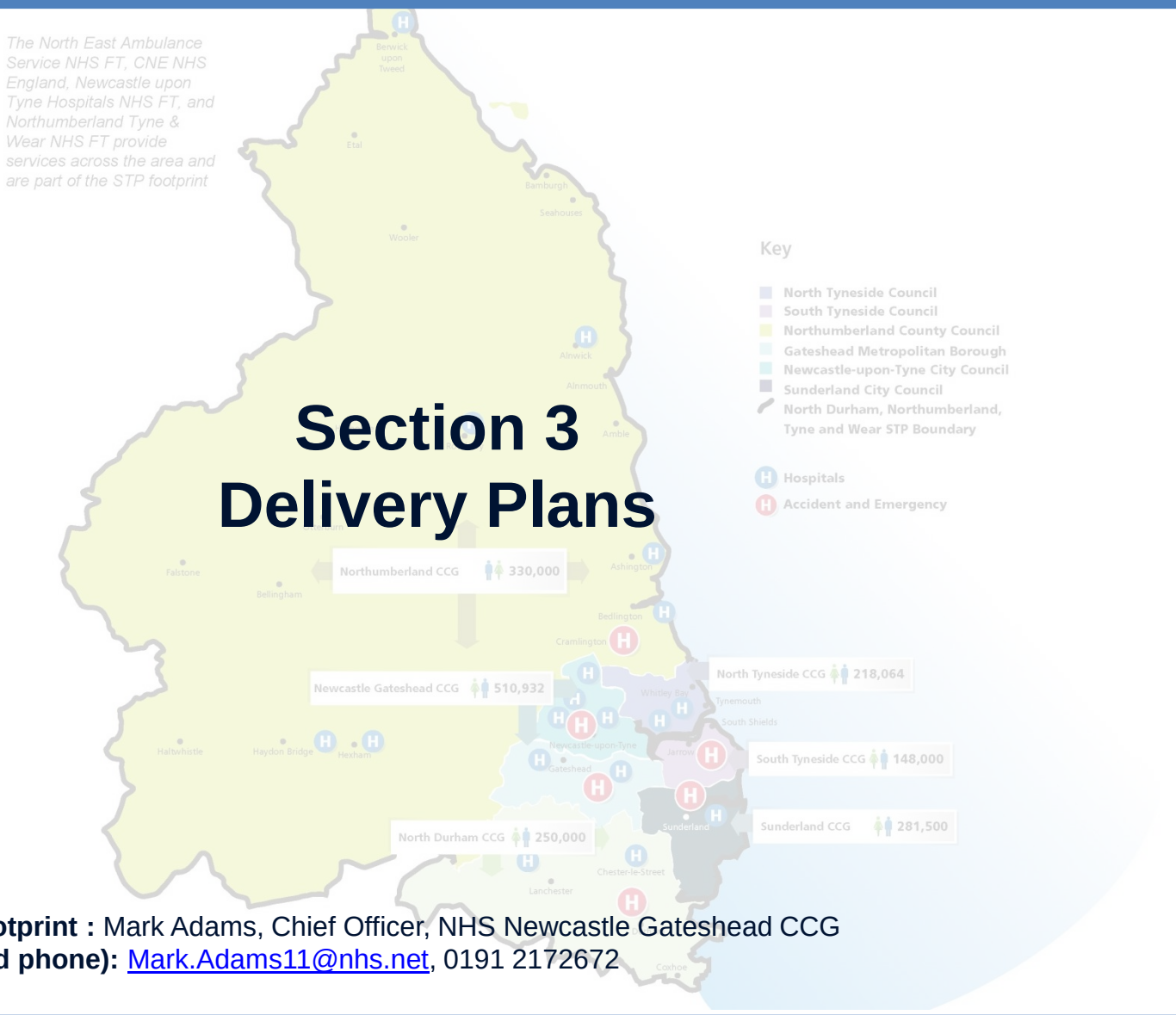
Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan



