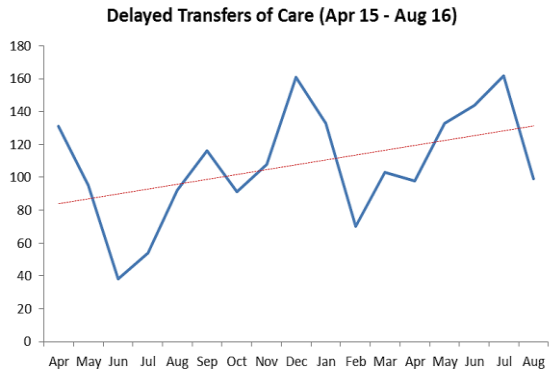
Activity reduction

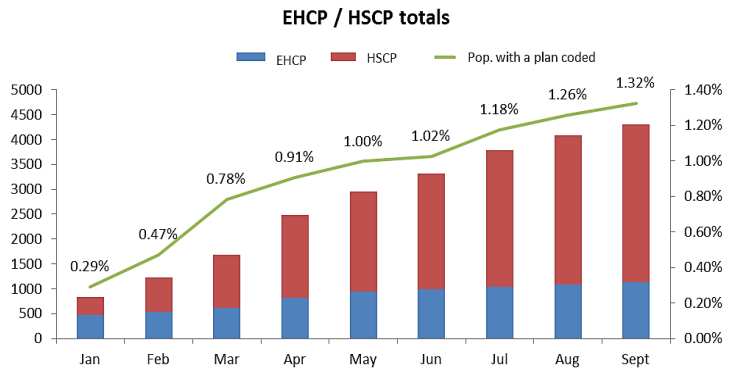
- ↘ Reduce non-elective admissions by 12.5% by 2019
- ↘ Reduce admissions to residential and care homes by 4% against 2015/16 baseline
- ↘ Reduce delayed transfers of care by 10% by 2017

atients outcomes

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

ACHEIVEMENTS TO DATE





Source: All Together Better Sunderland value proposition

• Case Study: Sunderland (3/5)

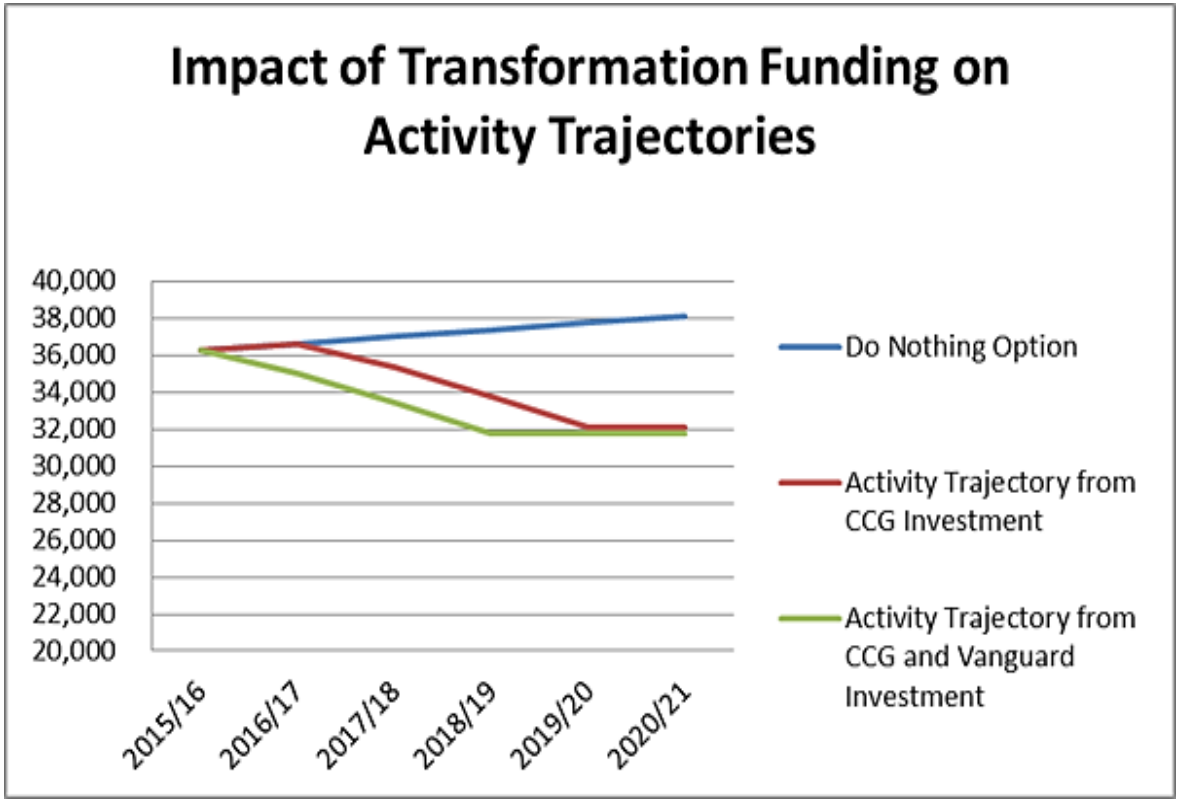
Key interventions and their targeted population cohorts

