NHS North Durham Clinical Commissioning Group
Operational Plan 2017-19 – Final Narrative refresh – April 2018

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STP Priorities

Welcome to our plan

The CCG was established and licenced as a statutory health body on 1 April 2013 through the NHS and Social Care Act 2012. The CCG is responsible for the planning and buying of healthcare services for people that live and use services across the geographical area that the CCG covers. This includes health services that are delivered in both an emergency and in a planned way. These services include:

- planned and emergency hospital care;
- rehabilitation and intermediate care services;
- community services such as district nurses and physiotherapists;
- mental health services;
- learning disability services;
- ambulance services;
- maternity care;
- GP services

We also arrange emergency and urgent care services throughout the area and commission services for any unregistered patients who live locally. CCGs are clinically-led organisations that bring together a range of healthcare professionals, such as GPs and nurses, with managers to use their collective knowledge about healthcare and the local population in order to develop services that meet their patient's needs.

As statutory organisations, CCGs should:

- offer patients greater choice and control in how their health and care needs are met;
- provide a greater focus on improving health outcomes;
- improve the quality and consistency of healthcare services delivered;
- understand and plan for the healthcare needs of patients now and in the future;
- purchase high quality services that offer value for money;
- NHS North Durham (ND) Clinical Commissioning Group Annual report 2015/16
- develop and design services in partnership with patients, the public, clinicians and other key stakeholders.

Local family doctors (GPs) understand the health needs their patients have. At ND CCG we put those GPs in a leading role, so we can use their healthcare knowledge to develop a range of services that will meet the needs of patients at a local level.

We think it is important for local people to have a say in the kind of health services that are available. We involve local people, patients and carers at every stage of our healthcare planning and delivery decision-making processes.

We have started to plan and pay for new services and change some existing services to better meet local needs. These improvements will enhance healthcare in our area and ensure it meets the specific needs of local people.

The closer alignment of health and social care is a key priority for the County Durham Health and Wellbeing Board. In conjunction with partners we have set out an ambitious aim to develop a health and social care plan for County Durham. A key aspect of this aim is to embed our new model for out of hospital services, Teams Around Patients, aligning primary and community care, social care and the community and voluntary sector. Our plans include the integration of commissioning functions and integrated governance for the management of the integrated provider model of health and social care in local communities.

We are committed to improving clinical engagement in the CCG. We have from the outset had a clinical accountable officer and clinicians as directors of the organisation. In addition, we have developed further clinical roles including locality leads, quality leads, prescribing leads and clinical champions. They ensure clinicians are involved in leading the development of our strategy and our commissioning intentions. They are also involved in making sure we use our resources efficiently and that we drive up the quality of care that is provided for our population.

Whilst a two-year operational plan was submitted in December 2016, the revised national planning guidance issued in February 2018 has set out further priorities and opportunities which builds on the progress made in 17/18, recognising the scale of unmet need in mental health the importance of cancer services and the pressure on primary care services.

Considerations to the revised financial framework within the planning guidance including the underlying assumptions and local systems will be embraced e.g. implications in relation to tariffs and local payment reforms will be developed with our providers through contracting negotiations and arrangements to assure innovations through potential incentives; to continue to implement the priority efficiency programmes which includes maximising the recommendations of the implementation of *Getting It Right First Time*; elective care transformation; making best use of the digital and technological systems and innovations available; moderation of emergency demand and the use of the Right Care programmes in relation to elective, non-elective care and prescribing efficiencies.

We are working closely with our largest provider on demand and capacity planning to ensure the delivery of RTT targets e.g. where this has worked well over the last year is the development of referral management solutions in varying forms and for differing specialties. . A financial recovery group is in place across the 3 CCGs in County Durham and Darlington, together with our main provider County Durham and Darlington NHS Foundation Trust to collectively manage the risks and pressures across the local health economy and try to deliver a sustainable local system.

Our CCG has and continues to work in a collaborative and collegiate way across 5 CCG organisations across County Durham, Darlington and Tees to improve efficiencies in terms of resources both staffing and financial reducing duplication where we can, sharing posts across organisations to create parity.

CCG Population Profile

POPULATION

If North Durham CCG was a Village of 100 people

Actual population: 244,361

- 1 x Dementia
- 1 x Mental illness
- 22 x Long-term illness
- 9 x Diagnosed Depression
- 4 x Chronic Kindey Disease
- 7 x Diabetes
- 2 x Cancer
- 6 x Asthma
- 15 x Raised Blood Pressure
- 2 x Have had a stroke
- 4 x Heart Disease

Understanding our three gaps as an NTWND STP

GAPS

HEALTH and wellbeing

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

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

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

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

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

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

CARE and quality

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

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

Inconsistency
of pathway between local and specialised services.

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

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

Capacity and resilience
of community care and community service.

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

7 Availability of seven day services and mental health advice.

FUNDING and finance

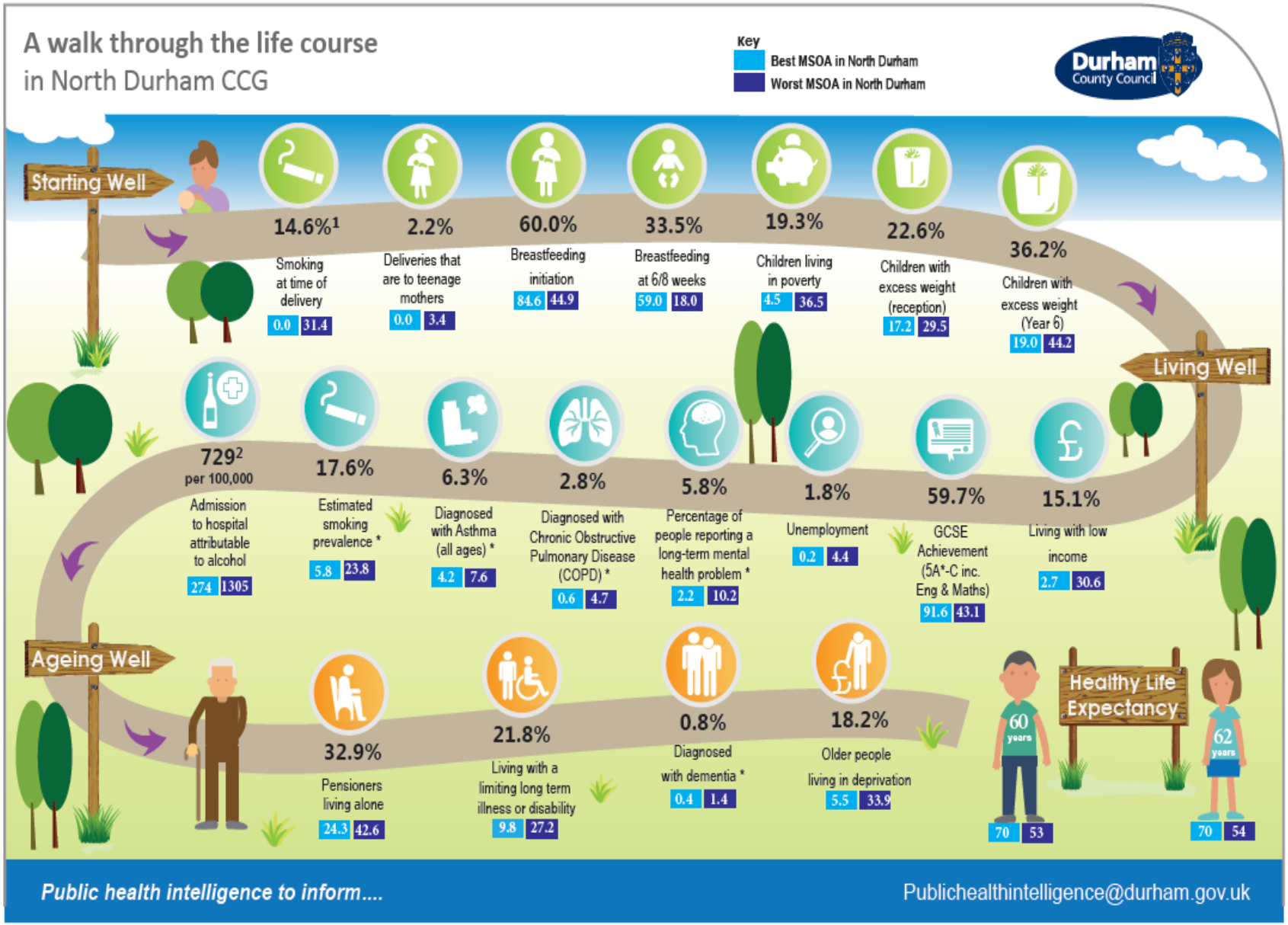
System efficiency and finance challenges:

£641m
gap across health by 2021

a figure as high as

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

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



Note: * denotes registered population. [1] Not comparable to national data. [2] Figure for County Durham, CCG data not available.

CNE STRATEGIC TRANSFORMATION PARTNERSHIP

When draft plans were originally produced, Cumbria and the North East (CNE) was divided into three STPs footprints. As focus has shifted from planning to implementation across local health systems, system leaders and STP leads in CNE recognised the important interdependencies across the health system in our region, with a number of workstreams being common to all three STP footprints.

This joint working strengthened the case for a combined STP approach across the whole of CNE, which has a population of 3.2 million, and a proposal was made to NHS England that our three existing footprints unite into a single Sustainability and Transformation Partnership.

Initial STP proposals are being updated to reflect the 2017/18 – 2018/19 contracting and operational planning round, and will be translated into local implementation plans with local partners. The plans will set out clear and ambitious milestones and accountabilities for delivering local priorities and the objectives described in *Next Steps on the NHS Five Year Forward View,* and should be ready for wider engagement in the Spring of 2018.

The CNE STP will have a single lead who's objectives for 2018/9 include:

- Oversee the development and successful delivery of a shared STP plan, focused on those issues that cut across geographical and organisational boundaries
- Develop a transparent system of collective governance, supported by all stakeholders, that respects organisational autonomy and statutory responsibilities whilst ensuring that the health system in CNE can make the shared decisions needed to make rapid progress on delivering the STP.
- Facilitate financial sustainability and enable organisations to achieve greater efficiencies by working together,
- Support CCGs to strengthen and streamline strategic commissioning (at both CNE and sub-regional level) whilst preserving CCGs' local health leadership and their key relationships with primary care, local authorities and the voluntary sector.
- Support Trusts and clinicians to work together to manage service change as they implement the recommendations emerging from the STP workstreams
- Ensure the STP has the necessary programme management and implementation capacity and capability, drawing resources from constituent organisations and from NHS England and NHS Improvement where appropriate.
- Lead the development of a CNE ACS so that NHS organisations (commissioners and providers), in partnership with local authorities, can take on greater collective responsibility locally for population health and devolved NHS resources.

JOINT DELIVERY PLAN & LINKS TO STP

The following slides outline, in further detail, the CCG operational delivery plan.

Transformational schemes and local CCG ambitions have been aligned to STP priority areas which are Early Intervention and Prevention, Neighbourhood & Communities, Acute Reconfiguration and Digital Care & Technology. This ensures the strong connection to the STP which supports joined up delivery, whilst ensuring consistency and alignment.

In keeping with the STP, milestones and actions have been mapped across the eight quarters which cover the first two years of the STP and the period for which the operational plan relates to. Each transformational area has a separate plan on a page which documents links to the nine 'Must do's', why the change is needed, future state, benefits and high level milestones.

We will Improve the quality and experience of care through Out of Hospital Collaboration and the Optimal Use of the Acute Sector by:

- Scaling up of the New Care Models from our Vanguards and development of a resilient and robust primary care sector;
- Providing clinical services through integrated models of care that are significantly more effective and efficient for patients through defining a unified core offering for out-of-hospital services across the system.;
- Acute service change through speciality level review to meet the emerging challenges around workforce pressures required to deliver clinical standards within a 7-day service;
- Development of an integrated life span approach to the integrated support of mental health, physical health and social need which wraps around the person, from enabling self- management, care and support systems within communities.

STP Vision 2020

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

Our c***ollective vision*** for the STP is simple yet effective:

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

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

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

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

As a system we will be moving:

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

STP Alignment 2020

Transformation across the whole of the STP footprint will see a shift towards improving 'population health' - moving from fragmentation to integration in care delivery, but also tackling social, economic and environmental challenges that heavily influence the health and wellbeing of our population. Acting together as a Health and Care system will see us focus on prevention and lifestyle support as well as developing New Models of Care across the following three areas of transformation:

- **Scaling up Prevention, Health and Wellbeing**
- **Out of Hospital Collaboration**
- **Optimal use of Acute Sector**

The STP provides an overarching route map for the future direction of travel across the area, our 2 year operational plans of each of our constituent NHS organisations reflect a more granular level of detail.

To date we have relied more on hospital based care than other parts of the country. We want to strengthen care outside of hospital so that neighbourhoods, communities and individuals are able to take more control of their health and maintain independence for longer whilst preventing or delaying the need for more services in acute and community care.

We have ambitious plans to strengthen services delivered in primary care, attracting more GPs to the area and growing the work force. Developing new roles that can support the primary care team to manage their workload, improve integration with social care and expand services that were previously provided in a hospital setting. The new model will enhance proactive care planning and delivery for patients at risk of hospital admission that require wider service support.