Section 3
Delivery Plans

Nominated lead of the footprint : Mark Adams, Chief Officer, NHS Newcastle Gateshead CCG
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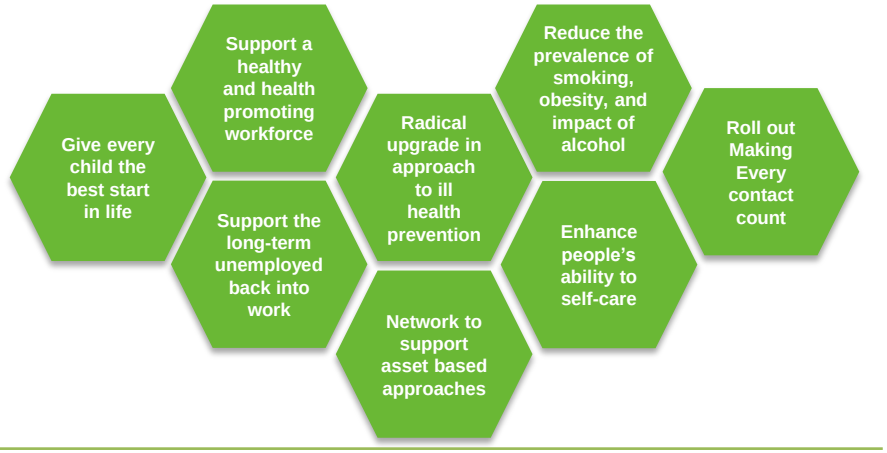
SCALING UP PREVENTION, HEALTH AND WELL BEING

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



Transformation Programmes

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

The Gap – Why Change is needed

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

Future State/Ambition

Our vision is to establish a health and care system in NTWND that supports population health and wellbeing as the primary objective. Without tackling the underlying health and wellbeing challenges in NTWND we will continue to face higher health and care costs, health inequalities and poor health outcomes.

We have calculated that if healthy life expectancy among all North East Combined Authority constituent local authority populations was to rise over the next 10 years to reach the national average healthy life expectancy, among both males and females, this would mean that there would be an additional 400,000 healthy life years lived across the 10 year period. Our aim is to work with the NECA to achieve this.

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

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

Financial implications (ROI)

In a broad sense we must use all of our collective health and social care spend and focus it on prevention. We will achieve this by undertaking a significant cultural shift across all services and monitoring them on the prevention outcomes they achieve.

Specifically, the prevention programmes we've identified in this plan will require NHS resources to pump-prime the shift towards prevention.

Benefits (Outcome Measure)

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

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

TRANSFORMING CANCER SERVICES

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

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

The Gap – Why Change is needed

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

Future State/Ambition for 2020/21

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

Benefits (Outcome Measure)

2016-17 deliverables:

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

Overall 2020 goals:

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

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

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

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

Financial implications (ROI for example)

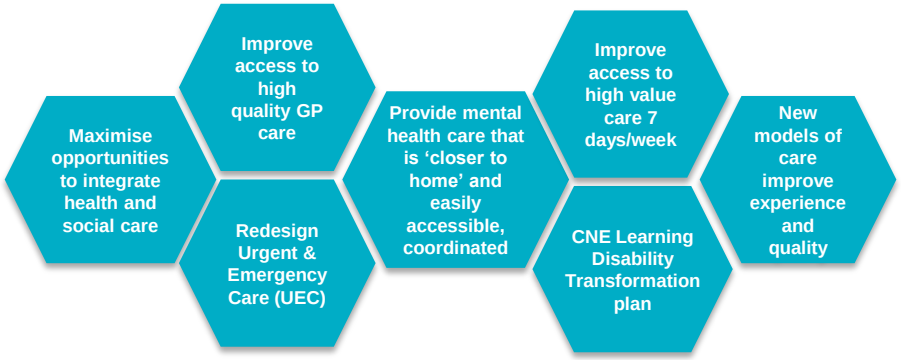
Commissioners and FTs count the investment in different ways. A review of this is to be developed by the Alliance.

