

Joined Up Care Derbyshire

Derbyshire Sustainability and Transformation Plan (STP)

October 21st Submission

Full STP Document

Derbyshire Sustainability and Transformation Plan

Name of footprint and no:

(12) Derbyshire

Region:

Midlands and East

Nominated lead of the footprint including organisation/function:

Gary Thompson - Chief Officer, Southern Derbyshire CCG

Organisations within footprints:

- **NHS Erewash CCG**
- **NHS Hardwick CCG**
- **NHS North Derbyshire CCG**
- **NHS Southern Derbyshire CCG**
- **General Practices across Derbyshire**
- **Chesterfield Royal Hospital NHS Foundation Trust**
- **Derby Teaching Hospitals NHS Foundation Trust**
- **Derbyshire Healthcare NHS Foundation Trust**
- **Derbyshire Community Health Services NHS Foundation Trust**
- **Derbyshire Health United Limited**
- **East Midlands Ambulance Service NHS Trust**
- **Derby City Council**
- **Derbyshire County Council**
- **Burton Hospitals NHS Foundation Trust – Associate Member**

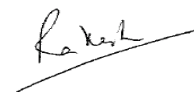
Derbyshire Health and Social Care Community

Statutory Body involvement and sign up to the Sustainability and Transformation Plan

On behalf of our Boards and Governing Bodies, we confirm that our Boards/Governing Bodies have discussed the Derbyshire Sustainability and Transformation Plan, understand the direction of travel as indicated in the iteration of the 21st October 2016 and confirm the support of the Board/Governing Body to continue to work together to develop the plan as we move into implementation of both the sustainability and transformational components.



Gary Thompson
AO Southern Derbyshire CCG



Rakesh Marwaha
AO Erewash CCG



Andy Gregory
AO Hardwick CCG



Steve Allinson
AO North Derbyshire CCG



Tracy Allen
CEO DCHS FT



Gavin Boyle
CEO Royal Derby Hospitals FT



Ifti Majid
Acting CEO Derbyshire Healthcare FT



Simon Morritt
CEO CRH FT



Stephen Bateman
CEO Derbyshire Health United

As Directors representing Derby and Derbyshire Local Authorities we confirm that both Organisations have been involved in the development of the Derbyshire Sustainability and Transformation Plan and that we support the strategic direction detailed in the iteration submitted on the 21st October 2016.



Andy Smith
Strategic Director of People
Derby City Council

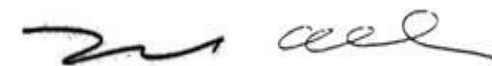


Joy Hollister
Strategic Director
Derbyshire County Council

As Chairs of Derby and Derbyshire Health and Wellbeing Boards we confirm that both Boards have had regular updates on the plan and its strategic direction.



Councillor Martin Repton
Chair Derby City HWB



Councillor Dave Allen
Chair Derbyshire County HWB

Executive Summary

Public Overview of the Derbyshire Sustainability and Transformation Plan (STP)

Health and social care organisations across England have been working together more closely than ever to produce Sustainability and Transformation Plans (STP), to look at improving care and services for people, making them as effective and efficient as possible.

Teams and individuals from across the NHS and Derby City and Derbyshire County Councils have jointly produced Derbyshire's STP, called **Joined Up Care Derbyshire**, which NHS England asked all health and care organisations across the country to produce, detailing priorities for the next five years to 2021.

Joined Up Care Derbyshire has highlighted what services are offered already, where gaps might be, and what changes should be considered to offer everyone the best care, now and in future, using all resources.

The work on **Joined Up Care Derbyshire** has considered feedback and information gained from ongoing conversations with Derbyshire's diverse communities in recent years. It includes many of the existing projects which are already in place and being progressed in partnership with local people.

What we know is that the way we provide services needs to change. Growing numbers of people need treatment. A lot of these people have more than one ongoing complicated health condition, such as diabetes, arthritis, or breathing problems. New technology is available, which provides better support but costs more to run.

Chances to improve people's health and support them to prevent illness, and offer the most appropriate care when they do need it, are being missed.

And by 2021 there will be a £219m financial gap for Derbyshire's health system – with an extra £136m gap for local authority care costs if organisations carry on working as they do currently, and people use services as they do today.

So we know the NHS and social care needs to change

Health and care organisations must work and plan together – looking beyond existing structures and ways of working – to make sure people:

- are kept as healthy as possible
- get the best quality care
- have well-run services which make the most of available resources

To do this **Joined Up Care Derbyshire** has highlighted five key priorities:

1. **More work is needed on preventing ill health and helping people take good care of themselves.** By preventing physical and mental ill health, and getting to grips with issues before they become bigger problems, people will lead happier, healthier lives.
2. **Care could be place-based.** This means services look after and focus on people in their community, rather than being offered at a distance in a particular building. By tailoring services to people and communities patients get better, more targeted care and support.
3. **Emergency care services can be used more effectively.** People should be able to access

the right care, whenever it is needed, so everyone gets high quality support, quickly, across the system. This would help keep accident & emergency, minor injury units and urgent care centres free for patients who really need them.

4. **Health and care organisations can work better together.** By working and planning together any gaps, overlap or doubling up of services can be ironed out to make sure people get the best care, offered in the most joined up and helpful way. Patients and users of services should only have to give their information once. Everyone should get the same high quality, well-organised services.
5. **Organisations need to be efficient** to make sure as much money as possible is pumped into services and care and running costs of providing these are kept low.

Health and social care services would fit the needs of communities recognised by local people, across the whole of Derbyshire. This would help keep quality and services consistent for everyone, and specialist, residential or hospital care would still be available for those in need of it.

21 communities have been identified for the whole of Derbyshire and they would:

- Give patients who have lots of health needs the support they need to stay well at home so they recover fully and more quickly
- Put £6.5 million into making sure people can access services when they need them, including evenings and weekends, and see a doctor, advanced nurse practitioner or other appropriate clinician
- Support 2,500 health and social care staff to focus care out in communities, where it is needed, in GP practices, pharmacies, social care, mental health, opticians, and other providers
- Offer more support to approximately 50,000 people across the city and county who have the greatest health needs, so they get extra help from professionals
- Give better care to approximately 150,000 patients who have ongoing issues such as high blood pressure, asthma and diabetes
- Reduce the number of people being unnecessarily treated in hospital, community or residential care when it is not best suited to their specific needs – instead giving them appropriate services, closer to home

During the next five years the plan will continue to evolve and develop and there will be opportunities for Derbyshire people to share their views to help make services the best they can be.

For more information, and to find out in coming months about how to get involved please visit www.southernderbyshireccg.nhs.uk/joinedupcarederbyshire

Any changes proposed to current services would involve local engagement and, if appropriate, consultation. Any consultation would follow legal guidance, and involve as many local people as possible.

Derbyshire STP – ‘plan on a page’

The summary below provides a high level overview of the Derbyshire STP

(1) The gaps

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the County:

- Fundamentally, we know that across Derbyshire people are living longer in ill health and significant inequalities exist
- We have made significant progress with beginning to ‘join up care’; however, there remain many opportunities to integrate care more effectively and consistently. We are still overly reliant on bed-based care
- We also know we have significant improvements to make in Primary Care and Urgent Care, as well as ongoing improvements in a number of other areas
- The financial gap for the Derbyshire health system is £219m, with a further £136m gap across the two local authorities (LAs) - there are a number of factors that are driving this position

To tackle the gaps requires transformational changes to the way in which care is provided.

To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole.

(2) Our priorities

Five priorities form the core of our Sustainability and Transformation Plan:

- **Place-based care:** We will accelerate the pace and scale of the work we have started to ‘join up’ care to operate as a single team to wrap care around a person and their family, tailoring services to different community requirements across our 21 places.
- **Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing
- **Urgent Care:** Transforming urgent care provides our single greatest opportunity to address fragmentation and unwarranted variation
- **System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers
- **System management:** Our organisations’ leaders will come together to manage the Derbyshire system through an aligned leadership and governance approach

(3) Impact & Implications

Delivering our STP will help us to:

- **For the people of Derbyshire:** meet our aims to keep people: (i) **safe & healthy** – free from crisis and exacerbation; (ii) **at home** – out of social and health care beds; and (iii) **independent** – managing with minimum support. We will begin to **address lifestyle issues** related to poor health and will **improve access** to urgent and routine care.
- **Achieve a financially sustainable system:** the combined impact of the priorities described will enable us to achieve a **financially balanced health system by 2020/21**.

We will significantly change the ‘shape’ of the system:

- **£247m more care delivered through Place** (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings
- Major changes to the workforce – **2,500 more staff delivering place-based care** (c.10% of our current workforce)
- Reduction of bed-based care – **535 fewer beds** (c.400 acute; 300 within Derbyshire system)
- And, changes to the physical configuration of place-based services

(4) Next steps

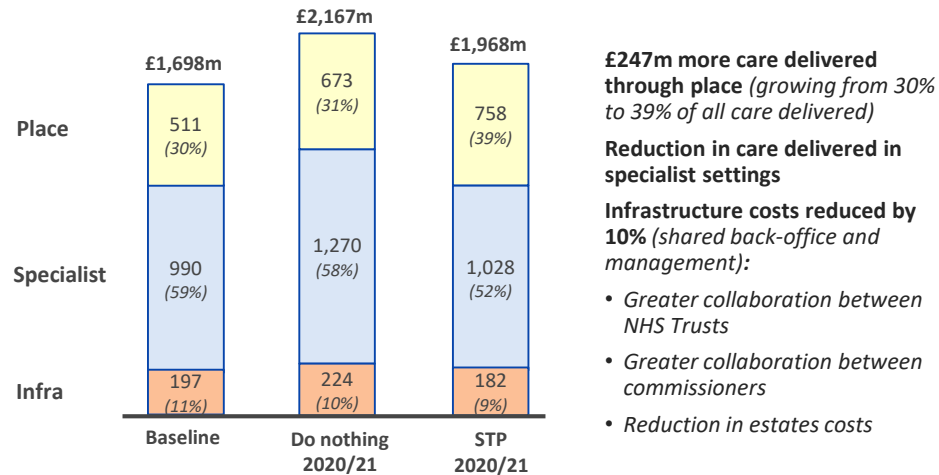
Delivering the STP:

- The work over the next five years to deliver our STP is part of and consistent with our ongoing journey – more place-based care to reduce the current reliance on institutional care. We will accelerate the pace and scale of these changes to have the necessary transformational impact
- We now begin the transition from planning into delivery (including through the revised 2 year contracting process)
- During the next 6 months we will:
 - Establish our system delivery team
 - Define and implement revised 2 year contracts monitored through the system-based architecture
 - Commence delivery of a number of high impact transformation schemes to support immediate sustainability
 - Continue our localised engagement programme focussing on staff, stakeholders and our local population.

Implications for the 'shape' of the system

The combined impact of the priorities will result in a significant transformation of the 'shape' of the system, more place-based care reducing the current reliance on institutional care. Clearly, this will result in (& rely upon) major changes to the workforce, our use of bed-based care and the physical configuration of services.

'Shape' of our system (costs)



Workforce implications

2,500 more staff delivering place-based care (c.10% of our current workforce)

Managing the transition - our workforce of 5 years time is predominantly the workforce we have now. This means that we must invest to support our workforce to transition into the Places with the skills and competencies our population needs.

Cultural change of focus:

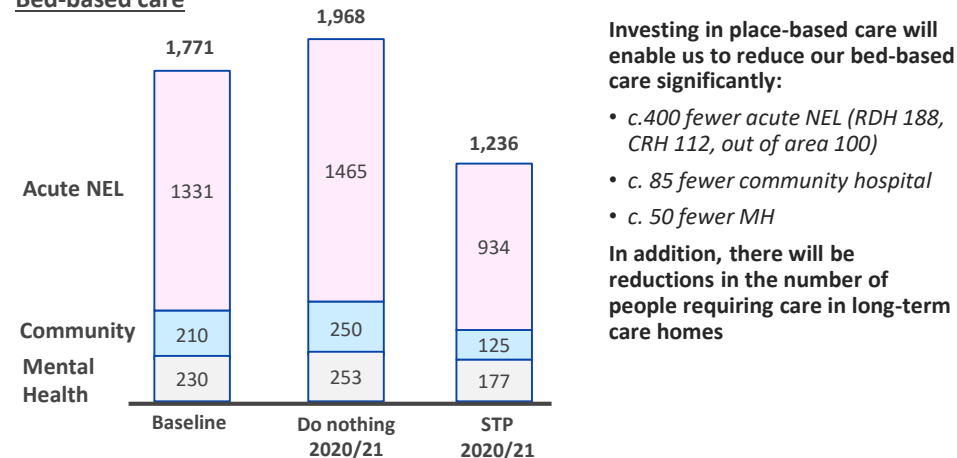
- Encourage and empower people to share decision-making about their care
- Provide person-centred care, engaging people, their families and carers as partners
- Deliver integrated place-based services which transcend organisational boundaries

Develop and attract key skills / capabilities / roles:

- Increase the number of people who enter into our **care workforce**, be that in private, voluntary, Local Authority or health provision
- Increase the number of **Advanced Clinical Practitioners**, drawing this workforce from not only nursing but AHP, Paramedic and Pharmacy workforce
- Ensure the supply of **medical (including GPs), therapy and nursing** workforce by being a place where learners thrive and wish to stay

We will use a **collaborative cross-system approach** (including health and social care) to employing, rewarding and developing our workforce

Bed-based care



Physical configuration of services

The development of place-based care and the greater integration of services and organisations will require:

- The development of place-based 'community hubs / networks' – aligned to local service needs (e.g. urban/rural) – fully integrated with Primary Care. This will mean, in some places, the reconfiguration / redevelopment of community (health and LA) and primary care facilities, and that MIUs/WICs will not exist as standalone services.
- Less bed-based care: c.12 fewer acute wards in Derbyshire; c.4-5 fewer community wards; 1-2 fewer specialist MH & 1 fewer dementia care wards).
- Some of the community hospital sites may not be required; others will play a key role within community hubs.
- The development of co-located Urgent Care centres at ED sites.
- Rationalisation of back-office facilities.

Section 1: The gaps

- The challenge and case for change

Overview of the Derbyshire STP footprint

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of the county.

Diversity, affluence and deprivation

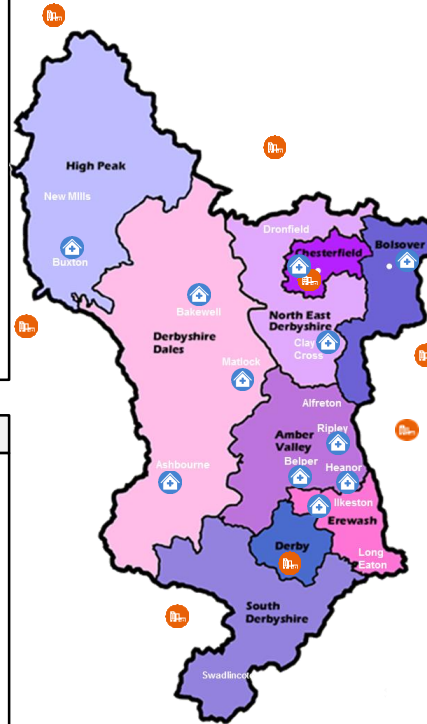
- High deprivation in Derby and the North East contrasts with affluence in the Dales and South West
- Dense urban communities in Derby and North East; rural comparatively isolated communities in the North and West
- Smaller urban centres a mix of more affluent market towns and more deprived ex-mining areas
- Rich cultural mix across Derby city, compared with 97.5% white British in the county

Our STP must be flexible to meet diverse needs – in relation to both geography and population. To achieve consistent quality we must not take a 'one size fits all' approach.

Demographic and health needs

- Total population over 1 million people. By 2033, 27.5% population will be over 65. By 2025, the number of over-75s will be more than 40% higher than today
- Life expectancy in Derbyshire county (M: 78.9, F: 82.7) is similar to the England average (M: 78.9, F: 82.8), while life expectancy in Derby city (M: 78, F: 82.2) is lower than the England average
- Life expectancy increases have slowed in recent years
- Obesity is higher than the national average in all four of our CCG areas.
- The proportion of mothers that smoke at the time of delivery (14.6%) is in the highest quartile of STP areas nationally
- The number of diabetes patients achieving all NICE-recommended treatment targets is in the lowest quartile of STP areas nationally

Our STP must be both realistic about the challenges we face, and ambitious in tackling them – particularly in addressing the causes of ill health to slow future increases in demand.



Acute Hospital



Community Hospital

(Note: Heanor Hospital is currently being re-developed)

A wide range of health and care commissioners and providers

- Four CCGs (Erewash, Hardwick, North Derbyshire, Southern Derbyshire), two local authorities (Derby City, Derbyshire County)
- Two acute Foundation Trusts in Derby (Royal Derby Hospitals) and Chesterfield (Chesterfield Royal Hospital)
- One community Foundation Trust (Derbyshire Community Health) and one mental health Foundation Trust (Derbyshire Healthcare))
- 119 GP practices (reg. pop. ranges (2-25k), plus Out of Hours provider
- Residential and care home providers
- Ambulance Trust – East Midlands-wide and a Vanguard MCP in Erewash

Our STP must provide a common framework – and, importantly, aligned incentives - for us to work together.

'Out of county' healthcare provision

- Significant patient flows to acute hospitals in Sheffield, Nottingham, Mansfield, Burton and Stockport
- Specialist/tertiary care is provided from Sheffield and Nottingham

Our STP must be sensitive to reflect the current flows between Derbyshire and neighbouring footprints.

Health and care spending

- Current health spend £1,698m. Spend is forecast to grow by 23% over by 2020/21 of which 11% is cost inflation and 12% is activity growth
- £30m 'outflow' of elective activity to 'out of footprint' providers, £16m 'inflow' of non-Derbyshire patients – net 'outflow' of £14m

Our STP must tackle and address the forecast growth in health and care service demand.

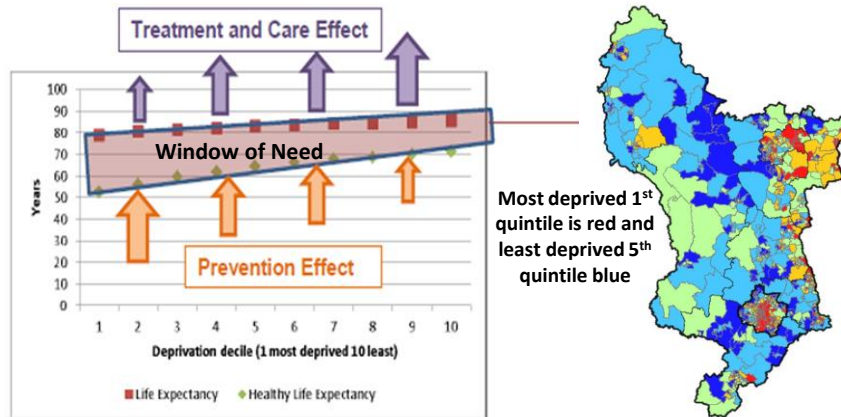
The health and wellbeing gap

Fundamentally we know that across Derbyshire people are living longer in ill health and significant inequalities exist...

More people in Derbyshire are living longer in poor health due to a combination of increasing life expectancy and decreasing healthy life expectancy. Therefore the period in people's lives when they require health and social care support is steadily rising (the 'window of need'). We are in the worst quartile of STP areas for key indicators of preventing disease (e.g. the number of mothers smoking at time of delivery) and reducing the impact of established disease (e.g. the number of diabetes patients to achieve all three NICE-recommended treatment targets).

We also know there are marked inequalities in healthy life expectancy. People who live in the more deprived communities in the footprint or are part of certain groups such as those with severe and enduring mental health or learning disabilities spend more of their lives in ill health.

There is increasing evidence of the importance of emotional health and wellbeing in early years. However, across Derbyshire only 25% of people get the support they need. Early intervention and prevention in childhood can avoid expensive and longer term interventions in adulthood.



Deprived communities have greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services.

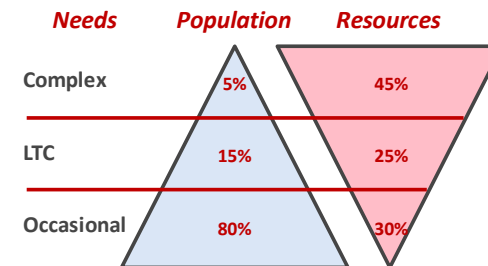
These wider determinants of health underpin lifestyle risk factors such as smoking, physical inactivity and poor diet, which are most prevalent in these communities.

The table below shows the variation in lifestyle and behaviour between our most and least deprived areas. Almost all are notably higher in the deprived communities.

Healthy behaviour (% of population)	Most deprived 10%	Derbyshire Average	Least deprived 10%	National Average
Healthy eating adults	22.1	28.8	34.9	28.7
Binge drinking adults	19.5	21.3	20.5	20.1
Under 18 conceptions	2.9	2.0	0.2	1.5
Regular smokers (aged 15)	12.4	9.8	7.9	8.7
Obese adults	27.4	24.9	21.2	24.2
Obese children in reception	10.0	8.8	7.0	9.4
Obese children in year 6	22.7	18.0	13.6	19.1

Because people are living longer with ongoing needs, and given the way health and care services are currently organised, consumption of resources occurs in a wholly disproportionate manner.

Within a population or given locality, around 5% of the population consume around 45% of the health resource. These are patients with complex chronic conditions. A further 15% have at least one long-term condition (e.g. diabetes) and this group consume a further 25% of the healthcare resources. In total this means 20% of the population consume 70% of the care budget. Much of the care received and contributing to this cost could be avoided by interventions 'upstream' that would improve quality of life and independence.



The care and quality gap

We have made significant progress with beginning to ‘join up care’; however, there remain many opportunities to integrate care more effectively and consistently and we are still overly reliant on bed-based care...

