

Humber, Coast and Vale STP

STP Submission v1.0

21st October 2016



Humber, Coast and Vale

Sustainability and Transformation Plan 2016 to 2021

Foreword

Our vision for the Humber Coast and Vale Sustainability & Transformation Plan (STP) is to be seen as a health and care system that has the will and the ability to help its population start well, live well and age well.

We are proud of our local health and social care services and the thousands of staff who provide them today, but there is much more to be done. 23% of our 1.4m population live in the most deprived areas of England and we are seeing significant variations in health outcomes seen in the diverse rural, urban and coastal communities. Adults in some areas are leading less healthy lifestyles and as a result are at greater risk of developing long term conditions that seriously impair their lives and future prospects.

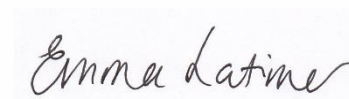
Our ideas are not just about medical solutions. We are facing unprecedented demand for services, a long-term shortage of the skilled people we need to provide them and a looming funding gap of more than £400m by 2021. This means that we must make changes that can support our people to be healthier, that improve the quality of care they receive and that balance our books financially. Making changes now is integral to drive improvements for the future.

The STP is an opportunity for the Public Services and our vibrant voluntary sector to work effectively together in a partnership that can deliver huge benefits. The plan focusses on the wider determinants of health in our footprint, with all public services working together to support people to take more responsibility for their own health. Our proposals are designed to give everyone access to the right care in the right place at the right time. National standards are minimum standards, and we think people in Humber Coast and Vale deserve more.

We believe that the ideas set out in this document are the right approach for the Humber Coast and Vale footprint, but they are not the easiest. We will not make any decisions without consulting our population and our staff on the changes we believe we should make. Indeed, much of what we propose is based on easing the concerns that people have already told us about.

We are now ready to work collectively to deliver the best care possible for the people of Humber, Coast and Vale. We will be as efficient as possible with the resources we have to meet our population health and care needs in the best way.

Emma Latimer



Emma Latimer

Humber, Coast and Vale STP
Lead & Chief Officer NHS Hull
CCG

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Chapter 1: Executive Summary



Humber, Coast and Vale

Sustainability and Transformation Plan 2016 to 2021

Executive Summary

Our vision for Humber Coast and Vale

Our vision for the Humber Coast and Vale Sustainability & Transformation Plan (STP) is to be seen as a health and care system that has the will and the ability to help patients start well, live well and age well.

To achieve our vision we aim to move our health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves. We want, over the course of the next five years, people who live in our communities to increasingly be saying:

I know how to look after myself to reduce the chance of falling ill

I have systems in place to get help at an early stage to avoid crisis

I only go into hospital when it is planned and necessary and I am in hospital for the minimum amount of time

How our vision will be achieved

System first, organisation second

As public sector organisations in Humber, Coast and Vale, we are committed to working more closely together to ensure the resources we have are used in the most appropriate way to improve things for our community. We have developed our priorities within this plan together and to achieve our challenging vision we know that there is no other way of working. We have established system governance to provide the rigour and challenge to develop our STP which will continue to be strengthened as we move into implementation.

Public Sector Reform at the heart of everything we do

The organisations delivering public services in our footprint are facing quality and financial challenge of unprecedented scale. Genuine public sector reform will be required to achieve our vision with all partners working collaboratively on the wider determinants of health, including housing, education and employment.

Combining the benefits of scale and localism

Our planning footprint covers communities in Hull, East Riding, Yorkshire, Scarborough and Ryedale, North Lincolnshire and North East Lincolnshire. This provides us with a breadth of opportunities. We can share scarce resource together in areas where we are currently stretched providing both a better service to patients and a better experience for the staff who work within those services. Services that support the front line such as finance can also be shared across our organisations to reduce cost and achieve efficiencies. The majority of things we do however will seek to deliver the best care we can do locally, shaped around local need.

Delivering our triple aim

We will deliver our big ideas for Humber, Coast and Vale through a relentless focus on three things in our footprint: achieving our desired outcomes, maintaining quality services and closing our financial gap. These are our 'triple aims'.

Executive Summary

What are our system challenges?

In Humber Coast and Vale we are facing a number of challenges in each of the triple aim areas:

Health

- People do not generally live as long as they do elsewhere
- More people smoke, drink alcohol and are overweight than elsewhere
- Cancer is the leading cause of death in the under 75s

Quality

- Many people who are in our hospital beds do not need to be there
- Many people can't see their GP when they need to so they go to A&E
- There is a significant waiting time to access many of our services

Efficiency

- If we do nothing differently we will be in a financial deficit of £407 million by 2020

We know from a health, quality and efficiency perspective, doing nothing is not an option. This plan sets out our big ideas for meeting our challenges.

What do we plan to do?

As a health and care system we have signed up to working together on six priority areas with the aim of improving health and care systems in our communities.



1. Helping people stay well

We know that many of us would like to take charge of our own care. We know that we currently have a see and treat culture and we want to reverse this and focus on prevention – in other words helping the population to stay well. Our big ideas are:

- Offer high quality smoking cessation services based on what we know works
- Take steps to identify and act early on Cancer
- Take steps to identify cardiovascular disease and diabetes early on
- Implement prevention activities that we know work well across all localities – areas where these may typically be focused on include obesity, alcohol misuse and tackling falls.



2. Place based care

Our communities have told us that access to GP appointments is difficult and as a result they turn to A&E and out-of-hours services for help. People want to receive excellent care, close to their home, at times that work with their lifestyle. They are also frustrated that they need to give the same information and story to different professionals, often on the same day. Our big ideas are:

- Invest significantly through the implementation of the GP Forward View in General Practice to improve access to GPs, allow practices to modernise and transform the way they work and over time increase the number of GPs in our footprint.
- Implement new integrated multi-disciplinary locality teams to join up local services to make sure the health system works for everyone. Local teams will coordinate and deliver as much care as possible in the community so people only go to hospital if required. These teams will in general include GPs, community services, social care some services normally found in a hospital and potentially services from our vibrant local community and voluntary sector.
- Transform our Urgent and Emergency care services to ensure that people are able to access the level of service that is appropriate to their need on a 7 day basis and reduce the need for them to go to hospital.

Executive Summary

3. Creating the best hospital care

People who work in our hospitals tell us that they want to collaborate, innovate and challenge the way services are currently being delivered. We know that we have a population that is getting older leading to an increase in demand for hospital services, therefore doing things differently is the only answer. Our big ideas are:

- Improve the quality of hospital services through working together to design the best way of doing things, both clinically and operationally.
- Develop high quality networked and sustainable specialist services. There are plans to review complex rehabilitation services, paediatrics, neonatal intensive care and specialised orthopaedics over the next 5 years.
- Share support services to become more efficient where there will be little direct impact on the quality of patient care. We are considering doing this for; Pathology, Pharmacy, Procurement and imaging.
- Develop a consistent 'Humber Coast and Vale' level of maternity care.



4. Supporting people with mental health problems

Consultation has told us that in Humber, Coast and Vale we have a lot to do to improve Mental Health services. More services need to be provided close to home rather than in a hospital. Citizens need better access to Mental Health support services. The local message is the same message as we are hearing nationally within the 5 year forward view of Mental Health – we need to do better. Our big ideas are:

- Improve the support to people to progress on their recovery journey. Ways we will do this include; making treatment in the community our default option, addressing existing gaps in onward placements and services, and making better use of beds across the patch.



- Invest in best start and prevention strategies for the under 5s focussed on bonding and attachment. This will be delivered through health visitors, schools and parenting support
- Create new services to avoid unnecessary hospital stays We will do this in collaboration with the new integrated multi disciplinary teams This will involve us designing alternative, more appropriate services
- Provide services which maintain independence. Due to the style of the care provided in hospital or other care settings, people, especially those with dementia, can start to lose their independence. We will work with hospital and community based services to identify how services can accommodate people to both continue with their activities of daily living and be supported to make informed decisions about their care.

5. Strategic Commissioning

Currently, patients may receive a different type of treatment or a different level of care depending on where they access services. Similarly, too many organisations are commissioning services. Our aim is to strike a balance between planning some services at scale across Humber Coast and Vale so that we can get the best value from them and planning other services on a local level so that they can be built around the needs of individual communities. Our big ideas are:

- Implement a strategic commissioning model that adopts an asset based approach and has a real focus on prevention, well being, self care and delivering outcomes that matter for patients.
- Plan hospital services at HCV level to reduce variation, measure the success of services against the things that are important to the population and make best use of the staff, particularly for services where it is hard to recruit people.



Executive Summary

- Plan services at ‘place’ level that will be developed locally on a smaller scale, for example our new integrated multi-disciplinary locality teams. This means that the services offered through these teams should meet the needs of the people who live there rather than a one size fits all approach.

6. Helping people through Cancer

A focus on improving cancer services is important as Humber Coast and Vale has higher than national average incidence and mortality rates for all cancers. The number of people living with and beyond cancer is predicted to increase by 28% by 2030, which means we need to change the way we currently treat cancer. We want to simplify the way that cancer treatment is accessed, reduce the current level of variation and increase our focus on the prevention of cancer.

Our big ideas are:

Being smarter with the way we manage our Cancer diagnostics. Through managing these services across the patch they should become more efficient which means citizens should be able to access them when they need them.

- Being smarter with the way we manage our Cancer diagnostics. Through managing these services across the patch they should become more efficient which means citizens should be able to access them when they need them.
- Provide a consistent cancer recovery service for all patients across Humber Coast and Vale
- Explore the possibility of some hospital sites becoming lead providers for some cancers. For example a hospital may specialise in lung cancer from prevention through to post treatment.

How will the big ideas be delivered locally?