Interdependencies:

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

OUT OF HOSPITAL COLLABORATION

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



Benefits (Outcome Measure)

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

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

The Gap – Why Change is needed

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

Future State/Ambition

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

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

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

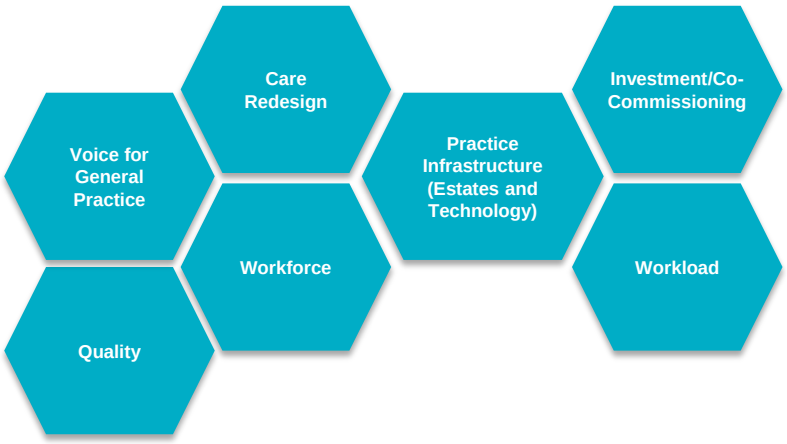
Financial implications (ROI)

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

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

TRANSFORMING GENERAL PRACTICE (General Practice Forward View)

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



The Gap – Why Change is needed

General practice voice
Working at scale and federation/locality group viability as providers as scale
Workforce capability and capacity
Workload – increasing and changing without the skills, capacity and infrastructure to support this
Investment/co-commissioning;

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

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

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

Implementation

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

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

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

Benefits (Outcome Measure)

Overall benefit - the sustainability of general practice and improved patient access through;

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

Financial implications (ROI

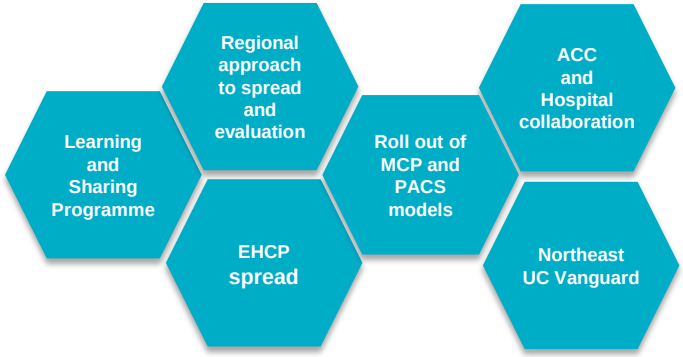
- Ensure the £3 per head GPFV transformation money is invested into the general practice
- Resources identified above to ensure general practice is able /supported to change
- If the above work to sustain general practice is not progressed costs of health care will continue to rise with increased secondary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

Interdependencies

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

SPREAD NEW MODELS OF CARE

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



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

The Gap – Why Change is needed

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

Future State/Ambition

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

Benefits (Outcome Measure)

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

This will tackle:

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

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

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

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

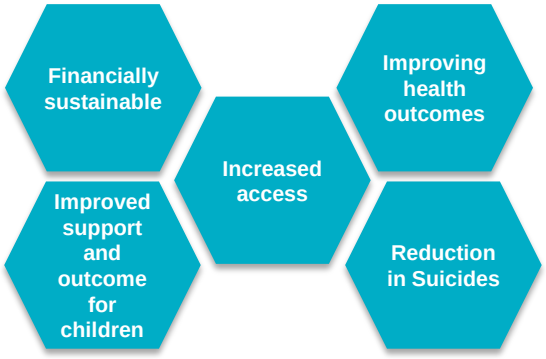
Financial implications (ROI,

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

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

TRANSFORMING MENTAL HEALTH (MH 5YFV)

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



Core MH5YFV Deliverables

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

The Gap – Why Change is needed

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

Future State/Ambition

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

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

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

Benefits (Outcome Measure)

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

Financial implications (ROI,

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

Interdependencies

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

TRANSFORMING LEARNING DISABILITY CARE AND SERVICES

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

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

Benefits (Outcome Measure)

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

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

The Gap – Why Change is needed

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

Future State/Ambition

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

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

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

Financial implications (ROI)

Financial modelling undertaken and reported to date has included the anticipated revenues and costs for constituent CCGs alongside those for NHS England specialised commissioning. Existing models had to be expanded to include financial and activity information from local authorities.