The lack of joined up care...

Services are not integrated effectively:

- Fundamentally, our health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care).
- These services are often characterised by organisation and role boundaries, not a system that is centred on people and communities.
- Individuals and teams do not work in an integrated way and are often conflicted and constrained by organisational priorities.
- Our services are struggling to meet the increasing demand for ongoing complex care (social, physical and mental) the way they are currently delivered.
- People with such needs often experience care that:
 - (i) does not support their independence and control;
 - (ii) is fragmented and difficult to navigate;
 - (iii) results in a poor quality of life for both the patients and their carers.

Care is not proactive:

- We do not routinely and systematically identify and support people with complex ongoing needs.
- Mechanisms for information sharing, care planning and care coordination are generally ineffective.
- There are occasions where harm could be prevented for vulnerable people (e.g. pressure ulcer and falls)

Results in...

Our system being overly reliant on bed-based care...

Frail elderly patients decompensate:

- Elderly patients sometimes spend too long in bed-based care (acute and community) causing physical, psychological, cognitive and social deconditioning resulting in lost independence.
- In our system, 1% of the population (c.10k people) account for 25% of our NEL admissions and 64% of our NEL beds. Of these patients, once admitted patients who stay more than 14 days account for 573 beds, of which 477 beds are used by patients aged over 65. These patients are usually complex in terms of the support they require and a fall often plays a part in their admission to hospital. In addition, >95% inpatient community hospital care supports people >65 years.

Patients are not supported to be independent:

- Adults of working age requiring admission for mental ill health stay in hospital longer than the England average, leading to bed occupancy of 100% and some being treated outside of Derbyshire.
- Derbyshire is an outlier for numbers of people admitted to care homes, key drivers are short-term stays leading to long-term stays and overprescribing of care home use on discharge from hospital.
- People with a learning disability and/or autism in Derbyshire are more likely than the national average to be receiving care in inpatient settings.
- Too many people with dementia are hospitalised which can have negative impacts on both physical and mental health, making a return home difficult.
- Current services for people with learning disabilities are fragmented, inequitable, overly reliant on bed-based care and offer poor value for money.

And...

Doesn't always provide care in the right settings...

Delayed transfers:

- Reported 'Delayed Transfers of Care' performance is in line with the standard, and overall performance across the STP footprint is in the best quartile nationally. However, local experience highlights flow and discharge issues.

Avoidable admissions:

- Patients are being admitted to hospital when they could be cared for in alternative, more appropriate ways if the necessary services were available. This includes care for our frail elderly patients but also ambulatory care for acute conditions (in particular UTIs and pneumonia) and chronic conditions (in particular COPD and heart failure).

End of life care in acute hospitals:

- Within Derbyshire, 48% of deaths occur in hospital.

Our most fundamental challenge is therefore posed not by any individual service, but by the overall shape of the current system and lack of joined-up care.

The care and quality gap

We also know we have significant improvements to make in Primary Care and Emergency & Urgent Care as well as continuous improvements in a number of other areas...



Primary Care

- Increasing pressure on General Practice due to increased demand; push for extended hours; complexity of patient needs; inability to attract / retain workforce; financial uncertainty.
- Variation in screening, early diagnosis and chronic disease management , means impact on quality of life, independence and life expectancy.
- Latest GP patient surveys highlight 15-25% patients waited a week or more for appointment (England av. = 18%). Overall experience of GP services is close to the national average.
- Lack of infrastructure/culture to support working at scale
- Of 48 practices rated, 2 are 'inadequate', 5 'require improvement'; many practices facing sustainability issues.



Urgent and Emergency Care

- Uncoordinated points of delivery, inequitable access, limited integration with General Practice is confusing due to inconsistent service provision – lack of clarity and confidence fuels acute setting as the default.
- Does not currently provide consistent care 7 days a week.
- 4 hour wait A&E performance av. for 15/16 = 93% at CRHFT and DHFT. A&E activity at acute providers has increased c.7% in past year.
- In Derbyshire's most rural areas MIUs are not fully utilised. Significant opportunity exists to better integrate MIUs with Primary Care, out of hours services and ambulance services.
- Ambulance response time standards not met 36% of the time; 44% of ambulance arrivals do not result in admission to an acute provider; conveyance from ambulance to ED is higher than rest of E. Midlands (8%).
- Reliance on acute and community (health and social care) beds is placing patient safety at risk as alternatives are not clear, easy to access or responsive and integrated.



Elective care

- Meeting RTTs, except: Ophthalmology, Oral Surgery, General Surgery, Urology, T&O and Plastics.
- Contacts with secondary care are not always valuable.
- Elective services largely delivered within acute hospital.
- Fragmented, siloed , duplicated services and a lack of end-to-end integration.



Cancer

- Access to cancer treatment within Derbyshire is currently better than the standard for 2 week waits; 31day and 62day performance is variable.
- 162,000 people in Derbyshire smoke. 80% of lung cancer (and up to 25% of strokes) are attributable to smoking.



Mental health

- Variable access to IAPT treatment.
- Increasing prevalence of dementia requires continual improvements to access. Current estimated diagnosis rate is above national average.
- Mental Health Nurses – difficult to recruit to band 5s, national shortage leading to use of temporary staff.



Care for Children and Families

- Services focus heavily on provision rather than on enabling children, young people and families to respond to their own needs.
- High-cost placements for vulnerable groups create pressure on provision.
- Waiting times need to be improved. Current data shows long waiting times for Autism, Clinical Psychology, Community paediatricians.



Acute Provider quality

- CQC: RDH 'good'; CRH 'requires improvement' – key themes: levels of registered nurse at night; patient flow; monitoring of deteriorating patients on wards and HDU; specific improvements required in paediatric care; difficulties in recruiting nursing and medical staff.



Workforce and skills

- There are whole-system challenges related to retaining, developing and attracting our workforce e.g. East Midlands accounts for 9% of population and receives 7% of junior doctor training posts.
- Existing ways of working and associated staffing models find it difficult to provide the capacity for developing and expanding proactive care and community based services.



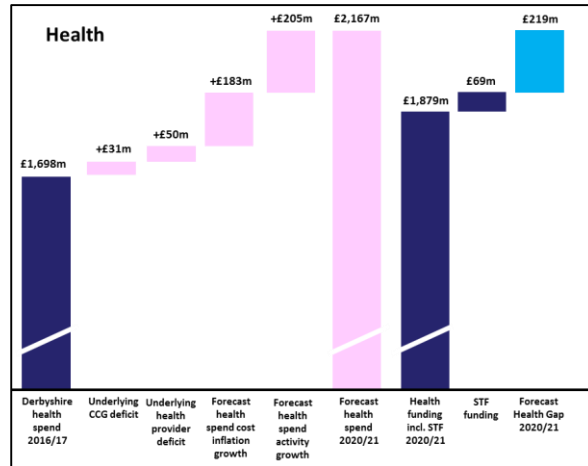
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- There is no single record of an individual's health and care that is accessible to the person and care professionals in the system.
- Data systems across health and care are not integrated or standardised.
- Use of telehealth and telecare to support people, particularly those with long- term conditions, is still embryonic.

The finance and efficiency gap

The financial gap for the Derbyshire health system is £219m, with a further £136m gap across the two LAs - there are a number of factors that are driving this position...

The financial gap across the Derbyshire health and care system is forecast to be £329m by 2020/21. This consists of an NHS gap of £219m (10% of forecast spend) and a social care gap (public health, adults and children) of £136m.



Although the nature and drivers of the challenge in health and care are different, we recognise the crucial interdependency between the systems, and of the services they provide to people and how this affects, and is affected by, their collective financial position.

However, given where the Derbyshire Sustainability and Transformation Plan governance arrangements have reached in terms of their evolution, the current focus of the plan is on addressing the NHS part of the health and care financial challenge. Local Authority leads will continue to play a critical role in the planning and delivery of the STP as we continue to develop our joint working arrangements and ensure we exploit opportunities and mitigate risks together. The Derbyshire NHS finance and efficiency gap is driven by a number of factors:

- Resources are not keeping pace with the rising demand and costs.** Both cost inflation (c.2.5% p.a.) and activity growth (c.3% p.a.) will place significant additional pressure on the health system over the next five years. Meeting the overall financial challenge will require us to tackle both of these.
- These pressures are further intensified by underlying structural financing issues.** Specifically the underlying deficit at Royal Derby Hospitals driven by the PFI arrangements (as identified in the Monitor 'Drivers of the Deficit' report), and cuts to social care and other Local Authority services translating into both increased NHS activity and, importantly, reduced support for the wider determinants of good health.

- Increasing productivity is challenging.** Unwarranted variation is increasing the cost of care, increasing opportunity cost through increased claims on clinical time, or both. Our fragmented system means not only testing and diagnosis, but also the associated clinical administration, as well as back-office functions, are duplicated, and service improvements and good practice are not shared.
- Inefficient care models are driving up costs and imposing significant opportunity costs.** Insufficient focus on prevention, self-care and care planning, treating people in the wrong care setting, all push up the cost of care. This is most obvious in the occupation of expensive acute beds by patients who do not need to be there, or whose admission could have been avoided. Such inefficiencies also lead to staff frustration and so to lower morale, recruitment and retention problems, leading ultimately to reduced staff productivity and increasing reliance on high-cost bank and agency staff. Lack of coordination also means duplication of information systems and the time required to use them.
- Duplication of functions across health and care organisations.** There are four Clinical Commissioning Groups in the Derbyshire footprint all with similar skills and capabilities delivering the same functions. In addition there are four NHS FTs with duplicated back-office and administration functions. This duplication is magnified even further by including the two Local Authorities.
- Inefficient use of estate.** The fragmentation of our services and organisations means that our estate is under-utilised. This means that building costs are higher than they need to be, opportunities for improving efficiency through effective co-location are missed, and some services could be provided much closer to patients if our building utilisation were coordinated centrally around people's needs.
- Perverse payment and incentive arrangements.** Currently, each of our organisations is expected to maintain financial balance each year – irrespective of whether this use of funding – and the pattern of services which drive it – is optimal for our system or population as a whole. This means that:
 - Organisations must strive to improve their own financial position even if an alternative arrangement would be more beneficial to the system as a whole (for example increasing elective referrals to secondary care which could be either avoided or treated in community settings); and
 - Organisations must focus on their in year financial position over longer-term plans, even when these will ultimately be better for both patients and system efficiency (for example investing in prevention).

Section 2: Our priorities

- The basis of our plan

So, what does good look like?

Within Derbyshire, to tackle the health & wellbeing, care & quality and financial gaps, requires major changes to the way in which care is provided. To direct the changes we have defined an aiming point - a place-based care system which is effectively joined up with specialist services and managed as a whole – and a set of 5 ‘levers’ through which changes will be planned...

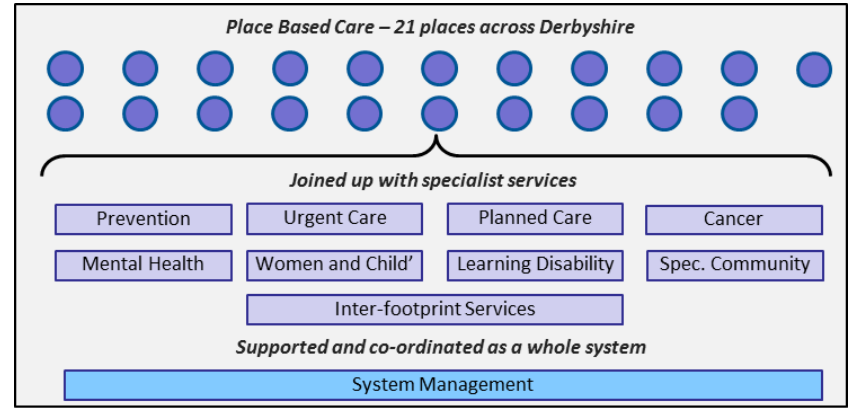
Fundamentally, we want the Derbyshire system to keep people:

- **Safe & healthy** – free from crisis and exacerbation.
- **At home** – out of social and healthcare beds.
- **Independent** – managing with minimum support.

...which will be founded on building strong, vibrant communities.

Specific areas of focus are chronic disease management, co-morbidity of mental and physical ill health, and frailty - supporting people to feel competent about self-care.

This covers Health & Wellbeing Strategy priorities: i) promoting control, independence, and responsibility ii) keep people healthy and independent in their own home.



3. Eliminate unwarranted variation in access to care:

Improving early diagnosis and intervention to ensure better outcomes and avoid unwarranted, more costly care - focus on cancer, CHD, diabetes, mental health and MSK. We will build on our current progress in early diagnosis of dementia. Ensuring that primary care provides consistent and informed access to diagnostics and treatments (including drugs, specialist (acute) care).

...and thereby avoid / reduce the demand for reactive episodic care.

When episodic care is needed, we will ensure:

4. That the ‘right care is provided in the right setting by the right people’:

People are directed to the right care setting; access is consistent and aligned to needs (7 day), and provided as close to home as possible.

Service capacity is aligned to needs (and is informed by shared patient information) and is of a consistent high quality. Patients ‘flow’ effectively through their care pathway – and are supported to stay at or near home wherever possible, and to return to ‘safely living independently at home’ following a stay in hospital.

5. That it is provided efficiently through improved care pathways:

Care pathways are streamlined with reduced duplication and hand-offs. Reduced duplication of service provision within Derbyshire and networking of services with other footprints.

Aligned and optimised clinical services (specifically diagnostics and pathology) and back-office including HR, finance, procurement, estates and management & Board functions.

We will:

- 1. Continue to improve the impact of primary and secondary prevention:**
Getting upstream to address the determinants of health and detect asymptomatic disease to slow or stop progression, aligned to local health inequalities and prevalence. Including Derbyshire-wide Health & Wellbeing Strategy priorities: i) prevention and early intervention ii) building social capital iii) creating healthy communities iv) Improving health and wellbeing in early years.
- 2. Better meet the needs of people who require complex ongoing care (tertiary prevention):**
Providing proactive planning and support to meet their ‘whole person’ needs (mental, physical and social care) – aligned to their individual goals.

Our five priorities for system sustainability and transformation

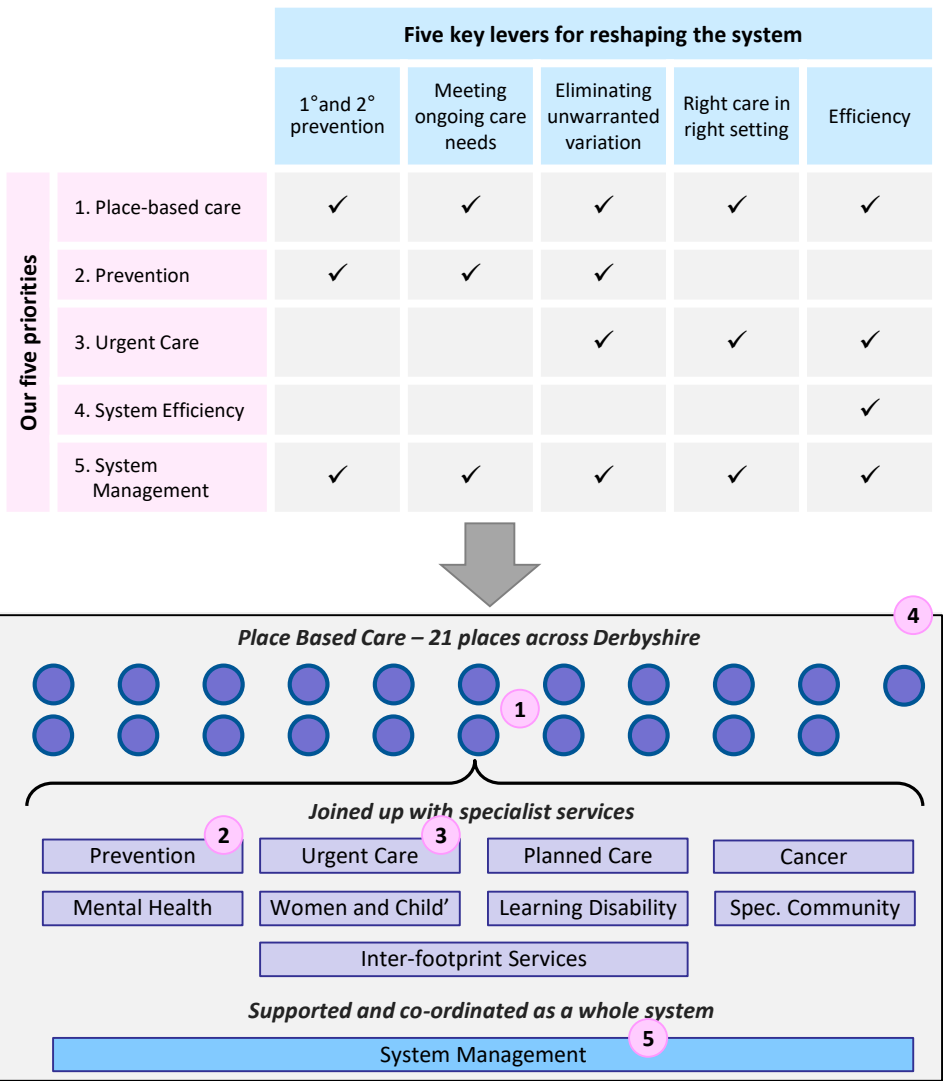
To translate our 5 levers into specific actions, we have identified five priorities for the Derbyshire health and care system. These form the core of our sustainability and transformation plan...

Working together, the five key levers for reshaping the system will allow us to address the health & wellbeing, care & quality and finance gaps.

Reshaping the system will require a fundamental change across all of our services, and planning is underway to refocus our transformation efforts around them. However, this plan focusses on the five areas where it will be most important to move together and at pace in order to make the biggest difference to reshaping the system – translating what we know about the five system levers into specific actions which we will take as local system leaders:

- 1. Place-based care:** We will accelerate the pace and scale of the work we have started through the previous transformation programmes in the North and South of the County to ‘join up’ primary care, mental health, community services, social care and the third sector. So they operate as a single team to wrap care around a person and their family, tailoring services to different community requirements.
- 2. Prevention and self-management:** By preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, we will improve health and wellbeing as well as supporting redesigned care models and improved efficiency through moderating demand.
- 3. Urgent Care:** Transforming urgent care provides our single greatest opportunity to address fragmentation and unwarranted variation and improve outcomes and efficiency.
- 4. System efficiency:** We will ensure ongoing efficiency improvements across commissioners and providers are a key component of ensuring we address the Derbyshire financial challenge.
- 5. System Management:** Our organisations’ leaders will come together to manage the Derbyshire system through an aligned leadership and governance approach, supported by aligned incentives and a single view of system performance. No financial savings are attributable to this scheme; however, we believe it is a priority for Derbyshire as it will enable us to overcome the organisation-centric perspectives and objectives that have often frustrated transformation efforts.

Although our five key priorities are at the core of our Sustainability and Transformation Plan to transform care in the County, transformation plans are also underway in a number of other specialist service areas. These will have an important role to play in addressing all three key challenges for our populations. The impact of these changes is being incorporated into the assessment of the overall impact of our plans as well as our implementation planning.



Section 2: Our priorities

– Place-based Care

Key priority 1: Place-based care - why is it a priority?

To better meet the changing needs of our population and make the Derbyshire health and care system sustainable, we must make a transformational shift from fragmented care based around institutions (and beds), to coordinated, joined-up care based around people and communities...

The national and local challenge

Our case for change has shown a lack of joined-up care means the Derbyshire health and care system is overly reliant on bed-based care, and often does not provide care in the right settings. This leads to both poor patient outcomes (such as those resulting from degeneration) and increased cost. To meet the changing needs of our population (growing demand for ongoing complex care – social, physical and mental) and make our system sustainable, we must make a transformational shift from fragmented care based around institutions and beds, to coordinated care based around people and communities, ensuring our hospitals and specialist providers deliver the specialist care only they can. Additionally, the diversity of need across the county (deprivation, rurality, disease profile etc.) means that joining up care in the most effective way will require different solutions in different areas but with a common drive to improve. One size will not fit all.

Central to achieving this joined up system is primary care. Across primary care, demand has grown hugely in recent years, in both volume and complexity. National research (King's Fund 2016) indicates that consultation numbers have grown by 15% in the last five years, but the primary care workforce grew much more slowly, and funding for primary care actually fell (by c.8%). This is despite significant rises in the groups most likely to use primary care (elderly and those with long-term conditions) and the acknowledged role of effective primary care in reducing demand for bed-based care. This pressure is forecast to continue to grow due to significant increases in the elderly population (aged 65+) over the next 15 years. There is also a widely-acknowledged and growing workforce crisis in primary care, which threatens to exacerbate the problems of rising demand and patient expectations.

The opportunity for change and transformation

The General Practice Forward View (GPFV) sets out a national programme to transform primary care which includes investing £2.4bn by 2020/21, tackling workload, building the workforce and stimulating care redesign. Place-based care will ensure that the GPFV is effectively translated into local delivery integrating primary care effectively into whole-system change.

Our Places will provide the framework to develop primary care at scale, including extending access, providing differentiated appointments, and sharing and rationalising back-office functions.

By driving quality improvement and reducing unwarranted variation, redesigning and standardising pathways of care through place-based care we will improve the use of

primary care staff (supported by the 10 high impact actions within the GPFV), whilst ensuring they can use their full range of skills, working at the top of their license, to provide a wider range of integrated services – the right care being provided by the right people, at the right time. This will increase staff satisfaction and so help us to recruit and retain the primary care workforce we need.

As the basis for multi-disciplinary teams, our Places will ensure that the additional staff (including GPs, mental health therapists, practice nurses and clinical pharmacists) funded through the GP forward view can work in the most efficient and equitable way for the benefit of our whole population.