Whilst initiatives under our priorities are described at Humber Coast and Vale Level they will be delivered within our six localities; East Riding, Hull, North Lincolnshire, North East Lincolnshire, Vale of York, and Scarborough & Ryedale. The relationship between priorities and localities will work in a number of ways. In some cases, particularly where resources are stretched priority groups will need to be prescriptive around how individual initiatives are implemented. However for many initiatives, particularly the implementation of integrated multi-disciplinary locality teams, high level guidance and implementation support will be given to localities but the detail will be planned and implemented locally. This allows initiatives to be tailored around the needs of local communities and the people within them.

How will we make the change happen?

Improving our health and care system in the way we describe in this document will not happen overnight. We are trying to resolve challenges that our communities and public and voluntary sector organisations have been tackling for a long time. It will also require consultation and a significant change in the way we work as organisations. There are a number of ‘enablers’ we will need to put in place to support us as a partnership in making this happen. These are:

1. Delivering a system control total.

We have developed a plan that will support us in closing the potential ‘do nothing’ £420m funding gap by 2021. Big changes in the way we will work to help us achieve this involve us delivering a system control total, where we will work collectively in the interests of Humber Coast and Vale to move towards sustainability. This will also involve planning and monitoring our services based on what people in our communities think is important, rather than the number of times we see patients.



Executive Summary

2. Building strong programme and governance structures.

Our Strategic Partnership Board and our Strategic Executive Group support us in making the right decisions. Our clinical advisory group will make sure clinical views are at the heart of what we do. We know we have to do more to support clinicians in playing this role. We have begun to recruit into our programme team and our governance and resource model will continue to strengthen as we move into implementation.

3. Developing the workforce for tomorrow.

Our Local Workforce Action Board (LWAB) have planned two initiatives to help us to make sure we have the skills we need to deliver our strategy across Humber, Coast and Vale. One involves developing support staff at scale and the other advanced practice staff at scale. Both of these initiatives will significantly help us to fill the gaps we have in our workforce.

4. Making the best use of our estate.

Implementing this plan means we will have different estate needs across Humber Coast and Vale Public Sector partners. As demand changes we will need to use our estate flexibly to deliver our strategy.

5. Developing our plan through communication and engagement.

We have challenging proposals for Humber Coast and Vale and are working on a comprehensive communications and engagement plan that has citizens and patients, staff and partners at its heart. We will not make any decisions without consulting our population and our staff on the changes we believe we should make.

6. Using technology as a foundation for service improvement.

We have a single plan across Humber Coast and Vale for using technology to transform our health and care services. This includes developing a single electronic care record that can be shared and accessed by Health and Care professionals. This means that people who live in the area should only have to say things once when they interact with health and care services.

What will be the impact of our plan on our communities and our staff?

We want our plan to make Humber Coast and Vale a better place to live and to develop health and care services that people want to both use and work in. Over the next five years, our staff and people in our communities to be increasingly saying:



Staff

- I have less duplication in my work which means I can focus on what is important
- I enjoy the work I do as I believe it makes a difference
- I feel services I work in are truly designed around the patient
- I feel I have enough time to do my job well
- I am satisfied in my work and understand the routes for progression if I want it
- I am able to work seamlessly across care settings to get the job done
- I can work easily and in partnership with my colleagues from other organisations



Our communities

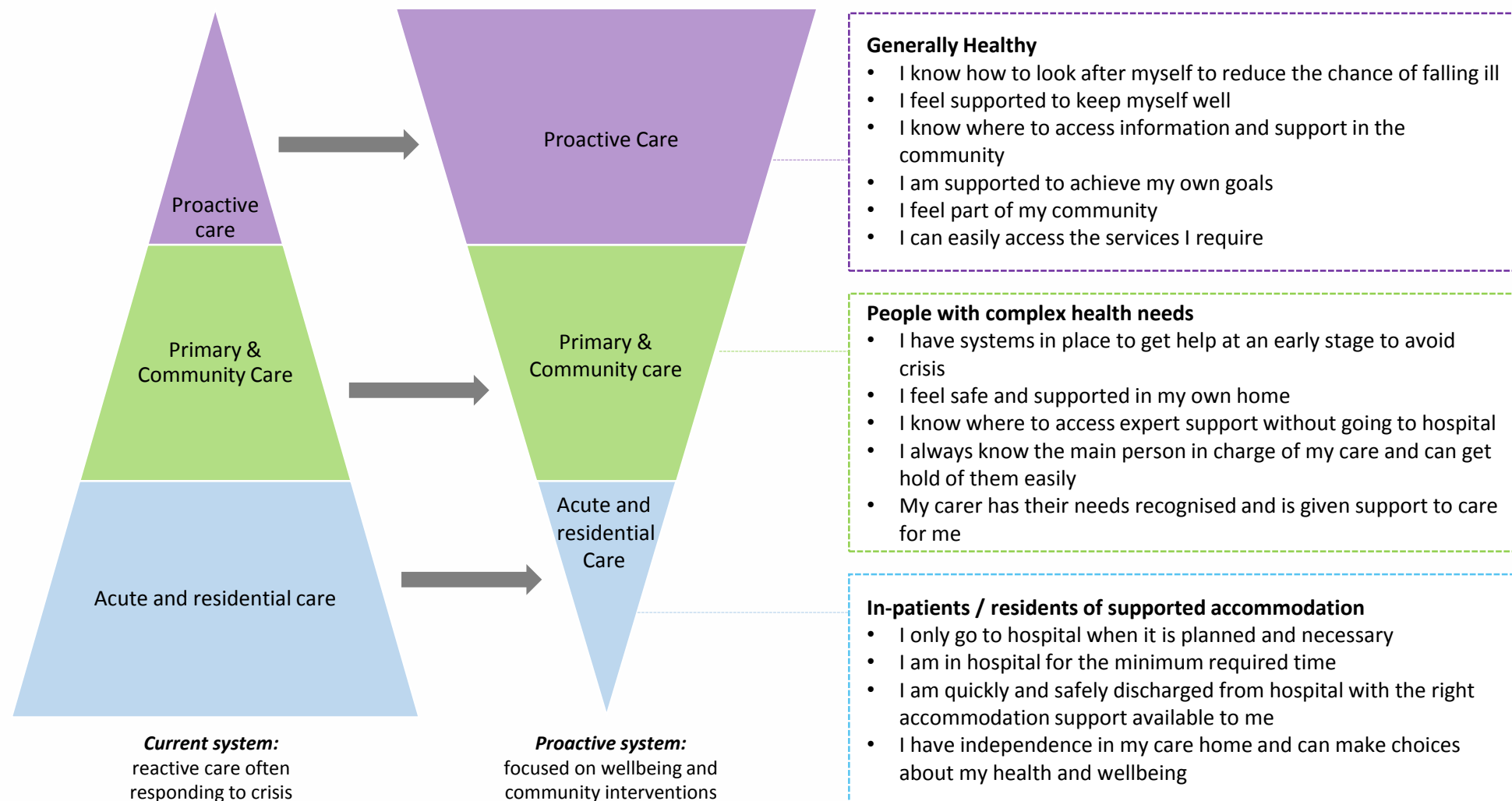
- I feel supported to keep myself well
- I have 24/7 access to an on call Primary Care Practitioner, or appropriate practitioner to meet my urgent care needs
- I understand better alternatives than using my local A&E for urgent care
- I have access to hospital services which meet my need
- I only go to hospital when it is planned and necessary
- I receive a consistent, excellent quality of treatment from all health and care organisations in the HCV patch

Chapter 2: Case for Change



Our Vision: start well, live well and age well

Everyone in the Humber, Coast and Vale footprint should have the opportunity to start well, live well and age well. We are facing major challenges in health and well being, quality and care and efficiency. Our proposals aim to move from a reliance on care delivered in hospitals and institutions to helping people and communities care for themselves in a proactive care system. We have set out below the kind of model we believe our patients and citizens are looking for and the aspirations we should be aiming towards.



Our Case For Change

Background

The Humber, Coast and Vale footprint was established in 2016. It covers the areas of; Hull, East Riding, North Lincolnshire, North East Lincolnshire, Vale of York and Scarborough and Ryedale. Despite being a relatively new partnership, there is a clear desire (and need) for collaboration and change across the patch. There are 20 organisations within the partnership:

- 6 Clinical Commissioning Groups
- 3 Acute Trusts
- 3 Mental Health trusts
- 6 Local Authorities
- 2 Ambulance Trusts

In addition to number other health and care organisations including community providers and community and voluntary sector organisations.

We are all committed to working together in partnership to tackle the major health and care challenges we are facing across the footprint.

Our Humber, Coast and Vale footprint faces some major challenges which we are committed to addressing.

- 23% of our 1.4 million population live in the most deprived areas of England.
- We have an ageing population of which 8.9% are over the age of 75 which will lead to an increasing strain on health and care services.
- Variation in life expectancy between the best and worst areas across the footprint is 20 years for men and 17 for women.

Triple aims

The national healthcare system is committed to narrowing the three gaps, or 'triple aims' of **health and wellbeing, quality of care and efficiency** through a strategy called the *Five Year Forward View* to create a sustainable healthcare system for the future. The table below outlines where in Humber, Coast and Vale are facing particular challenges under these three areas and therefore where we need to focus our plan:

Health and Wellbeing



Mortality – Standardised mortality is significantly worse than the national average. On average the death rate of under 75s is 153 per 100,000

Prevention – Smoking, alcohol abuse and obesity rates are higher than the national average

Cancer – Cancer is the leading cause of death in under 75s. Cancer kills over 4,000 people a year in the HCV patch, with lung cancer being the biggest contributor

Mental Health – 14% of people aged 16-74 have mental health disorders

Quality of Care



The Right Care – 40% of A&E patients require no treatment. 25-50% of hospital beds are used by people who don't need to be there

The Right Place – 27% of people seen by GPs could have had their issue resolved another way. 36.5% of A&E patients went there because the GP practice was unavailable or closed

The Right Time – Citizens will wait over 4 weeks for to access some mental health services

Elective Care – 51% of patients said they couldn't have an appointment at their GP on the day they wanted to

Efficiency



Deficit – If we do nothing as a STP footprint, will be in a deficit of £407 million by 2021

Turnover – Annual turnover of the footprint is £3bn

Estates – Total running cost of £208 million, which includes estates which are not used to their full capacity

Our Case For Change

We have engaged with more than 30 000 people over the past three years, using quantitative methods such as National Patient Surveys and our own qualitative methods via campaigns including Ambition for Health (latest report, "A4H what we know about Place of Care from previous engagement Aug16") and Healthy Lives, Healthy Futures*. We have worked with Healthwatch** and other engagement is currently underway including Urgent Care in Hull. Some of the headlines from our engagement to date are set out below.