We will increase the number of services that are delivered outside of hospital settings. In line with the County Durham health and care plan we will be implementing Teams Around Patients each covering a population of 30,000 to 50,000 people. Through the health and care plan we will work together in developing new models of care taking responsibility for the health and care of the population budget. This new way of working will enable us to reduce the number of people that require admission to hospital. When people require hospital admission they can often stay in hospital longer than is necessary so we are working closely as health and social care partners to improve support for patients leaving hospital, so that they can be discharged quickly when it is medically safe to do so. We recognise that we need a strong focus on creating sustainable nursing and residential care provision.

The County Durham health and care plan will enable us to strengthen links between health and social care commissioners. This includes plans to integrate commissioning functions where it makes sense to do so and we want to build and encourage the development of the voluntary sector so they can support patient care in the community, ensuring health and social care services are used effectively.

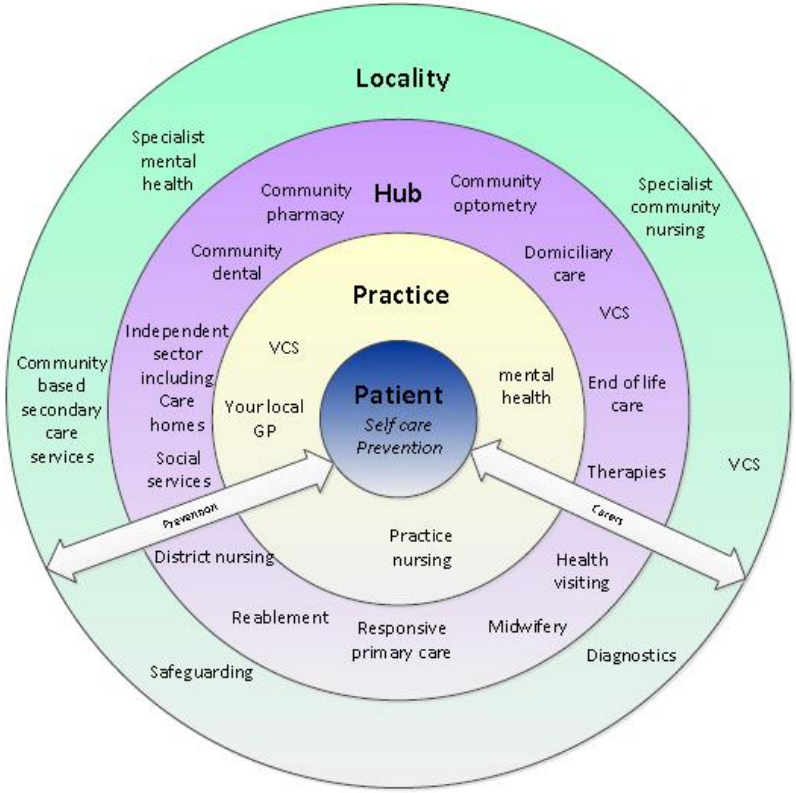
We will increase the number of patients and service users who have access to a Personal Health Budget enabling greater choice and control over their healthcare and the support they receive.

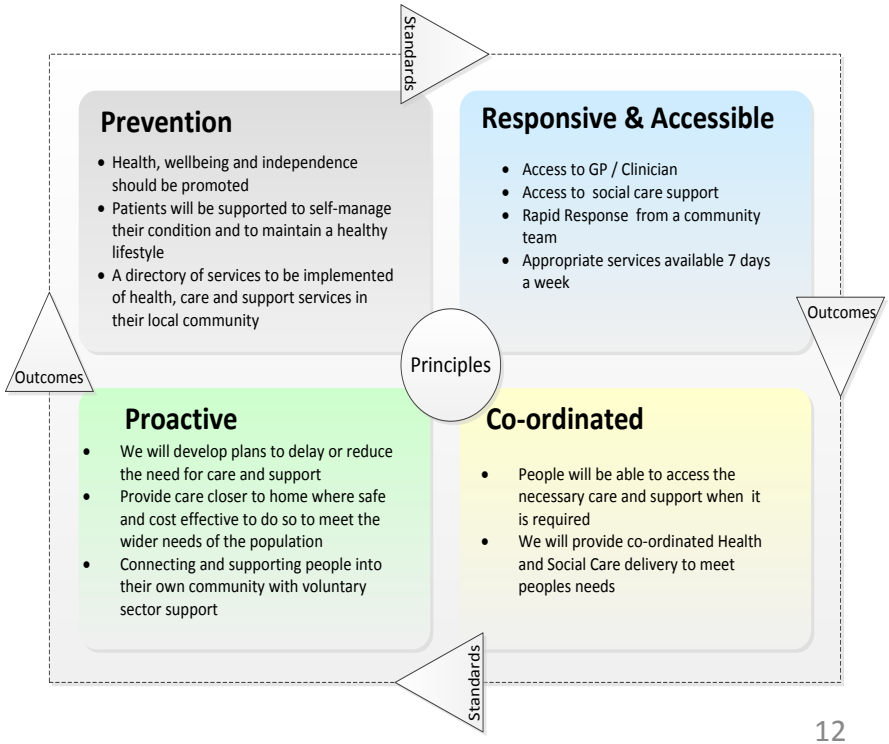
These principles apply for both physical and mental health and service users with a learning disability.

STP Vision 2020 Neighbourhoods and Communities

Stakeholders across the STP geography have approved a strategy and a set of quality standards which set out the ambition to deliver person-centred outcomes based on four key principles within our neighbourhoods and communities;

- Prevention
- Proactive care
- Responsive and accessible care
- Co-ordinated approach





County Durham Health and Social Care Plan

The development of teams Around Patients for the North Durham population supports a shared commissioning vision across County Durham set out in the health and social care plan to improve access, continuity and coordination of community-based health and care services.

The 5YFV provided the national policy context of reshaping of care in England over the next 5 years and beyond. It presented two emerging care models: Primary and Acute Care Systems (PACS) and Multispecialty Community Providers (MCPs). Having engaged extensively with local communities and clinicians through the Better Health Programme and the Sustainability and Transformation Plan (STP), North Durham continues to reshape out of hospital care around the fundamentals of the MCP model.

MCPs build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. The model will expand the leadership of primary care to include nurses, therapists and other community based professionals.

The foundation of the CCGs' plan to commission MCPs shall be the development of TAPs and the reshaping of care around them increasing the responsibility and accountability for a defined (registered) patient population. This specification builds on principles described in the chronic disease model and moves the concept from national policy, through to local strategy and delivery on the ground.

It is important to say at this stage that the development of TAPs is an iterative process, that will bring in a wide range of organisations to provide truly holistic preventative care for TAPs populations. Whilst the following provides details of the TAPs as of year 1, it is recognised that this s the first stage of a longer journey to transform community care delivery at a much larger scale.

The mechanisms for delivery is around developing workstream approach to deliver STP implementation

OUR DELIVERY PLAN

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.	

CCG QUALITY FRAMEWORK

Quality Risk Management

How is the impact on quality and safety including risk being recorded and how will it be managed?

- Risk registers are in place with appropriate mitigations assigned and action plans as necessary
- Service specifications in place which include quality requirements and reporting arrangements
- Quality impact assessments to be undertaken for each service development/scheme to identify any quality impact
- Local quality requirements aligned to schemes which will provide details of quality indicators at a local level
- CQUIN schemes in place for all providers. Provider schemes will include schemes to support the STP such as improved discharge arrangements and discharge to assess models. Frequent attender CQUIN schemes are also aligned to the Mental Health Concordat
- Patients safety monitoring which includes:
    - Use of appropriate incident monitoring systems including intelligence gained form GP reported incidents
    - Serious Incidents reports ; themes; trends ; lessons learned and action plans
    - Mortality and morbidity monitoring
    - Pathway developments to support improvements in key areas for example the early identification and treatment of Sepsis

How will patient experience and other quality intelligence be used to drive service improvements?

- Emerging themes from public events/complaints/incidents and patient feedback are used to inform commissioners of areas for development
- Areas of poor performance giving rise to quality concerns provide a focus for improvement
- Working collaboratively with other agencies such as Local Authorities to support providers in developments including areas of joint commissioning to ensure efficiency and consistency of approach on areas such as Care Home developments, mental health, Learning disability and children and young peoples services.
- CCGs continue to be an active and major partner in safeguarding boards (adult and children)
- Patient stories are used during quality meetings to inform debate

Does the CCG have a Quality Strategy to support implementation of the Operational Plan?

The CCG's quality framework includes:

- Monitoring of National quality indicators via contract performance which are reported into Quality Performance and Finance Committee monthly by exception including but not limited to HCAI; mortality and patient experience indicators.
- CQUIN schemes in place to support service developments and aligned with the national schemes
- Service Specifications which include quality requirements are in place and monitored in collaboration with contract management processes. In particular monitoring of safeguarding processes to ensure that the most vulnerable patients are protected
- Procurement processes are underpinned by quality appraisal assessment of tenders and responses
- Local quality requirements where appropriate are designed to monitor service delivery and drive improvement
- Each acute provider attends a 'Star Chamber' to provide assurance to the CCG of quality impact assessment of any cost improvement schemes. These are monitored regularly throughout the year via the clinical quality review group where discussion is held and challenge is provided
- Regular forum for discussion of performance issues including quality held with the provider on a monthly basis. This gives the provider the opportunity to share actions; provide assurance and share good practice
- Commissioner assurance visits are undertaken to triangulate information and provide assurance to the commissioners. For example; themes and trends from serious incidents may provide a focus for a commissioner visit. Collaborative working is also in place with the local authorities in the monitoring and sharing of intelligence for care homes including themes; trends and concerns analysis
- Clinical Quality Review meetings provide a forum for discussion by exception of issues of concern to the commissioners
- Regular one to one meetings with provider quality leads allow for an in depth discussion about areas of concern which need to be flagged at a senior level
- Serious incident monitoring including analysis of themes and trends and lessons learnt. Any issues with compliance against the national guidance is challenged and managed with the providers and contractual levers used if required
- Complaints about providers are monitored for themes and trends via the quality framework described and CCG complaints are reviewed regularly by the Governing Body through the QPF
- National audits such as Stroke; Trauma Peer Reviews and Cancer Peer reviews NICE guidance compliance and delivery against appropriate guidance is provided to the commissioners as assurance.
- New pathways are developed based on NICE guidance where available
- The CCG works in collaboration with regulators to ensure provision meets the required standard and regular intelligence is shared with regulators as required

CONTRACTING POSITION

The delivery plan with its transformational schemes and associated activity changes are dependent on signed contracts. It is pleasing to note that all contracts have been signed for 2018/19 financial year.

A number of contracts have been agreed on a block basis, these cover the majority of acute activity. These contracts include CDDFT, CHSFT, and Gateshead FT. NTHFT contract is a combination of block and marginal rates, whilst other tertiary contracts have been agreed on a traditional pbr basis – for NuTFT and South Tees FT.

The contract with CDDFT has been agreed over a three year period, with other contracts agreed on a one-year basis.

Contracts with TEWVFT and NEASFT have also been agreed for the year.

The agreement of a number of block contracts has enabled further stability for the healthcare system, providing certainty of income for providers and costs for commissioners. This also enables refocussing of attention away from transactional activity to transformational work across the system.

TECHNICAL NARRATIVE

CCG Technical Narrative

Activity lines - 17/18 FOT

The default for projecting activity forward was to take the latest position in the 17/18 data and used this to forecast the position for the remainder of the year for each indicator in most instances, and applied a percentage change to each consecutive monthly 17/18 figure based on the % change in the 16/17 figures for that indicator in the comparable period to account for seasonal variation.

We then compared that FOT position to those provided by NHS England in the MAOR template; if our FOT at a POD level was within 5% of the NHSE figure, we have defaulted to the NHSE position in the first instance

For PODs where NECS and NHSE forecasts are more than 5% out, we have investigated the variances and, where we feel there were inappropriate adjustments made by NHSE, we have applied a CCG FOT Difference into the Activity Waterfall section of the MAOR template to balance the FOT back to the NECS FOT position.

Monthly Profiling

The 18/19 monthly positions are profiled using the full year 16/17 position (at CCG & POD level) to apply an appropriate seasonal phasing to the monthly plans.

A&E 4 Hour Wait

When calculating the 18/19 plans for the A&E 4 hour wait indicator, we have taken the latest position as supplied by our main provider CDDFT for the first three quarters of the year with an assumption for Q4. When calculating the numerator for this metric, we have taken the following section from the 18/19 planning guidance: *"Our expectation is that the Government will roll forward the goal of ensuring that aggregate performance against the four-hour A&E standard is above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019".*

Constitutional indicators

When calculating the 18/19 plans for the constitutional indicators, we have again taken the latest position in the 17/18 data and used this to forecast the position for the remainder of the year, taking the denominator for each indicator and applying a percentage change to each consecutive monthly 17/18 figure based on the % change in the 16/17 figures for that indicator to account for seasonal variation.

We have then uplifted the above 17/18 FOT position to apply growth to the 18/19 denominators: Outpatient growth for the RTT and Diagnostic Waiting Times indicators; and Elective growth for the Cancer Waiting Times indicators.

