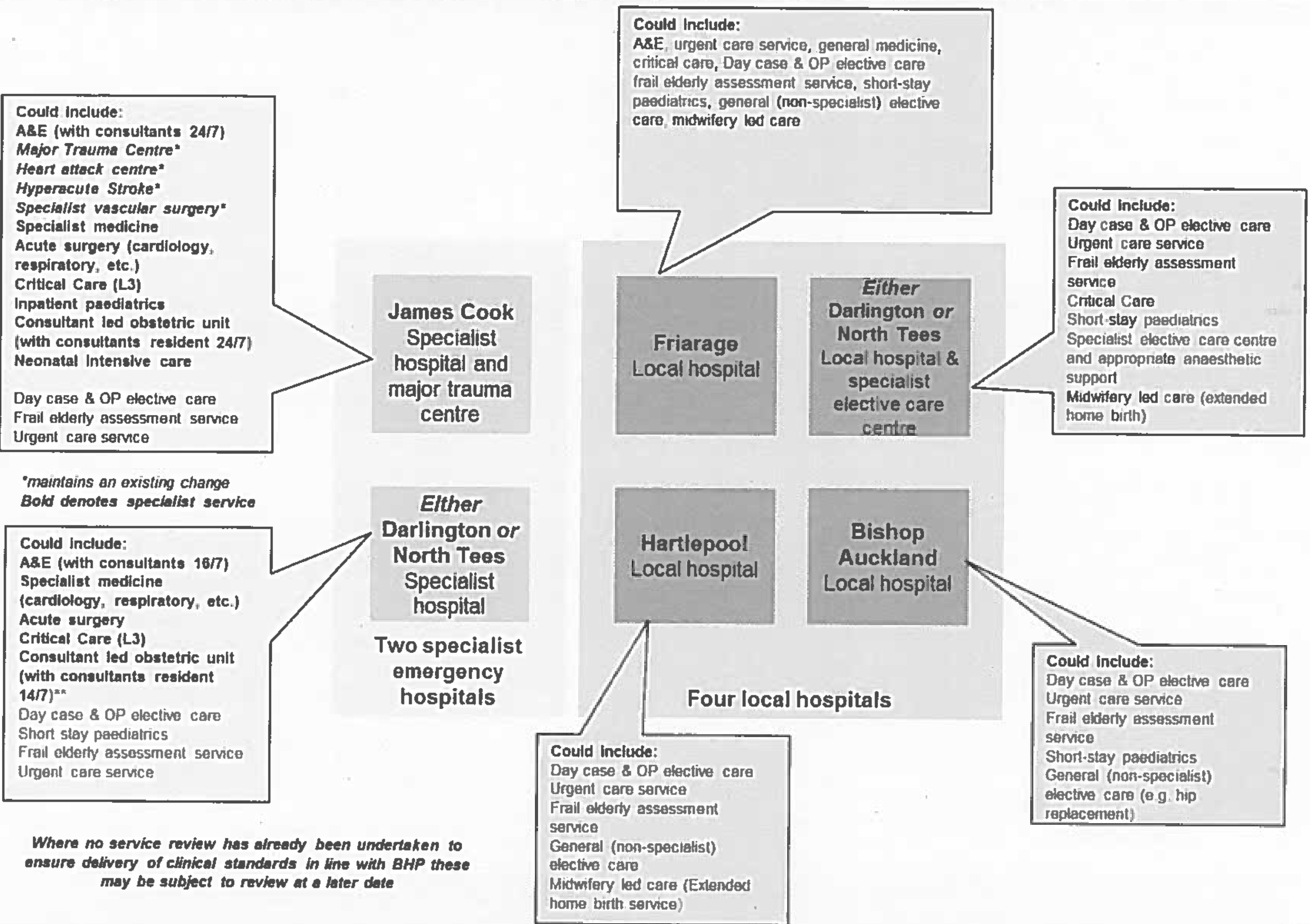
DDTHRW Vision 2020

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

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

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

DDTHRW Vision 2020



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

The nine must do's

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

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

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

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

In particular addressing our challenges in relation to;