**Latest report Local Voices: What are the public saying about health and care in Humber, Coast and Vale?

** A joint report from local Healthwatch to help shape the Humber Coast and Vale Sustainability and Transformation Plan July 2016.

How we will achieve our vision and address the case for change

To address the challenges highlighted in our case for change and to achieve our vision we need to change what we do. To achieve this we have identified five priorities which will focus on addressing Humber, Coast and Vale specific challenges, local place based delivery and on achieving national targets. They will set aside the traditional organisational forms and focus on improving health in communities and delivering the services that are needed in localities. They will also aim to support the health and care system in balancing the books. A summary of what we plan to deliver in each of the areas is outlined below.

Priority	Big ideas
Helping people stay well	 <ul style="list-style-type: none"> • Tobacco control • Take steps to identify and act early on cancer • Preventing Cardiovascular Disease and Diabetes • Implementing prevention activities at scale
Place based care	 <ul style="list-style-type: none"> • Changing how people access primary and community care • Integrating the different services that provide care to patients
Creating the best hospital care	 <ul style="list-style-type: none"> • Improve the quality of hospital services • High quality, networked and sustainable specialist services • Shared support services • Establishing our local maternity system
Supporting people through Mental Health	 <ul style="list-style-type: none"> • Plan hospital services at Humber Coast and Vale level • Plan local services at place level • A strategic approach to commissioning outcomes across the patch
Making the best use of our resources	 <ul style="list-style-type: none"> • Be smarter with the way we manage our Cancer diagnostics • Provide a consistent cancer recovery package for all patients • Explore the possibility of some hospital sites becoming lead providers for some cancers

Chapter 3: Big Ideas



Humber, Coast and Vale

Sustainability and Transformation Plan 2016 to 2021



Helping people stay well

What do we need to change?

We know that many of us would like to take charge of our own care. We know that we currently have a see and treat culture and we want to reverse this and focus on prevention – in other words helping the population to stay well.

Our aim is to build prevention into the heart of all health and care services that the citizens receive – allowing citizens to take control of their own health. In the case for change we noted the challenges that the system is currently facing in terms of an ageing population and an increasing number of people accessing services. A well focussed prevention programme will be essential for driving improvements. Our planned programme is set out below.

We aim to deliver most of our work through GP surgeries and other health and care professionals in the community. However there is also a focus on making sure prevention is at the heart of care patients receive in hospital.

What are we going to do?

1. Tobacco control

We will reduce lung cancer by supporting people to stop smoking through offering high quality smoking cessation initiatives across the Humber, Coast and Vale footprint. We will:

- Find out if the patient smoke when they attend a health or care appointment
- Offer support to stop smoking, usually in the community but in hospital if that is where the patient is
- Offer harm reduction support including guidance on e-cigarettes if they do not want to do this

2. Take steps to identify and act early on cancer

We will:

- Need to identify situations where identification of cancer is made late and encourage a more proactive approach.
- Find ways to encourage people living in those communities to take action if they spot signs of cancer. In addition to encouraging and supporting uptake of cancer screening programmes in these areas.
- Consider prescribing something that is not traditionally prescribed from a doctor (social prescribing)– for example exercise sessions, or other non-health services to help people remain independent.

3. Preventing Cardiovascular disease and Diabetes

At the moment we do a number of things in our areas that help citizens to prevent Cardiovascular disease and Diabetes. We know that some things work better than others and we want to do more of the things that work. As part of this action we will roll out the NHS Diabetes Prevention Programme in every locality and look to set better prevention standards.

4. Implementing prevention activities at scale

We will be implementing prevention initiatives that we know work well across all localities so everyone in Humber Coast and Vale has the opportunity to stay well, for example: injury prevention, including tackling falls; obesity and physical activity; alcohol misuse; prescription medicine misuse and care navigation.

What will the impact be?

- I know how to look after myself to reduce the chance of falling ill
- I feel supported by my peers to keep myself well
- I know where to access information and support in the community
- I am supported to achieve my own goals
- I feel supported to manage my illness

This priority aims to narrow the three 'gaps in the following ways':

Health

- Improve the health and life expectancy of the population
- Reduce proportion of population with colorectal, breast and cervical cancers diagnosed at a late stage
- Reduce proportion of population that are smokers
- Reduce proportion of elderly patients experiencing a fall

Quality

- Services that help people prevent and spot illness early are valued by the people they benefit

Finance

- Focussing on prevention could save the Humber, Coast and Vale Health Economy an estimated £11m through reducing unplanned and planned stays in hospital.



Place based care

What do we need to change?

Consultation has told us that access to GP appointments is difficult and as a result people turn to A&E and out-of-hours services for help. The population want to receive excellent care, close to home, at times that work with their lifestyle. People are also frustrated that they need to tell the same information and story to different professionals, often on the same day. We know our patients deserve better. We also want to create a place where our staff want to come to work and where people work seamlessly across community services. Our response to this is called Place based care and is set out below.

What are we going to do?

Our place-based care strategy will look at two things:

1. Changing how people access primary and community care
2. Integrating the different organisations that provide care locally

1. Changing how people access primary and community care

GPs are the cornerstone of our health and care system and we are delighted that a significant amount of additional investment will be allocated to our local practices in line with the GP Forward View. This takes the total expenditure in primary care to 10% of the overall STP resource.

The additional investment will allow us to improve our currently stretched GPs services to provide better care close to patients homes.

The GP Forward View programme is intended to increase the number of GPs, improve access to GP appointments and wider community services, give citizens greater choice and improve the quality of care. The potential changes proposed include:

- The redesign of our current primary care model to enhance access to the right profession first time. Patients will be able to access a seamless community service, with GPs, fully integrated with community services, mental health and social care and the voluntary sector;
- Managing the demand for GP services in different ways for example upfront triage to access need.
- GP surgeries working collectively to create local hubs or networks that will create additional capacity, standardise the quality of care and reduce the need for people to go to hospital when they do not need to do so; and
- Digital technology will be used to support citizens in their home so that we understand how their health is progressing and people can look after their own health without the need to go to hospital.

2. Integrating the different services that provide care to patients

We know that areas already combining NHS, GP and social care services have improved services for patients, with fewer people needing emergency trips to hospital or needing to move into nursing care homes.

Implement new integrated multi-disciplinary locality teams to join up local services to make sure the health system works for everyone. Local teams will coordinate and deliver as much care as possible in the community so people only go to hospital if required. An example would be making sure that the right support is in place for an elderly person quickly after a fall to make sure that they are quickly back on their feet and can support themselves effectively in their own home. These teams will in general include GPs, community services, social care some services normally found in a hospital and potentially services from our vibrant local community and voluntary sector

This priority aims to narrow the three 'gaps in the following ways':

Health

- Reduction in the number of people attending A&E
- Reduction in the number of unplanned stays in hospital

Quality

- Patients will only need to tell their story once, as care delivered is documented in an integrated health & social care record
- Increase the number of urgent and emergency calls being resolved on the phone
- Increase the number of people making health related visits to a pharmacist by as an alternative to A&E
- Reduce the number of GP consultations on minor ailments

Finance

- Focussing on place based care could save the Humber, Coast and Vale Health economy an estimated £32m



Place based care

Health & Social Care integration and support

We propose to improve the capability and capacity of the care market by undertaking a review of home care, active recovery and residential home capacity, and then rapidly implementing a plan where additional capacity is required. This will help ensure the sustainability of the care sector and see investment in services in people's own home, for example domiciliary care.

Proactive care to promote independence and positive wellbeing

GPs, community services and councils will work together to understand the citizens most likely to require long term care or be admitted to hospitals. They will then jointly help them to identify support and activities so they can look after themselves and stay healthy for longer. Examples of this kind of care include fitness programmes, dietary support or loneliness programmes.

Urgent and emergency care (UEC)

Knowing the right place to go to when patients get ill or have an accident can often be confusing. As we have seen from our case for change 40% of people who go to accident and emergency did not need to be there and could have received care closer to home. We need to simplify the system and make sure there are services in place that mean people don't need to go into hospital. To do this we will put in place:

- Digital solutions to help citizens identify where they need to go via apps or online self-help.
- A Clinical Advisory Service, in other words somebody to speak to patients over the phone to help them get the right care at the right time. This could include advice from GP's, specialist doctors, therapists, dental services and pharmacists.
- Urgent care services locally that can access 7 days a week that will also include GPs

What will the impact be?

- I have 24/7 access to an on call Primary Care Practitioner, or appropriate practitioner to meet my urgent care needs
- I can receive personalised care locally through the most appropriate practitioner.
- I can improve and manage my health and wellbeing
- I understand better alternatives than using my local A&E

Case Study #1 - Hull FIRST – a truly multi agency approach to tackling falls

Stanley Fieldhouse (88) from East Hull was one of the first people to be visited by the new Humberside Fire and Rescue Falls response team (Hull FIRST), commissioned by NHS Hull CCG. When Stanley had a fall at home his confidence was shattered. The fall happened upstairs and he had no choice but to remain up there as he was too heavy to be lifted down. The new Humberside Fire and Rescue Service Falls response Team came to his aid, visiting Stanley at home and putting a plan in place to get him downstairs safely.

Quite often someone has fallen in the middle of the night and they have been on the floor for some time. The Falls response service is able to get to people within an hour, pick them up, assess them and pass the information back to other care services who will let them know what action to take with the patient. The Fire Service Falls response team can then put a call in to the community falls assessment team which can bring equipment to help make their home a much safer environment.