Wider determinants such as employment, housing and education have a significant impact on the population's health. Strong and resilient communities are also known to have a positive impact on health and wellbeing. We will therefore look to work with our wider partners and our communities to improve the broader health of local populations and reduce the negative impact of the wider determinants of health.

Continuation of our transformation

The idea of place-based care is not new to Derbyshire; it has been a key component of the previous units of planning in the north and south of the county. They underpin the Erewash MCP Vanguard and are at the core of the planning of the recently launched 'Better Care' public consultation that covers a number of community based services provided to residents in the north of the county.

Each of our Places across the county will continue to be the focus for integrating health and care services and teams around people's needs, and for tailoring services to different community requirements, as well as providing a base for providing transformed specialist services closer to people.

We know we still remain too organisationally focussed. Place-based care will cut across longstanding organisational and professional boundaries to build services around people. This will be particularly important for those with multiple or complex needs such as the frail elderly. It will also provide a platform for ensuring equal priority for mental and physical health, and that co-morbidities between them are addressed effectively.

In the longer-term, our Places will provide a framework for reorienting our management of the system around population health - including system-wide planning and management through whole population budgets (delivering improvements in the wider determinants of health), and with accountability spread across communities, not concentrated in organisations.

Key priority 1: Place-based care – what do we mean?

We will ensure people with ongoing complex needs are helped to be independent and in control, with care plans specific to the outcomes that are important to them. We will make sure they are supported by a single local multi-skilled team that can easily draw on more specialist support when required.

We are defining place-based care as:

For a defined geographical community all services (partners) – primary care (GP, optometry, pharmacy), mental health, community services, social care and the third sector **operate as a single team to wrap care around a person and their family.**

For people with ongoing care needs, place-based care will support them to be independent and in control. They will have care plans in place, developed with them and their carers, specific to the outcomes that are important to them. They will be supported by people and teams who are multi-skilled to meet their mental, physical and social care needs. This will ensure that joined up services are provided – patients will not be aware of the multiple agencies that may be involved.

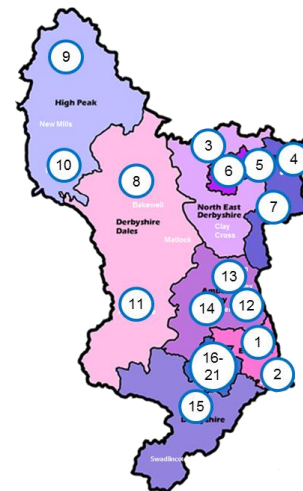
Clinicians, commissioners and providers recognise that current system behaviours, which are typically reactive and are characterised by organisation and role boundaries, must be replaced by a system that is centred on people and communities. The aim is to provide a system where:

- Support will be provided proactively, with a governing ambition to avoid / reduce the need for reactive care, characterised by a mindset that thoughtfully considers 'What matters to you?' instead of 'What's the matter with you?'
- People who need (or are at risk of needing) ongoing care are known; this includes people with complex multifaceted needs and those managing single long-term conditions. Whilst this will typically cover frail elderly people, the system will also provide Integrated Care to other vulnerable and high care need groups – including greater integration with Children's Services.
- People will be actively supported to take responsibility and manage their own care. Care will be planned with the individual (& carers).
- Significantly more support and care will be delivered by primary and community based integrated teams; less care being provided from bed-based facilities (health & social). Integrated teams will include social care, mental health, therapies, medical, nursing, voluntary sector etc.
- System users should not be aware of different care provider organisations. *Provider integration may be a necessary consequence to integrated care but is NOT the driver.*

Places will also be the organising units for much of our urgent care and will host more specialist services (although these will be organised across wider areas). This means that more appropriate services will be provided closer to where people live, and will be more integrated with the care they receive from their GP practice, and the support provided by their families and local community.

We have agreed and defined 21 'Places' which together provide coverage across our whole population. The principles of what good looks like may not vary across Derbyshire; however, it is recognised and accepted that how these are implemented and delivered will vary across the county due to different geographies, demographics and the distribution of existing health and care services.

Place characteristic:	Variation across 21 Derbyshire Places	
Population size (k)	30	100
Geography	City Centre	Very rural
Demographics	Young, ethnically diverse	Elderly white
Proximity to acute hospitals	Within 'place'	Considerable distance

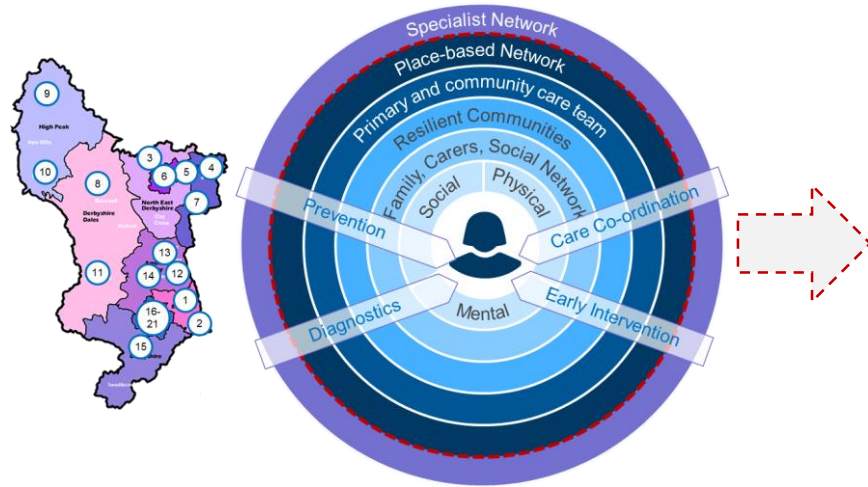


Place	Cost 2016/17 £m	
	System	Av. Place
Primary Care	131	6
GP OOH / Minor Injury Units	20	1
Community Services	52	2.5
Community Mental Health	50	2.4
Prescribing	171	8.2
Continuing Health Care	78	3.7
Learning Disabilities	9	0.4
Other	14	0.7
Total	525	25

Key priority 1: Place-based care – what changes will we make?

To make the required transformational shift we will support and enable each Place to deliver five initiatives; Proactive Care, Redesign Access to Primary Care, Reactive Integrated Care, Medicines Management and Managing Elective Activity...

Places will focus on providing integrated care for their populations. Our current thinking on the key services and interventions that each Place will provide is set out opposite.



In addition to these services, Places will be the coordinating units for more specialist services provided in **specialist networks** across the County or more widely. In particular:

- Prevention (primary and secondary)
- Community resilience
- Specialist support (e.g. outreach services - diabetes, T&O, sick children, frailty and end of life)

Prevention, early intervention, diagnostics and care coordination will be integrated across pathways, from the individual patient level (including self-monitoring, management and care) to specialist provision. For those with the highest needs, this will be a crucial part of intensive case management and condition management.

Initiatives	Interventions
1a. Proactive Care - Intensive case management <i>Typically 2 or more LTC; complex mental, physical and social care needs</i>	<ul style="list-style-type: none"> • Primary & Community integrated services (e.g. Primary, Community, MH, Vol. Sector, Social Care and specialist teams) • Comprehensive assessment and risk stratification • Care coordination and integrated individualised care plans • Improving primary care management of end of life care (advanced care planning) • Residential & Care Home support • Support for carers • Access to specialist input
1b. Proactive Care - Condition management <i>People with a moderate to high risk of deterioration</i>	<ul style="list-style-type: none"> • Individualised care planning • Annual Reviews • Person self-empowerment and education (personal resilience) • Professionals sharing decision making with patients • Primary & Community integrated services • Risk stratification and individualised care plans • Support for carers • Managing Ambulatory Care Sensitive conditions (inc. LTC services)
2. Redesign Access to Primary Care – including to deliver the aims and key elements of the ‘GP Forward View’	<ul style="list-style-type: none"> • Deliver primary care at scale • Support and grow the primary care workforce • Improve access to general practice in and out of hours • Transform the way technology is deployed and infrastructure utilised • Better manage workload and redesign how care is provided
3. Reactive, integrated multifunctional care support	<ul style="list-style-type: none"> • Rapid acute primary & community contact (place of residence) • 7 day GP/Primary & Community integrated services (pop. health) • Integrated rapid response community teams (e.g. Integrated Care Service) providing both step up and step down intermediate care • New models of service for primary and community ‘On-day’ and urgent care • Frailty services and effective supported discharge <p>Note: The impact of these changes are described within the urgent care priority</p>
4. Medicines Management	<ul style="list-style-type: none"> • Patient education and compliance • Ensuring best value and cost control (inc. providing clinicians with benchmark performance) • Medicine safety • Reducing clinically inappropriate variation (including reducing medicine waste) • Medication reviews and use of IT decision support tools • Transformed workforce – patient facing pharmacists, part of community MDTs (including polypharmacy)
5. Managing Elective Activity - improving referral quality reducing unwarranted variation	<ul style="list-style-type: none"> • Improving referral quality and standardisation (GIRFT) • Shared decision-making, patient education and self care/management • Reduce inappropriate clinical variation • Clinically appropriate referral management (inc. Reducing Procedures of Limited Clinical Value (PLCV), telehealth diagnostics, e-referral advice, appropriate triage) • Provide extended primary and community-based services

Key priority 1: Place-based care – what will be the impact of our changes?

Across Derbyshire we plan to invest significantly in place-based care to deliver better coordinated and joined-up services...

	Investment (per annum by 2020/21)				Impact (per annum by 2020/21 vs ‘do nothing’ scenario)				
Initiative	Scale (system)	£ Investment	Workforce	IT / infrastructure	Activity	Workforce	Bedded care	Gross cost saved / avoided	Net Impact
Proactive care Intensive Case Management	50,000 (5%) people will be proactively ‘case managed’.	<i>Described within the STP financial planning template</i>	Develop multi-disciplinary proactive care teams <ul style="list-style-type: none">• Primary Care• Community• Mental Health• Voluntary sector• Social care• Specialist input	<i>Check these...</i> <ul style="list-style-type: none">• Shared care records and care plans improves care coordination and decision making by MDTs• Telehealth – remote monitoring• Risk stratification	Reduced (avoided): <ul style="list-style-type: none">• <u>Reactive</u> use of primary and community care• Prescribing spend• NEL adm (10% - 9k spells)• Specialist MH care• Planned care• Use of CHC	Retrain and redeploy staff supporting bed-based care	Avoid: <ul style="list-style-type: none">• NEL acute beds (134)• MH beds (23)• Community beds (40) Reduced: <ul style="list-style-type: none">• <i>Use of long-term bedded care (care homes)</i>• <i>Bed-based LD</i>	<i>Described within the STP financial planning template</i>	<i>Described within the STP financial planning template</i>
Condition Management	The next 150,000 (15%) will be supported to better manage their ongoing care needs.								
Reactive integrated care (see urgent care)									
Redesign access to primary care (incl. GPFV)	Current spend £151m (incl. spend on MIUs & GP OOH)								
Medicines Management	Current prescribing spend £157m – forecast to grow by 19% (£30m) to £187m in 2020/21								
Managing elective activity	Current acute planned care spend £261m – forecast to grow by 17% (£44m) to £305m in 20/21								
Overall	Place-based care delivered in 21 places	c.£1-3m per place	Additional c.50-80 wte per place	Included in LDR investments	200,000 people supported to stay healthier	Integrated teams making the best use of capabilities	Avoiding c. 200 healthcare beds		

Key priority 1: Place-based care – where are we now? how will we get to where we need to?

We have defined 21 Places, these are at various stages of maturity. They have self-assessed their readiness for change and current delivery against the five initiatives. We have defined a process to continue their development and identified the need to invest c.£10m to support the transformation.

Local communities have been identified as a means to engage people in the development of services to meet their specific needs. Whilst the definition of these 'local communities' is not fixed (we will learn and adapt as needs and ways of working are better understood), as a starting point, 21 natural communities (covering the whole of Derbyshire) have been defined that largely link back to district and borough council boundaries.

As each of our places continue to mature, we recognise their differential starting points and the progress that is being made towards working together to share capacity and capability. The matrix shows a snapshot of our places and their continued development to meet the ambition of place-based care (self-assessment against the King's Fund Framework for population health systems).

To support this continued development, interim clinical, strategic and operational management support has been allocated to each place; these roles will provide the interface between places and the Place Coordinating Group.

The place Coordinating group is made up of the executive and place leads, who will support the design process and provide clarity and direction to place development (and where appropriate for schemes that cover more than one place), thereby enabling a consistent approach to delivery within the STP. As we continue to develop place we must:

- Recognise and balance diverse needs and starting points across our places, but provide central coordination to drive change at pace.
- Continue to increase the level of substantive support provided to places to ensure capacity and capability of delivery. This includes ensuring we have the right people and skills with dedicated time to manage change across all areas (clinical and managerial leadership, planning, improvement, OD, facilitation and change management). The minimum identified resource to support the transformation of the Derbyshire system through our 21 places is £10m (c.£0.5m per place). This will be secured through our CCG and Provider changes and efficiency measures detailed in the STP.
- Focus on improving outcomes and integrating services, not structures. Any organisational changes should be led by patient need.
- Continue to develop our detailed plans and business cases at Place level that set out the planned investment and benefits over the next five years for the prioritised change initiatives – ensuring that these are in line with the overall system-wide five year investment and divestment plan.

Derbyshire STP – Joined Up Care

October 21st Submission

Where we are starting from in 2016/17

Place	1a. Intensive management	1b. Condition management	2. Reactive, int. care	3. Redesigning primary care	4. Medicines management	5. Managing EL activity
1. Erewash MCP – Ilkeston	→	→	→	→	✓	→
2. Erewash MCP – Long Eaton	→	→	→	→	✓	→
3. Dronfield and North East	→	→	→	◇	◇	◇
4. North Hardwick & NE	→	→	→	◇	◇	◇
5. Chesterfield East	→	→	→	◇	◇	◇
6. Chesterfield Central	→	→	→	◇	◇	◇
7. Central and South Hardwick	→	→	→	◇	◇	◇
8. Dales North	→	→	→	◇	◇	◇
9. North High Peak	→	→	→	◇	◇	◇
10. Buxton	→	→	→	◇	◇	◇
11. South Dales	→	◇	◇	◇	→	◇
12. Heanor	→	◇	◇	◇	→	◇
13. Ripley	→	◇	◇	◇	→	◇
14. Belper Group	→	→	◇	◇	→	◇
15. South Derbyshire	→	→	◇	◇	→	◇
16. Derby City Centre North	→	◇	◇	◇	→	◇
17. Derby City Centre South	→	◇	◇	◇	→	◇
18. Derby City North East	→	◇	◇	◇	→	◇
19. Derby City North West	→	◇	◇	◇	→	◇
20. Derby City South East	→	◇	◇	◇	→	◇
21. Derby City South West	→	→	◇	◇	→	◇
Key:	Early progress made ◇		Some progress made →		Implemented at required scale ✓	

Process for delivering Place-based care by 2020/21 (for each of our 21 Places)

Derbyshire places defined	'Baseline' (needs, joint working)	Local vision	Prioritise change initiatives	Develop 'roadmap' for delivery	Define metrics and targets	Develop delivery plan(s)	Implement and refine
Clinical leadership / managerial leadership/ facilitation / service planning / team development / change management							

Section 2: Our priorities

- Prevention, self-management and community resilience

Key priority 2: Prevention, self-management and community resilience – why is it a priority?

Derbyshire's public health challenges are significant, and the widening 'window of need' means that many people across the county are living longer in ill health – with the greatest impact in our most deprived communities.

Prevention - the national and local challenge:

"...the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health". Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences (Five Year Forward View, 2014, p.3).

Currently, the NHS spends more than £15.5 billion per annum treating illness which directly results from alcohol and tobacco consumption, obesity, hypertension, falls, and sedentary lifestyles. Much of this treatment is avoidable:

- There are an estimated £34m avoidable costs to the Derbyshire healthcare system that are attributable to smoking. Around 80% of deaths from lung cancer and COPD can be attributed to smoking; 25% of all respiratory admissions are attributable to smoking.
- The estimated cost to the NHS in Derbyshire relating to excess weight and obesity is £116m. 90% of Type 2 diabetics are overweight or obese; 66% of hypertension is linked to excess weight and 85% to obesity.
- The costs relating to harmful drinking in Derbyshire are estimated to be in the region of £74m per year.

Health and Wellbeing in Derby and Derbyshire

There are a range of issues which need addressing across Derby and Derbyshire including:

- The increasing prevalence of largely preventable morbidity and mortality e.g. cardio-vascular disease, liver disease, some cancers and diabetes.
- The significant prevalence and unequal distribution of behaviours (e.g. smoking, excess weight, harmful drinking), and risk factors (e.g. hypertension, AF, diabetes) which increase incidence and exacerbation of disease.
- Healthy life expectancy (HLE) is decreasing in Derby with more people living longer in poor health.

The significant inequalities in life expectancy and HLE exist within and between areas in Derby and Derbyshire.

Reducing Need

Need and demand is continuing to grow, putting significant pressure on the local health and care system. However, demand management through other STP workstreams will only have a limited impact on the rising need for services and a focus on healthcare services alone will not reduce need.

A review¹ of research estimated the relative contribution of multiple modifiable determinants to health outcomes: *Lifestyle/ behaviours (e.g. smoking, alcohol) – 30%; Socio Economic–40%; Clinical care – 20% contribution to health; and Environment – 10%.*

Lifestyle/ behaviours are a major contributor to health outcomes and must be a core component of our approach. However, to fully maximise the opportunity to improve health, and therefore reduce demand, we must also focus on the social circumstances and environments in which people live as these have a complex causal relationship to health.

Impact on Need

- Do nothing – need and demand will continue to rise.
- Implementing Demand Management only – demand grows less rapidly, but need continues to grow.
- Implementing 'Whole Systems' Prevention – the increasing trend in need and demand will stabilise.

Supporting national priorities

As nationally, we will have a local focus and prioritisation of:

- Cancer – particularly prevention and early identification through screening.
- Diabetes – particularly prevention of diabetes, early identification and reducing associated risk.
- Obesity – significant focus and 'upscaling' of support to people who are overweight or obese within a 'whole systems' approach to tackling obesity including, for example, planning, licencing, access to green space, active travel and policy.

¹ Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute.

Key priority 2: Prevention, self-management and community resilience – what changes will we make?

We aim to lead a step change in the local system in preventing ill health and supporting people to live healthier lives through a system-wide approach to promoting health and wellbeing. At its core will be a fully integrated 'Wellness System' with a holistic approach to support individuals and their families aiming to reduce the impact of smoking, harmful drinking and excess weight.

Primary prevention, self-management and community resilience

Focusing on all the factors that impact on health, and therefore healthcare use: individual and lifestyle, socio-economic factors, social and community networks and living and working conditions. Avoidable morbidity and mortality though will be reduced through a combination of:

- **Primary Prevention:** taking action to reduce the incidence of disease before it occurs.
- **Secondary Prevention:** reducing the impact of disease by detecting and treating it as early as possible.
- **Tertiary Prevention:** reducing the negative impact of established disease, aiming to minimise the impact of disease on life quality and life expectancy.

To achieve this 'step change' in preventing ill health and supporting people to live healthier lives, we will be taking the opportunities to:

- Improve *efficiency and effectiveness* of the services delivered, increasing throughput and outcomes.
- Delivering at *appropriate scale* - provision needs to reflect the numbers of people with capacity to benefit.
- Effecting a *cultural shift* in health and care professionals, in the range of settings that promote 'wellness', in the public and patients – particularly in developing the confidence to self-manage and take a lead role in decisions about their health. And, recognising that delivering health is more than healthcare and requires a 'whole systems' approach.

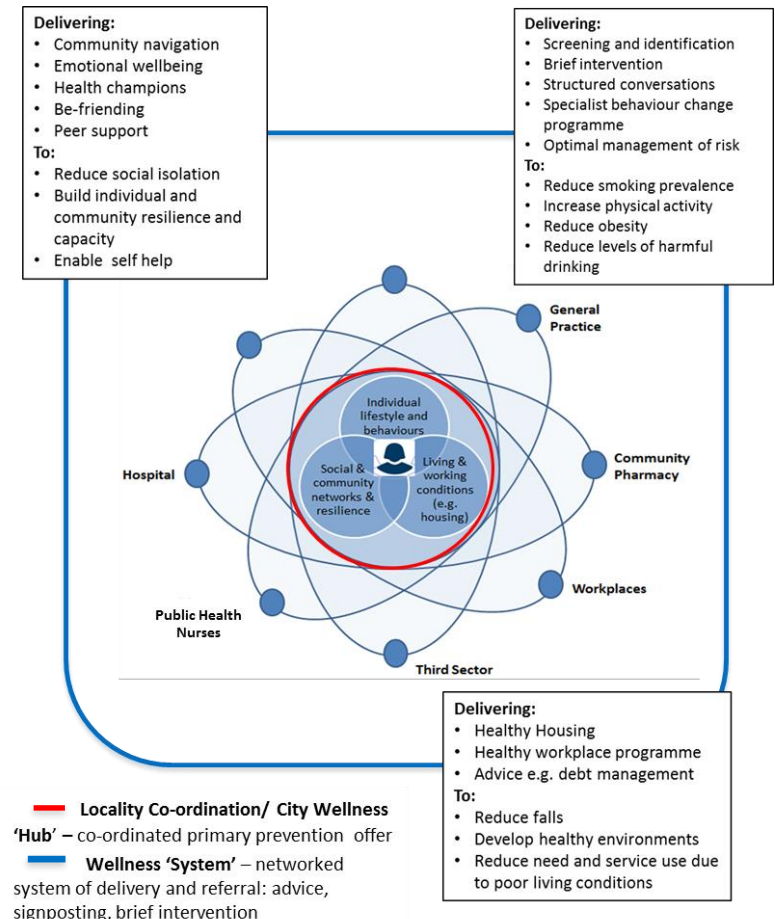
Prevention and Place

Primary prevention is the prevention and early intervention element of Place. Coordination of preventive efforts will be enhanced by full alignment and integration of the Wellness System, incorporating the established locality working arrangements to STP Places.