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

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

Strategic Plan on a Page CNE 02

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

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

Enablers	Efficiency
Estates	£9.6m
Workforce	£42.9m
Engagement	£110.7m
Governance	£100.8m

This presentati[illegible] to deliver the three gaps. Further refinement will be required as we work through appropriate governance arrangements including public engagement and f[illegible] processes

System management – Financial flows, contracting mechanisms and commissioning

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

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

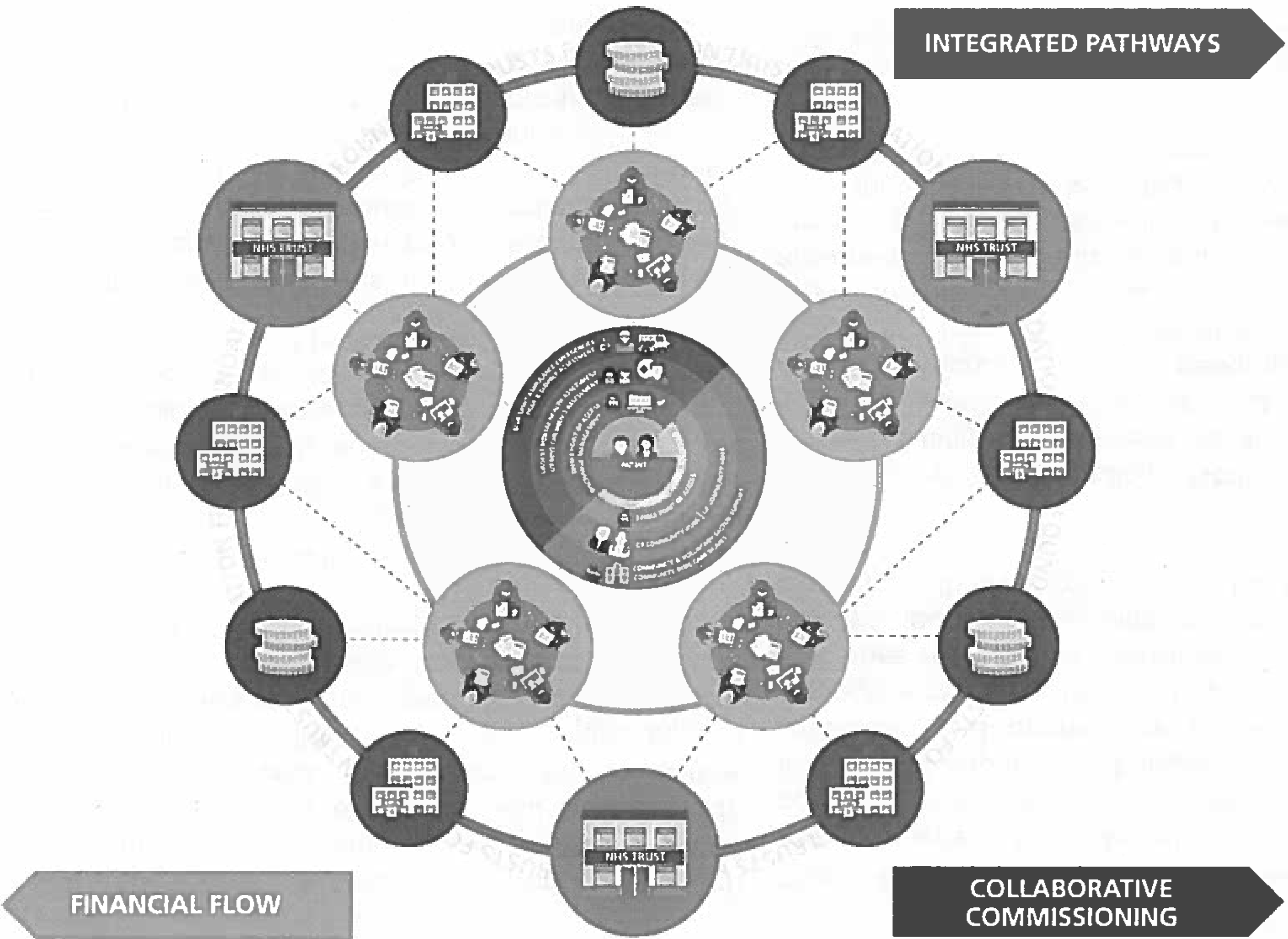
We will continue to explore the use of new contracting models that support the streamlining of our commissioning and provider activities and reduce duplication, including the use of the Prime Contractor, Prime Provider Contract and Alliance contracting models where applicable to the service model being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

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

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

The graphic on the following page represents this work.