Stanley said – “Gradually I've got moving again and to wanting to live again. The Fire Service has been fantastic. I can't thank them enough for what they've done. Getting me downstairs was the best thing that's happened. I've kept my independence and got some confidence back. The Falls Team has also been round a few times to check that I'm doing my exercises. It's just brilliant.”



Creating the best hospital care

What do we need to change?

People who work in our hospitals tell us that they want to collaborate, innovate and challenge the way services are currently being delivered. We know that we have a population that is getting older leading to an increase in demand for hospital services, therefore doing things differently is the only answer. We want to respond to these challenges whilst also improving the quality of care that we provide..

What are we going to do?

1. Improve quality of hospital services

We have three hospital trusts on our patch and at the moment patients may experience a different treatment or level of care depending on which one they attend. We want that to end. We are working together to identify the best ways of doing things both clinically and operationally. The first areas we are focusing on are Dermatology, Ophthalmology, Orthopaedics, Orthodontics and Maxillo-Facial. These specialties make up around 50% of appointments in our area.

2. High quality, networked and sustainable specialist services

Specialist services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients. The three hospital trusts in the STP footprint already work together in formal clinical networks for Cancer, Major Trauma, Vascular and Critical Care and have agreed to establish a new network for Cardiac Services. We envisage even closer working in the future, bringing teams together to further improve the quality and sustainability of these services. In addition, we recognise the need to work with commissioners and partners across Yorkshire and the Humber to develop some very specialist services. There are plans to review complex rehabilitation services, paediatrics, neonatal intensive care and specialised orthopaedics over the next 5 years.

3. Shared Support services

There are a number of services that hospitals all deliver that are not patient facing. Where this is the case we will aim to standardise what we do and share scarce resource to provide better and more efficient services. There should be little impact on the quality of care patients receive. We are considering doing this for; Pathology, Pharmacy, Procurement and imaging.

4. Urgent and emergency care

As a result of the initiative being progressed within the place based care priority it is anticipated that there will be less attendances at A&E. By working together the hospitals will ensure that a consistent quality of care is available 24 hours a day for people who have emergency and specialist emergency care needs, this work has commenced starting with a focus on delivering the 4 priority standards across the initial 5 specialties by Autumn 2017, and by 2021 will have implemented the standards across the remaining specialties.

The standards are:

- Timely access to first consultant review
- Access to diagnostics
- Access to consultant directed interventions
- On-going consultant review

The specialties are:

- Stroke
- Major Trauma
- Vascular
- Heart Attacks; and
- Paediatric Critical Care

This priority aims to narrow the three 'gaps in the following ways':

Health

- Improved access to right services when needed
- Strengthen links to primary care for pro-active case management

Quality

- Decrease the number of people who die in hospital
- Reduce the number of follow up appointments and the number of people who do not attend appointments
- Increase levels of performance across the three trusts

Finance

- Focussing on creating the best hospital care could save an estimated £130m by 2021 through general efficiency savings.
- Reducing cost by an estimated £15m through a review of pharmacy, diagnostics and estates



Creating the best hospital care

5. Maternity Services

Each hospital has its own maternity service and as with other services the care patients receive can be different depending on where they go to. We want to develop a consistent 'Humber Coast and Vale' level of maternity care and will be establishing a Local Maternity System.

Our desired outcomes are:

- A reduction in stillbirth and neonatal death rates
- Improved perinatal mental health.
- An increase in multi-disciplinary working focused around the individual women's/couples needs.

Specific changes to hospitals on the patch

The case for change sets out the reasons why the current level of hospital care cannot remain as it is now and one of the main aims of this plan is increasing the level of care that patients receive close to home so they do not need to go into hospital. Any changes to services would be developed alongside patients, public and staff. Change would also be subject to appropriate public involvement.

Changes to Scarborough Model of Care

It has been recognised for some time that the health and social economy in the Scarborough area is unsustainable both financially and clinically in its current form. Local partners are looking at options to rectify this, based around significant improvements to out of hospital care, and on those hospital services that are needed to support this approach. These options will be subject to engagement and involvement with the local community over coming months.

Changes to North Lincolnshire and Goole Hospitals (NLAG)

The Trust has developed options around how services will change across the three NLAG hospitals. These options now need to be consulted on more widely with other health and care partners, the patients and the public before they can be implemented. We are working across partners to consider outline proposals in October / November 2016 which will then be worked up into more detailed options appraisals, to support full engagement in summer 2016.

What will the impact be?

- When I am referred to hospital I quickly receive an appointment
- I receive a consistent, excellent quality of treatment from all hospitals in the HCV footprint
- I have access to hospital services which meet my need
- I only go to hospital when it is planned and necessary
- I am in hospital for the minimum required time
- I am quickly and safely discharged from hospital with the right accommodation or support available to me

Our changes to Urgent and Emergency Care aim to narrow the three 'gaps in the following ways':

Health

- We will deliver the four priority standards and seven day working for Acute Care. These are; timely access to first consultant review, Access to diagnostics, Access to consultant directed interventions



Creating the best hospital care

Case Study #2 - Centralisation of hyper acute stroke services at Scunthorpe General Hospital is helping patients in North and North East Lincolnshire

A decision was taken by North Lincolnshire and Goole NHS Foundation Trust in November 2013 to temporarily consolidate hyper acute stroke services on its Scunthorpe site and in doing so provide a service 24 hours a day, seven days a week.

In October 2014 this decision was made permanent, following public consultation.

The centralisation has enhanced many aspects of the service including thrombolysis treatment – a clot-busting drug that helps to preserve part of the brain affected by the stroke.

It means that eligible patients from across the region can receive this drug round-the-clock any day of the week including weekends. Before the centralisation it was only available from 8am to 8pm Monday to Friday. It has also meant there are more people with expertise on the condition in one place, equipment is all in one area and there has been room to develop roles within the department.

The quality of care provided is high. The Sentinel Stroke National Audit Programme (SNAP) measures the quality of stroke care provided to patients from when they arrive at hospital to up to six months after their stroke. The unit was rated 'A' on a scale of A to E, the highest out of all 17 stroke units in the Yorkshire and Humber region.

Julia McLeod, regional director across Yorkshire and East Midlands for the Stroke Association, said: "Stroke patients are more likely to survive, make a better recovery and spend less time in hospital if their stroke is treated as an emergency, and they receive specialist care from a coordinated team on a stroke unit.."



Supporting people with their mental health

What do we need to change?

Consultation has told us that in Humber, Coast and Vale we have a lot to do to improve Mental Health services. More services need to be provided close to home rather than in a hospital and citizens need better access to Mental Health support services. When people they no longer require a service we need to get better at making sure they have follow up services in place with the appropriate organisations. The public has also told us that staff working within our physical health and care organisations would benefit from having a better knowledge of Mental Health needs and that we need to get better at supporting people's physical health. The local message is the same message as we are hearing nationally within the 5 year forward view of Mental Health – we need to do better.

We also know that people from our black and minority ethnic community are significantly less likely to use Mental Health Services and we need to do something about this. We understand that the solutions to these issues are not only 'medical' and that we need to work with voluntary and community organisations based in the localities to address some of these challenges.

What are we going to do?

1. Improve the support to people to progress on their recovery journey

We will do this by making treatment in the community our default option, addressing existing gaps in onward placements and services, extending recovery college provision, and establishing a new bed use model across the patch. This will also enable us to reduce the number of people that are cared for out of the area and develop provision for complex individuals more locally.

2. Invest in best start and prevention strategies for the under 5s

focussed on bonding and attachment, delivered through health visitors, schools and parenting support including interventions to develop self care skills for mental health and well being, address domestic violence, increased capacity in CAMHS services and a community pre-natal service.

3. Create new services to avoid unnecessary hospital stays

We will do this in collaboration with the new integrated multi-disciplinary teams alongside our approach for developing place based care. This will involve us designing alternative, more appropriate services informed by lived experience. This will include development of more non clinical services to bridge the gap between self care and seeing a GP or a Mental Health practitioner, ensuring that extended assessment is available for all who would benefit in crisis, and ensure that we have 24/7 intensive home based alternatives to admission and effective 24/7 urgent & emergency liaison mental health services for all ages . We have also worked with each CCG to ensure that the priorities of the five year forward view for mental health and **Transforming Care are embedded in their local delivery plans.**

4. Provide services which maintain independence

Due to the style of the care provided in hospital or other care settings, people, especially those with dementia, can start to lose their independence. We will work with hospital and community based services to identify how services can accommodate people to both continue with their activities of daily living and be supported to make informed decisions about their care.

Mental Health - This priority aims to narrow the three 'gaps' in the following ways:

Health

- Reduced inequality in potential years of life lost by 10 years within 20 years
- Increase the employment and stable housing rates for people living with mental ill health
- Reduction in length of acute hospital stays through appropriate support in acute settings
- Reduced prevalence of mental health disorders in children

Quality

- Reduced stigma of mental health and development of self care capabilities
- Increased numbers of people returning to their home after admission by supporting independence in all settings
- Improved support to informed decision making
- More accessible environments
- Delivery of the Five Year Forward View for Mental Health and Transforming Care priorities

Finance

- Focussing on supporting people with their mental health could save Humber, Coast and Vale an estimated £5m



Supporting people with their mental health

5. Invest our resources differentially to address health inequalities

We will invest in evidence based practice, informed by lived experience to commission culturally competent and adaptable services designed to achieve comparable outcomes for all.

6. Ensure that all mental health treatment plans are developed with consideration for physical health

This will include proposing new pathways and prescribing guidelines which address the known potential impact of some mental health medications on physical health and the additional actions which should be taken to mitigate these.

7. Initiate a radical change in commissioning culture

To commission creative solutions for complex individuals which address both outcomes and financial risk, and create new opportunities for the local VCS. This includes raising expectations of what the VCS can deliver, challenging established assumptions that some outcomes can only be delivered through public sector providers and routine use of the Social Value Act to benefit from the added value that local VCS providers can bring.