For the numerators, we have looked at the latest performance of that indicator and if the latest performance is above the national threshold, then we have projected that this position will be maintained. If it is currently performing below the national threshold for that indicator, we have projected the numerator to meet the national threshold for each month going forward.

For some of the indicators where there are low numbers we have projected a higher performance than the latest position, this is due to the submissions requiring whole numbers. To achieve this, numbers have been rounded up rather than down. For some indicators this would lead to some months projecting 90-100% on indicators where the threshold is lower than that, this is simply so it will meet the validation criteria of the submission templates, without dropping below the performance target.

For the RTT 52 week waits, the CCG has had a very low number of these historically and we not anticipate any in 2018/19.

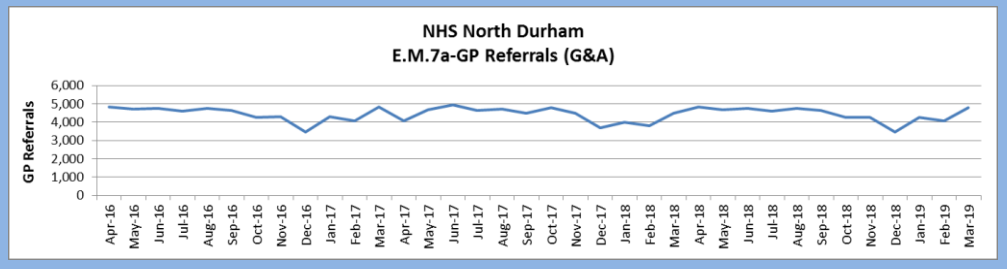
For the cancer waiting times 62 day upgrade metric there is no national target, and due to the low numbers we have set our CCG to attain 100%.

CCG Technical Narrative- Activity data

E.M. 7a – GP Referrals

GP Referrals

	Activity	% mov't
2017/18 Forecast outturn	52,728	
Known Factors	-	0%
2018/19 Planned Activity	53,309	
Net Growth & Transformation	581	1.1%



E.M.7a

E.M.7a GP Referrals (G&A)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	4,841	4,701	4,751	4,605	4,758	4,635	4,258	4,286	3,477	4,299	4,080	4,809	53,500
1718	4,083	4,682	4,937	4,621	4,695	4,483	4,794	4,470	3,668	4,008	3,804	4,483	52,728
1819	4,823	4,684	4,735	4,589	4,741	4,618	4,245	4,273	3,465	4,273	4,070	4,793	53,309

Forecast
1.1% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 2.5 % in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 1.1%

Initiatives to deliver plans

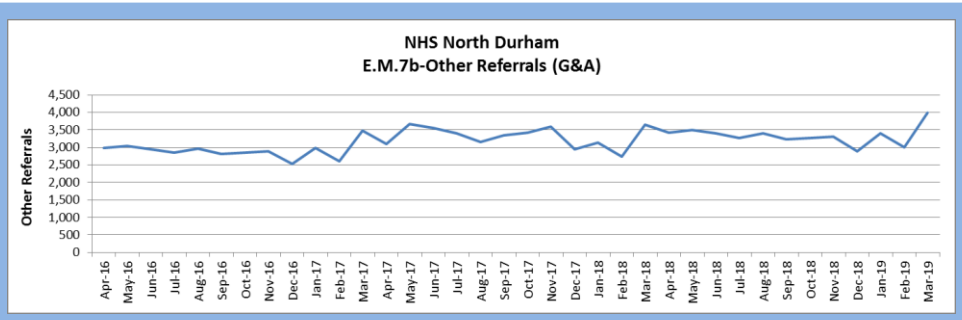
- Continuation of our Rapid Specialist Opinion (RSO) service implemented in late 2016/17 FYE 2017/18 to ensure practices follow clinical guidelines which have been agreed locally with GPs, hospital consultants and other relevant practitioners. RSO improves referral quality and ensures that all referrals follow the most recent clinical guidelines. In 2018/19 this is also being further expanded with four additional specialities included
- Impact of the Implementation of practice based budget approach
- The FYE of the revised MSK community Tier 1 and 2 pathway implemented during 2017
- In January we procured a community pain management service, shifting activity from acute to community which will further reduce GP referrals.
- Right care/pathway reviews - Many of these areas correlate with our Year 1 Right Care opportunities in MSK and respiratory, and our Year 2 opportunities are more widespread across specialties currently being scoped. The CCG continues to work with our NHS England Right Care Partners for yr 2.
- We continue to work together on identified pathway review areas with our providers to support the reduction of acute activity and address cost pressure for both organisations

CCG Technical Narrative- Activity data

E.M. 7b – Other Referrals

Other Referrals

	Activity	% mov't
2017/18 Forecast outturn	39,720	
Known Factors	-	0%
2018/19 Planned Activity	40,075	
Net Growth & Transformation	355	0.9%



E.M.7b

E.M.7b Other Referrals (G&A)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	2,989	3,044	2,955	2,857	2,964	2,818	2,852	2,882	2,520	2,985	2,611	3,480	34,957
1718	3,097	3,672	3,556	3,409	3,153	3,345	3,426	3,596	2,942	3,132	2,740	3,652	39,720
1819	3,428	3,492	3,399	3,276	3,399	3,232	3,270	3,305	2,890	3,398	2,995	3,991	40,075

Forecast
0.9% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 2.5 % in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 0.9%

Initiatives to deliver plans

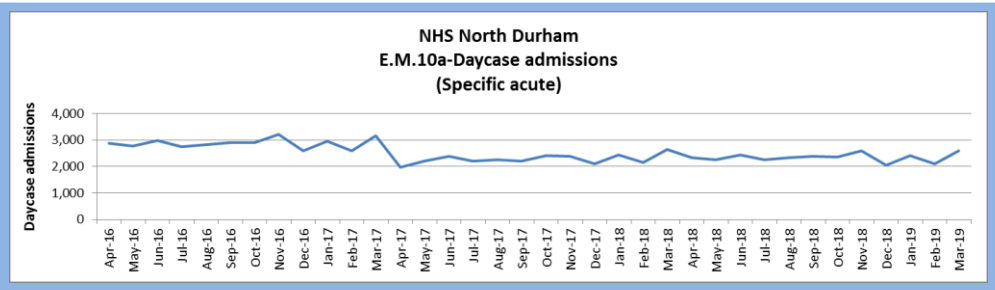
- Review and revise current consultant to consultant referrals review policy
- Other initiatives which will impact on other referrals include our Tier 2 provision services e.g. MSK

CCG Technical Narrative- Activity data

E.M.10a - Day Case Admissions

Daycase Admissions

	Activity	% mov't
2017/18 Forecast outturn	27,400	
Known Factors	-	0%
2018/19 Planned Activity	28,120	
Net Growth & Transformation	720	2.6%



E.M.10a

E.M.10a Daycase admissions (Specific acute)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	2,873	2,769	2,970	2,748	2,839	2,912	2,916	3,205	2,596	2,949	2,605	3,173	34,555
1718	1,975	2,212	2,382	2,216	2,261	2,210	2,410	2,388	2,097	2,449	2,164	2,636	27,400
1819	2,335	2,262	2,433	2,267	2,335	2,383	2,368	2,600	2,050	2,406	2,099	2,582	28,120

Forecast
2.6% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 3.1% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 2.6%

Initiatives to deliver plans

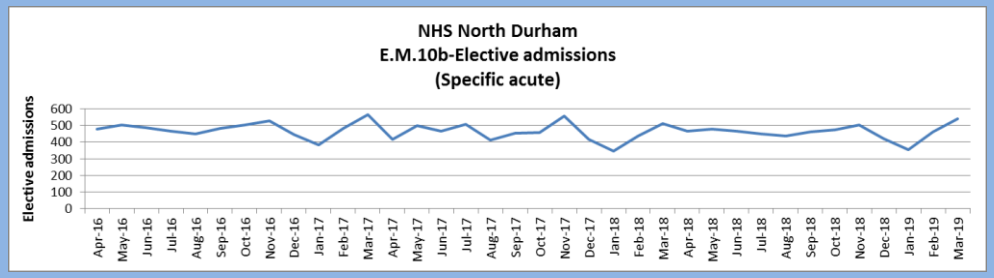
We made significant technical changes in 16/17 and 17/18 which contributed to a reduction in day case admissions and an increase in outpatient procedures in accordance with the national tariff arrangements and best practice. No further changes of this nature are anticipated in 2018/19 with expected demographic and non-demographic growth partially offset by the continued impact of our regional value based commissioning policies and prior approval processes.

CCG Technical Narrative- Activity data

E.M.10b – Elective Admissions

Elective Admissions

	Activity	% mov't
2017/18 Forecast outturn	5,479	
Known Factors	-	0%
2018/19 Planned Activity	5,514	
Net Growth & Transformation	35	0.6%



E.M.10b

E.M.10b Elective admissions (Specific acute)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	479	502	487	464	450	481	504	528	444	383	483	565	5,770
1718	416	498	464	506	412	455	458	556	418	347	437	512	5,479
1819	465	480	465	449	439	460	474	504	422	355	462	539	5,514

Forecast
0.6% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 5.9% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 0.6%

Initiatives to deliver plans

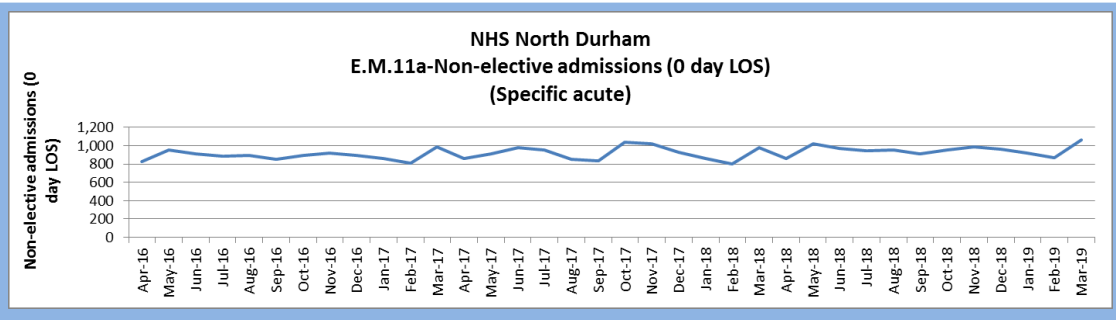
- Continuation of our Rapid Specialist Opinion (RSO) service implemented in 2017/18 to ensure practices follow clinical guidelines which have been agreed locally with GPs, hospital consultants and other relevant practitioners. RSO improves referral quality and ensures that all referrals follow the most recent clinical guidelines. In 2018/19 this is also being further expanded with four additional specialities included
- Impact of the Implementation of practice based budget approach
- The FYE of the revised MSK community Tier 1 and 2 pathway implemented during 2017
- Right care/pathway reviews - Many of these areas correlate with our Year 1 Right Care opportunities in MSK and respiratory, and our Year 2 opportunities are more widespread across specialties currently being scoped. The CCG continues to work with our NHS England Right Care Partners for yr 2.
- We continue to work together on identified pathway review areas with our providers to support the reduction of acute activity and address cost pressure for both organisations

CCG Technical Narrative- Activity data

E.M.11a – Non-elective Admissions

Non-Elective Admissions

	Activity	% mov't
2017/18 Forecast outturn	11,001	
Known Factors	-	0%
2018/19 Planned Activity	11,429	
Net Growth & Transformation	428	3.9%



E.M.11a

E.M.11a Non-elective admissions (0 day LOS) (Specific acute)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	825	956	912	888	892	852	889	921	897	863	808	990	10,693
1718	858	907	974	956	851	833	1,036	1,020	928	855	801	981	11,001
1819	881	1,023	973	947	953	909	952	985	960	921	864	1,061	11,429

Forecast
3.9% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 4.7% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 3.9%

Initiatives to deliver plans

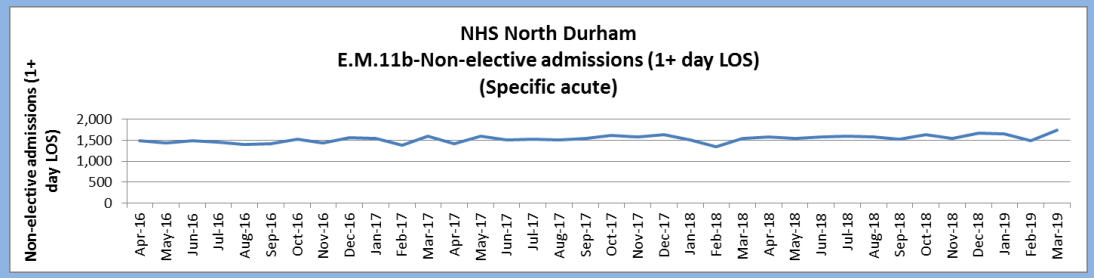
- Discharge to Assess was fully implemented across in 2017/18 in CDDFT which ensures medically fit patients are discharged safely.
- The development of TaPs across North Durham to improve access, continuity and coordination of community-based health and care services that will provide truly holistic preventative care and reduce the numbers of non-elective admissions.
- Key themes are ensuring care is delivered in the most appropriate setting including; the delivery of a community OPAT service, community paediatric services to avoid and reduce emergency admissions (a review of therapies provision has taken place in-year, a review of unplanned admissions continue to ensure the best possible care and care planning.
- Further development of the IC + scheme to support patients upon discharge and reduce hospital readmissions.
- Review and deliver improvements in the medical model for palliative care
- Elements of the Right care initiatives prevent these admissions particularly in respiratory as previously referred.