The promotion of healthy choices, healthy environments and resilient communities will be the foundation on which the STP sits to develop healthy individuals and communities who need less support from health and care.

A new model of delivery

The establishment of a coordinated 'Wellness System' is proposed which will have nine Wellness Hubs/ Localities delivering a range of provision in a holistic way, including not only a focus on an individual's lifestyle and behaviour but also on their social networks, housing and wider socio-economic factors which we know have an impact on health. These Wellness Hubs/ Localities will work within this integrated 'Wellness System' maximising the opportunities available within a range of 'healthy settings'.



Key priority 2: Prevention, self-management and community resilience

We plan to increase investment into lifestyle services as well as refocussing how this investment is used to maximise the impact.

	Initiative	Intervention	Scale - system	Current investment	Proposed investment	Impact	Scale of ambition	Gross cost saved / avoided	Net impact
Primary prevention	Reduce the impact of smoking	Development of Derbyshire-wide Wellness Plus Service	162,000 adult smokers in Derbyshire £34m avoidable costs to healthcare (240k primary care consultations, 33k OP attendances, 7k admissions, 103k prescriptions)	<i>Described within the STP financial planning template & Outline Business Case</i>	<i>Described within the STP financial planning template & Outline Business Case</i>	Reduced deaths from cancer, COPD, CHD & stroke Reduced healthcare utilisation	Reduce smoking prevalence to 15% (26,000 quitters)	<i>Described within the STP financial planning template & Outline Business Case</i>	<i>Described within the STP financial planning template & Outline Business Case</i>
	Reduce the impact of obesity	Brief interventions and settings approaches - brief intervention training programme - workplace wellbeing	585,000 adults in Derbyshire are overweight or obese (41% & 27%) £116m estimated NHS costs for Derbyshire (15k admissions, 85k OP attendances, 277k primary care consultations, 3k DC procedures, 9k prescriptions)			Reduction in diabetes, hypertension, liver disease etc. Reduced healthcare utilisation	Reduce excess weight by 3-5% (47,000 reducing weight)		
	Reduce the impact of harmful drinking		Estimated 190,000 increasing and higher risk drinkers in Derbyshire £74m estimated annual in spend (20k admissions, 37k OP attendances, 111k A&E attendances, 72k primary care consultations, 50k ambulance callouts, 3k prescriptions)			Reduction in emergency attendances/ admissions Reduction in primary care use Reductions in alcohol-related conditions e.g. fatty liver disease	Reduce the number of harmful drinkers by 5% (9,500)		
	Other services	Alcohol interventions and treatment services	Livewell Workplace MECC			As above	Contributing to above		

Key priority 2: Prevention, self-management and community resilience

We will make a collective commitment (Health and LAs) to provide the investment necessary to achieve the step-change required, recognising that many benefits (including financial benefits) will take time to realise...

We are not starting from scratch and we have a history of delivering preventative activities, particularly within communities. However, historically our efforts to prevent ill health have been ad-hoc and small scale, and we have not used the prevention potential of the infrastructure of the care and treatment system to best effect.

Public Health, within Local Authorities, currently commission services in both county and city to support healthy lifestyles. These arrangements are supported in the county by a wide range of locality-based activities run by statutory, voluntary and grant aided organisations – all of which have a role in primary and secondary prevention of ill health and support either physical or mental wellbeing.

The current number of referrals into lifestyle services from Primary Care is very low and there are hardly any from secondary care. Making Every Contact Count (MECC) training is available to all staff will support new ways of working.

Individuals who have been given a diagnosis of a long-term condition are able to either be referred, or self-refer to the commissioned self-management programme – a six week programme, that people attend for two hours each week, to empower individuals to manage their own conditions.

There is a range of services supporting Primary Care and people in the community including the public health commissioned Wellbeing Workers, the Practice Care Coordinators, the public health commissioned locality teams and the CCG commissioned vSPA. These arrangements need reviewing to ensure less duplication and more opportunity.

There are also activities to support community capacity and resilience and to tackle wider determinants such as Local Area Coordination, Healthy Homes Project, Healthy Housing Hub, CABx in GP practices etc.

How we will make the changes...

1. We will make a collective commitment (Health and LAs) to provide the investment necessary to achieve the step-change required, recognising that many benefits (including financial benefits) will take time to realise. This will require a commitment to the implications of this – including how it might affect funding of other services in the short-term. These commitments are necessary to ensure a sustainable health and care system into the future.

2. We see community resilience and the development of social capital as fundamental elements of ensuring effective prevention and in supporting individuals to act independently and to make their own free choice to enable shared decision-making. This work needs to continue to be prioritised and aligned to the aims of the prevention workstream and recognised within the wider STP plans.
3. We need to see a step-change in how we view health and wellbeing and how we support and improve it. This should include an increased focus on an 'asset-based' model rather than a deficit model of health and wellbeing.
4. We will embed a comprehensive approach to prevention (primary, secondary, tertiary where appropriate) across all areas of care delivery.
5. We will work with partners across the wider system to enable a 'whole-pathway' approach to prevention, particularly recognising the role and impact of wider determinants on morbidity, premature mortality, health inequalities and service utilisation.
6. We will re-procure some commissioned services to enable more appropriate services to be available to individuals. Delivering at greater scale should be able to offer efficiencies.
7. We need to support primary and secondary care in the development of pathways that include referral to healthy lifestyle services and community initiatives.
8. We will work with Public Health England to promote healthy lifestyles through a range of media on a national scale.
9. We need to embed prevention opportunities in all pathways and work streams, develop high-value pathways that are clinically cost effective, and develop place-based services where appropriate and feasible.

Prevention measures need to be built into all health and care pathways, applied systematically and delivered at scale if they are to have a level of impact that will reduce the gaps in life expectancy and healthy life expectancy and reduce the demand for health and care services. The system-wide approach to change taken by our STP provides a unique opportunity to do this.

Section 2: Our priorities

– Urgent Care

Key priority 3: Urgent Care – why is it a priority?

Across Derbyshire, as in many other parts of the country, urgent care services have developed in an organic and ad-hoc way, which results in confusion for patients, people not being treated in the most appropriate care setting, limited integration between different parts of the network and inefficient use of resources.

Urgent Care - the national challenge

The Urgent and Emergency Care (UEC) review sets an ambition for UEC services:

- People with urgent care needs, including mental health crisis, receive a highly responsive service that delivers care closer to home, minimising disruption and inconvenience for patients and their families.
- Those with more serious or life-threatening emergency care needs receive treatment in centres with the best expertise and facilities to maximise the chances of survival and good recovery.

Urgent Care - the Derbyshire challenge

Urgent care services in Derbyshire have developed in an organic and ad-hoc way, resulting in uncoordinated points of delivery, inequitable access, a dependency on hospital beds, limited integration with primary care and confusion for patients due to the multiple point of access and inconsistency in service provision. The result is an urgent care network that is not as effective or efficient as it could be. The current spend on Urgent Care across Derbyshire is £351m.

Urgent Care Service	Cost 2016/17 £m
Primary Care	£57
GP OOH / Minor Injury Units	£20
Community Services	£44
A&E	£36
Acute Hospital	£195
Total	£351

In addition, specialist emergency services delivered by acute hospitals are coming under increasing pressure to deliver consistent 7 day services.

Primary Care & Community Care

- 50% of patients attending General Practice have conditions that do not need a GP and could be appropriately treated by less qualified staff; a further 30% of patients have conditions that other clinical staff could treat.
- Primary Care delivers the majority of urgent care contacts. Locally some patients are reporting issues with access to their Practice.

- In some of Derbyshire's most rural areas MIUs have not been fully utilised and, whilst activity has increased over the last 12 months, significant opportunity exists to integrate MIUs with primary, social and mental health services . 70% of Minor Injury Unit (MIU) attendances could be seen in primary care.

Hospital-based care

- Delivery of the 4 hour A&E wait target is a continual pressure. 40% of ED attends could be seen in primary care.
- Too many patients are admitted to hospital from care homes , homecare and housing providers when care could be delivered in the patient's place of residence.
- Adults of working age requiring admission for mental ill health stay in hospital longer than the England average, leading to bed occupancy of 100% and some being treated outside of Derbyshire.
- Patients who have been admitted to acute hospitals non-electively and stay 14+ days, account for 45% of the total non-acute bed base (573 beds). The majority of these people are aged over 65, and are particularly susceptible to decompensation.
- In addition to an over reliance on acute hospital beds, across Derbyshire 210 community hospital beds are provided across 9 sites. The vast majority of these beds are used to care for elderly people commonly as a transition between hospital and home after an illness or injury.
- Neither Chesterfield Royal Hospital or Royal Derby Hospital meet the four clinical standards to be implemented first for 7 day hospital services.

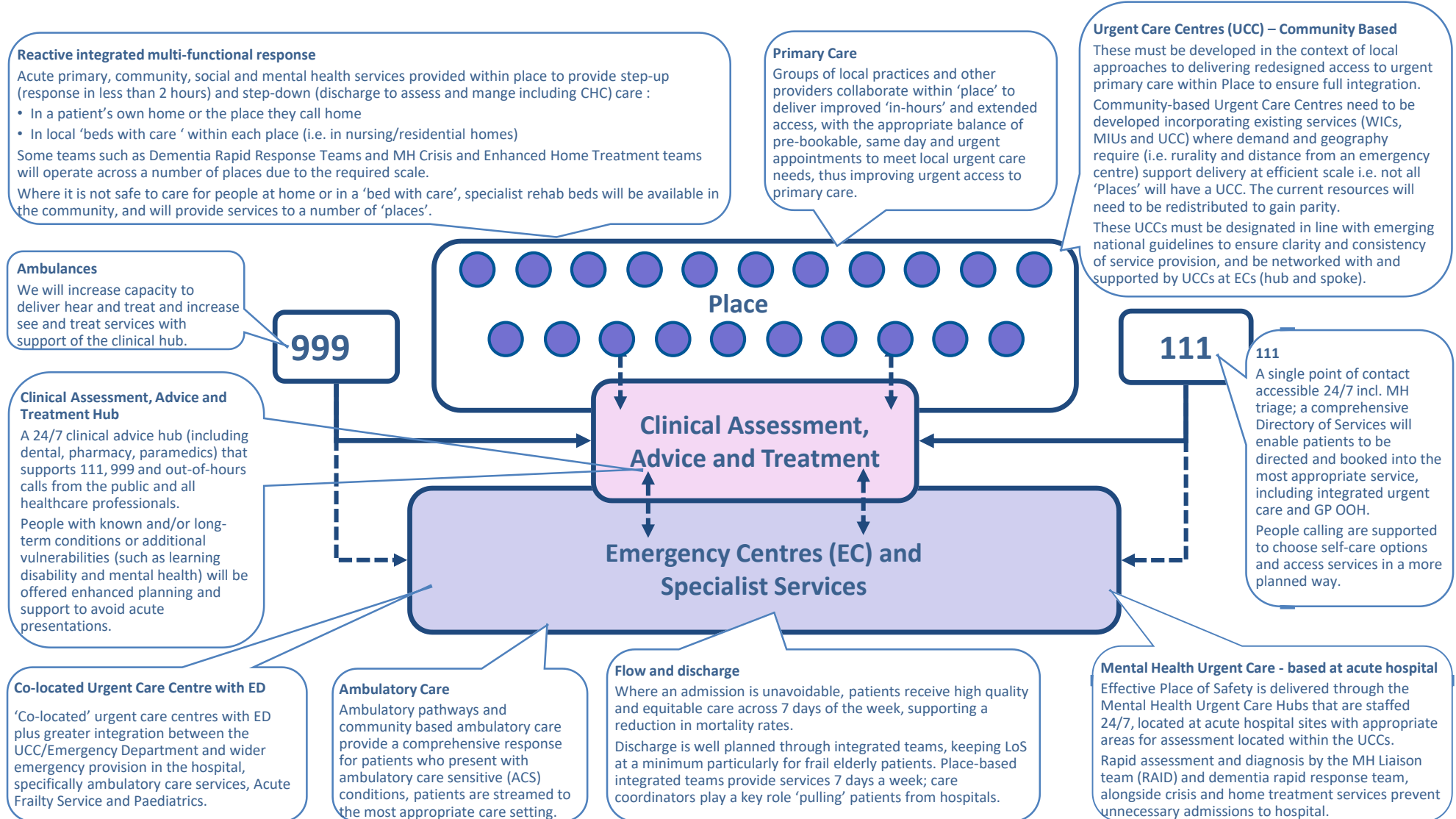
Ambulance and infrastructure

- Ambulance response time standards are not met 36% of the time, 44% of ambulance arrivals do not result in admission to an acute provider and conveyance from ambulance to ED is consistently higher than rest of E. Midlands (8%)
- The current IT systems do not meet the needs of patients or of organisations across the system; the lack of interoperability between the health and social care system impacts on both patient care and the efficiency of services within the system

Our challenge is to turn the National Guidance into a locally responsive and effective model for delivery, whilst recognising that Derbyshire is strategically aligned to two Urgent Emergency Care Networks (South Yorkshire and Staffordshire).

Key priority 3: Urgent Care – what do we mean?

We will develop a coordinated Urgent Care Network across Derbyshire that optimises the skills and capacity of each of the components to ensure people with urgent care needs receive a highly responsive service in the 'Place' where they live, and those with more serious emergency care needs receive treatment in centres with the best facilities and expertise...



Key priority 3: Urgent Care – what changes will we make?

We will ensure consistent access and assessment to urgent care services. We will provide coordinated, responsive urgent care services outside of hospital through Place, that are joined up with effective, appropriate and high quality specialist services.

Our redesigned Urgent Care network will be fully integrated with place-based care. Urgent Care pathways across acute, community and mental health settings will interface with place-based care through a 24/7 clinical assessment, advice and treatment hub. An enhanced directory of service and 111 service will support patients to access the most appropriate urgent and on the day care delivered 7 days a week. Our local interventions are focussed around the following seven initiatives.

Place-based Initiatives	Interventions
1. Proactive Care	<i>This is covered within the Place priority – it is not an Urgent Care service or response; however, it will significantly impact on Urgent Care activity</i>
2. Redesigning access to urgent primary care	<ul style="list-style-type: none"> Place-based approach to extended access / urgent and emergency on the day access , particularly evenings and weekends Where supported by demand and geography, integration of existing Minor Injury Units and Walk-in Centres with Primary Care and General Practice (aligned to work on extended access) to establish sustainable community based Urgent Care Centres that meet national designation requirements
3. Reactive, integrated multifunctional urgent care support	<ul style="list-style-type: none"> Integrated health and social care rapid response teams providing both step up care to avoid hospital admissions and step down care to support discharge to assess and manage. Key characteristics include: <ul style="list-style-type: none"> Focus on falls, frailty, end of life and long-term conditions In reach to 'pull' patients through the hospital for discharge Integrated with voluntary sector Extended service to care homes Support provided to people in their home / place they call home and local 'beds with care' Specialist input ('outreach') from specialist services e.g. frailty Specialist rehabilitation beds provided to support those patients who cannot be safely cared for at home or in local 'beds with care'. Units would provide higher intensity rehabilitation to support higher acuity patients. Discharge (step down) would be supported by the integrated community teams. Would be delivered through a place-based network – i.e. not within each 'place'. <i>Dementia Rapid Response Team to provide intensive support to people in their own homes / place they call home to reduce admissions to hospital for organic crisis presentation and support earlier discharge, delivered through a place-based network – included within MH initiative.</i> <i>MH Crisis and Enhanced home treatment - included in MH initiatives</i>

Specialist Urgent Care Initiatives	Interventions
4. Consistent access and assessment to urgent / on the day services	<ul style="list-style-type: none"> Implementation of a 24/7 Clinical Assessment, Advice and Treatment (CAAT) hub that takes calls from GPs, Care Homes, 111 and 999. Led by senior clinical decision makers (GPs and experienced practitioners, ECP, ANPs, paramedics) with track record of risk management on a rota to staff the service. Able to book calls / patients into the most appropriate setting e.g. urgent OPA, diagnostics, UCCs. Access to health record system / IT that identified whether patient known to 'place' teams. A multi-agency mental health triage hub that operates 24/7 will be part of the Integrated Assessment, Advice and Treatment Hub. Development of ambulance services to provide more 'hear and treat' and 'see and treat' services, with support of the clinical hub.
5. Effective and appropriate treatment at acute hospital sites	<ul style="list-style-type: none"> At Chesterfield Royal Hospital and Royal Derby Hospital the development and increased use of: <ul style="list-style-type: none"> Co-located Urgent Care Centres with ED Ambulatory care units Frailty assessment units Paediatric assessment units Efficient and effective short stay admission units MH Liaison Teams Greater integration between EDs and the wider services in the hospital, specifically the Ambulatory Care Units, Acute Frailty Service and Paediatrics Priorities for stroke pathway include delivery of consistent 7 day access, rehabilitation and social support following medical discharge
6. 7 Day Hospital Services – delivered for 10 identified specialties	<ul style="list-style-type: none"> Meet 10 standards for 7 day hospital services including: Timely consultant review, Improved access to diagnostics, Consultant directed interventions. Ongoing review in high dependency areas. Primary focus on the four standards prioritised by national review. Collaborative working by Chesterfield Royal Hospital and Royal Derby Hospital with Trusts within their respective UECNs to develop Hyper Acute Stroke Services and Pathways, with patients stepping up for their acute phase and stepping down for rehabilitation.
Enabler initiatives	Interventions
7. Key enablers for urgent care redesign	<ul style="list-style-type: none"> Use of digital technology/apps/diagnostics and remote monitoring Flexible workforce to work across organisational boundaries and settings IT systems that support a robust telephony system and data/information sharing between providers Contracting and payment models that support the new models of care

Key priority 3: Urgent Care

Across Derbyshire we plan to invest in place based care to deliver joint health and social care reactive integrated care services which are integrated with our acute urgent care services.

	Investment (per annum by 2020/21)				Impact (per annum by 2020/21 vs 'do nothing' scenario)				
Initiative	Scale (system)	£ Investment	Workforce	IT / infrastructure	Activity	Workforce	Bedded care	Gross cost saved / avoided	Net Impact
Reactive integrated multifunctional care support	Step up care supports c.15,000 episodes Step down care supports complex discharge and intermediate care for c.10,000 episodes	<i>Described within the STP financial planning template</i>	Develop place-based multi-disciplinary reactive care teams • Primary Care • Community • Mental Health • Voluntary sector • Social care • Specialist input	• Shared care records and care plans improve care coordination • Telehealth – remote monitoring	Reduced (avoided): • Use of secondary care NEL adm (15k spells) and LoS (c.17% of OBD) • Use of community bedded care • Use of long-term bedded care	Retrain and redeploy staff supporting bed-based care Develop integrated team culture incl. person and carers Attract and retain key skills (GPs, ANPs, care workers, therapists, ...)	Fewer: • NEL acute beds (143 adm avoid; 220 LoS) • Community beds (85) Reduced: • <i>Use of long-term bedded care (care homes)</i>	<i>Described within the STP financial planning template</i>	<i>Described within the STP financial planning template</i>
Redesign access to urgent primary care (also see Place)	Consistent cross Derbyshire integrated urgent primary care offer incl. MIU, OOH, EMAS		Bring specialist advice and support nearer to patients – increased hear/see & treat	• Use technology to enable remote assessment & support	• Improved access in & out of hours • Integrated primary care offer in place incorporates MIU / WIC services				
Consistent access and assessment	Integrated assessment, advice & treatment service (111/999/OOH)			• Improve interface between primary & secondary care	• Fewer A&E attends • Fewer ambulance conveyances				
Effective and appropriate urgent treatment at hospital sites	UCC co-located with A&Es; ambulatory care services; acute frailty services; paed assessment				• Fewer minor illnesses and injuries treated by A&E; fewer ACS admissions		Fewer: • NEL acute beds (34 through adm avoided)		
7 Day hospital services			Supporting 7 days services						
Overall	Increased place-based care	Additional investment in place - £1-2m per place	Additional investment c.25-40 wte per place	Included in LDR investments	Better access to urgent care	Integrated joined up place-based teams	482 fewer health care beds required		

Key priority 3: Urgent Care – where are we now?

We have begun to provide more urgent care services outside of hospital and ensure treatment is in centres with the best expertise and facilities, and have detailed plans for further change. We plan to accelerate the changes to deliver the scale of ambition we have for this priority to ensure people receive the right care in the right setting.

Redesign access to urgent Primary Care

- Across Erewash CCG, primary care hubs that deliver extended hours in the evening and at weekends have been established as part of the Prime Minister's Challenge Fund (PMCF). Going forward, to ensure the future sustainability of this service these will be delivered as an Advanced Nurse Practitioner led model rather than the current GP led service. Hardwick CCG has delivered an extended primary care hub in Alfreton through the PMCF initiative.
- Within the previous North Derbyshire Unit of Planning the current and future provision of the Minor Injury Units and Walk-In Centre was considered as part of the place-based planning that informed the recently launched Better Care consultation. Conclusions from this work were services dedicated to only servicing minor injuries would be an expensive and inefficient use of resources, and that a more integrated urgent care offer built around primary care is required to make the most efficient use of resources.
- Work is now commencing across the whole of Derbyshire to consider how the existing Minor Injury Units and Walk-in Centres can be integrated with Primary Care and General Practice (aligned to work on extended access) to understand the requirement and need for community-based Urgent Care Centres that can sustainably meet the national designation requirements

Reactive, integrated multifunctional support

- Through the previous North Derbyshire Unit of Planning Transformation Programme a business case has been developed to further invest in joint health and social care teams that provide step-up and step-down care. The focus of this investment is to support those elderly people who are currently cared for in a community hospital bed in the north of the county, most commonly as a transition between hospital and home after an illness or injury, within their own home or a local 'bed with care'. This service change would mean people are cared for in a setting more appropriate to their needs, thus reducing decompensation, and that 85 fewer community hospital beds are required. The model of care delivery and associated investment for this integrated team is one we will look to replicate across the county to support further step-up and step-down care not just to community hospital beds but also acute hospital beds. This business case underpins the Better Care consultation.
- Implementation of discharge to assess and manage has started at Chesterfield Royal Hospital across the Acute Frailty Unit and two further wards (Durrant and Ashover). However, this is being done within existing community resources and still requires significant further investment to deliver at the required scale and pace. A step-down model with the treatment of patients requiring IV has been established between Chesterfield Royal Hospital and Derbyshire Community Health Services.