What will the impact be?

- My services are optimistic about my future and support me to recover where possible and live well, maintaining my independence
- I have systems in place to get help at an early stage to avoid crisis
- I receive most of my care close to home
- My physical health is well managed and when I need care it takes account of my mental state and I am able to return to my home rapidly

Case Study #3 - Care Services working together to support people to remain in their own home towards the end of their life

“Chris” was a 60 year old gentleman with a severe learning disability, and other complex health issues.

“Chris” had lived in a local specialist care home for 7 years and his care team, with the agreement of his Mother, had referred “Chris” to the Community Palliative Care team for specialist advice and support due to a decline in his health. Chris and his mother said this was his preferred place of care as he knew the staff very well, they understood his needs and previous trips to hospital had caused him and his mother immense distress.

The care home team utilised a patient-centred care assessment and had clearly documented “Chris’s” needs, These were reviewed regularly. Due to the lack of “Chris’s” mental capacity regular best interest meetings were held involving “Chris’s” Mother the care home team, the Consultant Neurologist, the GP, the Epilepsy Nurse Specialist, the Learning Disabilities Team, the Community Nursing Team and the Community Specialist Palliative Care team. They all contributed to his care decisions; always reflecting back to “Chris” and his Mother’s wishes.

“Chris” died peacefully in familiar surroundings therefore achieving his preferred place of death. Chris’s mother sent a letter of gratitude to the team saying – *“Chris spend his last 12 days in his own personal room, with familiar sights when he was awake, familiar sounds and smells. Best of all, his own special nurses and carers, who loved and understood him, were there for him..... in an atmosphere that was full of warmth and compassion.”*

Case study from the City Health Care Partnership (CIC)



Strategic Commissioning

What do we need to change?

Currently, patients may receive a different type of treatment or a different level of care depending on where they access services. Similarly, too many organisations are commissioning services.

Our aim is to strike a balance between planning some services at scale across Humber Coast and Vale so that we can get the best value from them and planning other services on a local level so that they can be built around the needs of individual communities.

What are we going to do?

1. A Strategic Approach to commissioning outcomes across the patch.

Move to strategic commissioning across HCV that adopts an asset based approach and has a real focus on prevention, well being, self care and delivering outcomes that matter for patients.

2. Plan hospital services at Humber Coast and Vale level.

There are a number of services that it makes sense to plan at Humber Coast and Vale level. Through doing this we aim to reduce variation, measure the success of services against the things that are important to the Humber, Coast and Vale population and make best use of the staff, particularly for services where it is hard to recruit people. This is mainly hospital services and potentially Cancer and Mental Health services. Areas we look at first will be informed by the work carried out under the Creating The Best Hospital Care priority. We aim to start doing this from April 2017 and a group is already in place to support us in planning for this.

3. Plan services at 'place' level

We will plan services that will be developed locally on a smaller scale, for example our new integrated multi-disciplinary locality teams. This means that the services offered through these teams should meet the needs of the people who live there rather than taking a one size fits all approach. Technology is now available that allows us to get a thorough understanding of the needs of small populations, right down to street level, and we will be using this to make sure the services we plan really meet local needs, in addition to asking what is important to patients and citizens.

What will the impact be?

- I receive a consistent, excellent quality of treatment from all health and care organisations in the HCV patch
- I access services locally that meet my needs

Strategic Commissioning - the This priority aims to narrow the three 'gaps in the following ways':

Health

- With the correct incentives in place this initiative should help organisations to work together focused around patient needs.
- Keeping people healthy through emphasis on prevention should help us keep more people out of hospital and get better results from the services we have

Quality

- Operating 'at scale' will support making the best use of clinical staff
- Faster access to specialised services with more patients seen in a shorter period of time will improve RTT performance.

Finance

- Focussing on strategic commissioning could save an estimated £10m through a reduction in duplication and minimised waste through working closer together.

Helping people through cancer

What do we need to change?

We have a clear vision of what people want and need from cancer services, from diagnosis to recovery.

People want:

- To know that they will get an appointment quickly.
- To given a clear explanation of clinical tests.
- Follow up care that provides assurance and access to specialists.
- A named clinical nurse lead and specialist
- Ease of access to a professional, including being able to pick up the phone and contact someone who knows about their case.
- To be involved in their care
- More information and communication on life-style and practical post treatment advice.
- Care to be delivered through competent ward nurses, allowing the patient to have trust in them.
- Planned and effective discharge from care.
- Coordination between hospital and GP practice so care is ongoing.

A focus on improving cancer services is important as Humber Coast and Vale has higher than national average incidence and mortality rates for all cancers. The number of people living with and beyond cancer is predicted to increase by 28% by 2030, which means we need to change the way we currently treat cancer. We want to simplify the way that cancer treatment is accessed, reduce the current level of variation and increase our focus on the prevention of cancer.

What are we going to do?

1. Be smarter with the way we manage our Cancer diagnostics

At the moment diagnostics (for example scans and x-rays) are managed within individual organisations. As demand for these services changes frequently, equipment is in variable condition and there are often shortages in people who work in these areas these services can be challenging to run. Through managing these services across the patch they should become more efficient which means patients should be able to access them when need them.

2. Provide a consistent cancer recovery package for all patients

The good news is that more people are now surviving cancer. We need to make sure that everyone who survives cancer receives the same level of treatment across the patch. This includes a Holistic Needs Assessment; Treatment Summary; Cancer Care Review and access to Health and Wellbeing initiatives. We plan for all cancer survivors across Humber, Coast and Vale to be able to access this package of care.

3. Explore the possibility of some hospital sites becoming lead providers for some cancers

Hospitals already specialise in providing certain types of care. For example, some specialise in stroke care, others in cancer care. In the future we will consider further specialising of cancer care, for example a hospital may specialise in lung cancer from prevention through to post treatment.

What will the impact be?

- I can easily access the support services I require
- I have access to tests when I need them
- I had excellent treatment in hospital and close to home

Cancer Services - This priority aims to narrow the three 'gaps in the following ways':

Health

- Improved survival rates for lung cancer.
- Reduced cancer mortality and increased cancer survivorship in the HC&V.
- Reduction of side effects, and reduced mortality through earlier diagnosis

Quality

- Delivery of 28 day 'In/Out' diagnosis for cancer and 62 day target.
- Improved quality of life post treatment.
- Improved patient experience throughout patient pathway.
- Reduction in unwarranted variation in service provision.

Finance

- Efficient use of diagnostic services

Chapter 4: Making the change happen



Humber, Coast and Vale

Sustainability and Transformation Plan 2016 to 2021

How our plans will be delivered

Whilst the initiatives under our priorities are described at Humber Coast and Vale Level they will be delivered within our six localities; East Riding, Hull, North Lincolnshire, North East Lincolnshire, Vale of York, and Scarborough & Ryedale. The relationship between priorities and localities will work in a number of ways. In some cases, particularly where resources are stretched, we are limited by the number of specialist health and care professionals available or where there is significant variations in quality, priorities will need to be prescriptive around how individual initiatives are implemented. However for many initiatives, particularly the implementation of integrated multi-disciplinary locality teams, high level guidance and implementation support will be given to localities but the detail will be planned and implemented locally. This allows initiatives to be tailored around the needs of local communities and the people within them. The diagram below demonstrates which of our STP initiatives are to be delivered at Humber Coast and Vale level and which at locality level.

	1. Helping people stay well	2. Place based care	3. Creating the best hospital care	4. Supporting people with mental health problems	5. Strategic Commissioning	6. Helping people through Cancer
Delivered and planned at scale			<div>Elective Care & Specialised Commissioning</div> <div>Back Office & Pathology</div> <div>Creating Single Acute Network</div>	<div>Reducing the amount of people cared for out of area</div> <div>New models of care to prevent unnecessary hospital stays</div>	<div>Strategic Commissioning Function</div> <div>Acute & Specialised Commissioning</div>	<div>Lead providers for cancer</div> <div>Diagnostic management</div> <div>Consistent cancer treatment</div>
Delivered locally	<div>Tobacco control</div> <div>Identifying cancer earlier</div> <div>Preventing cardiovascular disease and Diabetes</div> <div>Individual prevention initiatives</div>	<div>New Integrated multi-disciplinary locality teams</div> <div>Diversification pathways to reduce acute demand</div> <div>Changing how people access Primary Care</div> <div>Accountable Care Partnerships</div>	<div>Urgent and emergency care initiatives</div> <div>Local maternity system</div>	<div>Invest in best start – secondary and prevention strategies</div>	<div>ACO & Place based commissioning</div>	

Humber Coast & Vale Delivery Roadmap

Priorities	2016 Oct – Dec	2017 Jan – Marc	2017 Apr – Jun	2017 Jul – Sep	2017 Oct – Dec	2018 Jan – Mar	2018 Apr – Jun	2018 Jul – Sep	2018 Oct – Dec	2019 Jan – Mar	
	Shadow Running Preparation & Detailed Design		1		Shadow Running		2		Cut-over to Business as Usual (BAU)		3
1. Helping people stay well	Dev Ph 1 Programme, e.g. injury prevention, wider determ.	Phase 1 Programme roll-out and review			Develop Phase 2 Programme		Phase 2 Programme roll-out and review. Ongoing benefits realisation.				
2. Place based care	P Care Review & Redesign		Plan and roll-out in localities				Refine and benefits realisation				
	Pathway redesign: elective and complex discharge.		Plan and roll-out in localities				Refine and benefits realisation				
	Detailed Design: social prescribing & community navigation		Plan and roll-out in localities				Refine and benefits realisation				
	Implement Electronic Care Record										
	HCV Integrated Multi- disciplinary Locality Teams Framework & Op Model Design (incl. enablers)		Shadow running of Integrated Multidisciplinary Locality teams in localities (incl. enablers)				Steady state running and commissioning of new ACOs in localities				
	Care market capacity review		Plan & roll-out in COGs								
3. Creating the best hospital care	Detailed review and options appraisals: Elective, Acute Network, Specialised Commissioning, Back-office and pathology		Consult & Pilot across HCV acute hospitals			Detailed design and implementation across HCV acute hospitals					
	U&E: 4 P Standards Planning	U&E: 4 P Standards Roll-out									
4. Supporting people with Mental Health problems	Design shared HCV MH Standards		Establish shared commissioning & resourcing models, run pilots			Steady state running of new model and benefits realisation					
5. Strategic Commissioning	Strategic Review	Plan Shadow Run. & options appr.	Shadow running and pilot governance arrangements , including suspension of PBR				Implement steady state commissioning op model and new contractual arrangements.				
6. Helping people through cancer	Detailed planning: 62 day target, lung cancer p/way, diagnostic mod		Pilot, review and iterate			Steady state running of new model and benefits realisation					

Implementing our big ideas locally*

I live in Vale of York and Scarborough – what changes will I see?