CCG Technical Narrative- Activity data

E.M.11b – Non-elective Admissions

Non-Elective Admissions

	Activity	% mov't
2017/18 Forecast outturn	18,314	
Known Factors	-	0%
2018/19 Planned Activity	19,065	
Net Growth & Transformation	751	4.1%



E.M.11b

E.M.11b Non-elective admissions (1+ day LOS) (Specific acute)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	1,490	1,439	1,488	1,460	1,393	1,415	1,527	1,431	1,564	1,551	1,385	1,593	17,736
1718	1,421	1,589	1,506	1,529	1,503	1,544	1,618	1,576	1,636	1,504	1,343	1,545	18,314
1819	1,579	1,547	1,576	1,591	1,517	1,526	1,641	1,545	1,676	1,646	1,484	1,737	19,065

Forecast
4.1% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 4.7% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 4.1%

Initiatives to deliver plans

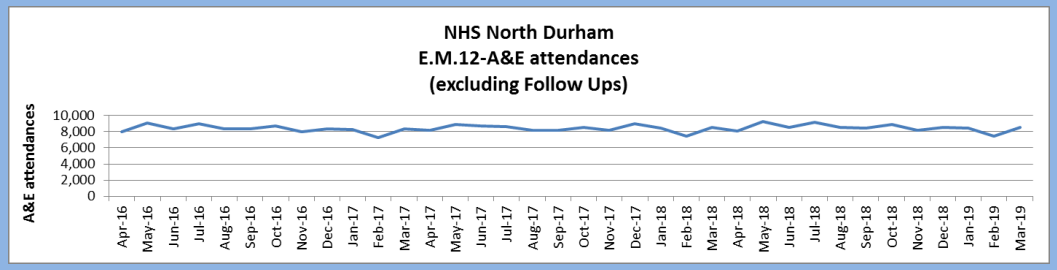
- Discharge to Assess was fully implemented across in 2017/18 in CDDFT which ensures medically fit patients are discharged safely.
- The development of TaPs across North Durham to improve access, continuity and coordination of community-based health and care services that will provide truly holistic preventative care and reduce the numbers of non-elective admissions.
- Key themes are ensuring care is delivered in the most appropriate setting including; the delivery of a community OPAT service, community paediatric services to avoid and reduce emergency admissions (a review of therapies provision has taken place in-year, a review of unplanned admissions continue to ensure the best possible care and care planning.
- Further development of the IC + scheme to support patients upon discharge and reduce hospital readmissions.
- Review and deliver improvements in the medical model for palliative care
- Elements of the Right care initiatives prevent these admissions particularly in respiratory as previously referred.

CCG Technical Narrative- Activity data

E.M.12 – A&E Attendances

A&E Attendances

	Activity	% mov't
2017/18 Forecast outturn	100,700	
Known Factors	-	0%
2018/19 Planned Activity	101,640	
Net Growth & Transformation	940	0.9%



E.M.12

E.M.12 A&E attendances (excluding Follow Ups)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	7,957	9,067	8,348	8,995	8,339	8,301	8,708	8,017	8,349	8,272	7,289	8,371	100,013
1718	8,153	8,847	8,678	8,638	8,203	8,140	8,501	8,192	8,973	8,425	7,424	8,526	100,700
1819	8,087	9,212	8,482	9,142	8,485	8,434	8,847	8,146	8,483	8,409	7,404	8,509	101,640

Forecast
0.9% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 1.1% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 0.9%

Initiatives to deliver plans

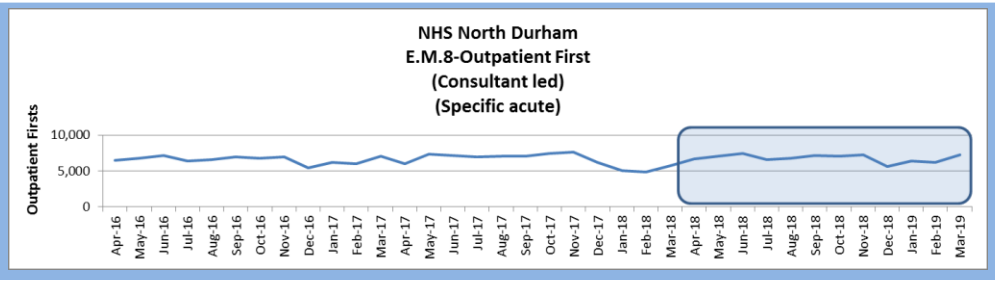
- To maintain, sustain and complete implementation of the Teams around the Patients (TaPs) model (previously known as Community hubs) which has been implemented partially in-year, with expected impact on A&E in 2018/19, with FYE 19/20.
- We have worked with practices and agreed a model of extended access in line with the GP FYFV to provide access -Monday to Friday (6-8pm) and Saturday and Sunday, this was implemented Q3 17/18, expect FYE 18/19. The model will continue to utilise 111 for direct booking into primary care both on weekdays and the weekend.
- In 2018/19 a High Intensity User (HIU) service (developed by NHS Blackpool CCG) offering a robust way of reducing frequent user activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients and reduce costs. It uses a health coaching approach, targeting high users of services and supports the most vulnerable clients within the community to flourish, whilst making the best use of available resources.
- GP Streaming commenced in October 2017 for our patients, expected impact FYE 2018/19.

CCG Technical Narrative- Activity data

E.M. 8 – Outpatient First

Outpatient First

	Activity	% mov't
2017/18 Forecast outturn	78,450	
Known Factors	-	0%
2018/19 Planned Activity	81,589	
Net Growth & Transformation	3,139	4.0%



E.M.8

E.M.8 Outpatient First (Consultant led) (Specific acute)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	6,464	6,811	7,151	6,372	6,534	6,940	6,797	6,986	5,436	6,181	5,975	7,013	78,660
1718	6,011	7,387	7,149	6,962	7,094	7,015	7,450	7,658	6,208	5,003	4,836	5,677	78,450
1819	6,709	7,056	7,419	6,600	6,786	7,192	7,046	7,246	5,631	6,412	6,205	7,287	81,589

Forecast
4% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 8.6% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 4%

Initiatives to deliver plans

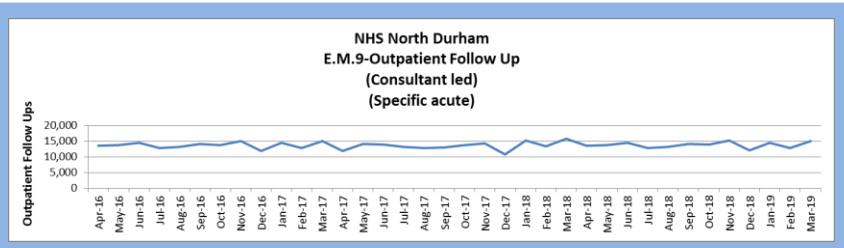
- We have continued to work with clinicians and managers from CDDFT with a focus on a joint workplan on areas including paediatrics, dermatology, MSK and pain management. We have progressed work in relation to MSK which includes a greater focus on self-care/education and increased utilisation of community based physiotherapy to reduce onward referrals.
- Implementation of community pain management service
- Impact of the Implementation of practice based budgets
- We implemented a new diabetes model of care, with the aim of providing improved outcomes for patients closer to home, impacting on outpatient activity.
- We also implemented a Rapid Specialist Opinion (RSO) service which has demonstrated a reduction in OP attendances in 2017/18. This scheme will continue in 2018/19 with four additional specialities added
- Other key themes we focus on as part of our work to manage demand and activity more appropriately include; work to maximise opportunity through delivery of Value Based commissioning policies ensuring compliance with current thresholds and the full year impact of the prior approval ticket process
- Ensuring care is delivered in the most appropriate setting e.g. maximising primary and community care provision and ensuring that practices work together so that the whole population has access to services outside of hospital such as Vasectomy, tele-dermatology and ophthalmic services.

CCG Technical Narrative- Activity data

E.M. 9 – Outpatient Follow Up

Outpatient Follow Up

	Activity	% mov't
2017/18 Forecast outturn	162,188	
Known Factors	-	0%
2018/19 Planned Activity	165,431	
Net Growth & Transformation	3,243	2.0%



E.M.9

E.M.9 Outpatient Follow Up (Consultant led) (Specific acute)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
1617	13,570	13,685	14,527	12,807	13,249	14,061	13,845	15,147	11,984	14,458	12,824	15,002	165,159
1718	11,943	14,067	13,964	13,234	12,753	12,962	13,843	14,233	10,823	15,170	13,455	15,741	162,188
1819	13,604	13,695	14,543	12,827	13,267	14,074	13,876	15,173	12,020	14,471	12,843	15,038	165,431

Forecast
2% growth applied to 1718 FOT

"Do Nothing"

"Do nothing" growth of 6.5% in 18/19 has been applied consistent with the local assumptions and the locally adjusted forecast out turn.

This is partially offset by the impact of CCG QIPP and transformation schemes to give a net growth of 2.0%

Initiatives to deliver plans

- We have continued to work with clinicians and managers from CDDFT with a focus on a joint workplan on areas including paediatrics, dermatology, MSK and pain management. We have progressed work in relation to MSK which includes a greater focus on self-care/education and increased utilisation of community based physiotherapy to reduce onward referrals.
- Implementation of community pain management service
- Impact of the Implementation of practice based budgets
- We implemented a new diabetes model of care, with the aim of providing improved outcomes for patients closer to home, impacting on outpatient activity.
- We also implemented a Rapid Specialist Opinion (RSO) service which has demonstrated a reduction in OP attendances in 2017/18. This scheme will continue in 2018/19 with four additional specialities added
- Other key themes we focus on as part of our work to manage demand and activity more appropriately include; work to maximise opportunity through delivery of Value Based commissioning policies ensuring compliance with current thresholds and the full year impact of the prior approval ticket process
- Ensuring care is delivered in the most appropriate setting e.g. maximising primary and community care provision and ensuring that practices work together so that the whole population has access to services outside of hospital such as Vasectomy, tele-dermatology and ophthalmic services.

E.B.3: Incomplete RTT pathways performance

RTT Incomplete		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Total patients treated	161,943	No	Activity numbers have been projected in line with plans to maintain the level of activity currently which will deliver the national standard of 92% as currently slightly higher than the average.
	Patients treated < 18 weeks	149,985		
	% patients waiting for initial treatment on incomplete pathways within 18 weeks	92.6%		
Forecast Achievement 2017/18 (based on current performance)		17/18		
	Total patients treated	158,547		
	Patients treated < 18 weeks	147,847		
	% patients waiting for initial treatment on incomplete pathways within 18 weeks	93.2%		
	Gap	N/A		

E.B.4: Diagnostic test waiting times

Diagnostics		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Total patients	60,429	No	Activity numbers have been projected in line with plans to maintain the level of activity currently which exceeds the national standard.
	Patients waiting > 6 weeks	565		
	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	0.9%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Total patients	55,910		
	Patients waiting > 6 weeks	272		
	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	0.5%		
	Gap	N/A		

E.B.6-7: Cancer two week waits

Cancer 2ww		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Total patients	9,352	No	Cancer two week waits have steadily improved throughout 17/18 and remains above the constitutional standard. The CCG has worked collaboratively with North Durham, Darlington and HaST CCGs to utilise Cancer Alliance early diagnosis transformation funding place three cancer navigator posts within CDDFT and one post within NTHFT focussing on supporting patients through Lung, Head & Neck and Upper/Lower GI pathways. Collaboration with our main provider has seen the implementation during March 2018 of an improved lung cancer pathway with patients now able to receive a CT scan prior to their first consultant outpatient appointment. The CCG is working in collaboration with Upper & Lower GI service and clinical leads on strategies to improve 2ww performance in these pathways. The CCG continues to support its main provider by attending regular patient tracking list meetings to identify any areas requiring additional resource.
Planned Achievement	Patients seen < 2 weeks	8,889		
Planned Achievement	% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	95.0%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Total patients treated	9,236		
Forecast Achievement 2017/18 (based on current performance)	Patients seen < 2 weeks	8,739		
Forecast Achievement 2017/18 (based on current performance)	% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	94.6%		
Forecast Achievement 2017/18 (based on current performance)	Gap	N/A		

E.B.8-11: Cancer 31 day waits

Cancer 31 days first definitive treatment		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Total patients	1,397	No	Risk to delivery of the Cancer Standards continue to be with the Cancer 31 and 62 Day Standards; the CCG continues to work closely with providers to ensure delivery of this standard and where the standards are being achieved and exceeded we have planned activity to sustain.
	Patients treated < 31 days	1,386		
	% of patients treated within 31 days of a cancer diagnosis	99.2%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Total patients treated	1,376		
	Patients treated < 31 days	1,362		
	% of patients treated within 31 days of a cancer diagnosis	99.2%		
	Gap	N/A		

E.B.12-14: Cancer 62 day waits

Cancer 62 days		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Total patients	796	Yes	Risk to delivery of the Cancer Standards continue to be with the Cancer 31 and 62 Day Standards; the CCG continues to work closely with providers to ensure delivery of this standard and where the standards are being achieved and exceeded we have planned activity to sustain.
	Patients treated < 62 days	682		
	% of patients treated within 62 days of an urgent GP referral for suspected cancer	85.7%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Total patients treated	749		
	Patients treated < 62 days	626		
	% of patients treated within 62 days of an urgent GP referral for suspected cancer	83.6%		
	Gap	N/A		

E.B.5: A&E waiting times –total time in the A&E department

A&E		Activity 18/19	Risk?	Narrative
Planned Achievement	Total Attendances	218,541	Yes	Throughout 17/18 a huge amount of focus concentrated in this area having had a whole systems enquiry visit from ECIP in 16/17, worked with the Trust on the priority areas which align with the national A&E Improvement plan to allow the whole systems to concentrate on a limited number of actions that will have a high impact on performance., which will enhance the work of our local A&E delivery board. The collaborative working with our main A&E provider has seen a shift change however some key targeted work going forward is planned for improvement, whilst this last year has not seen the improvement expected we are focussed on working in partnership with our provider to achieve the targets. The CCG has invested in several primary and community care services to in order to alleviate A&E. The CCG is currently reviewing its service improvements implemented in 17/18 to ensure they continue to be fit for purpose, ensuring our population is seen in the right place at the right time.
	Number waiting > 4 hours	21,096		
	% of patient attending A&E seen within 4 hours	90.3%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Total Attendances	216,163		
	Number waiting > 4 hours	19,087		
	% of patient attending A&E seen within 4 hours	91.2%		
	Gap	-1.1%		

E.B.17: Ambulances - Proportion of calls closed by telephone advice

Ambulances - Proportion of calls closed by telephone advice	Activity	Risk?	Narrative
	18/19		
Planned Achievement			
Forecast Achievement 2017/18 (based on current performance)	Northumberland CCG will submit this as lead commissioner and the narrative will show both regional and local initiatives to support delivery.		