- As part of the Better Care work a business case has also been developed to invest in a Dementia Rapid Response Team in the north of the county to reduce the requirement/dependency on community dementia beds and support more people at home. This would mean 20 fewer community dementia beds are required.
- Care homes support services are delivered across the county to support the proactive management of residents and reduce avoidable admissions. However, we recognise we need to improve the scale and quality of these. Across the north of the county an Airedale Telehealth Pilot has been in place in 2015/16 that will evolve in 2016/17 to form part of an extended care homes support offering.

Consistent access and assessment

- 111 re-procurement is complete and will deliver the new clinical hubs model; interoperability issues between systems have now been resolved to enable 111 to book directly into MIUs and the Erewash primary care hub.
- EMAS community model is being developed to extend hear and treat and see and treat and interface services with the community responder/ first response vehicle.

Effective and appropriate urgent treatment at hospital sites

- An outline business case has been produced for an 'Urgent Care Village' at Chesterfield Royal Hospital that would expand the ED and develop a co-located UCC, rapid response assessment facility for frail elderly, paediatric assessment unit and flexible short stay admissions unit.
- It has been agreed in principle that a UCC should be co-located at Royal Derby Hospital, and this should be explored together with how the ED can be better integrated with wider services in the hospital, specifically Ambulatory Care Units, Acute Frailty Service and Paediatrics.

7 day hospital services

- The 'Seven Day Services East Midlands Collaborative' has been established to support the development of regional/network service development.
- Both Acute Hospitals are working collaboratively with Trusts within their UECN to develop Hyper Acute Stroke Services and Pathways, with patients stepping up for their acute phase and stepping down for rehabilitation.
- Following the outcomes from the recent audit, work is now underway to understand how each specialty will contribute to the delivery of the 7 day service standards.

Key enablers

- We have aligned our Local Digital Roadmap.

Section 2: Our priorities

– System Efficiency

Key priority 4: System Efficiency

We know our health system is inefficient in a number of ways, and therefore improved efficiency must be a key part of our plan.

The financial gap across the Derbyshire healthcare system is forecast to be £258m by 2020/21. We know our health system is inefficient in a number of ways, and therefore improved efficiency must be a key part of our plan.

We know we can:

- Streamline care pathways with reduced duplication and hand-offs, and aligned clinical governance processes;
- Reduce duplication of service provision within Derbyshire and network services with those in other footprints;
- Align and optimise clinical support services with a specific focus of diagnostics and pathology;
- Align and optimise 'back-office' services (finance, HR, IM&T, facilities management);
- Optimise procurement of equipment and medicines across all providers;
- Optimise management and Boards functions (commissioners and providers);
- Reduce reliance on agency/locum staffing;
- Rationalise and optimise estate; and
- Make better use of technology.

This efficiency opportunity is also recognised nationally. The financial gap across the NHS as a whole has been identified as £22bn by 2020/21. National planning by NHS England has identified that £8.5bn of this can be delivered by provider efficiency savings, the equivalent of 2% per annum efficiency savings, plus a further £6.3bn of efficiency savings from commissioners. Based on Derbyshire commissioners' shares of national CCG allocations the local 'contribution' to these figures would be c.£160m for provider efficiencies and c.£118m for commissioner efficiencies.

To support thinking and planning in this area Lord Carter recently published the Carter Review that looked at productivity and efficiency in English non-specialist acute hospitals, which account for half of the total health budget. This report concluded that there are significant efficiency opportunities worth an estimated £5bn nationally.

Therefore, reflecting and building on the Carter Review, when we talk about efficiencies with the Derbyshire Sustainability and Transformation Plan we mean technical efficiencies. That means ensuring that all of our services run as efficiently as possible – including reducing waste, best-value procurement and efficient staffing.

It also means using technology and information systems to reduce wasteful

duplication, and to make best use of clinical time (which is often the most significant constraint on our services). Plus we must also think about the time resource of patients, which has been described as “the burden of treatment,” and which impacts significantly on experience but is often forgotten in institution-focussed service design.

Our efficiency initiatives are set out in the table below.

Initiatives	Interventions
1. Optimised use of clinical workforce	<ul style="list-style-type: none"> • Workforce & team efficiency • Align to demand (rotas, job plans) • Skill mix / working to top of license • Sickness levels and turnover
2. Hospital pharmacy and medicines optimisation	<ul style="list-style-type: none"> • Hospital Pharmacy Transformation Programme (accountable lead, pharmacist resource used for direct medicines optimisation activities, Electronic Prescribing and Medicines Administration systems, consolidated medicines stock-holding and modernising the supply chain)
3. Procurement	<ul style="list-style-type: none"> • Procurement Transformation Programme (accountable lead, purchasing price index, shared procurement functions, adoption of NHS Standards of Procurement)
4. Estates and facilities management	<ul style="list-style-type: none"> • Community hospital/facility rationalisation • Acute hospital (incl. PFI) optimisation • CCG offices • Technology to support agile working • Shared estate functions • Shared procurement of revenue/capital items
5. Back-office costs – provider & commissioner	<ul style="list-style-type: none"> • Provider shared functions (finance, HR, IM&T) • Rationalisation of management • CCG shared functions
6. Agency Costs	<ul style="list-style-type: none"> • Better control of staffing through e-rostering systems • Improved workforce planning to ensure substantive staff are recruited and trained • Cost control through agency caps

Improving efficiency across the Derbyshire system is central to our savings plans for 2016/17. We have assessed the overall planned scale of our efficiency initiatives described above against our plans for this year, this is shown on the next page.

Key priority 4: System Efficiency

We will target system efficiencies, using benchmarks from Carter to ensure a greater proportion of our funding is spent on direct patient care...

Initiative	Investment				Impact (per annum by 2020/21 vs 'do nothing' scenario)		
	Scale (system)	Investment	Workforce	IT / infrastructure	Outcome	Gross cost saved / avoided	Net impact
Optimised use of clinical workforce	Current spend clinical service workforce circa £700m (Derbyshire providers)	None proposed (although significant investment in other work streams)	<ul style="list-style-type: none"> Review of workforce variation Tackling sickness levels and turnover Aligning staffing levels to patient need Review of training methods and variation 	<ul style="list-style-type: none"> E-rostering ('firmer grip') Electronic job plans Benefits realisation from Electronic Staff Record 	Workforce & team efficiency; align to demand (rotas job plans); skill mix; top of licence (for those areas not otherwise significantly impacted by STP changes)	Described within the STP financial planning template	Described within the STP financial planning template
Hospital pharmacy and medicines optimisation / diagnostics review	Current acute spend (incl. specialist) est. £90m	None proposed (although there will be clinical pharmacy investment in other work streams)	<ul style="list-style-type: none"> Development of collaborative arrangements for pharmacy Benchmarking of drug costs in collaboration with national bodies Further collaboration around pathology and radiology 	<ul style="list-style-type: none"> Electronic prescribing and medicines administration systems Orders and invoices are sent and processed electronically 	Majority (80%+) of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits Reduced cost of diagnostics		
Procurement	Current spend in scope across Derbyshire providers c.£140m	None proposed	<ul style="list-style-type: none"> Develop shared procurement functions Improved collaboration across providers / sectors / procurement hubs / supply chain 	<ul style="list-style-type: none"> Support to NHS Procurement Transformation Programme Effective system control and compliance, building supply chain capability 	More effective use of procurement skills across the system to secure best value		
Estates and facilities management (FM)	Current spend circa £147m	Capital investment will be required to fund some of the proposed changes	<ul style="list-style-type: none"> Develop shared estates and FM functions Shared procurement of revenue / capital items 	<ul style="list-style-type: none"> Use of technology to promote agile working Use of technology to gain a Derbyshire view of assets 	Focus on system solutions rather than organisational to ensure best use of current estate		
Back-office cost – provider & commissioner	Current spend circa £43 m (provider) and circa £31m commissioner	£10m investment to support the development of place-based care	<ul style="list-style-type: none"> Review of back-office services Collapse of commissioning teams Develop system management and transformation team 	<ul style="list-style-type: none"> Common IT systems Use of technology to remove processes 	More effective and efficient use of back-office resource		
Agency Costs	Current spend circa £25m	None proposed	<ul style="list-style-type: none"> Workforce planning to ensure right staff trained and recruited to meet patient need 	<ul style="list-style-type: none"> E-rostering Control systems over agency usage and cost 	Improved workforce efficiency Reduced reliance on agency		
Inflation Avoidance		None proposed			Cumulative achievement of year on year efficiencies avoids growth cost		
Other	Ambulance provider efficiency & other schemes	Net investment in digital roadmap of £5m	<ul style="list-style-type: none"> Ambulance provider efficiency through new ways of working / improved vehicle utilisation 	<ul style="list-style-type: none"> Significant progress with digital roadmap 	More efficient ambulance service Enablers in place to support the delivery of the plan		

Section 2: Our priorities

– System Management

Key priority 5: Transforming system management

Reshaping care across the Derbyshire footprint will only be possible if we work effectively as a system. This will require us to put in place a single, ‘boundary-spanning’ leadership and governance approach to support system-level working and accountability.

Why is this a priority?

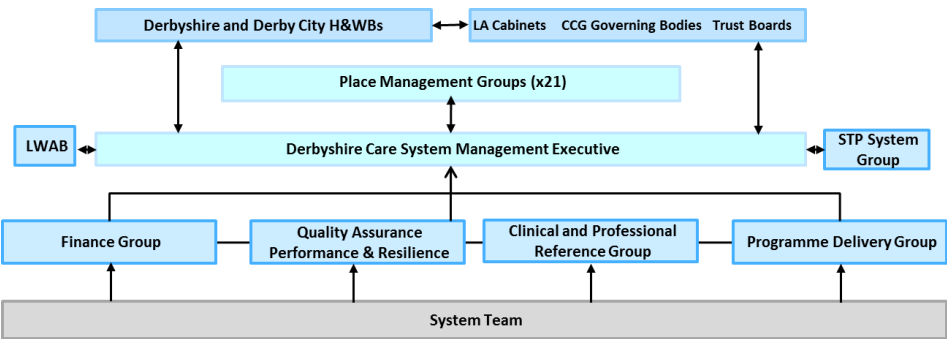
Many of the initiatives within our STP priorities are not new. However, so far they have not yet been implemented to deliver the necessary transformational impact – in either care quality or financial improvement terms. And, we believe that this is significantly due to our existing system management arrangements, which drive competing organisational priorities and an inability to divert funding and investment from historical patterns of provision that do not meet the changing needs of the population.

So, we need to ensure that this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change including the lack of cross-system working, misaligned incentives and the predominant organisational focus over system-wide and patient-centred perspectives.

Transforming how we work together across organisations to manage the system is therefore a priority for our STP. We must make system-level working the default option - ‘business as usual’ - as an approach for managing all of the care we commission and provide.

What changes we will make?

We will work together to put in place a single, ‘boundary-spanning’ leadership and governance approach to support system-level working and accountability.



System Management Executive - to strategically manage and direct the Derbyshire care system to deliver its strategic goals – including the effective transformation to deliver integrated sustainable services. The Executive will meet monthly for 3 hours and the membership will be the STP Executive Chair, Accountable Officers and Chief

Executives from the Derbyshire NHS organisations, Clinical Leaders from Commissioners and Providers, the Derbyshire County Council Director of Adult Social Care, and the Derby City Council Director of People. The Executive’s objectives are:

1. To deliver a sustainable (clinically, professionally and financially) care system
2. To empower and support communities to deliver place-based care
3. To have a clear and shared understanding of system performance
4. To agree and direct strategic and tactical investment and disinvestment within the care system
5. To hold organisations (each other) to account for delivery of the system aims and outcomes - recognising and supporting joint responsibility for cross performance
6. To agree changes to the Sustainability And Transformation Plan
7. To agree and adjust contracts to enable cross-system working

Place Management Groups – to establish and develop multifunctional operational teams at ‘place’ level that are responsible for delivering change within ‘place’.

System Group – a dedicated forum for Chairs, Chiefs and Elected Members to establish a shared understanding of the STP and progress towards delivery.

Programme Delivery Group – to guide design work, direct delivery and provide advice on prioritisation and funding of care service changes. The group will be clinically and professionally led.

Clinical and Professional Reference Group – a wider body of clinicians and professionals to provide advice and challenge to the Programme Delivery Group.

Finance Group – to ensure the system’s financial position and risks are presented and managed in a transparent way.

Quality Assurance Performance and Delivery Group – to monitor and report on system-wide performance - ‘one version of the truth’.

System Team – a dedicated team to support transformation and management of the system including a ‘single version of the truth’ to guide system action. Core capabilities: Planning, Finance, Business Intelligence and Analytics, Programme Management, Change Management.

Public and lay input will be through the Health and Wellbeing Boards and each of the Place Management Groups.

Key priority 5: Transforming system management – next steps

Derbyshire has a track record of working collaboratively between both health and social care organisations; the STP process has made significant further progress with this and System Leaders are now committed to managing as a system in a more integrated manner – as the only way to effectively deliver the STP.

System Management Executive Roadmap

Gary Thompson has led the development of the Derbyshire STP for the last six months and will continue in the role as SRO. We have appointed Ifti Majid as System Managing Director with the responsibility for the delivery of the plan, the associated cultural changes within the system and the operational, clinical and system governance mechanisms. During the next 6 months the priorities for the system will include:

October to December 2016

- Agree system investment and divestment plan for 2017/18 (based on robust business cases)
- Agree contracting plan and associated mechanism in line with 2017/18 investment and divestment plan. Agree 17/18 risk share
- Finalise the detail of the business cases that then enable the development of mobilisation plans
- Hold inaugural meeting of the Programme Development Group
- Develop implementation plans for 5 high impact, rapid implement schemes that can take effect during 2016/17
- Agree STP implementation structure
- Commence initial engagement processes with stakeholders and local population

January to March 2017

- Continue with structured engagement with local population groups
- Agreement of joint engagement process with LMC
- Complete HR processes for populating structure
- Start monitoring system metrics through the QAPR Group
- Creation of clinical and professional reference group
- Agree TOR and MOU between organisations for the initial period including an outline scheme of delegation for decisions to be taken collectively
- Develop the 'Engine Room' as part of monitoring and reporting structures
- Develop role of Health and Wellbeing Boards in monitoring progress against plan

Collaboration

CCGs

During late October, the CCGs will present a co-authored paper to Governing Bodies that sets out the case for a new way of working and timescales to:

- better deliver CCG core business
- better enable delivery of programme priorities and the development of Place
- increase the value and efficiency of back-office delivery.

The CCGs will collectively make a decision on the new governance arrangements, ways of working and the plan for the coming months and years.

Derbyshire Community Health Services NHS FT and Derbyshire Healthcare NHS FT

During the development of the STP the Boards of these two organisations have identified a number of ways in which greater collaboration between the two organisations could enable the two strong, capable providers to accelerate service transformation to support the system vision. This collaboration will look to:

- drive an integrated approach to physical and mental health within the emerging Place-based Teams;
- streamline governance and shift resources into the transformation required;
- provide a strategic integrated response to reducing demand on the acute sector.

A Strategic Options Case will be considered by Boards in October.

Derby Teaching Hospitals NHS FT and Burton Hospitals NHS FT

The Boards of these two organisations have formed a strategic partnership seeking to improve:

- the provision of NHS services resulting in benefits to the populations served;
- the financial positions of the trusts and therefore the local health economies.

A Strategic Options Case for an arrangement of clinical services and back-office functions which address these questions will be considered by Boards in October.

Chesterfield Royal NHS FT and South Yorkshire and Bassetlaw STP

Both Chesterfield Royal and the South Yorkshire STP have agreed to strengthen the arrangements currently in place, particularly in respect to specialist and tertiary flows.

Health and Wellbeing Board Collaboration

Both of the local Health and Wellbeing Boards are committed to the STP, have started to hold joint meetings as a vehicle to increased collaboration.

Section 2: Our priorities

– Other areas

Other transformation schemes...

In addition to our priorities, transformation work is also underway in a number of other areas that will make a vital contribution to our overall reshaping of the system...

Initiative and interventions		Investment	Impact	
			Gross cost saved / avoided	Net impact
Planned Care	<ul style="list-style-type: none"> An integrated 'end to end' planned care system – for a particular patient group / service / specialty (shift from acute setting to community, incl. developing GPs' skills and GPWSI) One standardised planned care system (standardise protocols theatre efficiency, LoS etc.) 	<i>Described within the STP financial planning template</i>	<i>Described within the STP financial planning template</i>	<i>Described within the STP financial planning template</i>
Cancer	<ul style="list-style-type: none"> Development of integrated clinical care pathways Redesign access to the Acute Oncology Service in line with Urgent Care redesign Redesign access to primary and community care in place Develop integrated services for palliative and end of life care Development diagnostic capability and capacity To attract, develop and train a workforce to address capacity deficits 			
Mental Health	<ul style="list-style-type: none"> Enhanced Organic Pathway Enhanced Home Treatment and Re-ablement Develop Dementia Rapid Response Team MH Urgent Care The above will shift from acute setting to community - Reduced OP activity, EL activity and DC activity. Will need to retrain and redeploy staff supporting bed-based care 			
Children's and Maternity	<ul style="list-style-type: none"> Long-term conditions Develop local alternatives for OOA, TCP or Tier 4 placements Establish 'place-based' preventative delivery model Delivering Future in Mind programme and increased investment in CAMHS Simplification of provision and commissioning landscape Embed and improve maternity services Improve local health offer for SEND and neuro-development 			
Learning Disabilities	<ul style="list-style-type: none"> Community-based Assessment Treatment and Support Services Enhanced Intensive Support Team Specialist community accommodation for temporary alternative care These will drive a reduction in reliance on bed-based care increased community provision 			
Specialist Community	<ul style="list-style-type: none"> Development of integrated specialist services as part of the planned care system Develop skill mix and capacity of the specialist teams to deliver a wider range of clinical interventions to patients with complex health and care needs Development diagnostic capability and capacity 			
Continuing Health Care (CHC)	<ul style="list-style-type: none"> Improve the efficiency of CHC management and delivery 			

Section 3: Impact and Implications

– What is our plan saying?