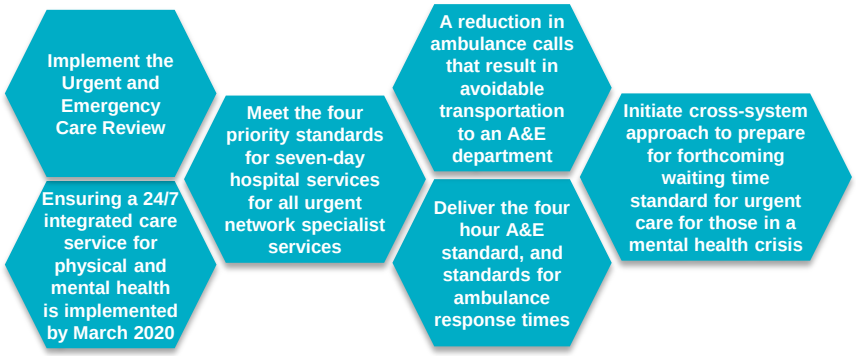
- Resources released from closure – these are the reductions in inpatient costs to commissioners that arise when providers are able to close wards and beds following patient discharges under TC.
- Additional community care costs – these are the projected additional costs to the health and social care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

Interdependencies

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

TRANSFORMING URGENT AND EMERGENCY CARE SERVICES

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



Key Actions

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

The Gap – Why Change is needed

- **Context:**
  The North East Urgent and Emergency Care Network (NEUECN) covers a population of 2.71 million across diverse geographies and incorporating large pockets of both densely populated and dispersed populations, the highest regional unemployment, high levels of deprivation and life expectancy for both men and women is lower than the England average. We have significant performance and financial constraints across both Commissioner and Provider organisations. North East population has an over reliance on hospital based care, at 20% above the national average.
- **Rationale:**
  Fragmented urgent care services with multiple points of entry result in patient contact duplication and patient confusions across the region, which is inefficient and does not promote positive patient experience. To ensure that patients receive the 'Right Care, Right Place, First Time' it is essential that we implement a single point of access, improved content and access within the Directory of Services and Clinical Specialists to provide patient and healthcare professional signposting and referral.

Future State/Ambition

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

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

- **Funding:**
  National Vanguard, Regional Commissioning, Exploration of other sources
- **Organisational Leadership:**
  Individuals from member organisations: Transformation Board, Clinical Reference Group, Strategic Network, Operational Network and Project Boards
- **Knowledge:**
  Regional, national and international best practice, Sharing learning with other Vanguards, Collaborative working with North East Vanguards
- **Time:**
  Making time available

Benefits (Outcome Measure)

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

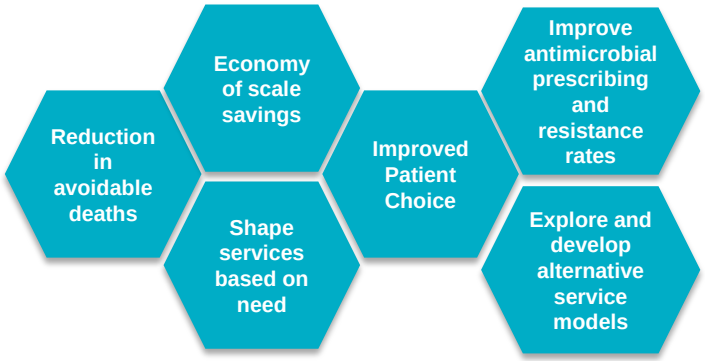
Financial implications

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

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

OPTIMAL USE OF THE ACUTE SECTOR

Overall scheme lead: Ken Bremner - CEO (CHS/ST NHS FT)



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

Benefits (Outcome Measure)

Therefore by 2021, we will aim to:

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

The Gap – Why Change is needed

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

Future State/Ambition

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

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

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

Funding

- Capital, infrastructure, technology

Organisational Leadership

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

Knowledge

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

Workforce

- Modelling to understand future demand and gaps

Time

- Making time available for clinical involvement and co-design

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

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

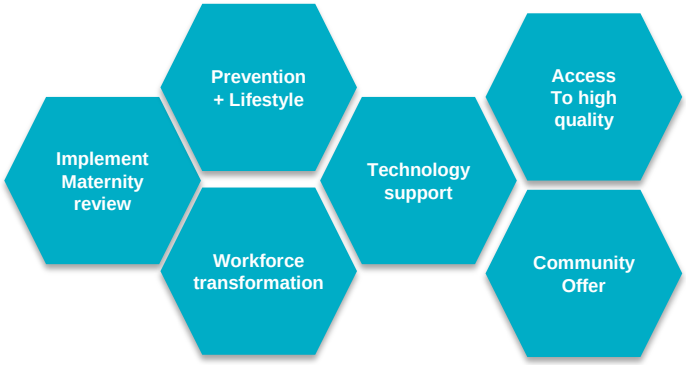
Cost savings were estimated to be achieved in three ways: Scale economies on shifting activity:/Delivery model savings:/Fix cost release. Analysis below is based on these assumptions:

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

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

TRANSFORMING MATERNITY SERVICES – BETTER BIRTHS

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



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

The Gap – Why Change is needed

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

Future State/Ambition

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

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

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

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

Benefits (Outcome Measure)

What impact will these actions have?

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

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

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

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

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

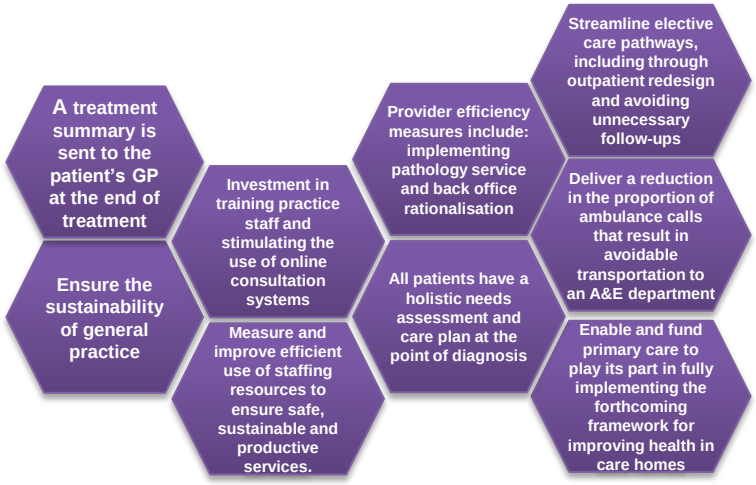
Financial implications (ROI)

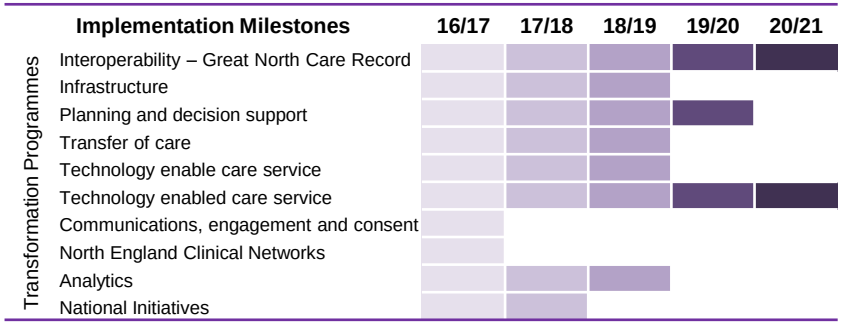
The main financial implications of the project – apart from the project management team – are the capital resources needed for developments such as the creation of community maternity hubs, as well as increased capacity at those units likely to experience a greater demand on their services.