E.B.17: Ambulances - Proportion of calls closed by telephone advice

Ambulances - Proportion of calls closed by telephone advice		Activity	Risk?	Narrative
		18/19		
Planned Achievement				Northumberland CCG will submit this as lead commissioner and the narrative will show both regional and local initiatives to support delivery.
		17/18		
Forecast Achievement 2017/18 (based on previous year's performance)				

E.B.18: Ambulances - Proportion of incidents managed without need for transport to Accident and Emergency departments

Ambulances - Proportion of incidents managed without need for transport to Accident and Emergency departments	Activity	Risk?	Narrative
	18/19		
Planned Achievement			
Forecast Achievement 2017/18 (based on current performance)	Northumberland CCG will submit this as lead commissioner and the narrative will show both regional and local initiatives to support delivery.		

E.B.18: Ambulances - Proportion of incidents managed without need for transport to Accident and Emergency departments

Ambulances - Proportion of incidents managed without need for transport to Accident and Emergency departments		Activity		Risk?	Narrative
		18/19			Northumberland CCG will submit this as lead commissioner and the narrative will show both regional and local initiatives to support delivery.
Planned Achievement					
		17/18			
Forecast Achievement 2017/18 (based on current performance)					

E.A.S.1: Estimated diagnosis rate for people with dementia

Dementia Diagnosis Rate		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Estimated Dementia population 65+	35,652	No	Currently we are exceeding the national standard and have set the projections to maintain and sustain this high level , the CCG is committed to achieving the current performance.
	Number of people diagnosed with Dementia (65+)	24,492		
	Dementia Prevalence 65+	68.7%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Estimated Dementia population 65+	24,096		
	Number of people diagnosed with Dementia (65+)	34,896		
	Dementia Prevalence 65+	69%		
	Gap			

E.A.3: IAPT roll-out

IAPT Roll Out		Activity	Risk?	Narrative
		18/19		
Planned Achievement	The number of people who have depression and/or anxiety disorders	104,052	No	The estimated prevalence figures have been maintained at current levels as they have been set by NHSE for a number of years. In terms of performance we have projected to meet minimum standards over the next two financial years. The IAPT 'roll out' relates to four constitutional targets. Performance notices and recovery action plans have been put in place with providers and performance has improved over recent months. The IAPT services across County Durham and Tees are currently being reviewed.
Planned Achievement	The number of people who receive psychological therapies	4,536		
Planned Achievement	The proportion of the local population estimated to have a primary care mental health condition who enter therapy	4.4%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	The number of people who have depression and/or anxiety disorders	104,048		
Forecast Achievement 2017/18 (based on current performance)	The number of people who receive psychological therapies	4,320		
Forecast Achievement 2017/18 (based on current performance)	The proportion of the local population estimated to have a primary care mental health condition who enter therapy	4.2%		
Forecast Achievement 2017/18 (based on current performance)	Gap			

E.H.1-3: IAPT waiting times – 6 weeks

IAPT Waiting Times		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	2,412		The CCG has implemented primary care mental health workers based in GP practices. This additional resource has helped to better identify patients that can benefit from IAPT services.
	Number of ended referrals that finish a course of treatment in period	3,216		
	The proportion of people who received their first appointment within 6 weeks	75.0%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	2,780	No	
	Number of ended referrals that finish a course of treatment in period	3,020		
	The proportion of people who received their first appointment within 6 weeks	92%		
	Gap			

E.H.1-3: IAPT waiting times – 18 weeks

IAPT Waiting Times		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	3,056		As previous slides
	Number of ended referrals that finish a course of treatment in period	3,216		
	The proportion of people who received their first appointment within 18 weeks	95.0%		
		17/18		
Forecast Achievement 2017/18 (based on current performance)	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	3,000	No	
	Number of ended referrals that finish a course of treatment in period	3,020		
	The proportion of people who received their first appointment within 18 weeks	99.3%		
	Gap			

E.H.4: Psychosis treated with a NICE approved care package within two weeks of referral

Psychosis treated with a NICE approved care package within two weeks of referral		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	32	No	The trajectory estimates the levels of current prevalence to continue, despite the availability of only two months baseline information. Performance levels have been calculated to ensure the CCG is meeting the minimum national standard required. This is still a relatively new target but performance levels have been consistently high over 2017/18. ND CCG will continue to maintain and sustain current achievement and increase this for 18/19.
	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	60		
	Proportion of people who start a NICE-recommended care package within 2 weeks	53.3%		

E.H.10 –E.H.11 waiting times for Urgent and Routine Referrals to Children and Young People Eating Disorder Services

	Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Activity	Risk?	Waiting times for Urgent Referrals to Children and Young People Eating Disorder Services	Activity
		18/19			18/19
Planned Achievement (Within 4 Weeks)	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	76		Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	8
	Number of CYP with a suspected ED (routine cases) that start treatment	80		Number of CYP with a suspected ED (urgent cases) that start treatment	8
	Proportion of CYP who are seen within 4 weeks of referral	95%		Proportion of CYP who are seen within 1 week of referral	100%
		17/18			17/18
Planned Achievement (Within 1 Week)	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	60		Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	4
	Number of CYP with a suspected ED (routine cases) that start treatment	80		Number of CYP with a suspected ED (urgent cases) that start treatment	8
	Proportion of CYP who are seen within 4 weeks of referral	75%		Proportion of CYP who are seen within 1 week of referral	50%

E.N.1: Personal Health Budgets

Personal Health Budgets		Activity 17/18 Q1	Q2	Q3	Q4	Risk?	Activity 18/19 Q1	Q2	Q3	Q4
Planned Achievement	Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	20	30	40	60	No	80	105	130	162
	GP registered population (total number per CCG)	253,299					254,205			
	Rate of PHBs per 100,000 GP registered population	7.90	11.84	15.79	23.69		31.47	41.31	51.14	63.73

E.O.1: Percentage of children waiting more than 18 weeks for a wheelchair

	Percentage of children waiting more than 18 weeks for a wheelchair	Activity	Risk?	Activity
		17/18		18/19
Planned Achievement	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	50	No	116
	Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	65		116
	%	77%		100%

E.P.1: NHS e-Referral Service (e-RS) Utilisation Coverage

NHS e-Referral Service (e-RS) Utilisation Coverage		Activity	Risk?	Narrative
		18/19		
Planned Achievement	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	57,258	No	The trajectory estimates the levels of current prevalence to continue, despite the availability of only two months baseline information. Performance levels have been calculated to ensure the CCG is meeting the minimum national standard required. This is still a relatively new target but performance levels have been consistently high over 2017/18. ND CCG will continue to maintain and sustain current achievement and increase this for 18/19.
	Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	57,258		
	% Utilisation	100%		

Transformation Programmes

Operational Plan on a Page 2017-2019

'Working together for excellent health for the local communities'

Health & Wellbeing Gap

Early Intervention and Prevention

Transformation Scheme	CCG Initiatives
Cancer	Develop with Public Health and our local health networks audience appropriate messages that target all age groups/sectors with the aim of encouraging healthier lifestyles and early access to diagnostics/ screening for lung, breast, bowel and cervical cancer. There will be a particular emphasis on seldom heard and young people .
Lifestyle, Early Intervention and Prevention	Work with public health in a targeted approach in key areas of deprivation across the ND communities. Continued implementation of the national diabetes prevention programme. Increase and improve training and development across working practice to improve secondary prevention in primary care and secondary care
Providing every child with the best start in life	Work with public health to improve maternal care including maternal mental health, breastfeeding, maternal obesity, maternal smoking, parental drug and alcohol issues, parenting programmes, school readiness and narrowing the gap. Working together with others to reduce Child poverty which is part of much broader indicator set; Improve the first 1,001 days of a childs life to support the reduction in long term illnesses.

Quality & Care Gap

Integration

Transformation Scheme	CCG Initiatives
Urgent Care	Provide an improved service to meet the urgent care needs of our local population, resulting in some changes to services currently being delivered. Continued provision of minor injury and GP out of hours services will be complemented by extended and enhanced GP services. GP services will be extended from 6:00 pm-8:00 pm weekdays as well as extended weekend provision on a Saturday and Sunday morning . In addition to this there will be enhanced availability of same day urgent appointments with GP practices.
Primary Care	The four key objectives are; to develop seven day services; to develop disease specific pathways for integration of services and budgets; to develop and implement the GPFYFV concepts; to wrap services around primary care through the development of community hubs .
Mental Health	Key priorities are to; expand IAPT by extending the scope to include Children and Young People; improve the appropriateness of prescribing of anti-psychotics, reduce the impact on long term health problems; improve our response to crisis by improving ambulance response times; develop a intensive Home Treatment service for children and young people. We have also set out a priority improve the all age autism pathway.
Learning Disabilities	Increase the proportion of patients with LD having annual health checks; conduct reviews into premature deaths; increase cancer screening; carry out eye screening; increase flu vaccination rates and reduce the numbers of patients with a learning disability in a specialist inpatient setting where they can be managed in a community setting. Our priorities also include taking forward the SEND reforms with partners.
Right Care	We will continue to reduce variation across a number of key areas e.g. respiratory; MSK; Cancer, Genito-Urinary and Mental Health prescribing
Neighbourhoods and Communities	North Durham are developing Teams Around Patients which are integrated teams working together to cover a population's health and care needs. We will improve access, continuity and community based health and care services.

Funding & Efficiency Gap

Reconfigure Hospital Based Services

Transformation Scheme	CCG Initiatives
Better Health Programme	Through the development of TAPS models the integration of providers within health and social care our population will benefit from; Integration of information systems; A developed workforce that delivers care as part of a care planning approach; A care model that is based around a triangulation of needs, incorporating: Highest needs model supported by multidisciplinary team, with risk stratification to identify patients who will benefit most from intensive support; Ongoing care needs – Integrated primary and community care MDTs, based around population hubs, working closely with specialists, carers, other sectors and with a care co-ordinator. GPs ensuring continuity of responsibility for patients on their list, supported by standardised tools for LTC management.

Technology

Transformation Scheme	CCG Initiatives
Digital Health and Technology	We will support our Sustainability and Transformation Planning footprint in the development of technology which will support the: Reduction in admissions to hospital; Reduction in duplicate medications and tests; Reduction in duplicate back office resources; Increased capacity in services through patient self management

TRANSFORMING CANCER SERVICES

Scaling up prevention, health and well being

Must Do's

- STP – Implementation & delivery
- Elective Care – RTT & Implementation of 'Better Births'
- Cancer – Achieving world class cancer outcomes

Future State/Ambition for 2020/21

To commission world class cancer services and outcomes in order to;

- Prevent cancer by addressing cancer risk factors – including smoking, alcohol & obesity
- Diagnose more cancers early, increasing the proportion of cancers diagnosed at stage 1 and 2. The CCG will improve all cancer pathways as well as substantially increasing diagnostic capacity (especially imaging/radiology). These actions will result in fewer cancers diagnosed as an emergency, and an increase in one and five-year survival rates.
- By 2020, everyone with a suspected cancer should receive a definitive diagnosis or within 28 days.
- By 2020, all patients will have access to high-quality modern therapeutic services, such as personalised treatment informed by molecular diagnostics. They will be cared for during and after their treatment, benefiting from increased support to live well after treatment.
- Patients will have a better experience of their cancer care, with less variation across the STP.