Vale of York

- Organisations in the Vale of York will work together in a new way (called an Accountable Care System – ACS) and develop locality teams to provide a new approach to service delivery from April 2017
- By services working together to help people stay healthy, the Locality Teams aim to provide care as close to home as possible rather than having to go into hospital for care.
- Through locality working there will be support, information and advice to stay well, stop smoking, maintain a healthy weight and prevent ill-health or accidents at all stages of life
- There will be improved diagnosis of dementia and local access to mental health support with new mental health in-patient facilities for the local area in 2019

Scarborough

- Scarborough will be implementing a integrated multi- disciplinary team structure (called a Multispecialty Community Provider - MCP) October 2017.
 - It will bring together Social Care and Primary care under a single organisation so care should feel more 'joined up' for people who live there.
 - The service aims to help residents stay well through having a single contact for information on health and care services, and rapid access to care close to home for people with an urgent care need.
-



I live in Hull and East Riding – what changes will I see?

- Hull and East Riding will be implementing integrated multi-disciplinary locality teams from April 2017
 - The new team will bring a number of services together including GPs, community services, mental health and adult social care into a single function team so to respond to the needs of the population, therefore services will be much more 'joined up' for people who live there
 - New services to help people stay well will focus on reducing smoking rates and reducing alcohol misuse.
-

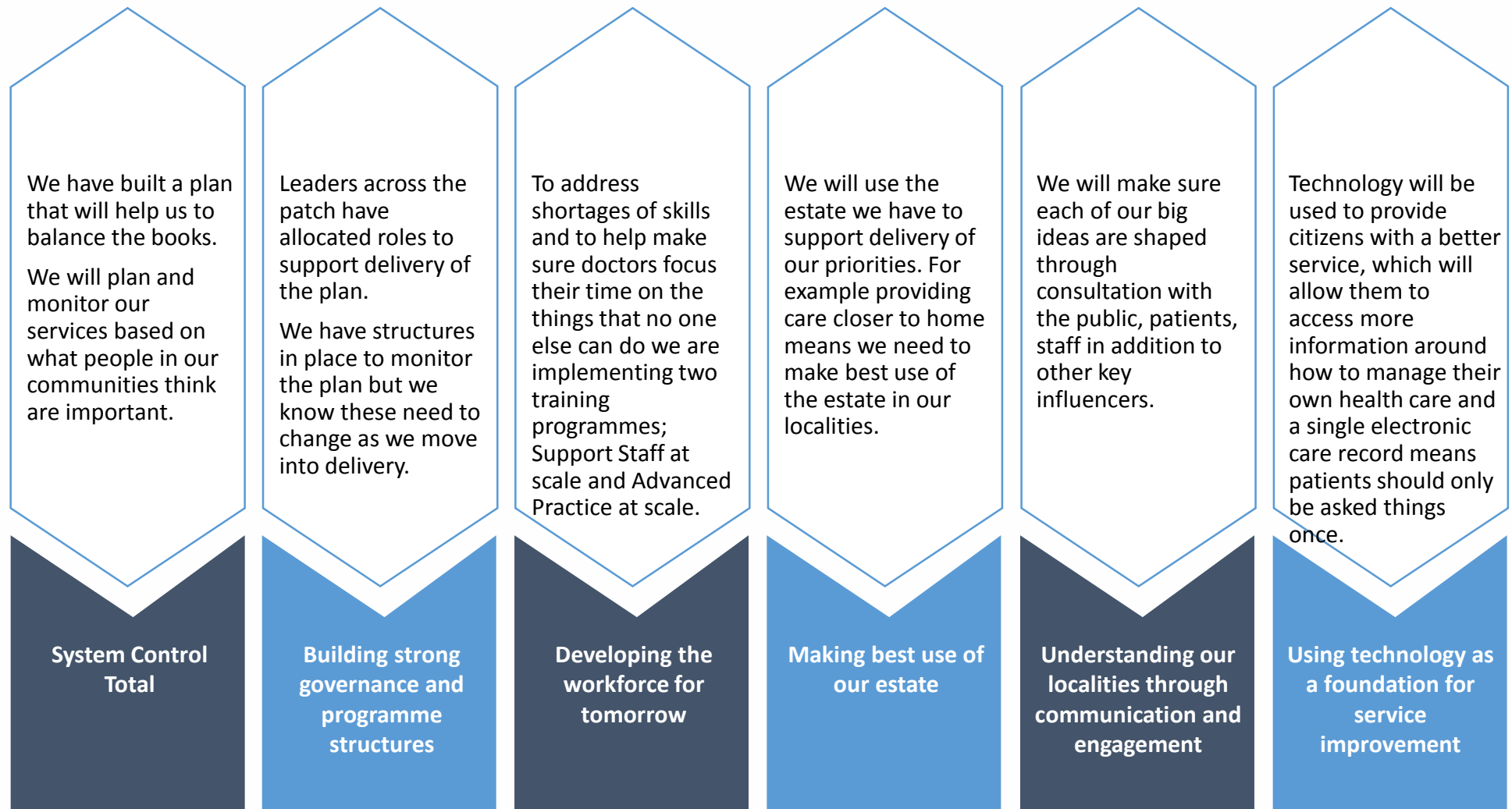
I live in North Lincolnshire and North East Lincolnshire – what changes will I see?

- Through Healthy Lives Healthy Futures (HLHF) we are developing locality approaches from March 2017 that will operate within our Accountable Care Partnerships (ACP)
 - These teams will include community services, mental health services, social care, public health, GPs and acute providers, working together to respond to the needs of the population, therefore services will be much more 'joined up' for people who live there. Over time other partners from the community are expected to join, such as hospices, care homes and other community providers.
 - In North Lincolnshire the approach will be delivered through three Care Networks wrapped around general practices for smaller populations of 50 – 60 thousand people across the patch which began working together in April 2016. Their first priority is working with local care homes to provide rapid and enhanced support to residents and the staff supporting them.
 - In North East Lincolnshire the model is being provided across two areas. Teams will be clustered around GP Practices and build on the experiences of the local social enterprise providers in delivering holistic care.
 - New services to help people stay well include - implementing over 75s wellbeing checks, community wellbeing checks, and targeted programmes to reduce smoking and alcohol misuse.
-

*Please note that these proposed changes will be subject to review to ensure they comply with the organisations statutory duties

Making the change happen

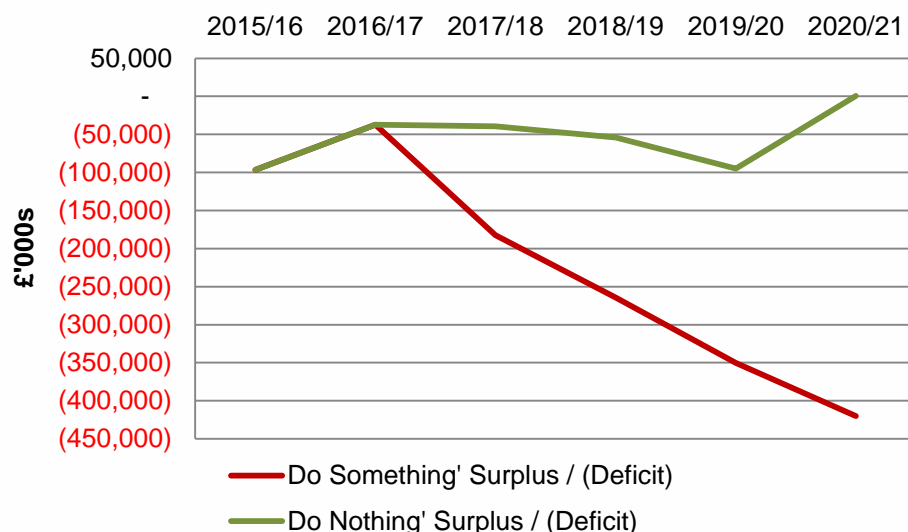
So far we have set our strategy for achieving our vision of start well, live well and age well for our Humber, Coast and Vale population. However delivering this strategy will not be easy. We will need a strong focus on 'enablers' to support us in turning our strategy into real change on the ground. We have summarised what we will do below, and there is more detail on these in the next section.



Making the books balance by 2020/21

The Challenge

Our challenge is to create a transformed health and social care system that balances from a financial perspective. If we do nothing, we forecast we will have a £420m funding gap by 2021. We believe that our plan can enhance health and wellbeing, ensure quality and safety of our services and deliver the savings we need to guarantee a financially sustainable healthcare system for the people of Humber Coast and Vale.



The 'Do Something' section of the graph shows the financial impact of our six priorities and shows that we plan to balance the books by 2020/21. We are focusing on patient need creating an STP wide focus on patient pathways and care rather than the system we currently operate which tends to focus on transactional analysis and organisation preservation. We will work together as an STP to create a financially stable health care system for the future but having a collective approach to appropriately managing activity, agreeing investment plans and reducing cost where this is identified as necessary.