	Target group	Description	Predicted services changes	Benefits
CITs	High-cost segment of the population: 1-3% accounting for 40% of all costs Particularly frail and elderly	• A GP provides clinical leadership to the MDT • MDTs meet weekly and use risk stratification tools to identify appropriate patients. • Care Plans are developed to meet patient needs. • Teams work across organisational boundaries.	Activity shifts expected but still to be modelled: • Reductions in NEL for frail elderly population • Reduction in outpatient appointments • Reduction in A&E attendances Latest data shows reductions in A&E attendances and NEL for the majority of patients seen by an MDT.	• Improved quality of care • Fewer unplanned admissions • Fewer unplanned readmissions • Reduction in length of stay • Improved coordination of community, social and mental health care
EPC	Patients with at least one long-term condition, across the (not only high-cost): 4-12% of the pop.	• 5 locality based hubs delivering insulin initiation and Type 2 diabetes management • Care Home alignment with GP practices • Roll out of Map of Medicine across all practices in the city. • Development of post discharge clinics pilot in one locality.	Activity shifts expected from individual level project pilots contributing to overall aims of the OOH model.	• Improved quality of care • Increased capacity within General Practice community • Increased partnership working across General Practice in support of GP 5 Year Forward View.

Source: All Together Better Sunderland value proposition

Case Study: Sunderland (4/5)

Predicted impact on NEL admissions



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

Source: All Together Better Sunderland value proposition

Case Study: Sunderland (5/5)