The Gap / Why Change is needed – identified via STP

- Significant gap between life expectancy across the STP footprint and that of England cancer is a significant contributor to this and this is also an issue for our CCG
- Higher than national average prevalence rates for incidents of smoking, including smoking during pregnancy
- Significant inequality gap within communities across our localities
- We have too many people diagnosed at a late stage
- Too many people die within 12 months of diagnosis

Benefits

- Achieve cancer waiting time standards
- Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test - Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one
- Pooled clinical capacity across the system (diagnostics, welfare advice, screening) leading to a multi-disciplinary workforce to ensure every contact counts
- All patients to have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment
- Treatment summaries to be sent to the patient's GP at the end of treatment
- Cancer care reviews completed by the GP within six months of a cancer diagnosis
- Reduction in smoking rates
- Increased uptake in all cancer screening programmes
- A demonstrable improvement in the proportion of cancers diagnosed at stages 1 and 2

Priority Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Implement the Independent Cancer Taskforce: Achieving World Class Cancer Outcomes Strategy (AWCCO) 2015-20 via the Joint Durham and Tees CCG Cancer Project Group.								
Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard								
Ensure all parts of the Recovery Package are available to all patients								

GIVING EVERY CHILD THE BEST START IN LIFE

Scaling up prevention, health and well being

Must Do's

Implement the national maternity services review

Better Births, through local maternity systems

Future State/Ambition for 2017/19

All children and families to be able to access improved services for ; maternal mental health, mental health, breastfeeding, maternal obesity, maternal smoking, parental drug and alcohol issues, parenting programmes, school readiness

•Support organisations to realise the benefits of physical activity is an important component of early brain development and learning. Communication skills depend on well-developed physical skills, such as effective movement and eye contact; parenting programmes; Daily mile – schools; Park runs - communities

•Supporting all children and families to access child heath prevention programmes

•All children and families to access - food in settings - hospitals, nurseries, schools, workplaces

•All organisations to Healthy weight declaration or sugar smart city

•Implement prevention pathways in maternity contracts

•Improved poorly child pathways

•Improved public mental health across the life course.

The Gap – Why Change is needed

This is a priority as County Durham reports above the national average highlighted in the annual National Child Measurement Programme (NCMP) reports, particularly for children in Year 6.
Data from the NCMP for County Durham (2012/13-2016/17) shows us that obesity prevalence is over one and a half times higher amongst the most deprived 4-5 year olds and 10-11 year olds compared to the least deprived.
Data from PHE shows that North Durham has significant child poverty and several worsening areas of health e.g. mortality; MMR immunisations uptake ; levels of child development; rise in children in care

Benefits

•Reduce the prevalence of overweight and obese children at Reception and Year 6

•A reduction in maternal smoking

•Reduce mortality rates

•Increase in chid development

•Reduction in children in care

•Reduction in A&E Attendances for children

•Reduction in non-elective activity

•Improve School Readiness

•Improve Childhood Immunisation Rates

•Increase Breastfeeding Rates

•Reduce Teenage Pregnancy

•Improve Maternal Mental Health

•Improve the mental health of children

•A reduction in self harm emergency admissions and suicide rates.

Priority CCG Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Re-design of the Family Initiative Supporting Child Health (FISCH) service								
Implementation of perinatal mental health service								
Review of unintentional injuries in children and associated pathways								

LIFESTYLE, EARLY INTERVENTION AND PREVENTION

Scaling up prevention, health and well being

Must Do's		
	Implementing Right Care	**Support self care and prevention**
	Implement the cancer taskforce report	Make progress in improving one-year survival rates

The Gap – Why Change is needed

Key themes have been identified through analysis of right care that has identified key areas such as respiratory, CVD and cancer.
Survival rates following cancer diagnosis are worse than the England average
Alcohol misuse contributes significantly to 48 health conditions, wholly or partially, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time.
Smoking is the single largest cause of health inequalities and premature death, within North Durham, over 1 in 5 adults smoke (17.9%).
Smoking is the primary reason for the gap in life expectancy between those in the most deprived quintile and those in the least deprived quintile.
Obesity rates for North Durham are high for children at Year 6 and for adults (16+)
Poor diet and physical inactivity are causal factors of obesity and obesity disproportionately affects the most deprived communities.
Themes identified to improve outcomes focus on preventative interventions specifically screening and early diagnosis, lifestyle changes, vaccinations

Future State/Ambition for 2017/19

- Greater focus on screening initiatives to improve effective early detection and management of long term conditions
- Improved support services for people admitted with alcohol related admissions along with provision of brief advice in primary and secondary care settings and sustained engagement with high-impact users..
- Refocus of local tobacco control efforts and smoking cessation services on priority groups; the poorest 10% of our community, people with long term conditions including mental health illness and smoking in pregnancy
- Integrate weight management and mental health services
- Care pathways will endure referral to appropriate support services at key trigger points in the patient journey and where possible provide support proactive self management
- Secondary prevention in all acute contracts and audited to monitor delivery
- Extending the use of personal health and social care budgets and supporting people to use and manage these effectively to ensure people will have increased choice and control over all aspects of their life.
- Scaling up wellbeing / wellness programmes in the community and expanding capacity to deliver as part of self care as system default building upon existing programmes with an equal focus on mental health
- Increase the role of physical activity as prevention, early intervention, pre-habilitation and rehabilitation for physical and mental health.

Benefits

- Increase in screening rates
- Increase in vaccination rates
- Increase in physical activity
- Reduce premature deaths
- Reduce health inequalities
- Support self care and prevention and Making Every Contact Count
- An increase in smoking quitters at 4 weeks
- An increase in the number of people accessing Personal Health Budgets

Priority CCG Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Continued implementation of the National Diabetes Prevention Programme								
Re-design of the Family Initiative Supporting Child Health (FISCH) service								
Targeted delivery of Wellbeing for Life service (respiratory)								
Implement Better Health at Work Award								

NEW MODELS OF CARE – Teams Around Patients

Out of hospital collaboration

Must Do's

Development of an Accountable Care Network	**Reduce over reliance on hospital based services**	**Define hub populations**
Formalise alliance agreement and contracts	**Develop local teams and budgets**	Develop governance processes
Increase self care	**Monitor and deliver outcome improvements**	Reduce admissions to hospital

The Gap – Why Change is needed

Currently 2% of the population are classed as frail and elderly and it is expected that this will rise to 3% or 8636 people over the next 20 years.

Currently 28% of the North Durham population have one or more LTC and this is forecast to rise to 29% or 88,127 people over the next 20 years.

Services for these patient cohorts are currently fragmented and there is significant duplication in care. There is also an over reliance on hospital based services for the North Durham population and higher than expected rates of admission to hospital .

There is an opportunity cost associated with more pro active management of patients with a LTC or those at risk of admission to hospital. Preventing admissions to hospital will free up funding to invest in enhanced community based services and to meet the expected number of patients that will require healthcare services.

Future State/Ambition for 2017/19

North Durham has a vision to improve access, continuity and coordination of community-based health and care services.

The system change required is the creation of functionally integrated holistic teams at a population level. These teams will include community services, allied health professionals, social services, and specialist nurses and will be linked to GP practices using the Primary Care Home model. The integrated health and social care teams will be based around a population size of 30-50,000 to provide joined up, accountable and personalised services. TAPS will provide a single main point of contact for patients and carers. Each patient has a key worker within this team who coordinates their care and acts as the point of contact. Integrated teams pool expertise to deliver a bespoke service at the benefit of individual patients; this is not about diluting expertise, service quality, or quality of outcome.

A risk prediction tool will identify a list of patients that are at high and medium to high risk of accessing healthcare services. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised. It will enable identification of resource need and resource utilisation.

We will have moved away from the traditional model of care (see, treat and discharge) to a chronic care model where self-management support is a responsibility and an integral part of the delivery system. Care is delivered by a prepared proactive workforce enabling patients to move away from being passive recipients to becoming informed and activated to self- manage (identify, integrate and co-manage).

Benefits

MCPs build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. The model will expand the leadership of primary care to include nurses, therapists and other community based professionals.

A range of outcome improvements have been identified. These include, but are not limited to:

Reduction in permanent admissions to cursing/care homes

Reduction in non elective admissions

Increase in patients dying in their preferred place of death

Priority CCG Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Implementation of model								

Primary care

Must Do's

- Ensure the sustainability of general practice by implementing the Forward View
- Ensure local investment meets or exceeds minimum required levels
- Tackle workforce and workload issues to increase the number of doctors working in general practice
- Investment in training practice staff and stimulating the use of online consultation systems
- Extend and improve access in line with requirements for new national funding
- Support general practice at scale

Themes	16/17	17/18	18/19	19/20	20/21
Investment		CCG investment into developing and supporting primary care			
Workforce	Recruitment and retention initiatives	Recruitment and retention initiatives Training care navigators Medical assistant roles	Training care navigators Medical assistant roles		
Workload		Reform OOH/111 Paper free			
Infrastructure		New models of care			
Care Redesign	Fund protected learning		Extended access	Propose MCP contract	

The Gap – Why Change is needed

A new style of primary care is required to strengthen the connections between healthcare professionals and the people they care for. Primary care is pivotal in delivery in the NHS and has the ability to ensure early intervention and prevention. There is a high use of services including A&E which could be dealt with through early intervention and improved access to primary care.

Primary care needs to change to meet the challenges of an ageing population and to better serve those living with complex health and care needs. This means providing personalised, proactive care to keep people healthy independent and out of hospital through a risk based approach and reducing variation in approaches to delivering care. There is a need to expand and change the skill mix of the workforce in primary care as within our STP there is an ageing workforce and difficulty in recruiting GPs.

Future State/Ambition

Our vision for the future state of Primary care is that a new style of Primary care intervention is delivered through integrated primary care teams.

- Member GP practices are facing GP and primary care staff recruitment and retention issues. By offering newly qualified GPs and practice nurses via the 'Career Start Scheme' the opportunity of guaranteed continuing education, portfolio working and a minimum guarantee of salary ND CCG is hoping to recruit nine new GPs.
- An increase workforce in general practice supported by new roles beyond traditional GP's such as mental health counsellors/therapists, physician associates and clinical pharmacists
- ND CCG is engaged and has active participation in the new DCO Practice resilience programme
- ND CCG has an IT Strategy in place that includes digital roadmaps and system interoperability.
- Primary care records shared across the local health economy, including community pharmacy, with the introduction of common standards, paperless transfer of notes and digital summary care records.
- Implementation of a new model of care that integrates provision of primary and community to ensure a whole population health approach to service delivery with the required infrastructure and 'fit for purpose' premises
- Introduction of Care Navigation / Care Co-ordination utilising the specific NHS England funding
- NDCCG has set up a dedicated multi professional education and training steering group which identify training needs and opportunities for all practice staff
- All ND CCG practices have been given the opportunity to purchase additional clinical pharmacist sessions with a view to embed a clinical pharmacist within the practice
- A ND CCG GP is working directly with Newcastle Medical School to place 10 Physician Assistants in General Practice
- ND CCG will use technology to deliver the paper free agenda, pushing forward with the 2020 vision of having fully interoperable electronic health records in place, so that patients' records are paperless at the point of care
- A Referral Management system is currently being implemented in ND CCG by all practice to help reduce demand

Benefits

- Increase in GP numbers and skill mix with healthcare professionals
- Improved access times to primary care
- Improved patient access to community mental health services
- Improved skills for non-clinical staff
- Improvements in practice infrastructure
- Increased 111 access to general practice appointment systems
- Improved information sharing and data flows across health services
- Increased scope of services available in primary care
- Improved satisfaction rates for access to primary care
- Increased funding in primary care
- Reduction in A&E attendances

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

- Access to and utilisation of Estates and Technology Transformation Funding
- Additional investment to primary care access through the sustainability and transformation package of support from 17/18 to 18/19
- Additional workforce capacity through working practice and innovation and increased recruitment and retention
- Transformation resource to support the implementation of new models of care

Urgent Care

Must Do's

GP 5YFV requirements or ambulance response times	Direct booking from 111 to all urgent care services	Monitor the Urgent care service /systems and make regular improvements
Ensuring a 24/7 integrated care service /model is in place	Implement Urgent Treatment Centre (UTC) Standards / principles and services October 2018	Support the implementation of the new Clinical Advice system (CAS)

The Gap – Why Change is needed

- There are many ways to access the system which can be confusing
- There are a number of different services with a variety of opening times making it difficult for patients and carers to navigate the system
- System is complex to manage
- There a number of different providers which creates the inability to share patient care records between organisations which impacts on continuity of care
- There is duplication within the system. Different services are providing similar treatments at the same time
- The current system is not providing value for money
- Services need to be integrated and streamlined across the county
- Need to meet the national must dos on the UTC standards
- Need to continue to improve commissioned services monitoring what's working well and not so well
- Need to continue to work more collaboratively
- Practices need to ensure they deliver same day services to patients and extended access and all provide booked and same day options
- Current Primary Care Services hubs aren't utilised to capacity
- GP practices would now like to see the services changed
- Potential to look at number of sites that are delivering services – for example UTCs (rationalise services in the future)

Future State/Ambition

The UEC Network recently did an exercise to look at whether our CCGs had care centres that met this spec and concluded that the following did: University Hospital of North Durham Urgent Care Centre Shotley Bridge Urgent Care Centre, Darlington Memorial Hospital Urgent Care Centre Bishop Auckland Urgent Care Centre Peterlee Urgent Care Centre, therefore UTCs launched on 1st April 2018.
The aim of this service is to deliver an integrated service and an Out of Hours service. The service will be a Nurse Led model with GP leadership. Further models of delivery are currently being explored around centralised services and remote /home visiting services after 12 midnight .