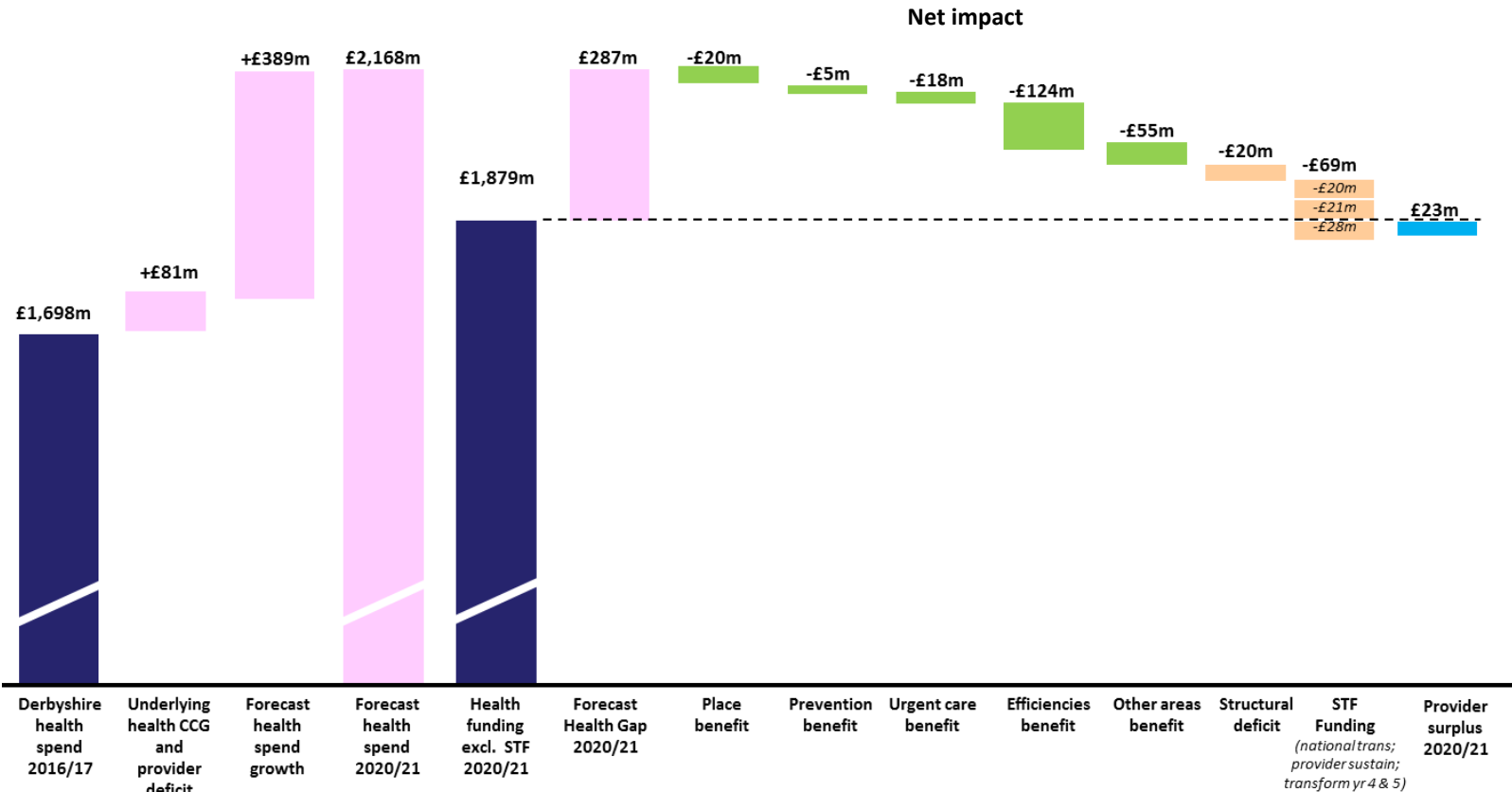
Implications for the people of Derbyshire

*Delivering our STP will help us to meet our aims to keep people: **safe & healthy** – free from crisis and exacerbation; **at home** – out of social and health care beds; and **independent** – managing with minimum support. We will address lifestyle issues related to poor health and will improve access to urgent and routine care.*

Priority	For the whole population	For people with identified (often complex) ongoing care needs
Prevention	<ul style="list-style-type: none"> More people will be supported to stay physically and mentally healthy - including referral to NHS and voluntary services for specialist support if they need it. Not only GPs, but all health professionals may discuss people's lifestyles with them and specifically what they can do to stay as well as possible. Rather than receiving support from individual lifestyle/behaviour changes, people will access a more holistic services that cover a range of interventions. 	<ul style="list-style-type: none"> People with ongoing care needs (c.20% of our population) will have a single care plan, to which they and their carers have contributed, around which all of the health and care professions they see will work. As appropriate, they will be supported by their Care Coordinator who will help to ensure services are joined up. The care plans will specifically focus on support to help them stay well, and will have regular checks to ensure that their condition – and their overall health – is being managed as effectively as possible. This will include any necessary support for their carers. Information technology will be used to support ongoing monitoring and effective access to care plans and records.
Place-based care	<ul style="list-style-type: none"> People will have faster access to GP and other primary care appointments (including urgent appointments) at more accessible times. As appropriate, people will use technology to monitor their health and to consult their GP. If they need diagnostics or specialist care this will often be provided locally Services will be delivered and coordinated through 'community hubs / networks'. 	<ul style="list-style-type: none"> Where a risk – such as of a fall within the home – is identified, place-based care teams will act swiftly to address it. People will receive the full facts about care and treatment options, and will be encouraged (and helped) to make 'shared decisions' with professionals about them. Routine care will be provided at home or in the local area - including some of what previously happened in hospital. Medication will be reviewed regularly by a specialist.
Urgent Care	<ul style="list-style-type: none"> Consistent and reliable access to same day urgent primary care appointments seven days a week, by seeing GPs and other primary care professionals across their locality. 111, 999 and ambulance services will treat problems immediately where possible, or will book people directly into the services which are best placed to help them, rather than attending A&E. In hospital, tests and consultant-led care will be available seven days per week. All services will have electronic access to medical records, allowing them to provide the best care. 	<ul style="list-style-type: none"> In addition to 'universal' urgent care, people with ongoing complex needs will have specific elements of their care plan where appropriate, managed by their Care Coordinator to help keep them out of hospital. Where risks of hospitalisation or urgent needs are identified, specialist multifunctional teams will take action quickly to deal with them. When leaving hospital, they will receive specialist support at home – meaning they can go home earlier thus avoiding the unwanted effects of long stays in hospital. And, through appropriate and effective intermediate care helping people to return to their homes, more people will avoid being admitted to long-term care homes.
Other services	<ul style="list-style-type: none"> Standardised care pathways across the system for elective and cancer care will provide greater consistency of patient care and outcomes; alternative community based services and the use of technology to support care delivery will provide patients with increased flexibility and choice. Children, young people and their families will only need to tell their story once. Care will be delivered through a community-based approach that supports young people through the transition to adulthood. Families will receive early help through multi-agency teams. Fewer children and young people cared for out of Derbyshire. The capacity and capability of our workforce will be invested in and developed to reflect our changing models of care and focus on 'place'. Integrated teams will be empowered to deliver the most appropriate support, advice and care to people to meet the individual's needs, reducing confusion, hand-offs and duplication for patients. 	<ul style="list-style-type: none"> People requiring regular health and care interventions to manage complex needs and support independent living will receive specialist services as a part of their care plan, care coordinators will 'step up care' to access hospital services when clinically necessary Children and young people will receive CAMHS services in the community, reducing the need for them to be placed People requiring access to Specialist Mental Health will access enhanced treatment and reablement in their home with support from neighbourhood teams and high intensity community rehabilitation People with learning disabilities will receive intensive support in their homes and be provided with temporary alternative care in the community rather than be admitted to hospital

Financial sustainability of the system

The combined impact of the priorities described will enable us to achieve a financially balanced health system by 2020/21.



The health system financial gap (£287m) will be addressed by the combined impact of the priorities previously described supported by STF funding. Figures are shown as the net contribution by 2020/21. Plans have been developed by understanding the gross changes less any necessary investment to either avoid the need for care (mitigate demand) or to deliver care more effectively in the right settings.

Our plan shows a total net benefit of £222m to enable us to achieve £23m provider surplus by 2020/21.

Further details are provided in the Finance and Efficiency Template submission.

Investment in line with the National priorities (e.g. GPFV) are built into the net position and summarised in a table overleaf.

Derbyshire STP – financial plan

The summary below provides a high level overview of the financial plan for the Derbyshire STP.

(1) Assumptions

The key assumptions driving the financial model are:

- NHSE assumptions around activity growth
- NHSI assumptions around provider cost inflation
- Financial adjustments have been modelled based upon expenditure changes, and not to income, to ensure efficiencies are real to the system
- The structural deficit of £20m is assumed to be funded nationally
- The system will hold a risk reserve comprising 0.5% CCG contingency, 0.5% CCG non-recurrent reserve, and 0.5% provider CQUIN
- The financials exclude the impact of HRG4+ on providers
- The financials assume that all provider Boards will agree control totals

(2) Investments

Within the financial plan, we have made the following investments in national and local priority areas, and assumed that this will be funded from national STF allocations:

Investment from National Allocation	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s
Seven Day Services	2,000	0	0	0
GP Forward View	5,480	7,285	7,285	7,285
CAMHS	1,778	0	0	0
Mental Health Taskforce	5,069	7,509	7,509	7,509
Digital Roadmap	5,673	5,206	5,206	5,206
	<u>20,000</u>	<u>20,000</u>	<u>20,000</u>	<u>20,000</u>

(3) Financial Plan Phasing

The financial plan shows an improving surplus over the model.

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Allocations	1,698	1,734	1,771	1,812	1,879
STF Funding to Providers	13	21	21	47	49
Assumed Structural Deficit Funding	0	20	20	20	20
Revised Allocations	<u>1,711</u>	<u>1,775</u>	<u>1,812</u>	<u>1,879</u>	<u>1,948</u>
Expenditure	1,725	1,788	1,818	1,881	1,945
Surplus / (Deficit) as per Model	<u>-14</u>	<u>-13</u>	<u>-6</u>	<u>-2</u>	<u>3</u>
National Allocations assumed	0	20	20	20	20
Net Surplus / (Deficit)	<u>-14</u>	<u>7</u>	<u>14</u>	<u>18</u>	<u>23</u>

(4) STP Financial Plan to Contracts

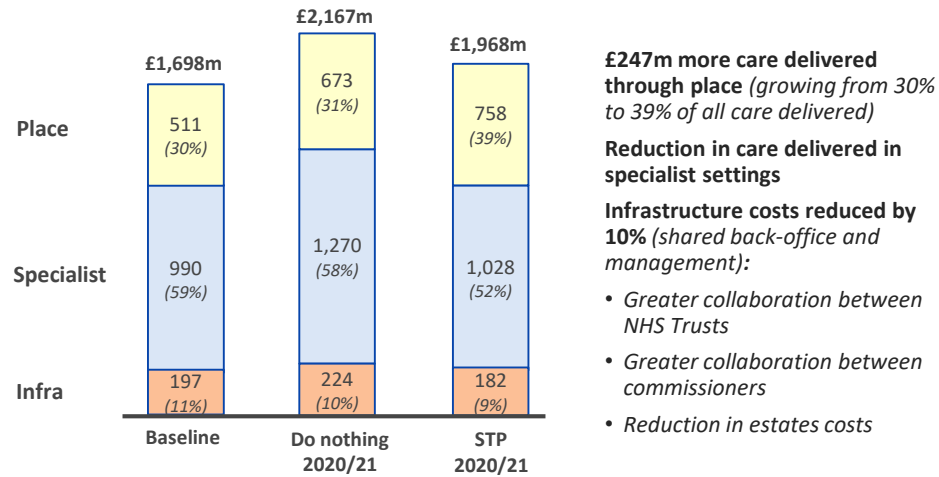
The STP will use the financial plan as the basis for agreeing contracts with providers to ensure the sustainability of the system:

- 2017/18 baseline will be based upon actual costs in the system
- The baseline will be uplifted for growth and inflation
- Transformation plans will be agreed and allocated to providers based upon where the cost will be released
- Commissioners and providers will also deliver technical efficiencies within their own organisation
- Block contracts will be agreed on this basis, with risk management arrangements in place managed through the system governance arrangements

Implications for the 'shape' of the system

The combined impact of the priorities will result in a significant transformation of the 'shape' of the system, more place-based care reducing the current reliance on institutional care. Clearly, this will result in (& rely upon) major changes to the workforce, our use of bed-based care and the physical configuration of services.

'Shape' of our system (costs)



Workforce implications

2,500 more staff delivering place-based care (c.10% of our current workforce)

Managing the transition - our workforce of 5 years time is predominantly the workforce we have now. This means that we must invest to support our workforce to transition into the Places with the skills and competencies our population needs.

Cultural change of focus:

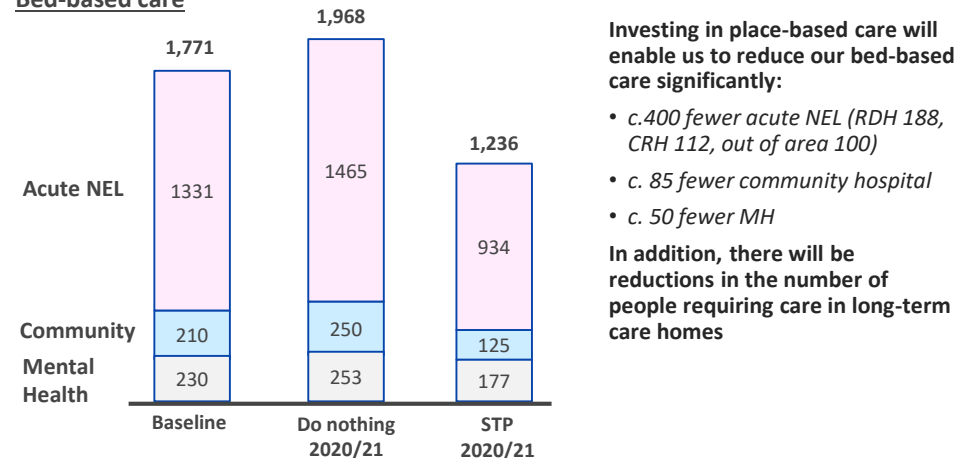
- Encourage and empower people to share decision-making about their care
- Provide person-centred care, engaging people, their families and carers as partners
- Deliver integrated place-based services which transcend organisational boundaries

Develop and attract key skills / capabilities / roles:

- Increase the number of people who enter into our **care workforce**, be that in private, voluntary, Local Authority or health provision
- Increase the number of **Advanced Clinical Practitioners**, drawing this workforce from not only nursing but AHP, Paramedic and Pharmacy workforce
- Ensure the supply of **medical (including GPs), therapy and nursing** workforce by being a place where learners thrive and wish to stay

We will use a **collaborative cross-system approach** (including health and social care) to employing, rewarding and developing our workforce

Bed-based care



Physical configuration of services

The development of place-based care and the greater integration of services and organisations will require:

- The development of place-based 'community hubs / networks' – aligned to local service needs (e.g. urban/rural) – fully integrated with Primary Care. This will mean, in some places, the reconfiguration / redevelopment of community (health and LA) and primary care facilities, and that MIUs/WICs will not exist as standalone services.
- Less bed-based care: c.12 fewer acute wards in Derbyshire; c.4-5 fewer community wards; 1-2 fewer specialist MH & 1 fewer dementia care wards).
- Some of the community hospital sites may not be required; others will play a key role within community hubs.
- The development of co-located Urgent Care centres at ED sites.
- Rationalisation of back-office facilities.

Section 4: Next steps

- Delivering the STP

Delivery the STP: Outline Plan 2016 - 2019

The phased impact of the plans described by the outline business cases for the key elements of the plan is summarised in the table below. Where relevant, the proposed changes are subject to the necessary public engagement and consultations...

Priority	Initiatives	Year 2 (2017/18)	Year 3 (2018/19)	Year 5 (2020/21)
Place	Case Management	<ul style="list-style-type: none"> 2% (20k) of our most complex patients – particular focus on frail elderly (severe & moderate) 	<ul style="list-style-type: none"> 3% (30k) of our most complex patients – frail elderly and other complex needs 	<ul style="list-style-type: none"> 5% (50k) of our most complex patients
	Condition management	<ul style="list-style-type: none"> Focus on helping people to better manage their long-term conditions – in particular: mild frailty at risk of deterioration; respiratory diseases; diabetes and arterial diseases 		<ul style="list-style-type: none"> 15% of our people with ongoing care needs (long-term conditions)
	Access to primary care	<ul style="list-style-type: none"> Investment and support to ensure the sustainability of primary care consistent with GPFV Practices supported to provide extended access as defined by GPFV Primary care playing a core role in place-based care (with necessary resources and investment) 		<ul style="list-style-type: none"> All GP practices are working together to offer improved access (either as one or many linked together) as a core component of place-based care
	Reactive integrated care	<ul style="list-style-type: none"> Step-up care provided to avoid 4,500 admissions (avoiding 15k OBD) Step-down care for 4,800 episodes (avoiding 51k OBD) 	<ul style="list-style-type: none"> Step-up care provided to avoid 9,000 admissions (avoiding 30k OBD) Step-down care for 6,000 episodes (avoiding 61k OBD) 	<ul style="list-style-type: none"> Step-up care provided to avoid 15,300 admissions (avoiding 52k OBD) Step-down care for 10,000 episodes (avoiding 111k OBD)
	Medicines Management	<ul style="list-style-type: none"> Align Medicines Management Team to support place with core support at practice level Manage prescribing spend to less than 3% growth p.a. 	<ul style="list-style-type: none"> Increase number of patient facing independent prescribing pharmacists at part of practice teams in line with GPFV Manage prescribing spend to less than 3% growth p.a. 	<ul style="list-style-type: none"> Transform and optimise medicine management services in primary care to maximise health outcomes Manage prescribing spend to less than 3% growth p.a.
	Managing elective activity	Focus on MSK, PLCV, ophthalmology, dermatology – effective demand management and assessment (triage, telephone advice, e-advice, etc.)		<ul style="list-style-type: none"> Manage growth in referred activity to less than 1% p.a.
Prevention	Primary prevention	<ul style="list-style-type: none"> Realign and improve effectiveness – consistent cross county Pilot wellbeing system established 	<ul style="list-style-type: none"> Increase scale 	<ul style="list-style-type: none"> Coordinated wellness system established
Urgent Care	Consistent access and assessment	<ul style="list-style-type: none"> Implement CAAT – reduce ambulance conveyances; increase see and treat; assess opportunity for rationalising single points of access 		
	Effective hospital care	<ul style="list-style-type: none"> Expand ACCs at RDH and CRH Implement Health Based Place of Safety North and South for Mental Health Patients Implement / expand primary care streaming & GP triage 	<ul style="list-style-type: none"> Co-located UCC RDH & CRH (capital dependent) 	<ul style="list-style-type: none"> Reconfiguration of ‘front doors’ to the hospitals
Bedded Care	Combined impact	200 fewer beds (Mar-18): Acute (130; 2 RDH + 2 CRH); MH (20 dementia care); community beds (50 BCCH)	300 fewer beds (Mar-19): Acute (+ 50; 1 RDH + 1 other); MH (+33 Adult MH); community beds (+20 South)	535 fewer beds (Mar-21): Acute (397); Adult MH (33); community beds (85)

Delivery the STP: Outline Plan 2016 - 2019

The phased impact of the plans described by the outline business cases for the key elements of the plan is summarised in the table below. Where relevant, the proposed changes are subject to the necessary public engagement and consultations...

Priority	Initiatives	Year 2 (2017/18)	Year 3 (2018/19)	Year 5 (2020/21)
Efficiency	Workforce optimisation	1% p.a. productivity improvement	Additional 1% p.a. productivity improvement	Total 5% productivity improvement – avoid increase in workforce spend
	Clinical Support	Improve productivity and effectiveness: <ul style="list-style-type: none"> • Radiology - Single acute and community service across Derbyshire • Pharmacy – integrated medicines budgets, consistent services, reduce duplication • Pathology – Derbyshire-wide pathology service 		
	Procurement	Cross-system collaboration to hold costs of procured goods and services – zero inflation		
	Estates	Rationalise and optimise use of estates – avoid overall cost increase		
	Back-office – provider	Reduce cost of back-office functions to no more than 6% through shared functions and services		
	Back-office – commissioner	Single strategic commissioning function across Derbyshire;; reduce cost by 66%.		
Other	Planned care & cancer	5% of first OP & 15% of OP FUP delivered in right care setting @ 75% of cost; 5% productivity in acute activity (e.g. day case rates, theatres, LoS)		
	Mental Health	Enhanced organic pathway; enhanced home treatment & re-ablement; dementia rapid response team; MH urgent care;		
	Children's and maternity	Services delivering effective: universal resilience; prevention & self management; early help & identification; specialist intervention; high cost intervention		
	Learning Disability services	Services transformed to deliver: Integrated community service; assessment & treatment model; short break offer; advanced pathway for autism Resettlement of 'Winterborne View' cohort		
	CHC	CHC and continuing care assessments provided in place by place; assessment routine completed and care provided at home		

Risks to Delivery the STP

Through our governance structures, we are actively managing a set of cross-system risks...

Risk No.	Date Raised	Theme	Risk Description	Risk Owner	Initial			Current			Mitigation Actions	Target			Review Date	Status
					Likelihood rating	Impact Rating	Risk Rating	Likelihood rating	Impact Rating	Risk Rating		Likelihood rating	Impact Rating	Risk Rating		
1	29/07/2016	Engagement	Lack of 'buy-in' to STP due to restriction on sharing the STP submitted in June with stakeholders, particularly GPs	SME	Almost Certain	Major	20	Almost Certain	Major	20	Communications and Engagement strategy and plan that shares as much on STP as allowed Specific actions with GP stakeholders including working with the LMC on briefing materials and engagement groups Reflect recent guidance from NHS in Communication and Engagement plan	Unlikely	Moderate	6	28/10/2016	Live
2	26/08/2016	Finance	Lack of clarity from centre within required timescales on financial planning assumptions: funding of structural deficits; use of 1% non-recurrent; STF allocation, capital availability; control totals	SME	Likely	Major	16	Possible	Moderate	9	Planning guidance Support from NHSE and NHSI regional teams	Possible	Moderate	9	28/10/2016	Live
3	26/08/2016	Delivery	LA financial planning and NHS contracting/planning cycles not aligned	SME	Likely	Major	16	Likely	Moderate	12	Commitment by Local Authority Health and Well Being Chairs to STP	Possible	Moderate	9	28/10/2016	Live
4	26/08/2016	Delivery	STP delivery structure not established and in place	SME	Likely	Major	16	Likely	Major	16	SME agree delivery structure	Possible	Moderate	9	28/10/2016	Live
5	27/09/2016	Finance	Increase in required financial savings in 2017/18	SME	Likely	Major	16	Likely	Major	16	Establish financial challenge in light of revised control totals Reflect any increase in required saving in business planning process	Likely	Moderate	12	28/10/2016	Live
6	27/09/2016	Engagement	Sign up' from all partners to STP	SME	Likely	Major	16	Likely	Major	16	Weekly Chiefs meetings Monthly Chiefs and Chairs meeting	Rare	Major	4	28/10/2016	Live
7	11/10/2016	Finance	Lack of centrally available capital will constrain plans for the development co-located UCCs @ RDH & CRH	SME	Likely	Major	16	Likely	Major	16	Development of clear business cases (including ROI) to make the compelling case Considering alternative methods of funding	Unlikely	Major	8	28/10/2016	Live
8	18/10/2016	Sustainability	In the short and medium term, General Practice is under pressure - with a number of Practices having closed, others who have merged due to financial issues and some that have moved to another funded model completely to mitigate liabilities or where personal income has fallen so low they cannot continue practising.	SME	Likely	Major	16	Likely	Major	16	The sustainability and transformation of General Practice is addressed by GP Forward View. Current sustainability issues need to be better understood. Derbyshire CCGs will create a single short framework, that will support Practices to complete the undertaking of a gap analysis to enable the system to understand and identify the key challenges and financial investment required.	Unlikely	Minor	4	28/10/2016	Live

Appendices:

- Governance arrangements
- Engagement process
- Local digital roadmap
- Addressing the ‘ten big questions’
- Bed reduction rationale

Appendix 1: Governance arrangements

Governance arrangements – Design Principles

“Much of what we describe has been known for some time, yet it is not applied in practice. Why? Because while it is relatively straightforward to impart knowledge about what to change, it is much harder to create the culture and enthusiasm required to deliver change, particularly when working across organisational boundaries.” *(King’s Fund 2015)*

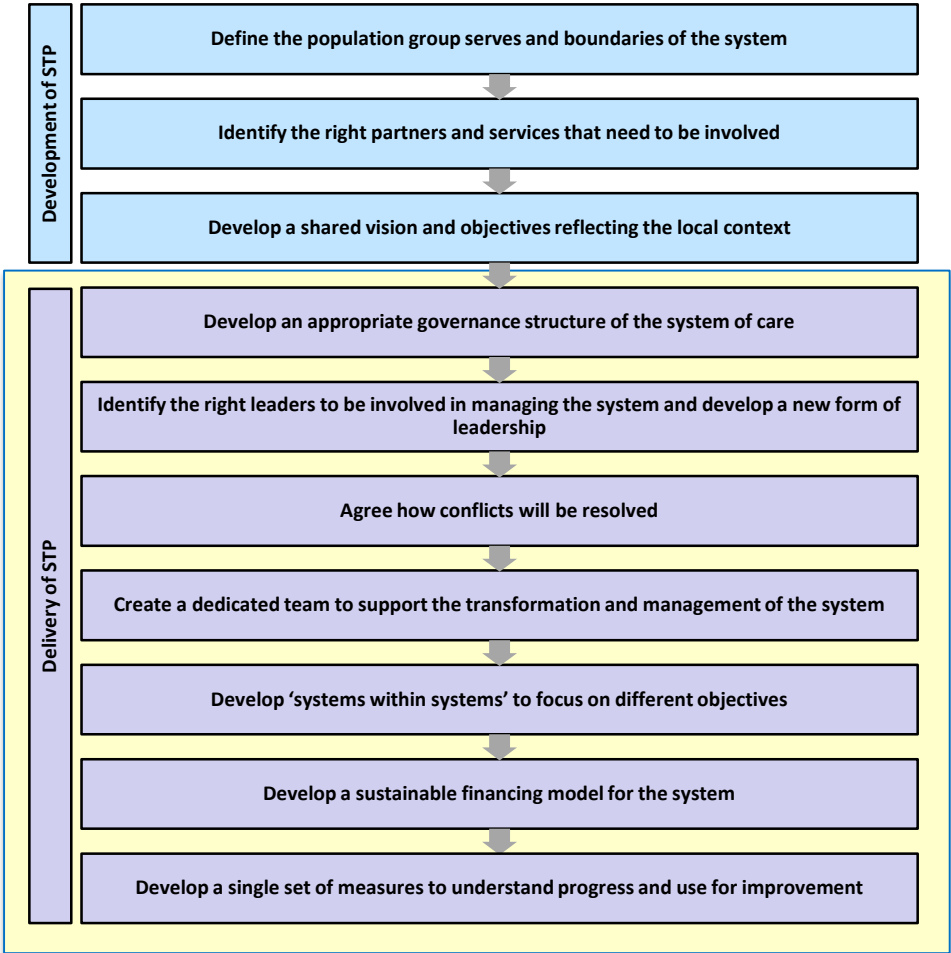
Reshaping care across the Derbyshire footprint according to our Sustainability and Transformation Plan will only be possible if we can work together effectively as a system. This is the overriding logic not just of our priorities, but of all of the changes we propose.