Financial analysis

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

Comparison with wider STP estimates

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

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

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

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

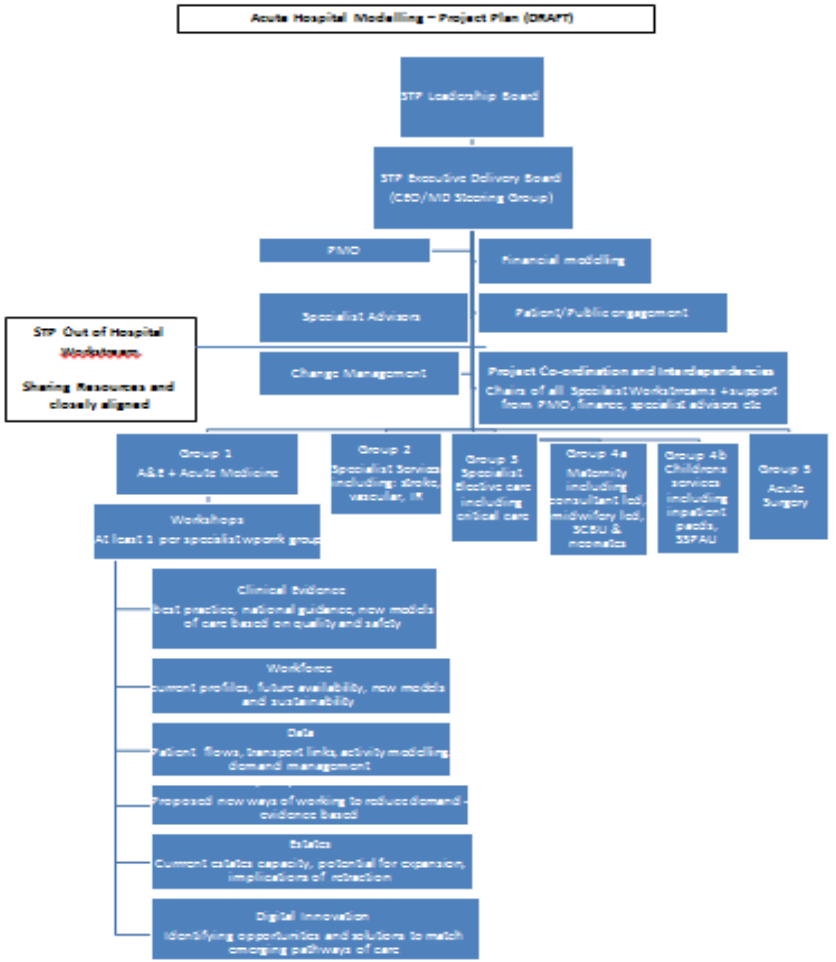
Source: All Together Better Sunderland value proposition

2.5 OPTIMAL USE OF THE ACUTE SECTOR

Optimal use of the Acute Sector – Next Steps

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

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



NTWND STP impact and ambitions - Care and Quality

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

Better Care impact by 2021	Priorities	Ambitions 2021
Citizens ✓ In control ✓ Self Care ✓ Less hospital use (if needed) ✓ Alternative options (care placement) **System** ✓ Access, choice, navigation and flow of care will be simplified ✓ Responsive to need ✓ High value and preferable closer to home care **Workforce** ✓ Well trained, satisfied, collaborative working to manage need ✓ Less reliance on agency staff ✓ **Clear tariff based prevention pathways** **Digital / innovation** ✓ Solutions will provide choice and operate 7 days ✓ Creating opportunities of 'excellence'	Increasing demand for hospital and bed based services Unwarranted Variation Variation in quality, safety and experience of people using health and care services Clinically sustainable services whilst maintaining high levels of care and quality Infrastructure and workforce required to deliver fully integrated health and care services outside of hospital Seven day services	➢ Reduce Accident and Emergency attendances per 1,000 population by 15% ➢ Reduced Elective Care and Out Patient activity by 10% ➢ Reduce Emergency hospital admissions per 1,000 population by 15% ➢ Reduce non-elective admission rates chronic ambulatory care sensitive conditions by 17% by 2020/21, reducing the gap in admission rates between the STP and England by 50%. ➢ Remove variation in acute sector activity rates for elective MSK by 14.8%, bringing each locality within the STP in line with their Right Care peer group. ➢ Remove local variation in day case and outpatient procedure ophthalmology activity across the STP, achieving a combined activity reduction of 6.7%. ➢ Remove variation in and reduce levels of QoF exception rates in key disease areas to the level of the best performing CCG in the STP (Asthma 6%, COPD 11%, Heart Failure 9%, CKD 4%, dementia 4% and SMI 9%) ➢ 100% of primary care providers rated good or outstanding by 2020/21. ➢ 100 % of secondary care providers rated good or outstanding by 2020/21. ➢ All providers of acute stroke services to achieve an overall rating of B or better in the annual SSNAP audit. ➢ Remove variation in women's experience of maternity services based, achieving a STP score of 84.9 in the 2015 CQC National Maternity Services Survey, matching the best performing CCG within the STP. ➢ Reduce aggregate Trust sickness absence rates to 3.4% matching the best performing region in the country. ➢ Diabetes: % of GP practices that participated in the National Diabetes Audit. ➢ % of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral. (National ambition: 85%) ➢ Achieve an overall satisfaction rate of with GP services of 89.1%, matching the best performing CCG in the STP and maintaining above average performance above national peers. ➢ Achieve an overall satisfaction rate of with people feeling supported to manage their LTC of 71.3%, matching the best performing CCG in the STP and maintaining above average performance above national peers. ➢ Increase the number of weekend and out of hours (18:30 to 20:00) appointments available in primary care to a minimum of 30 minutes per 1,000 population per week and achieve a utilisation rate of at least 75%. ➢ 100% of referrals to consultant led services to be made electronically. ➢ 100% of prescriptions and repeat prescriptions to be made electronical ➢ Increase the number of weekend and out of hours (18:30 to 20:00) appointments available in primary care to a minimum of 30 minutes per 1,000 population per week and achieve a utilisation rate of at least 75%.