Finance design principles going forward:

- 1 Operate a single control total for HCV STP; early work has commenced to ensure the STP as a whole finishes 2016/17 in the best possible financial position and that the single control total operates formally from 2017/18.
- 2 Look at establishing alternative payment mechanisms for 2017/18 onwards which have collective focus on managing activity levels and reducing cost.
- 3 The underpinning finance template shows clearly the impact on activity, benefits (costs and returns), capacity, workforce and investment requirements over time.

The Humber, Coast and Vale's finance submission meets the required validation checks and an analysis of the impact of the recently notified control totals for 2017/18 and 2018/19 has been undertaken.

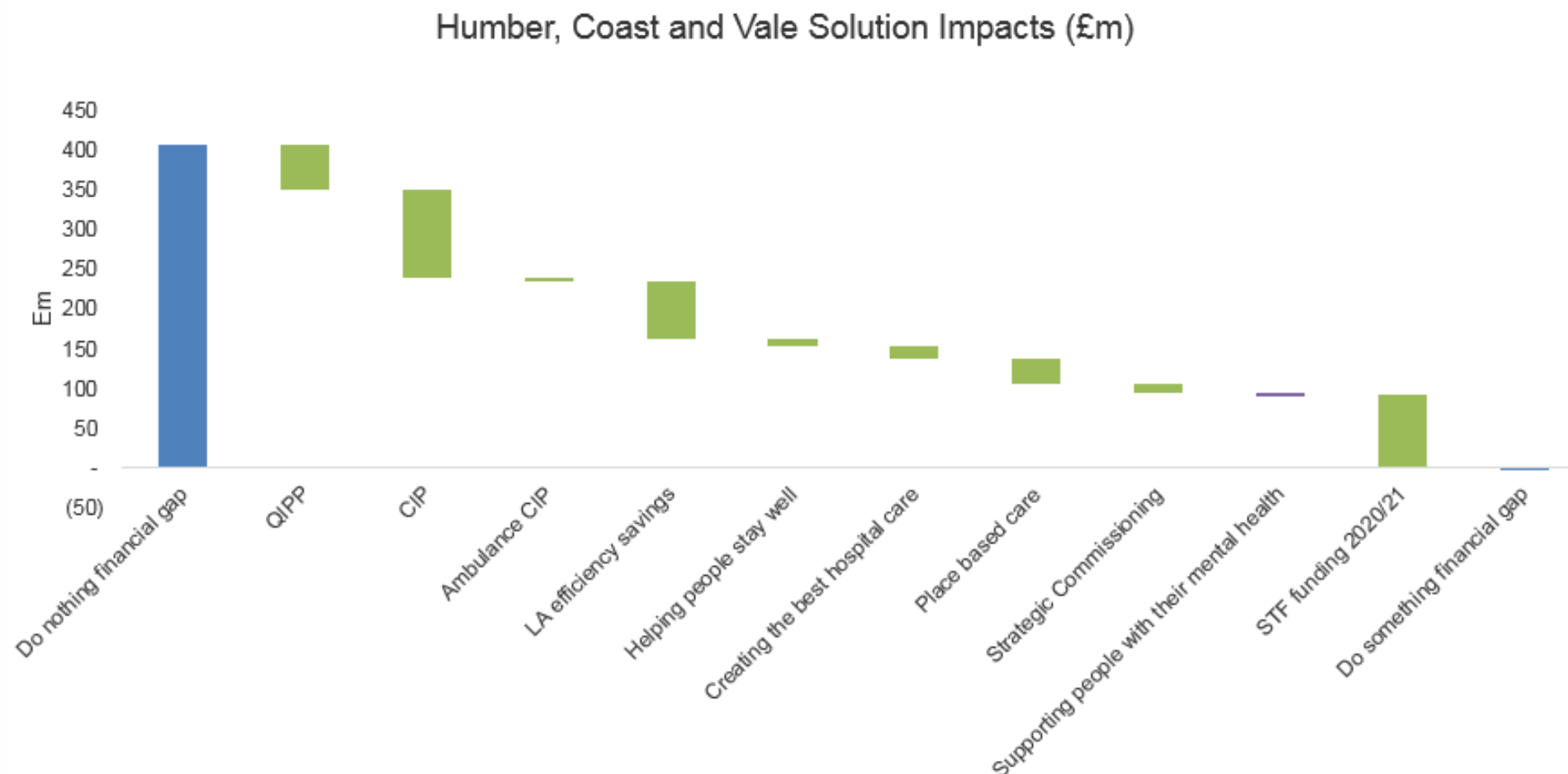
Each STP area has access to a pot of money called the Sustainability and Transformation Fund. An assumption around receipt of the STF has been made for 2017/18 and 2018/19 within the finance template and it is anticipated that the residual gap for these 2 years will be covered by access to residual CCG drawdown as well as HCV STP Transformation funding.

Requirements

The capital requirements of the current ongoing projects are included in the 'do nothing' position. Capital plans linked to delivering the interventions are fairly embryonic and further work to refine these is required. We accept that we are in a capital constrained environment, and will be actively exploring alternative sources of funding e.g. Public Private Partnership Arrangements that deliver value.

Making the books balance by 2020/21

The waterfall graph below demonstrates how we plan to close the £420m financial gap to achieve financial balance by 2020 / 21



Our STP priorities are ambitious from many perspectives and HCV STP will require a conversation with NHS Improvement and NHS England representatives about the process for managing resources across these respective sector boundaries. Collective financial risk management protocols and ways of working are being drafted in order to be in place no later than 1 April 2017.



Building Strong Governance and Programme Structures

Governance arrangements.

A governance structure has been put in place to help us in turning our strategy into a reality. However we recognise that the only way we will make the change real is to work together differently as organisations around a common purpose.

Our governance arrangements are built around our Strategic Partnership Board and our STP Executive Group which are fully aligned to the wider health and social care governance arrangements – see diagram opposite.

Strategic Partnership Board.

Strategic Partnership Board (SPB) is the group where all key recommendations are made about the STP are discussed. A senior leader of each partner organisation sits on the group. The group includes representatives from organisations that span the public sector including health, Local Government, GPs and the Voluntary Sector. A list of organisations represented on the SPB can be found in appendix 1.

An MoU (memorandum of understanding) is in place which outlines the way partners will work together on this group.

STP Executive Group.

Our STP Executive group is responsible for delivering the plan. Chaired by the STP lead, this group includes all priority and locality leads. Most of these people are at Chief Officer level. Having leads for each key area, from different health and care organisations across the footprint has helped us to develop devolved leadership and shared a sense of ownership for our strategy and plan across the patch.

Clinical Advisory group.

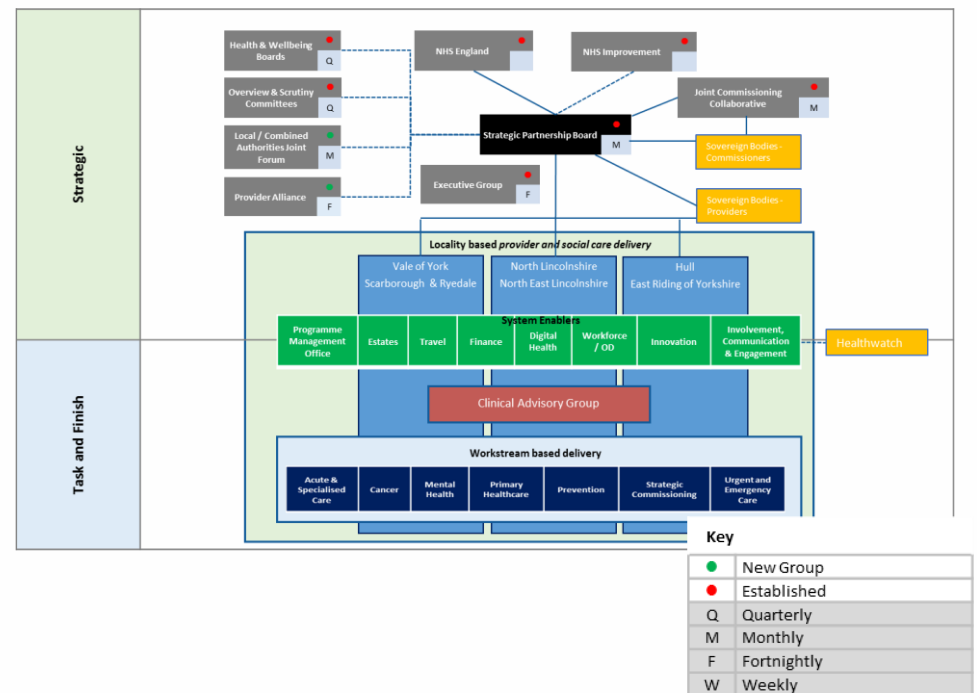
A clinical advisory group has been set up to make sure key decisions made on the future shape of health and care services across the patch have been shaped by doctors and other health and care professionals. A clinician sits on each of the priority groups which means all projects receive input from a clinician at an early stage. We know we have to do more to support clinicians in playing this role.

Programme Management arrangements.

STP Programme Management arrangements have now been put in place. This means that the progress made against our big ideas will be checked and problems can be resolved as soon as possible.

We acknowledge that as we move from strategy development into delivery more work will be necessary to make sure we have the right governance structures in place to make key decisions and we will need to develop more detailed implementation plans.

Our current programme structure



Developing the workforce and making best use of our estate

Developing the workforce for tomorrow.

Patients want to be able to see the right person with the right skills at the right time. A shortage of clinical staff means that we need to focus professionals such as GPs on doing the work that only they can do, this combined with the new workforce needs of the integrated multi-disciplinary locality teams mean that we need to do things differently.

Our Local Workforce Action Board (LWAB) have planned with two initiatives to help us to make sure we have the skills we need to deliver our strategy across Humber, Coast and Vale.

1. Support staff at scale:

We are investing in bringing through additional support staff and investing in developing their skills. These support staff will work in hospital and in the community developing skills for development of support staff across primary, secondary and social care. There will be a clear progression structure to help retain staff and the opportunity to work in different parts of the system. We will also look to use our current staff differently for example creating multi disciplinary roles for receptionists pharmacist and mental health practitioners. This programme will start in 2017 which is when staff will enter the workforce.