The new Primary Care model will deliver care closer to home enabling GPs to manage patients with long term conditions more effectively in their own GP practice, and those with same day need however CCG need to ensure appropriate levels of usage and value for money therefore are looking to implement some local changes following engagement with the public and service users.
The new service is aimed at providing additional clinical capacity in general practice, at a time when there is considerable pressure.

The CCGs will be working to integrate the new Clinical Advice System within current contracts and monitor the impact and effectiveness. This will be integrated with NHS 111 remote booking and NHS 111 new online service due to launch.

Benefits

As well as commissioning urgent care services in line with national policy the new urgent treat centre model care will bring a number of benefits to our patient population these are as follows;

- GP led service with other multidisciplinary clinical workforce
- Open for at least 12 hours a day seven days a week 365 days a year
- Digital: Direct booking from NHS 111 and other services
- Digital: Access to care records
- Digital: e-prescribing ability (national solution to follow)
- Access to simple diagnostics
- Access to x-ray facilities, with clear access protocols if not available on site
- Value for money services that are equitable across the county.
- Services that are utilised appropriately and care closer to home for patients .
- One clear delivered service
- Urgent care must dos achieved at local level
- Better use of primary care appointments
- Patients seen in the right service first time

Priority CCG Milestones/Tasks	18/19 Q1	18//19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4
New UTC to go live 1st April 2018 – continue to support improvements and developments								
Modify the Primary care Support services – rationalise services to ensure VFM								
Potential to look to rationalising sites that are delivering services across North Durham and DDES UTC's								
Support the implementation of the CAS and NHS 111 online services								

EMERGENCY CARE

Must Do's

- **Front door primary care streaming**
- **Achievement of 4 hour A&E standard**
- **Hospitals providing 7 day services**
- **Hospital to Hone -** *Improve hospital discharge s and reduce Delayed Transfers of Care (DToCs)*
- **Implementation of Full Capacity Protocol**
- **Addressing ambulance handover delays**

The Gap – Why Change is needed

- Commitment to adhering to NHS England's plan for recovering the A&E waiting time performance to 95%
- There are no opportunities to expand the bed base in County Durham and Darlington to cope with increased demand therefore our current systems need to reform their processes and pathways with a greater focus on whole system improvement
- There is currently a mismatch of capacity and demand and inadequacy of patient flow across the whole health and social care system
- Growth in non-elective admissions
- Ambulance handover delays increasing
- Increasing numbers of medical occupied bed days

Future State/Ambition

The aim of the CCGs within County Durham and Darlington is to reduce unwarranted variation and improve the quality, safety and equity of emergency care provision by working with partners across the health and social care economy to radically transform the whole system. This will be overseen by our Local A&E Delivery Board whose objectives are to:

- Take a whole system approach to ensure recovery of the 4 hour A&E target
- Coordinate and oversee the five mandated improvement initiatives for all LADBs
- Work with the Urgent and the Emergency Care Network (UECN) on the longer term delivery of the Urgent and Emergency Care Strategy and Delivery Plan
- Work towards the delivery of a zero tolerance approach to ambulance handover delays and ensure all measures to reduce the impact of handover delays are embedded in normal practice in all organisations across the system
- Increase access to primary care for patients with urgent primary care needs who self-present to the Emergency Department (ED)
- Streaming at A&E 'front door' for walk-in patients with minor ailments to manage demand and increase direct referrals to ambulatory care and other acute speciality assessment units direct from triage
- Improve hospital discharge so that patients only stay in hospital as long as they clinically need to be there

Benefits

- A reduction in hospital admissions
- Reduction in avoidable A&E attendances
- Delivery of the A&E 4 hour standard
- A reduction in 999 ambulance dispatches and improved ambulance response times
- Improved ambulance handover times and zero ambulance diverts
- Clear escalation processes in place
- Increase see & treat and hear & treat
- Early intervention and enhanced health in care homes
- Reduction in DTOCs
- Improved patient flow throughout hospitals
- Fewer patient assessments being carried out in acute settings

Priority CCG Milestones/Tasks	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4
Continue to support the implementation of CDDFTs Transforming Emergency Care (TEC) improvement plan	■	■	■	■				
Engage and participate with NHSI's 2018 Action on A&E Programme. County Durham and Darlington LADBs focus topic: "Discharge and Recovery – why not home? Why Not Today?"	■	■	■	■				
Focus on reducing non-elective admissions		■	■	■	■	■		
Set and recommend schemes to utilise available resilience funding within the CCG's baseline to assist the management of system pressures at times of surges in activity and winter pressures			■	■			■	■
Continue to work with the Urgent and Emergency Care Network to deliver their 2017/18 three year strategy	■	■	■	■	■	■	■	■
Work in partnership with NEAS to deliver Ambulance Handover Action Plan	■	■	■	■				

Transforming Mental Health All Age

Must Do's

- At least 25% of people with common mental health conditions will get access to psychological therapies
- Ensure 95% if children and young people with and Eating Disorder receive treatment within four weeks
- Ensure that at least 60% of people experiencing a first episode in psychosis begin treatment within two weeks
- 35% more children and young people with a mental health condition will receive treatment
- Deliver Mental Health access and quality standards including 24/7 access to community crisis services
- Continue to develop integrated healthcare through achieving mental health liaison core standards by 20/21

Future State/Ambition for 2020/21

Mental Health is everywhere and the health needs of our population are increasing. We are looking to build high quality services and a highly skilled workforce that not only delivers value for money but is financially sustainable and provides early intervention and increased access across all treatment areas.

North Durham Clinical Commissioning Group aims to meet the standards set out in the Five Year Forward View for Mental Health by 20/21 and in some cases , where possible, earlier. This will include achievement of access standards and associated trajectories within the operational plan which is across all ages.

The Gap – Why Change is needed

Due to the prevalence of disease and long term illness coupled with high levels of deprivation, individuals are more susceptible to developing mental health problems in our footprint.

Recognising that within our footprint there are a significant number of armed forces personnel and veterans who may require enhanced mental health support – it is therefore essential to ensure more is done to provide early identification and support to access the care that is in place.

North Durham CCG are committed to ensuring investment levels defined by the Five Year Forward View are committed to Mental Health Services in order to close the gap between mental and physical health provision.

Improvements to the all age autism pathway.

Benefits

The success of the improvement under the Mental Health Five Year Forward View will mean that more people, of all ages, will have improved access to timely mental health treatment and earlier interventions. These interventions will be more specific to individual needs and therefore improved outcomes in health and wellbeing are expected for people affected by mental health .

North Durham Clinical Commissioning Group anticipate that individual scheme benefits will be seen in terms of direct improvements to national standards,. There will also be an impact around closing the mortality gap for individuals with a mental health condition. General improvements to health and well being will be expected along with increases in the level and quality of care as well as financial efficiencies.

Priority CCG Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
CYP Eating Disorder Services Operational and meeting national standards								
Mental Health Liaison Service operating at Core Standards (Dependent on funding wave)								
Early Intervention in Psychosis – Service meeting nice guidance and increased access targets								
Design and develop service model to meet increased IAPT rollout requirements								
Develop CAMHS Services in line with Local Transformation Plans								

Transforming mental health services

Must Do's

At least 25% of people with common mental health conditions will get access to psychological therapies	35% more children and young people with mental health conditions will receive treatment	Ensure that at least 60% of people experiencing a first episode of psychosis begin treatment within two weeks
Increase access to individual placement support for people with severe mental illness in secondary care services	Ensure that 95% of children and young people with an eating disorder receive treatment within four weeks	Reduce suicide rates by 10% against the 2016/17 baseline
Deliver mental health access and quality standards including 24/7 access to community crisis resolution	Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence	Eliminate out of area placements for non-specialist acute care by 2020/21

	16/17	17/18	18/19	19/20	20/21
60% of people with first episode psychosis treated with NICE concordant therapy within 2 weeks of referral	50%				
95% of children and young people with eating disorders are seen within 4 weeks of referral (1 week for urgent referrals)					
Comprehensive core 24 liaison service in place in acute hospitals (1 hour response in urgent care, 24 hour response to inpatient settings)					
Access to specialist perinatal mental health services both community and in patient					
25% of people with common MH conditions access psychological therapies	15.8%	16.8 %	19%	22%	25%
Access to liaison and diversion services across the criminal justice system					
Mental health access standards for crisis care					

Future State/Ambition

24/7 urgent and emergency health response, an all-age mental
departments and in-patient wards, multi-agency suicide preven
10%

Mental health is everywhere and the health needs of our popul
build high quality services and a highly skilled workforce that no
financially sustainable, but that provide more of our population
access to treatment across all of our communities

What resources are required to deliver / what capacity and cap

- To deliver the 60% target for first episode psychosis further
funding is required to ensure access to the full range of NIC
- In order that 35% more CYP with a diagnosable MH conditio
community MH service, further targeted investment in line
available to support CYP IAPT programme, CAMHS crisis and
disorder and tier 2 and 3 CAMHS
- Development of growth and investment plans for workforce
at least 25% of people with common MH conditions get acc
by 2020
- Ensure that commitment is sustained so that all of our acute
health liaison service achieving Core 24 service standard
- Continued support to community mental health services to
for non-specialist acute mental health care and improve em
- Develop opportunities for collaborative commissioning with
for specialist mental health services and integrated mental
- Investment in workforce and services is required to ensure
support in the community and in patient settings by 2020/2
- Continued focus on memory clinics and cross system deme
of diagnosis rate and effective post diagnosis support.
- Work with all agencies to develop and implement a range o
services.
- Increased investment in individual placement support in sec
- Ensure continued multi agency support to suicide task grou
reduction plans

Benefits

The success of the improvement areas under the Mental Health
vastly more people, of all ages, will have access to high quality,
intervention, specific to their needs and improvements in health

RIGHT CARE

Must Do's

- Mental Health Prescribing
- Genito-Urinary
- Respiratory
- MSK
- Cancer

The Gap – Why Change is needed

For North Durham the key prevalence areas set out in RightCare are; **Respiratory** - admission rate for lower respiratory infections (adults); admission rate for lower respiratory infections (children); admission rate asthma (children); COPD prevalence; asthma prevalence; **MSK** - admission for MRI; back pain prevalence; fracture rate in 65+; Prevalence of rheumatoid +inflammatory arthritis. **Mental Health (Prescribing)** - spend on primary care prescribing. **Cancers** - higher rate of emergency admissions; overall higher disease prevalence for all cancer types. **Genito – Urinary** - spend on non-elective admissions; send on primary care prescribing; rate of bed days; patients on CKD register treated with an ACE-1 or ARB;

Future State/Ambition for 2020/21

- Better access to excellent care, improved patient experience and greater involvement in decisions about their care for our patients.
- Opportunities to redesign patient care with a focus on prevention and early intervention.
- Active involvement in the redesign of patient journeys across primary and secondary care., together with our secondary care colleagues.
- Plus, support to meet the requirements of the Carter Review to reduce unwarranted variation.
- Closer working with our LA colleagues in a transparent way for how limited resources are prioritised, helping meet legal duties under the Health and Social Care Act 2012 to reduce health inequalities.
- Partnership working to develop a common view of what 'excellent' looks like and promote opportunities for clinical engagement and reform including opportunities to reduce whole system costs
- an opportunity to embed a proven approach that delivers better outcomes and reduces variation across North Durham and our borders.