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

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

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

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

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

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

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

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

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

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

Table A – Activity Shifts

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

Table B – Financial benefits

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

Table C – Phasing of benefits

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

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

2.7 DELIVERING THE NINE MUST DO'S

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

2.8 OUR ENABLERS TO SUPPORT ACHIEVEMENT

Enablers to support achievement of our plan

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

See section 3 for detailed deliver plans

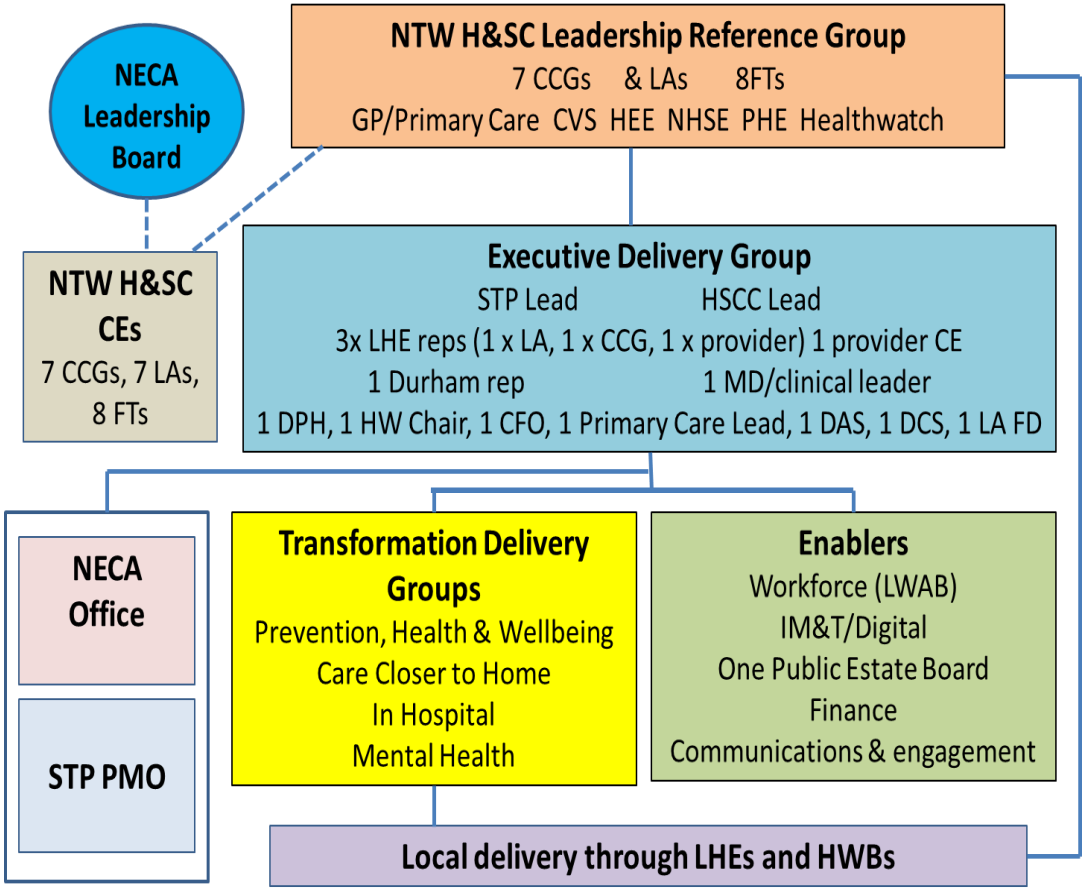
2.9 LEADERSHIP AND GOVERNANCE

NTWND Leadership and Governance

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

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

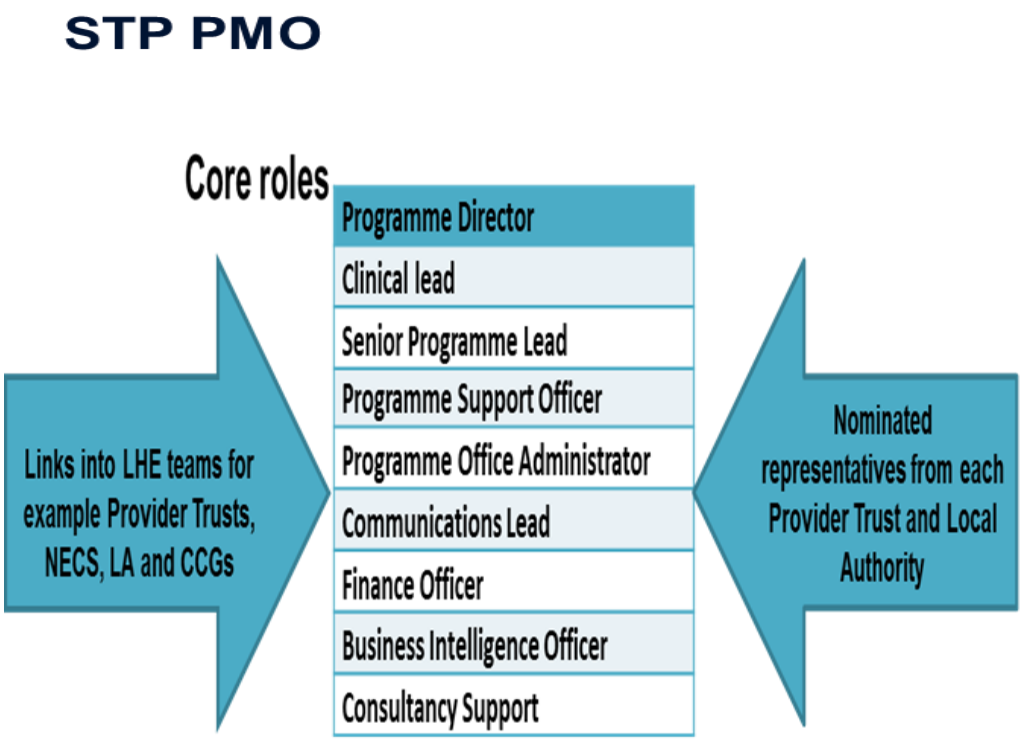
This will oversee delivery of those transformation areas, including enablers being tackled at a STP / NECA level.



2.10 PROGRAMME MANAGEMENT OFFICE

NTWND programme management office

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



2.11 FUTURE COMMISSIONING LANDSCAPE

Future Commissioning Landscape

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

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

- **Financially challenged CCGs.** For example, Explore how Newcastle Gateshead CCG might support North Tyneside CCG with a joint management team across both CCGs, to give consistent and strong leadership whilst focusing on immediate financial recovery

- **Sustainability of CCG in the long-term** – small versus larger organisational stability

- **Expertise and Quality** – opportunities to improve the quality of commissioning through consolidating expertise around key commissioning responsibilities

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

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

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

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

2.12 PRE ENGAGEMENT AND POST ENGAGEMENT

Engaging local people and stakeholders

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

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

Pre- October 2016

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

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

Communication and Public Engagement Objectives

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

Post - October 2016

Communication and Public Engagement strategy includes:

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

Public Publication date: 23 November includes:

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

Outline timescale – 5 stage approach

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

2.13 LIMITATIONS AND RISKS

Limitations and risks

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

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Limitations and risks

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

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

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

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