2. Advanced Practice at scale:

We are investing in the developing 'advanced practitioners' both in hospital and in the community. This will help to fill gaps in the workforce and will have a clear career path to encourage people to continue working with us. This programme will begin in 2017 and staff will take two years to qualify.

Our local initiatives will be supported by the GP five year forward view which aims to increase the growth rate in GPs through new incentives for training, recruitment, retention and return to practice.

We are also working with the University of Lincoln to design a number of programmes to address the training required to equip our staff to be able to deliver the new integrated ways of working as effectively as possible'

3. Benefits for our staff

Our changes to workforce will drive a number of benefits for our staff including:

- Less duplication in the way they work
- Increased job satisfaction
- More for filling job roles and career opportunities, as a result of working across typical organisational barrier
- Opportunities to work seamlessly across care settings.

Making best use of our estate.

In order for patients to be able to access care in the right place we need to rethink what estate we have and how we can use it better. As demand changes we will need to use our estate flexibly to deliver our strategy.

This will include joining up the healthcare estates with the local authority estate to maximise the value of our joint asset.

Currently the HCV estates covers 67,641 sqm and has a total running cost of £208 million each year.

Our plan is to continue to develop our estates strategy to make sure it supports us in achieving our priorities. We will continue to identify and value the opportunities to reduce the estate and land that we currently hold as the need arises.



Developing our plan through communication and engagement

We have challenging proposals for Humber Coast and Vale and are working on a comprehensive communications and engagement plan that has our staff, our partners and our people at its heart.

Each of our partner organisations have communication and engagement professionals working for them. These teams will build upon their current stakeholder relationships and use their networks to involve their communities in developing the plan.

Our activities under the STP will, wherever possible, use the vehicles of locally established programmes including Healthy Lives, Healthy Futures and Ambition for Health.

We will engage and consult with:

- Health and Wellbeing boards
- Service users and the wider public
- Staff, including clinicians : our Clinical Advisory Group will support the communications and engagement work with staff as well as the public, translating the messages from the plan and developing the clinical assurance elements so that staff can confidently embrace the plan and recommend its principles to their patients.
- Other key influencers: MPs, other elected members, oversight and scrutiny boards.

Since the publication of the Five Year Forward View we have engaged with more than 30 000 people in a dialogue about future and current change.

We have been working with:

- patient groups,
- the voluntary sector,
- hospitals,
- GPs,
- local councils,
- commissioners of services

This work will continue, supported by the expert organisations who are already involved, such as local Healthwatch, ensuring that protected and hard-to-reach groups and those facing the greatest inequalities will be heard.

At programme level, we are working with The Consultation Institute to ensure that our consultation activities are appropriate, timely, legal and cost-effective. We are also working with our communications and engagement colleagues in neighbouring STPs to ensure that the cross-cutting activities that we know already exist are recognised and supported. Communications activity will be focused on supporting the operational teams with the messages and materials that they need.

A summary of our communications and engagement plan is:

- Finalise content for website and website go live – November 2016
- Feedback from the October plan through democratic engagement – January 2017
- Formal consultation on STP – from February 2017
- Consultation informs the strategic plan for STP footprint – May 2017
- Consultation around specific interventions – from summer 2017



Using technology as a foundation for service improvement

What do we need to change?

A Local Digital Roadmap* has been developed for each place in the footprint. Health and care organisations across the patch have been involved in developing these together. There has been a lack of investment generally in recent years in technology across the system, however better, joined up systems will be important to support services working together to deliver seamless care to our local population.

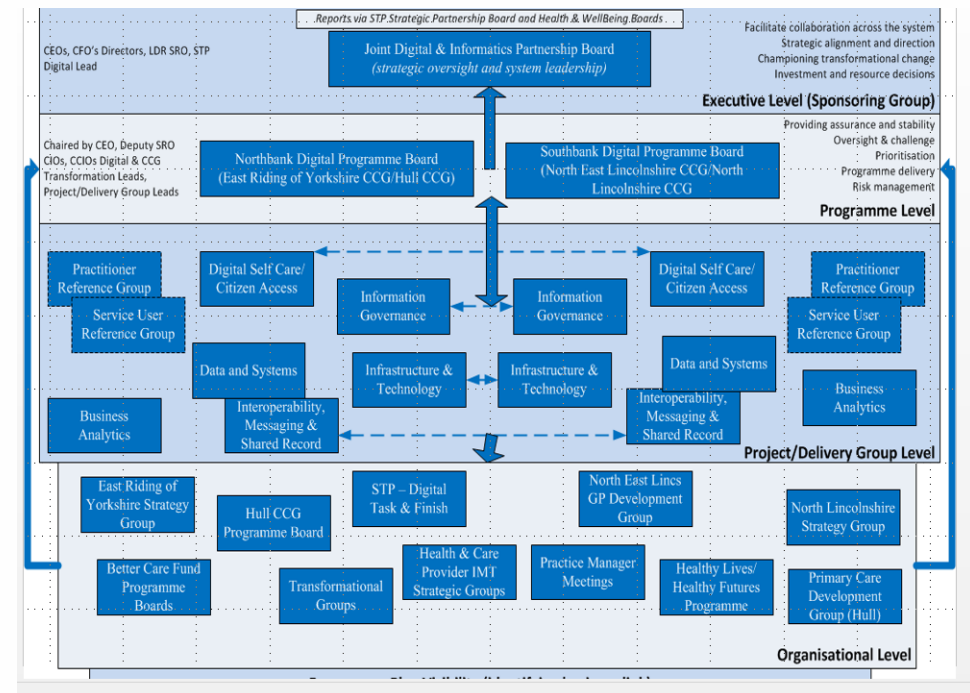
What will we do?

- Develop a single electronic care record that can be shared and accessed by Health and Care professionals involved in patients care. We will start to make key information available to those who need it, and with patients consent, efficient working practices from March 2017.
- Develop an information hub for citizens to access their health records and provides information on how to manage their health and to help them find out about other health and care services available to them.
- Update our infrastructure and IT equipment, to enable staff to be more mobile and deliver care where and when it is needed. Supporting all of the health and care services to implement more.

What does this mean?

- I only have to say things once to health and care professionals
- I can make decisions about my own health care needs with the information I am provided with
- I have the information I need to find out about health and care services in my areas
- I can be confident that my personal health and care data is secure and is shared with only those who need to see it, to best deliver my care.

Our local digital roadmap



**The digital roadmaps doesn't include any capital estimates, but there will definitely be a funding requirement*

Appendices



Humber, Coast and Vale

Sustainability and Transformation Plan 2016 to 2021

Appendix 1

Members of the STP Executive Board and Strategic Partnership Board



Humber, Coast and Vale

Sustainability and Transformation Plan 2016 to 2021

Members of STP Executive Board

Organisation	Role
Emma Latimer	STP Lead / SRO of Strategic Commissioning
Emma Sayner	STP Finance Lead
Peter Melton	STP Clinical Lead
Nigel Pearson	STP Local Authority Rep
Mike Proctor	SRO of Enablers Workstream
Karen Jackson	SRO of Acute & Specialised Workstream
Jane Hawkard	SRO of Cancer Workstream

Organisation	Role
Andrew Burnell	SRO Out of Hospital Workstream
Tim Allison	SRO Prevention
Helen Kenyon	SRO of Urgent & Emergency Care
Chris Long	SRO of Hull & East Riding
Simon Cox	SRO of Vale of York and Scarborough and Ryedale
Liane Langdon	SRO of Mental Health Workstream and North & North East Lincolnshire



Members of Strategic Partnership Board

Organisation	Role
Care Plus Group Charitable Trust	Chief Executive
City Health Care Partnerships CIC	Chief Executive
City of York Council	Senior Strategic Community Development Lead
East Midlands Ambulance Service NHS Trust	Chief Executive
East Riding of Yorkshire Council	Chief Executive
East Riding of Yorkshire Council	Director of Corporate Strategy and Commissioning
Focus Independent Adult Social Care Work C.I.C.	Chief Executive
Hull City Council	Chief Executive
Hull City Council	Director of Public Health and Adult Social Care
Hull and East Yorkshire Hospitals NHS Trust	Chief Executive
NHS Humber Foundation Hospitals Trust	Chief Executive
NAVIGO Health and Social Care CIC	Chief Executive

Organisation	Role
NHS England (North Yorkshire & Humber)	Director
NHS England (North Yorkshire & Humber)	Assistant Director Specialised Commissioning
NHS Hull Clinical Commissioning Group & HCV STP Lead	Chief Officer
NHS Hull Clinical Commissioning Group	Chief Finance Office
NHS Improvement	Delivery & Development Manager
NHS North East Lincolnshire Clinical Commissioning Group	Clinical Chief Officer
NHS North Lincolnshire Clinical Commissioning Group	Chief Officer
NHS Property Services Limited	Head of Property Services
NHS Property Services Limited	Property Strategy Manager
NHS Scarborough & Ryedale Clinical Commissioning Group	Chief Officer

Members of Strategic Partnership Board

Organisation	Role
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	Chief Executive
North Yorkshire County Council	Associate Director Integration
Rotherham Doncaster And South Humber NHS Foundation Trust	Chief Executive
Royal College of General Practitioners	GP Forward View ambassador
Tees, Esk & Wear Valleys NHS Foundation Trust	Chief Executive
Yorkshire Ambulance Service NHS Trust	Director of Business Development
York Teaching Hospitals NHS Foundation Trust	Chief Executive

Organisation	Role
Yorkshire & Humber Partners Academic Health Sciences Network Limited	Chief Operating Officer
NHS East Riding of Yorkshire Clinical Commissioning Group	Chief Officer
NHS England (North Yorkshire & Humber)	Locality Director (North)
North and East Lincolnshire Council	Chief Executive
North Lincolnshire Council	Chief Executive
NHS Vale of York Clinical Commissioning Group	GP representative
York Teaching Hospitals NHS Foundation Trust	Director of Community Services