Benefits

Cancer and tumours: A reduction in mortality from all cancers: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard
•Reduction of expenditure cancer programmes of care.
•Respiratory conditions: A reduction in mortality from respiratory disease: Under 75 Directly age-standardised rates (DSR) per 100,000.
•Reduction of expenditure on respiratory programmes of care.
•Reduction of expenditure on Primary Care prescribing items where identified as appropriate.
•Musculoskeletal issues: An increase in % of patients aged 75+ years with a fragility fracture treated with an appropriate bone-sparing agent - Excludes Trauma

Priority CCG Milestones/Tasks	Q4 17-18	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19
Identify our opportunity using the RightCare approach					
Develop plans for each opportunity with clinicians					
Implement pathway changes					

DEMENTIA

(The University of Oxford, Health Foundation, University of Bradford and London School of Economics initiative)

Must Do's

Implement three changes to improve care at no additional cost →

- 1 quick-win (2017)
- 2 changes (2018 & 2019)
- 3 Track outcomes & indicators
- Potentially realise savings

Make commissioning process more inclusive and assess benefit of this approach

Raise awareness of available services to improve health outcomes and maximise ROI

Priority CCG Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Map locally available services								
Implement initial quick-win (likely to be related to currently underused out-of-hours services)								
Implement change 2								
Implement change 3								
Improve awareness of available services among clinicians (date TBC)								
Improve awareness of available services among patients and carers (date TBC)								

The Gap – Why change is needed

- Becoming greatest area of NHS spend - care needs to be more effectively/efficiently provided
- Ageing population
- Lack of awareness of available services and pathway among clinicians, patients & carers and commissioners
- Likely unwarranted variation in care
- Underuse of available services
- Delays in accessing available services
- Lack of coordination between different sectors
- Health provision for dementia lacks cohesion
- Unnecessary hospital admissions & bedblocking
- Likely underuse of voluntary sector
- Absence of a strong message around dementia prevention
- Complexity of navigating dementia care system
- Complexity of referral pathways
- Hostility of the hospital setting (lack of training around dementia for hospital staff; lack of dementia-friendly environments)
- Lack of advance care planning for carers to avoid crisis
- Lack of crisis support services specific for dementia
- Lack of support for carers
- Inadequacy of out-of-hours services

Future State/Ambition for 2020/21

- Implement a more collaborative and transparent approach to commissioning and providing dementia care. This means bringing together people living with dementia, their carers, care providers, commissioners and other relevant stakeholders.
- Reduce use of higher-cost interventions and services by maximising benefit of lower cost services that are either currently available or prospective.
- Widespread and uniform awareness of what is available among clinicians and patients
- Shared understanding of dementia care pathways
- Physical and mental crisis: Improved preparedness and understanding
- Capitalise on pre-existing third-sector groups that have first-hand insight and can pre-empt the needs of people affected by a recent diagnosis – either as a patient or a carer
- Established support system for carers

Benefits

- Raised awareness will reduce waste in services currently not being used at or near capacity
- Reducing inefficiencies will lead to increased resources for possible reallocation
- Reduction in emergency readmissions – less costly and implies better health outcomes
- Better universal understanding will lead to better use of care across County Durham
- Improved advance care planning will:
  - allow people living with dementia to live independently for longer
  - allow carers to feel more supported from point of diagnosis or even prior to this
- Accessing third-sector support groups will provide social benefits and reduce reliance on primary care

Learning Disabilities

Out of hospital collaboration

Must Do's

- Deliver Transforming Care Partnership plans with local government partners & enhancing community provision
- Improve access to healthcare for people with learning disability
- Reduce over reliance on inpatient bed capacity and inappropriate admissions
- Reduce premature mortality by improving access to health services, education and training of staff

Future State/Ambition for 2020/21

Our ambition is for the footprint is to be as good as anywhere in the world to live for people with a learning disability and / or autism and a mental illness or behaviour that challenges. This covers all ages. This vision was developed by all partners and stakeholders, including people with a learning disability, families and carers. By developing community infrastructure, supporting workforce development, avoiding crisis, earlier intervention and prevention the North East and Cumbria will be able to support people in the community so avoiding the need for hospital admission.

The North East and Cumbria Learning Disability Transformation Plan and the Yorkshire Transforming Care Plan aims include less reliance on in-patient admissions, developing community support and alternatives to inpatient admission, prevention and early intervention, avoidance of crisis and better management of crisis when it happens to create better more fulfilled lives.

The Gap – Why Change is needed

- The current experience for people with learning disabilities within the footprint is very varied. This is, in part, apparent by looking at the data but also by listening to the stories of service users, families, providers and commissioners. However, there are many challenges in understanding the true picture because of a lack of consistent data across the whole system. We understand pockets of activity such as for patients inpatient settings, but on the whole we have poor visibility of what people's needs are, how they are currently being met (or not), and what issues they are encountering.
- Data shows that although a proportion of patients in specialist learning disability inpatient settings require this type of care, many of them could be managed in the community. The data also shows that people often stay in inpatient settings for longer than necessary, with some people admitted for very long periods of time (up to 25 years).
- The pace of transformation in respect of the community infrastructure is paramount in facilitating the safe reduction in inpatient beds across the locality. Without the matched level of investment and resource the demand on inpatient beds will continue to be a pressure. This is further influenced by the changes in commissioning across NHSE Specialised Services, which will see less treatment programmes being delivered in secure settings and more patients being managed in the community. The transfer of patients through the rehabilitation pathway will require the CCG to ensure that the necessary settings are available to safely respond to patients with associated behavioural and forensic needs.

Benefits

- Less reliance on in-patient admissions, delivering a reduction in avoidable admissions to inpatient learning disability services and delivery of a commissioned bed reduction trajectory by 2020.
- Developing community services and alternatives to inpatient admission
- Prevention, early identification and early intervention
- Increasing the number of annual health checks and health promotion/prevention programmes
- Avoidance of crisis and better management of crisis when it happens
- Better more fulfilled lives.
- Improved quality of life
- Improved service user experience

Priority CCG Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Increase the proportion of patients with LD having an annual health check								
Conduct reviews into premature deaths for those with a Learning disability								
Increase cancer screening rates for patients with a learning disability								
Carry out eye screening for patients with a learning disability								
Increase flu vaccination rates for patients with a learning disability								
Reduce the number of patients with a learning disability in a specialist inpatient setting where they ca be managed in a community setting								

WORKFORCE

Must Do's

- GP Career Start Scheme
- Updating workforce strategy
- Nursing Career Start Scheme
- Development of workforce plan for community hubs

The Gap – Why Change is needed

There is duplication in the delivery of out of hospital care with some patients receiving multiple visits from health care staff in the same day. We would like to reduce duplication wherever possible and have teams focussed on the care of the individual rather than being constrained by the contractual requirements and specifications of individual health care services.

Individual sectors struggle with staffing in some cases. Creation of an integrated workforce will enable the development of rotational roles.

In addition to this the CCG is continuing a programme of work to sustain General Practice including work on recruitment and productivity.

Future State/Ambition for 2017/19

The system change required is the creation of functionally integrated holistic teams at a local level. These teams will include community services, allied health professionals, social services, and specialist nurses and will be linked to GP practices following the Primary Care Home model.

This will require a flexible and integrated workforce with the ability to Organisational development addressing cultural change and new ways of working is essential for the new model.

Modelling of staffing structures for TAPS models is underway. Further work is required on a cross sector workforce model. The CCG will co-ordinate a mapping exercise that will ascertain the community nursing, specialist nurses and social care staff required at local or wider population level. This will also be within the aligned notional budgets from each provider in the TAPS.

The CCG has developed a primary care workforce strategy and has developed a career start scheme for GPs and nurses. Further work is required on a health and social care workforce model.

North Durham CCG and the 3 primary care federations have been successful in becoming a Community Provider Network for Durham. This will increase our focus as a learning organisation and increase the opportunity for more GP and Nurse trainee primary care placements.

We will give flexibility to community hubs to determine their own staffing structure in future. Vacancies will be filled in services based on the need s of the local population.

The three GP Federations are fully supportive of the workforce strategy and work closely with the CCG for their constituent practices .

Benefits

Reduction in vacancies across primary ad community care
Reduction in duplication of patient contacts
Increased staff satisfaction
Increased patient satisfaction

Priority CCG Milestones/Tasks*	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Development of staffing model for each TAP	■							
Development of cross sector workforce model	■	■						
Continuation of career start schemes for GPs and nurses	■	■	■	■	■	■	■	■
Continuation of schemes to support recruitment in General Practice	■	■	■	■	■	■	■	■
Extension of clinical pharmacy working in General Practice	■	■	■	■	■	■	■	■
Work with Federations to develop a locum bank to support local practices	■	■						
Support Practices to train/use Physicians Associates within General Practice	■	■	■	■				
Use of Mental health therapists working directly in support of General Practice	■	■	■	■	■	■	■	■

OPTIMAL USE OF THE ACUTE SECTOR

Must Do's

- Improve quality of care
- Measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services
- Implement the national maternity services review, Better Births, through local maternity systems
- Progressing population-health new care models
- Improving the management of continuing healthcare processes
- Support the implementation of urgent and emergency care strategy

Future State/Ambition for 2020/21

Our future state and ambition is to :

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

The Gap – Why Change is needed

- We need to assess our services in meeting over 700 standards set by the Royal Colleges, NCEPOD and Emergency Care Academy.
- We need to develop optimum evidence based **pathways of care** to improve outcomes and reduce variation working alongside academic bodies (e.g. NICE), Clinical Networks and Senates. Use analytical and modelling tools such as Right Care
- As healthcare is becoming increasingly specialised it is becoming more difficult to have that level of expertise available in every hospital for every service.
- Changing patterns of need; medicine is advancing with revolutionary new treatments saving and transforming lives. As well as living longer, the nature of illness is changing with far more patients with chronic long term conditions rather than a brief acute illness that resolves within days
- Our challenge is the availability of a specialist workforce at consultant and senior doctor level. We need to address this so that to ensure consistent specialist consultant decision making , 7 days a week, 16 hours per day and where this applies to a major trauma centre 24 hours per day.
- Our population and our specialist consultant medical workforce are in balance but spread over too many hospitals to respond to the medical advances now and in the foreseeable future

Benefits

- 100% delivery of the clinical /quality standards
  - 7 day consultant presence
  - 16 hours per day Consultant specialist access
  - Over 75% of patients assessed by a Specialist Consultant on admission and 100% assessed within 12 hours by a Consultant
- Less variation in outcomes across the system, e.g.,
  - Top 3 outcomes for each service agreed by Clinical Leadership Group, for example, hyper acute stroke, 18 weeks, patient cancellations, obstetrics and neonatal services.
  - Operational excellence in contributing to better value for money
  - Better retention and recruitment of highly skills consultant and clinical staff with reduced spend on locum staff.

Priority CCG Milestones/Tasks	**16/17** Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Implementation of local CCG acute pathway reviews using support tools such as Right Care (Phase 1) T&O, ophthalmology, breast services, dermatology,. colorectal									
(Phase 2) Implementation of local acute pathway review, Paediatrics, neurology, vascular , radiology, gastroenterology									
Outline case for change and consultation for local pathway reviews									
Establish governance and PMO arrangements for oversight and delivery STP level Optimum use of the Acute Sector.									
Undertake clinical standards assessment and workforce modelling for STP level Optimum use of the Acute Sector									
Undertaken modelling work for the Optimal Use of the Acute Sector , including workforce and finance									
Engagement work with partners, patients and the public									

[DIGITAL CARE AND TECHNOLOGY TEMPLATE]

Must Do's

A treatment summary is sent to the patient's GP at the end of treatment	Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups	Provider efficiency measures include: implementing pathology service and back office rationalisation
Ensure the sustainability of general practice	Investment in training practice staff and stimulating the use of online consultation systems	All patients have a holistic needs assessment and care plan at the point of diagnosis
Enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes	Deliver a reduction in the proportion of ambulance calls that result in avoidable transportation to an A&E department	Measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services

The Gap – Why Change is needed

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

Future State/Ambition

- More patients treated locally preventing the need for care outside of the local community
- By 2021 we will make a lasting contribution to the health and well-being of our population through the sharing of information securely and effectively. By end 16/17 we will have in place a critical milestone to this – sharing of GP records across all providers.
- The Great North Care Record will make information more widely available and accessible to support frontline care, individual self-management, planning and research.
- Through the use of TECS patients, carers and citizens will use digital technologies to be able to feel more in control of their condition
- A significant in crease in the level of digital maturity of secondary care providers
- Digitally enabled health and care system with a move from isolation to integration.
- A paper free system with information flowing seamlessly between primary, secondary and social care digitally

Benefits

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

Milestones/Tasks	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
First steps towards achieving a Great North Record via Medical Interoperability Gateway (MIG) Project. Data flows with 12 North East Receiving Organisations including (A&E, Urgent Care, OOH, Ambulance) to view patient information at the point of care . Information Sharing agreements signed off via Information Sharing Gateway System (ISG) regional approach.	(NE U&EC MIG Project Closure Expected Mar-17)							
CCGs will continue to work with partners and practices to maximise existing technologies and national solutions where appropriate as well as deliver interoperability solutions which support structured messaging, sharing of patient information views. Deliver robust IT infrastructure, mobile working, patient self care technologies and systems. Enable research and pilot initiatives to support better patient pathways.								
County Durham & Darlington Foundation Trust to Procure & Implement Electronic Patient Record System which will provide the foundations to allow interoperability and integration to be achieved as part of the digital programme of work.								
Tees Esk and Wear Valleys Foundation Trust to deliver the Civica PARIS system programme and transfers of care which will support the digital programme of work.								
Durham County Council to procure new Social Care Systems for Children's and Adult social services. Strategy is to look at existing systems within the health and care community to ensure integration and interoperability can be achieved with the chosen solution. Promote and extend delivery of the Child Protection Information System across the region.								
Darlington Borough Council to implement Liquid Logic for Children's and Adult social services. Extend access to the system with care providers via information sharing agreements. Subject to availability of National Adapter Service - implement a solution to support information transfer to social care including assessments discharge and withdrawal notices . (Joint working with CCGs)								

Digital care and technology

(this is the Local Digital Roadmap summary, vision and pathway to deliver)

Vision – addressing three gaps:

Care and quality

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

Finance and efficiency

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

Health and wellbeing

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

Becoming paper free at point of care

Records assessments and plans

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

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

Care plans will be developed and shared electronically

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

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

Great North Care Record

Transfers of care

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

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

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

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

Decision support

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

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

Alerts about patients issues and preferences will be

Remote Care

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

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

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

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

Orders and results management

All requests for consultation and diagnostics will be done electronically

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

Medicines management and optimisation

Medicines are prescribed electronically

Digital records give a view of all exisiting medications and prescriptions

Asset and resource optimisation

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

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

Supporting infrastructure

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

Connected information

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

Information sharing approach

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

Governance and delivery LHE governance and delivery plans → STP joint working → Regional working