Many of the initiatives within our chosen priorities are not new. However, they have not been as transformational – in either care quality or financial improvement terms - as we believe they can be due to our existing system management arrangements, which drive competing organisational priorities and an inability to divert funding and investment from historical patterns of provision that do not meet the changing needs of the population.

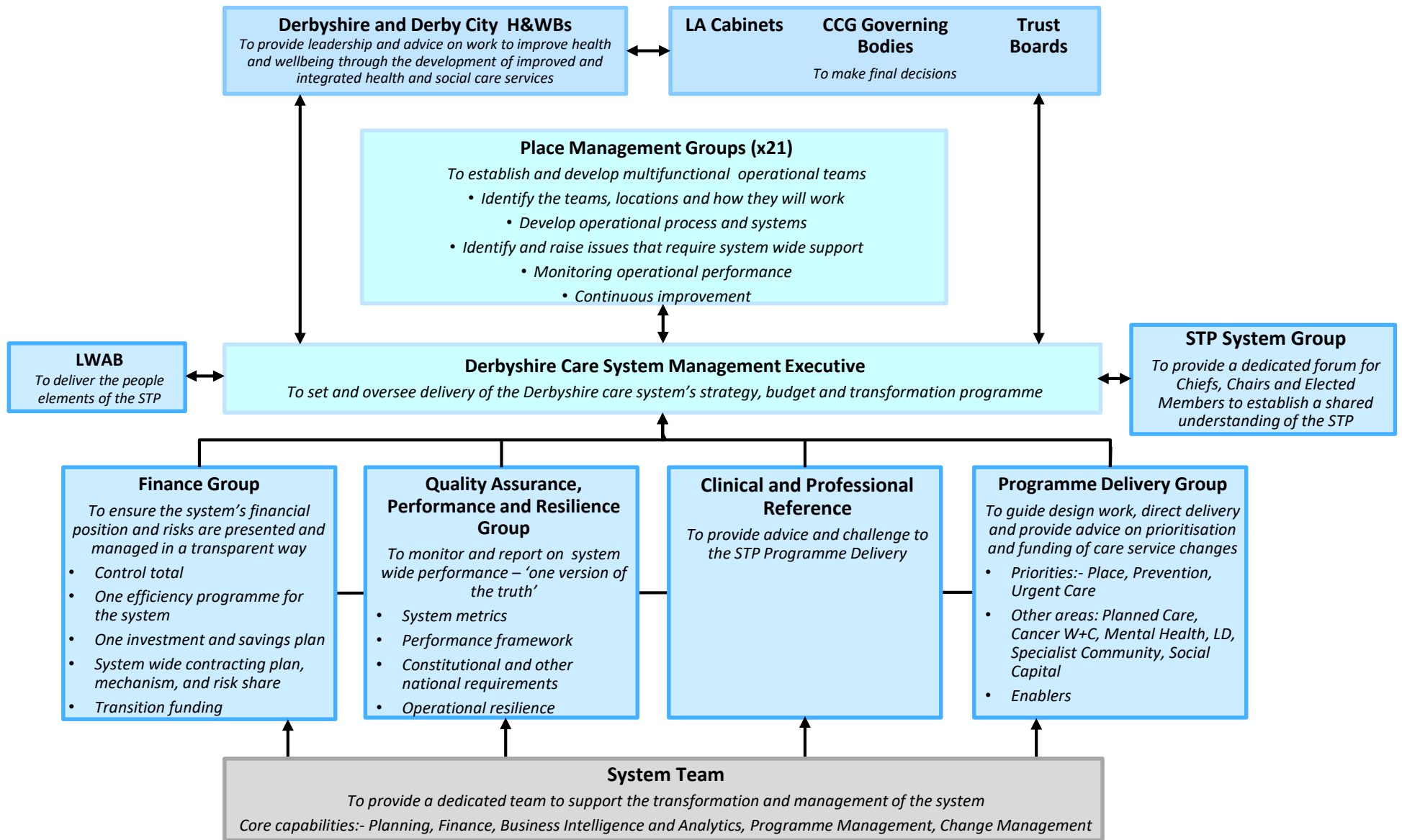
So we need to ensure this time we put the arrangements in place to drive sustainable, embedded change. These arrangements must address past barriers to change - including lack of cross-system working, misaligned incentives and the predominance of organisational over system-wide or patient-centred perspectives.

Transforming how we work together across organisations to manage the system is therefore a priority for our STP. We must make system-level working the default option – ‘business as usual’ - as an approach for managing all of the care we commission and provide.

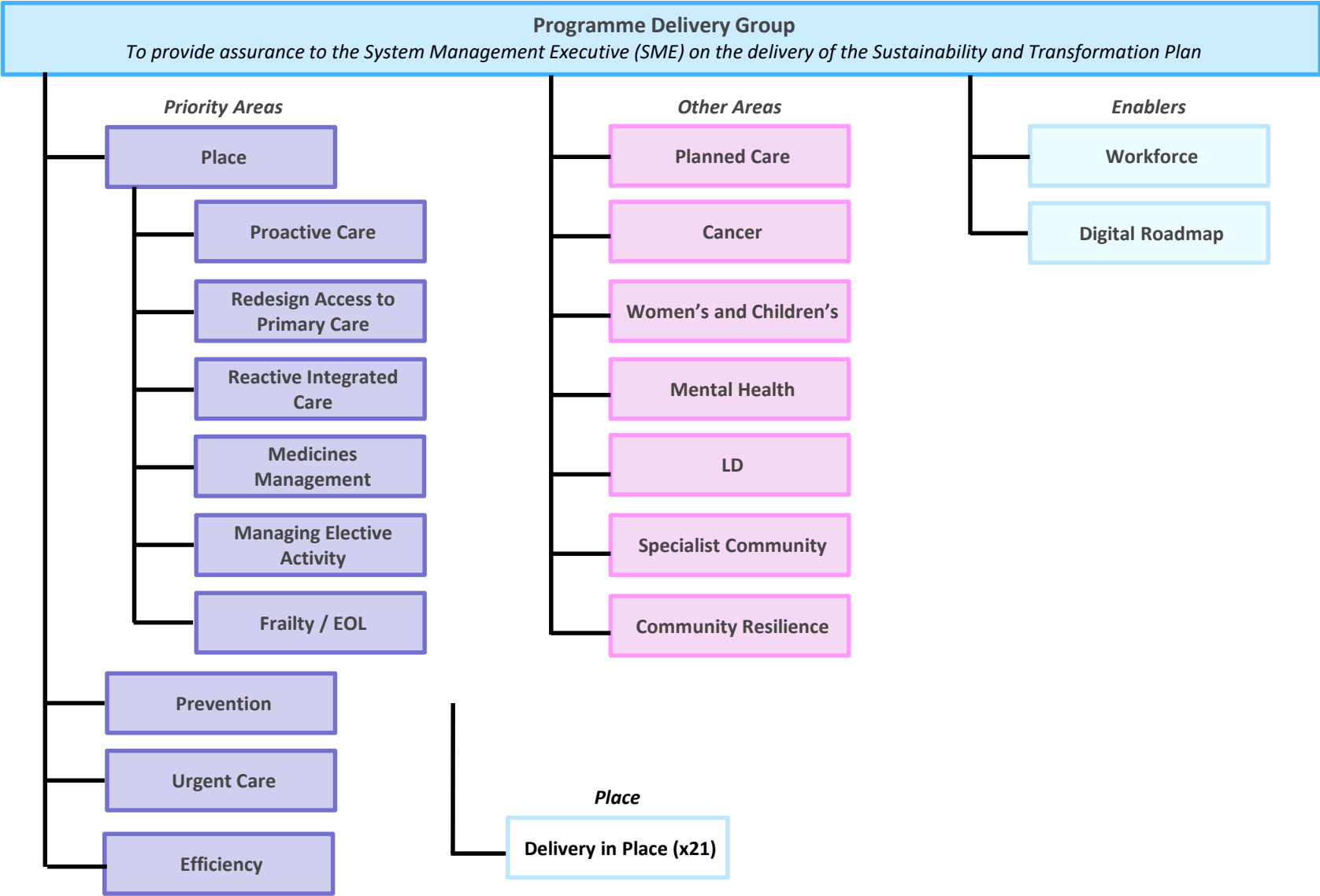
In developing our arrangements for transforming system management, we have adopted the King’s Fund’s design principles for the development of systems of care, as well as built on the experience of the management and governance for the two previous transformation programmes in the north and the south of the county. The design principles for transforming our system management are set out in the figure to the right.



Governance arrangements – Structure

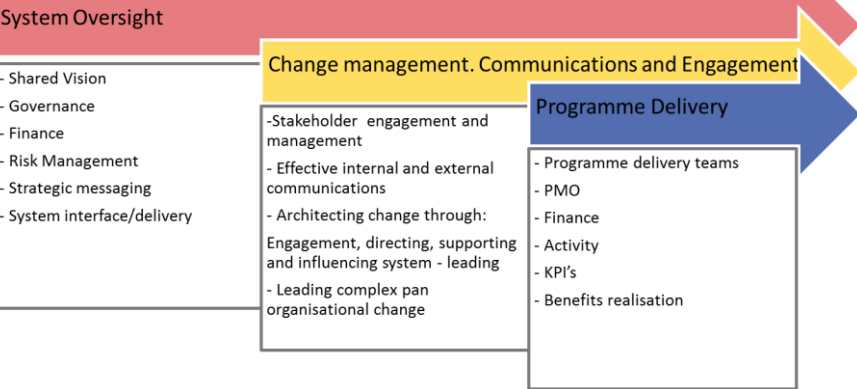


Governance arrangements – Programme Delivery Group and Work Streams



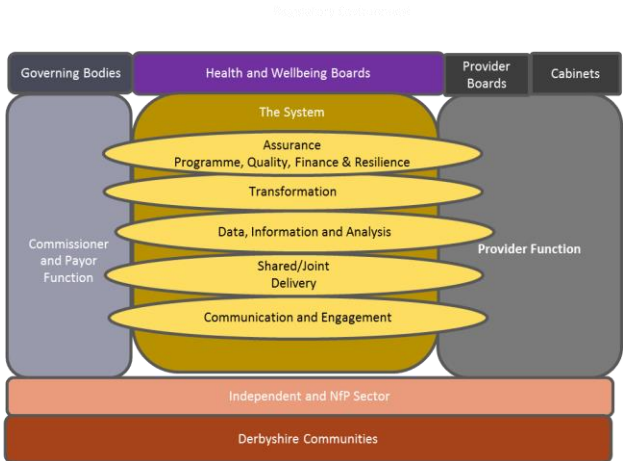
Governance arrangements – System Team

Principles

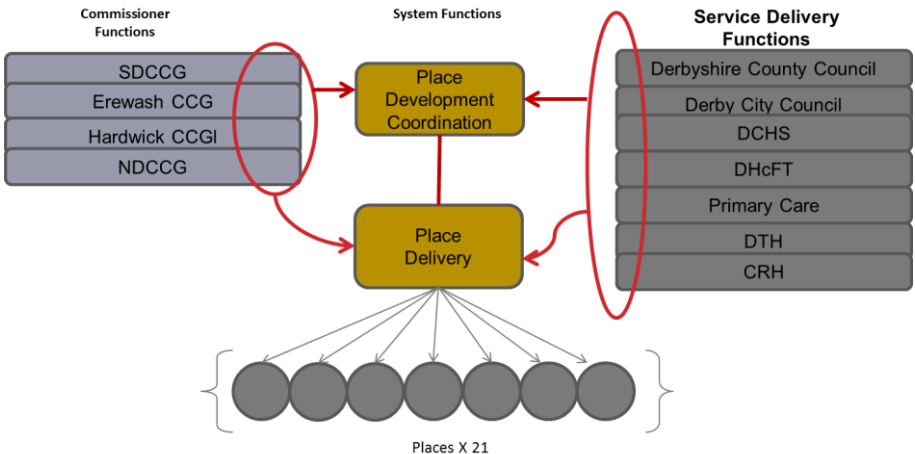


Purpose

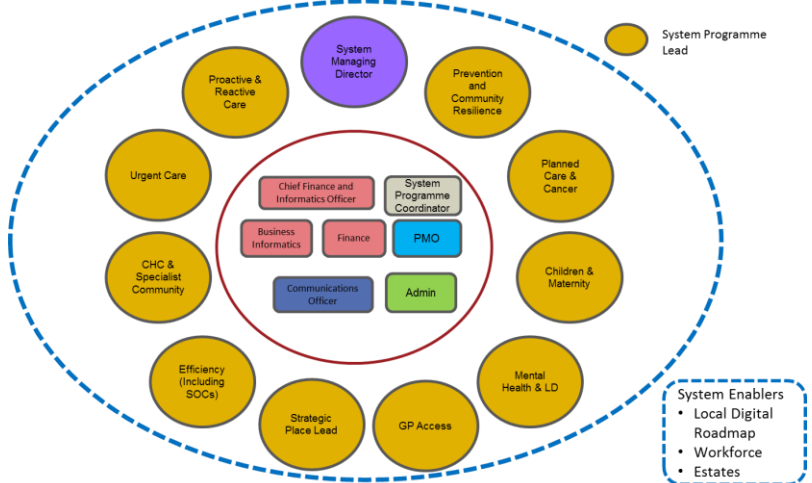
- To provide leadership across organisations to ensure the delivery of change supporting sustainable services for people of Derbyshire
- To act as the guardian of the system principles
- To play an interim role in the development and leadership of complex integrated services
- To engage and communicate with system stakeholders, staff and the public.
- To support programme delivery and assurance
- To support system assurance focussing on quality, finance and resilience.



Shared Delivery



System Team



Appendix 2: Engagement process

Engagement Process

Ensuring internal and external engagement in the STP

Background

The Derbyshire STP builds on a set of principles that were developed and agreed on a Derbyshire basis through wide scale public engagement started in 2011 with health and social care coming together to work on a project called 21st Century Healthcare. This engagement was taken forward in North Derbyshire with 21C and Joined Up Care in the South of Derbyshire and shared principles were agreed.

These principles are to:

- Continue to improve the experiences our patients have
- Ensure the best possible outcomes for all
- Ensure for patients that ‘no decision about me is made without me’
- Helping people to help themselves
- Delivering the right service every time
- Care is provided in the right place
- Flexible and integrated working across organisations
- Be innovative
- Responsible information sharing

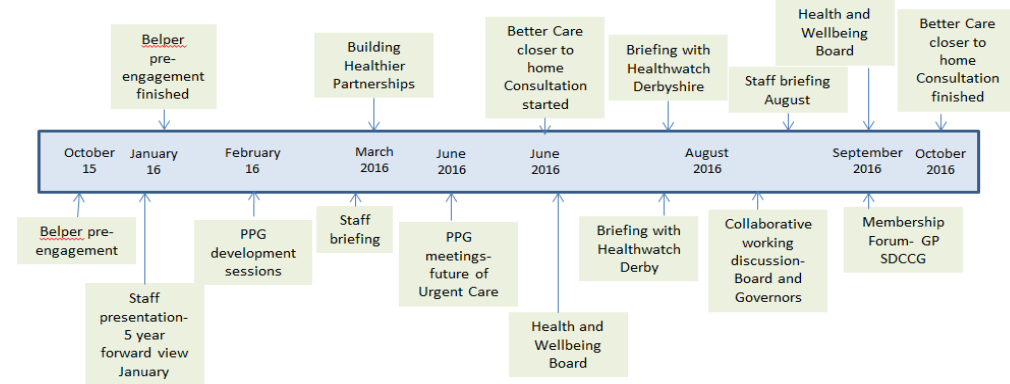
The Public

Engagement with the Public to date has been centred around the Better Care Closer to Home Consultation and the Belper Health Services Pre-engagement, both of which gave a clear direction on the way NHS services will change. All discussions with the Public continue to have a focus on the Forward View and the principles of change in the NHS.

Key stakeholders

Key stakeholders including providers, commissioners, Local Government, voluntary organisations and both Healthwatch organisations have been introduced to the principles of the STP through engagement. Additional meetings have taken place about closer joint working between Derbyshire Healthcare NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust.

Engagement timeline- Public and key stakeholders



Developments sessions have been held for staff to give updates and an overview of the STP development. Staff also are able to access information through regular internal staff communications.

Clinical Engagement

A development session for GPs to ensure their involvement in the development of the principles behind the STP have taken place.

Clinical Leads on the STP work streams have been appointed and their role to disseminate and collate feedback has been clarified.

To support robust clinical engagement a ‘Place’ section on the SD CCG internet has been developed.

North Derbyshire CCG organised a practice engagement event to explore the Sustainability and Transformation Plan and what it means in North Derbyshire and engagement events with both North Derbyshire and South Derbyshire Volunteer forums have been held.

Health and Wellbeing Boards in Derby and Derbyshire continue to be briefed at each meeting and have agreed to commence joint meetings to specifically support a more integrated approach to monitoring STP development.

For clarity the detail of the STP documents have not been disclosed during briefing sessions to staff, public and stakeholders.

Engagement

The summary below provides an overview of specific recent engagement...

Better Care Closer to Home

- Over a three month formal consultation window, we engaged in effective face-to-face dialogue with more than 1,000 colleagues and:
 - 1,700 people responded by completing a feedback form
 - 1,500 took part in the public meetings over three months
 - hundreds more phoned or wrote in or contributed in other ways such as emails
 - many chose to share personal accounts of their experience of care.
- Engagement was led by the executive directors and comprised of more than 30 briefings and drop-in sessions for public and staff, to discuss the proposals
- Several other briefings were held specifically for governors to keep them abreast of the plans
- A coordinated face-to-face briefing session is being planned to communicate the outcome of the consultation and to ensure we are able, with our clinicians and other professionals, to shape the future of community-based care together.

Belper Health Services Review Joined Up Care

- In August 2015 the CCG initiated a review of health care services within Belper and the surrounding areas. The review involved assessing people's current healthcare needs and what we expect them to be in the short, medium and longer-term alongside the continued development of the CCG's vision for community services. The review also assesses current local service provision.
- The pre-consultation phase of the review started in August 2015 and closed at the end of January 2016. The pre-consultation gave local people an insight and overview on the future of local health and social care and how they will need to adapt to ensure they are suitable for the future.
- This phase sought to obtain the input of the local population to inform the creation of a range of options regarding the future of community services within the Belper area.

- Following pre-engagement we have ensured all stakeholders have been kept up to date on progress and understand that we are working on the viability of the options for a consultation.
- GPs have been presented the draft options and discussions have take place which covered the connection to the STP.
- A number of face-to-face briefing sessions have been held with staff and colleagues in the Belper area to help inform proposals set out in any future consultation.