System management – Financial flows, contracting mechanisms and commissioning



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

APPENDIX 1

FINANCIAL & ACTIVITY ASSUMPTIONS

Finance and activity assumptions

Summary Solutions

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

Summary Solutions – Activity Reduction

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

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

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

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

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

Finance assumptions

Triple Aims	STP Priorities	Efficiency	
Health & Wellbeing Gap	Early Intervention and Prevention	**Early intervention and Prevention**	**£9.6m**
		Consolidation across sites for obstetrics, paediatrics and NICU	
		• Consolidation of obstetrics	£4.8m
		• Consolidation of paediatrics services	£4.2m
		• Consolidation on NICU	£0.6m
Quality & Care Gap	Neighbourhoods and Communities	**Neighbourhoods and Communities**	**£42.9m**
		• Role substitution	£11.0m
		• Primary care Demand Management (Based on CCG RightCare packs, current average of top 5 opportunity)	£16.5m
		• Not in hospital	£15.4m
	Reconfigure Hospital Based Services	**Reconfigure Hospital Services**	**£110.7m**
		• Better Health Programme (Consolidation of A&E, Acute Surgery and Acute Medicine)	
		➢ Consolidation of A&E departments on to two sites	£2.2m
		➢ Consolidation of Acute Medicine onto two site	£7.2m
		➢ Consolidation of Acute Surgery onto two sites	£2.0m
		• Carter opportunities: Reducing unwarranted variation	£36.6m
		• Pathology Collaboration: Consolidation of pathology services	£21.7m
		• Consolidation of Providers: Reduced corporate costs	
		➢ Consolidation of provider Boards	£2.0m
		➢ Corporate and Admin reduction	£39.1m
Funding & Efficiency Gap	Technology	**Other Financial Savings**	**£100.8m**
		• Business as usual CIP	£42.8m
		• STF Funding	£41.5m
		• Commissioning Efficiencies	£5.9m
		• Medicines management savings	£10.6m

Estates

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

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

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

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

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

The current estate:

Portfolio	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Estate Running costs pa (£m) (rent, s'charge, FM)	Back-log*** Maintenance £m
GP premises	221	-	31,230ᵗ	19*	3.5
NHS PS	96	-	85,318	22	
CHP	5	-	17,994	7	0
Provider estate**	7	71.80	377,290	272	70
Mental Health Trusts**	14	30.81	73,809	33	0
Public Health Estate					
Totals	**343**	**102.61**	**585,641**	**353**	**73.5**

Performance Measures:

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

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

Estates

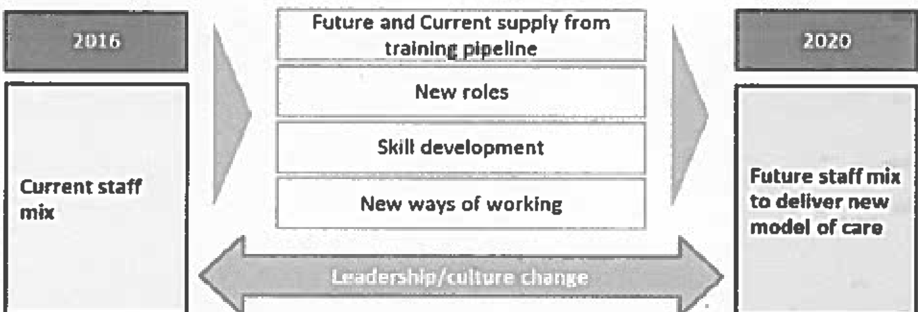
Key next steps towards deliver:

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

Workforce

The Gap – Why change is needed

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



Workforce Design Principles

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

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

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

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

Benefits and impacts

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

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

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