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

DIGITAL CARE AND TECHNOLOGY

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





The Gap – Why Change is needed

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

Future State/Ambition

The regional **vision** is that:

- More patients treated locally preventing the need for care outside of the local community
- By 2021 the **Great North Care Record** will make a lasting contribution to the health and well-being of our population through the sharing of information securely and effectively.
- The Great North Care Record will make information more widely available and accessible to support frontline care, individual self-management, planning and research.
- To work collectively to deliver the regional vision and facilitate a regional conversation so we can have a coordinated approach to expedite plans.

Enabling professionals and carers to have legitimate access to the right information at the point of need

- Through the use of TECS patients should feel more in control of their condition
- A significant in crease in the level of digital maturity of secondary care providers
- Digitally enabled health and care system with a move from isolation to integration.
- Bottom up learning from the City Hospitals Sunderland FT work as a national implementer site
- A paper free system with information flowing seamlessly between primary, secondary and social care digitally.

Benefits (Outcome Measure)

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

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

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

Interdependencies

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

DIGITAL CARE AND TECHNOLOGY

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

Vision – addressing three gaps:

Care and Quality

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

Finance and Efficiency

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

Health and Wellbeing

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

Becoming paper free at point of care

Records Assessments and Plans

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

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

Care plans will be developed and shared electronically

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

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

Great North Care Record

Transfers of Care

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

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

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

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

Decision Support

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

Professionals across care settings will be made aware of end-of-life preference information

Alerts about patients issues and preferences will be conveyed.

Remote Care

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

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

Professionals will communicate with each other in different ways e.g. electronic MDTs

Telehealth solutions will support remote monitoring and motivation of patients to support self care

Orders and Results Management

All requests for consultation and diagnostics will be done electronically.

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

Medicines Management and Optimisation

Medicines are prescribed electronically

Digital records give a view of all existing medications and prescriptions

Asset and Resource Optimisation

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

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

Supporting Infrastructure

Mobile working for frontline staff at the point of care
Systems which connect together to support joint working

Connected Information

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

Information Sharing Approach

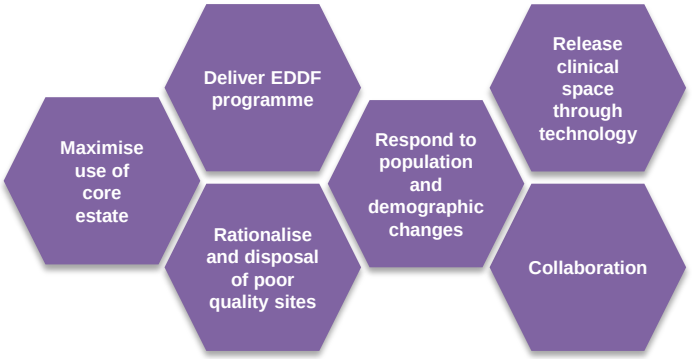
Single data sharing agreement across all providers
Robust and compliant with Information Governance
Patients informed and able to control who accesses their information

Governance and Delivery

LHE Governance and Delivery → STP Joint Working → Regional Working

DELIVERING THE ESTATES STRATEGY

Overall scheme lead: to be confirmed



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

Benefits (Outcome Measure)

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

The Gap – Why Change is needed

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

Future State/ Ambition for 2021

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

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

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

Financial Implications (ROI)

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

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

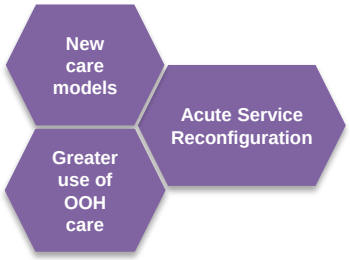
WORKFORCE

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

Working Examples Assumptions

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

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



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

Benefits (Outcome Measure)

By 2021, we will aim to contribute to:

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

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

For patients

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

For staff

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

For the system

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

The Gap – Why Change is needed

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

Future State/Ambition

If we succeed in delivering our priorities:

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

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

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

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

Funding

- Capital, infrastructure, technology

Organisational Leadership

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

Knowledge

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

Workforce

- Modelling to understand future demand and gaps

Time

- Making time available for clinical involvement and co-design

Financial Implications (ROI)

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

Interdependencies : All other Workstreams