Collaborative Working

- Derbyshire Community Healthcare Services and Derbyshire Healthcare have been exploring potential benefits of greater collaborative working. An initial engagement event comprising of both Boards, Councils and Governors and other key stakeholders took place on 31 August to gather feedback on potential benefits of collaboration and help inform the Strategic Outline Case. Similar work is being undertaken to the same timescale by Derby Teaching Hospitals and Burton Hospitals.
- Staff across all organisations have been kept regularly updated through coordinated and aligned communications programmes. A communications plan has been developed to engage with staff, governors and other stakeholders following the decision of both Boards.

Engagement Next Steps

Our Approach

- The engagement approach must be targeted and evolving, and will naturally occur in a number of phases as the STP moves through its development and implementation.
- Our engagement activity will restate the ground we have covered previously in developing our principles, but seeking at all times to be adding layers on information which paint pictures of how services might/will look on the ground in defined places. It is only through articulating the particular effects and benefits and implications of the STP on individuals and their communities that we will see real engagement.

Phase	Activity	Output
1	Communicating the basics of STP to staff and internal stakeholders, including CofGs <ul style="list-style-type: none"> What STP is What it's looking at Who's involved What the timetable is What are the emerging priorities 	General understanding of STP among staff, boards and governors
2a	Engaging staff in the development of the first level plans	Emerging plans which can demonstrate clinician and wider staff involvement in their development
2b	Engaging communities and external partners in the development of the STP, to outline <ul style="list-style-type: none"> The engagement to date which have informed how we will plan The requirements now upon us and our initial analysis Their initial input into the issues at hand and the potential solutions we see in places 	<p>A segmented engagement programme which helps local people understand the impact of place based commissioning</p> <p>Emerging plans which can demonstrate initial community in their development</p> <p>An STP submission which includes details of robust engagement across our places and priorities</p>
2c	Clinical engagement in the development of first level plans	<p>Clinical leads established at work stream level</p> <p>Robust engagement mechanisms developed including easily accessible online resources to offer a wide range of opportunities for engagement</p>
3	Development of robust communications and engagement plans across all business case/workstream areas	Communications and engagement plans which ensure segmented population and condition groups are fully engaged, involved and, where necessary, consulted in proposed service developments and change.
4	Delivery of communications and engagement plans to support implementation	Coordinated communications and engagement activity which supports STP implementation

Targeted Approach As required through the planning phase we have started engaging with our local staff and population, taking into consideration two cross sections:

Our geographical communities/places

We are segmenting our populations based on 'places', utilising population analysis to support communications and engagement to understand local need and service commissioning/provision. We will continue to target existing geographical communities ensuring that we take our offer to the places in which people congregate, rather than expecting communities to travel to an NHS conference-style event. This mitigates the 'usual suspects' risk and ensures we can better reach into the heart of communities and obtain the real views of local people.

In addition, in Phase 2 of our plans we will ensure we are talking about potential service changes rather than focussing on theory and principles, to ensure that the conversation is meaningful and helps people to engage in change that they can understand may affect them and their care.

We will utilise Foundation Trust membership, PPGs and local community groups (including links established through Local Area Coordinators) as our primary sources of engagement.

Our communities of interest which form through health conditions and other factors, rather than geography

Working through existing mechanisms, in collaboration with the charitable and voluntary sector, we will aim to engage with groups which are associated through a particular health or care condition or need, where these are not naturally defined by geography. This will certainly include mental health, learning disability, dementia, LTCs and carers, along with other groups as they emerge through our analysis.

Engagement going forward – an overview of the proposed work ahead

Action	Detail	Action – next steps
Staff	Pull together materials, key messages	To be agreed w/c 1/11/16
Public	Pull together materials, key messages	Outline approach agreed at Comms Group which sees engagement in places using 'aunt sally' plans to demonstrate the scale of change. Possible risk of raising expectation/challenge.
What are the 'gaps' we are looking to close?	This detail will ensure we can do detailed segmentation of the target communities and tailor communications and engagement accordingly.	Ongoing engine room process on gap analysis. Communications review to begin to understand segments and potential approaches, linked to place development.
What does the future service model look like?	Describing an 'aunt sally' of what the model looks like in practice, using real services and real locations, will help local people to better engage in their community as they will see a tangible proposal.	Using defined places, gaps and service models, develop draft case studies to use as basis of public engagement. ST to set up session for STP comms group reps and STP planning and information team to meet by 08/11/16
Write engagement plan	Define engagement plane to ensure it is targeted.	Engagement plan requires roll out after an understanding has been clarified of where we are following the consultation in the North.
Map staff events	Ensure existing mechanisms can be used across organisations. Collate presenters pool across all orgs to ensure everyone knowledgeable enough to lead staff discussion on STP. Consider additional support for presenters as required.	STP Partner comms lead to map events/ opportunities using standard pro forma (provided), Establish feedback process to ensure all input from staff can be captured.
Trade Unions	Confirm approach to briefing and engaging TUs for now and throughout process. To be routinely briefed, especially ahead of any new staff engagement activity.	ST liaise with Amanda Rawlings to establish best process.
Map public meeting opportunities	Map provision bookings for public and NHS/LA venues across all Derbyshire places, plus existing forums to approach key stakeholders.	Started but needs revisiting for footprint. Need to agree approach in north to match with 21C Discuss 21C/north with LS Opportunities mapped Venues provisionally booked Presenter pool matched to venues Opportunities promoted/launched
Develop PR and launch plan for engagement	Ensure STP engagement is widely communicated to raise awareness of opportunities to get involved (internal and external).	ST draft plan for discussion among STP Comms Group membership.
Develop newsletter copy to bring key internal stakeholders up to date ahead of public launch.	To include detail behind headlines, work stream leads and next steps. To include YSWD from staff engagement processes/other feedback to answer queries centrally and consistently.	To be drafted and circulated to comms leads 16/9/16
Identify roles on clinical leads for engagement	Public discussions hosted by members from Chiefs group and identified clinical 'circle'	Chiefs discussion about clinical leads: Rick Meredith, Ian Lawrence,

Appendix 3: Local Digital Roadmap

Local Digital Roadmap

The LDR and how it is aligned to the STP is described by the Outline Business Case and is summarised below...

Derbyshire LDR Supporting the STP – ‘Plan on a Page’

The summary below provides a high level overview and Introduction to the IM&T Components of the Derbyshire STP

(1) The Gaps

In order to ensure that the STP achieves its maximum potential, it will need to be supported by a robust IM&T Programme:

- Clinicians will need to have fast, reliable, agile access to the most complete, accurate and up to date clinical records of their patients, wherever care is given
- While there has been substantial improvements in the quality and availability of Derbyshire IM&T systems and services, there is still much to do before all care professionals have all the tools that they need to deliver the best possible care
- Derbyshire has a rich history of collaboration between all the IM&T services, providing a strong foundation for transforming future services
- A total investment programme of £33m has been identified to meet the needs of the whole community, putting IM&T on a sound footing in all locations and settings

A targeted programme of transformational change to Informatics is needed, to maximise the benefits of existing and future IM&T assets, to deliver best possible care

(3) Impact and Implications

Delivering the LDR will support the STP:

- **For the people of Derbyshire:** ensure that their care records are complete, up to date, and available to individuals providing their care: **safe and healthy** – identifying issues before they become problems; **at home** – supporting their care needs; **and independent** – able to monitor and manage their own health
- **Achieve a financially sustainable system:** recognising that IM&T is crucial to providing the information needed to ensure sustainability, but also must ‘play its part’ in controlling costs

Transform infrastructure to support new models of care

- £33m investment to deliver improved IT systems, accessibility and security
- Changes to technical and ancillary workforce

(2) Our Priorities

Derbyshire LDR has 5 programme workstreams:

- Derbyshire Care record – on-line availability to the shared care record, 24/7 ensuring that the right information is available to the right people at the right time
- Sharing Systems - the security, governance and tools to support access to key support systems where and when they are needed (Out of Hours, on the move)
- Mobile working – the delivery of the technical infrastructure to allow access to the shared Derbyshire systems
- Business Intelligence – analytics data, to support improved care and whole system planning
- Mainstreaming and maximising – ensuring that the existing systems are used in the most effective and efficient ways. This programme has started with primary care, focussing on standardised processes

(4) Next steps

Delivering the LDR will support the STP to deliver robust plans:

- The LDP has started on a journey to transform IM&T services in the county. There is a clear recognition that the nature, quality and availability of services must improve to a level that all users can have absolute confidence in its effectiveness and reliability
- The work is starting from a firm base, as one of the strongest LDR submissions, nationally, but there will be more to do, as the exact nature of care services undergoes transformational change. In addition, the standards that will be expected are continually being driven up through ever rising expectations
- During the next year the nascent LDR programmes will strengthen integration and interoperability of the collective IM&T resources throughout the county, as a prelude to developing more advanced capabilities

Appendix 4: Addressing the ten big questions

Appendix: How our priorities address the ten key questions

		Five Key Priorities				
		Place-based care	Prevention and self-management	Urgent Care	System Efficiency	Transforming system management
Ten Key Questions	How are you going to prevent ill health and moderate demand for healthcare?	Intensive case management, condition management, risk stratification and care planning to reduce avoidable admissions	Range of initiatives for primary, secondary and tertiary prevention.	Intensive case / condition management, reactive, integrated care support to reduce avoidable admissions		Reformed system management arrangements will underpin system-wide coordination of all of the priorities, and therefore support us in addressing all of the key questions
	How are you engaging patients, communities and NHS staff?	Co-developing place-based care models	Promoting self-management and shared decision-making. Workplace wellbeing			
	How will you support, invest in and improve general practice?	Redesigning primary care to deliver GPFV	Brief intervention training programme in primary care.	Redesigned urgent primary care	Support general practice to deliver the 10 high impact actions within the GPFV	
	How will you implement new care models that address local challenges?	Integrated care designed around place – adapted to local needs	Redesigned care pathways include effective tertiary prevention Integrated with 'Place'	Integrated and simplified urgent and emergency care pathways incl. single point of contact Integrated with 'Place'		
	How will you achieve and maintain performance against core standards?	Referral standardisation to reduce variation. Integrating MIU/WICs with general practice	Redesigned pathways include tertiary prevention Prevention lowers demand	Improve hospital 'front door' and ambulance performance to ensure appropriate use of A&E	Streamlined pathways reduce duplication	
	How will you achieve our 2020 ambitions on key clinical priorities?	Transforming access to general practice (7 days) Support cancer survival and diagnosis rates Support dementia diagnosis	Supports cancer survival and diagnosis rates	Close the gap/greater integration with MH and LD services		
	How will you improve quality and safety?	Places coordinate specialist care closer to home. Integrated care reduces duplication.	Supports reduction in avoidable deaths	Roll out 4 priority 7 day hospital clinical standards	Streamlined pathways reduce duplication Aligned clinical governance	
	How will you deploy technology to accelerate change?	Aligned to Derbyshire Local Digital Roadmap	Aligned to Derbyshire Local Digital Roadmap	Aligned to Derbyshire Local Digital Roadmap	Aligned to Derbyshire Local Digital Roadmap	
	How will you develop the workforce you need to deliver?	New roles (incl. retraining) and ways of working in multi-disciplinary teams. Growing GP workforce.	Training to support behaviour change and using 'teachable moments'	Flexible workforce – integrated assessment, advice, triage service	Optimising the workforce – tackling variation, aligning staffing to need, reduce agency spend	
	How will you achieve and maintain financial balance?	Net impact £20m	Net impact £5m	Net impact £18m	Net impact £124m	

Appendix 5: Summary Overview of Planned Changes to Bed Based Care

Baseline & 'do nothing' for bed based care

The table below summarises the bed based health activity delivered to the people of Derbyshire in terms of baseline, growth to 2020/21 and hence the 'do nothing scenario':

For NEL acute activity:

- It shows the bed usage at 100% occupancy;
- And, to provide a reference to actual bed usage assuming 95% occupancy;
- The baseline includes and shows care provided out of area.

	Baseline (2015/16)		Growth	Do Nothing 2020/21
Acute NEL beds	1,268 (100% occupancy)	1,331 (95% occupancy)	134	1,465
Royal Derby	596	626		
Chesterfield Royal	355	373		
Out of Area	317	333		
Community Hospital beds	210		40	250
Mental Health beds	230		23	253
Adult	180		18	198
Older Persons / Dementia	50		5	55
Total Health	1,771		197	1,968

How we are currently providing our NEL acute bed based care

National evidence

Evidence from NEL acute bed audits (Source: Monitor – Moving Healthcare Closer to Home):

- Bed audits, which assess patients’ care needs in acute hospitals to identify patients who can be treated in alternative settings, have found up to 50% of bed days in these wards could theoretically take place in other settings.
- Of the 50% of patients who could be treated in alternative settings, around 80% of bed days are for patients who could, in principle, be treated more appropriately in other services such as intermediate care, rehabilitation and reablement, district nursing, social care or mental health.
- For the remaining 20%, the patient could have returned to their usual place of residence without additional support.

This is supported and enhanced by evidence from the MCAP-CRU point prevalence survey tool (Source: Oak Group (UK) Ltd):

- 25% of admitted episodes were non-qualified
- 60% of continuing beds days were also non-qualified
- A non-qualifying admission or bed day is one for which the care (as planned within the acute setting) could have been delivered in an alternative setting with lower clinical risk.

Local evidence – usage of beds

A small proportion of our population, particularly elderly patients, typically have long lengths of stay and account for a high proportion of acute hospital non-elective beds:

- In the Derbyshire system, 1% of the population (c.10k people) account for:
 - 25% of our acute hospital non-elective admissions (c.25k admissions)
 - 64% of our acute hospital occupied bed days (298k out of 463k), which equates to 812 out of 1,268 NEL beds
- The vast majority of this ‘1%’ are elderly:
 - 81% (7,860) of patients are aged 65+
 - Of those 78% (6,133) are aged 75+
- The average length of stay for this ‘1%’ is 11.4 days, however a disproportionate number of occupied beds are used by patients staying in hospital for longer periods of time. Of the 812 beds used by this group:
 - Patients staying 14 days or more equates to 573 beds (477 are used by those aged 65+)
 - And, within this, patients staying 30 days or more equates to 250 beds

Local evidence – understanding the patient cohorts

To help identify and plan the necessary interventions, cohorts of patient needs have been defined:

	NEL Adm (,000)	NEL Beds
Frail Elderly (FEAT)	10.6	293
Acute ACS single	1.7	5
Chronic ACS	7.6	95
65+ outside of FEAT	32.9	549
Other admissions	47.3	326
Total	100.1	1,268

(Activity based on baseline period)

FEAT Criteria: age 75+ with a fall; 75+ with Delerium; Nursing and Residential Home Admissions; 85+ with 4+ Co-morbidities (LTC)

How we are currently providing other bed based care

Adult Mental Health Beds

Adults of working age requiring admission for mental ill health stay in hospital longer than the England average. The mean length of stay for patients at DHcFT is in the top three highest amongst 47 peers at over 45 days compared to a mean of 30 days.

2015/16 bed baseline = 180

Community Hospital rehabilitation beds

Utilisation review of community hospital beds (InterQual, 2011) identified 169 patients out of the 278 patients reviewed (61%) did not need to be in a community hospital on the day of audit – their care needs could have been met mostly in home or care home settings.

2015/16 bed baseline = 210

Older Persons Mental Health / Dementia beds (delivered from Community Hospitals)

North Derbyshire has 50 Older Persons Mental Health beds, for a population of 390,000. Sheffield has 21 specialist dementia beds for a population of 552,000. Southern Derbyshire has seen change at this scale and this is reflected in the figure above. The proposed STP work is to implement the same model in the north of the county.

2015/16 bed baseline = 50

Methodology for bed base change calculations:

$$\frac{\text{No. of episodes impacted upon} \times \text{Av. LoS}}{365}$$

Overview of the impact of the proposed changes...

			Avoiding episodes		Delivering care differently									
	Baseline		Proactive care & primary prevention (avoid growth)		Reactive integrated care: step up		Reactive integrated care: step down		Acute urgent care		Overall			
	2015/16	Do Nothing 2020/21	Interventions & impact	Beds	Interventions & impact	Beds	Interventions & impact	Beds	Interventions & impact	Beds	Growth avoided	Fewer than baseline	Do Something 2020/21	
Bed setting														
Acute NEL beds	1,331	1,465	9,000 @ 5.4 ALoS	-134	15,288 @ 3.4 ALoS	-143 (11%)	8,543 @ 9.4 ALoS	-220 (17%)	3,415 @ 3.6 ALoS	-34 (2%)	-134	-397 -188 -112 -97	-30%	934
Royal Derby	626	689												
Chesterfield Royal	373	410												
Out of Area	333	366												
Community Hospital beds	210	250	686 @ 21.3 ALoS	-40			1,457 @ 21.3 ALoS	-85			-40	-85	-40%	125
Mental Health beds	230	253									-23	-53	-23%	177
Adult	180	198		-18		-14		-19			-18	-33	-18%	147
OP/Dementia Care	50	55		-5		-20					-5	-20	-40%	30
Total Health	1,771	1,968		-197		-177		-324		-34	-197	-535	-30%	1,236

Proactive

- Intensive case management-particular focus on Frail Elderly (FEAT)
- Condition management – long term conditions

Primary Prevention

- Wellness hubs including life style interventions (smoking, alcohol and weight)

Step up

- Acute Home Visiting
- Falls Pick Up
- Care Home Service
- Rehabilitation
- IV Therapy
- Enhanced Dementia and Delirium Pathway
- Enhanced Integrated MH team - home treatment

Step down

- Discharge to Assess and Manage
- End of Life
- IV Therapy
- Enhanced Integrated MH team - rehab

Urgent Care

- Ambulatory Care
- UCC
- Paed assessment
- MH in integrated teams

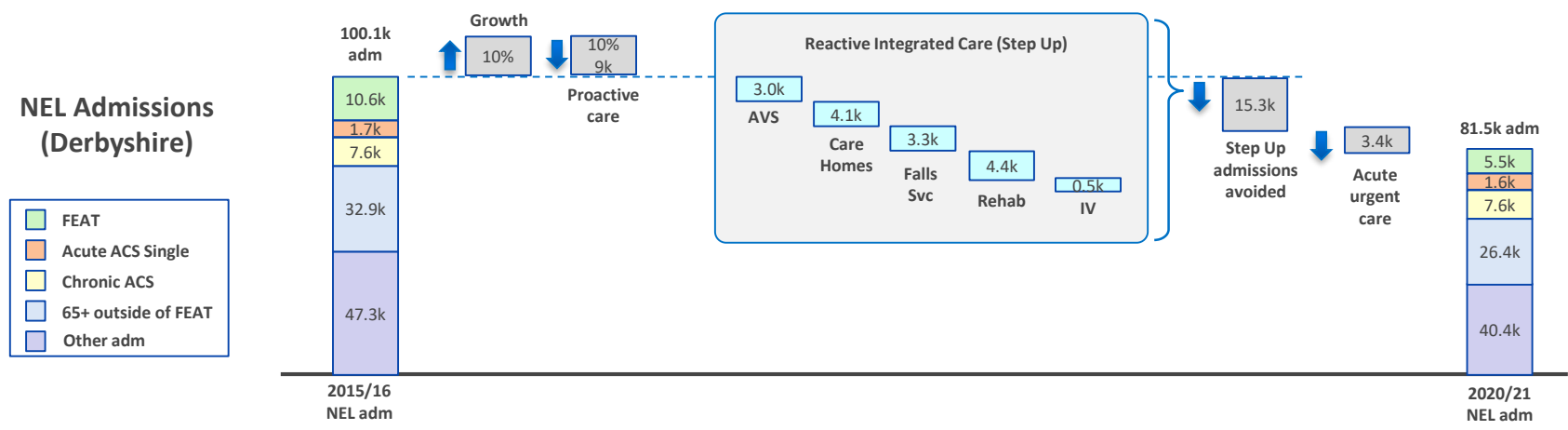
Notes:

- Acute NEL bed reduction against baseline = 30%; evidence suggests c.50% of acute NEL bed days could be treated in alternative settings
- Community hospital bed reduction against baseline = 40%; evidence suggests c.60% of community hospital bed days could be treated in alternative settings
- Adult mental health bed reduction against baseline = 18%; evidence suggests c.33% of adult mental health bed days could be treated in alternative settings
- OP/Dementia bed reduction against baseline = 40%; evidence suggests c.75% of dementia bed days could be treated in an alternative setting

Overview of the impact of the proposed changes on NEL admissions, by change initiative...

The figure below describes the impact of the proposed initiatives:

- Proactive care to avoid the forecast growth in NEL admissions – c.9k admissions
- Reactive integrated care: step up to reduce 2015/16 NEL baseline by 15.3k admissions through:
 - Acute home visiting service (3.0k)
 - Care home service (4.1k)
 - Falls service (3.3k)
 - Rehabilitation (4.4k)
 - IV service (0.5k)
- Acute urgent care (GP triage and primary care streaming) to reduce 2015/16 NEL baseline by 3.4k admissions
- Total NEL admission reduction against 15/16 baseline = 18.6k



Overview of the impact of the proposed changes on NEL acute beds, by change initiative...

The figure below describes the impact of the proposed initiatives:

- Proactive care to avoid 5 year forecast growth in NEL beds – 134 beds
- Reactive integrated care: step up to reduce 2015/16 NEL bed baseline by 143 beds
- Acute urgent care (GP triage and primary care streaming) to reduce 2015/16 NEL bed baseline by 34 beds
- Reactive integrated care: step down to reduce 2015/16 NEL bed baseline by 220 beds through:
 - Discharge to assess and manage (179 beds)
 - End of life (10 beds)
 - IV therapy (31 beds)
- Total NEL bed reduction against 15/16 baseline = 397

