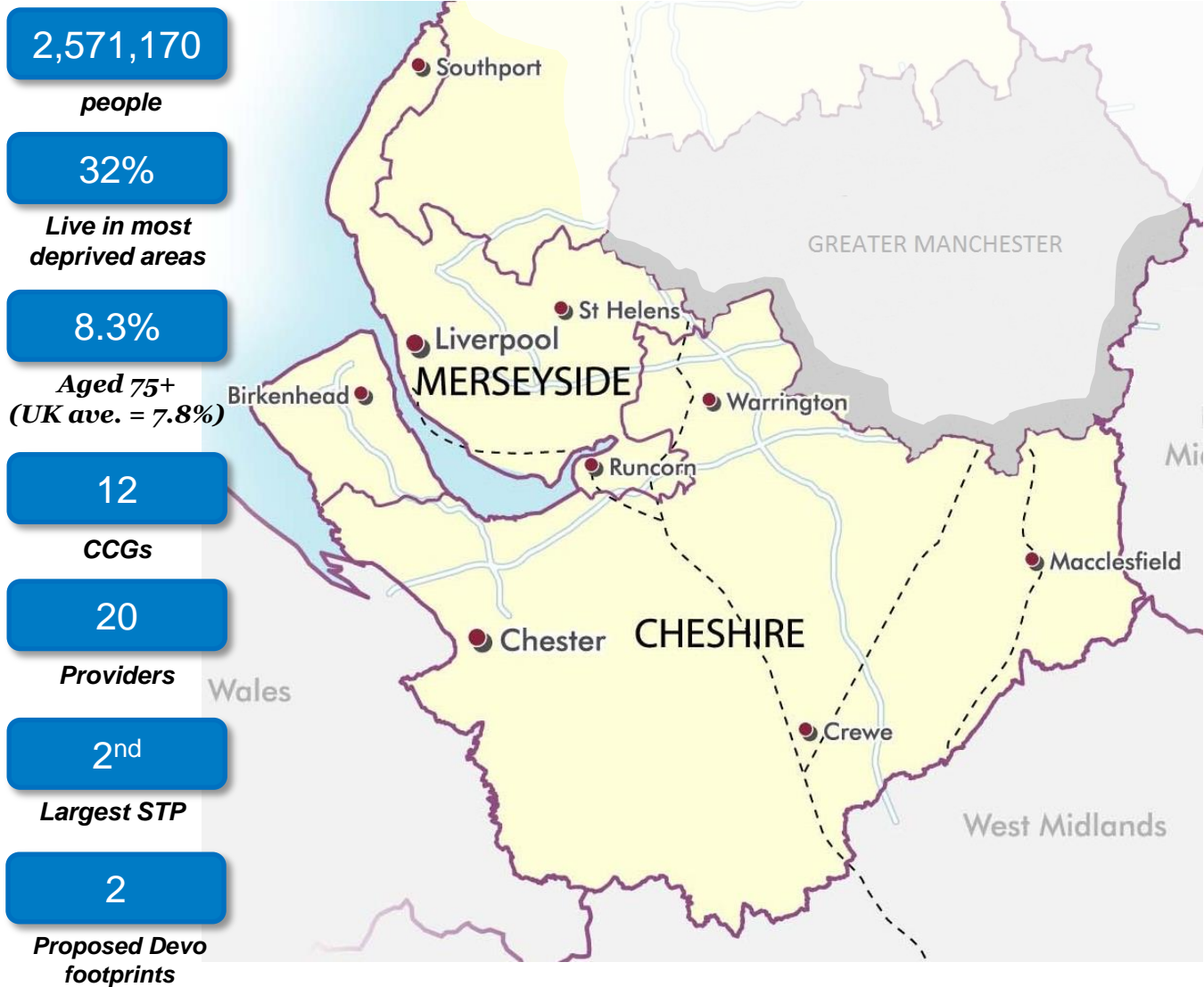


# Cheshire & Merseyside Sustainability and Transformation Plan

21 Oct 2016 version 3.3



## Key information

**Name of footprint and no:** Cheshire & Merseyside; No. 8

**Region:** North

**Nominated lead of the footprint including organisation/function:** Louise Shepherd, Chief Executive, Alder Hey NHS FT

**Contact details (email and phone):** [louise.shepherd@alderhey.nhs.uk](mailto:louise.shepherd@alderhey.nhs.uk) – 0151 252 5412

**Organisations within footprints:**

**CCGs** – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington

**LA's:** Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral

**Providers:** Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Trust

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## Foreword

Partners across Cheshire and Merseyside have been working together over the last 4 months to develop further the blueprint we set out in June to accelerate the implementation of the 5YFV for our Communities. We have come together to address head on the challenges we articulated then: that people are living longer, but not always healthier, lives; that care is not always joined up for patients in their local community, especially for the frail elderly and those with complex needs; that there is, as a result, an over-reliance on acute hospital services that often does not provide the best setting for patients; that there is a need to support children, young people and adults more effectively with their mental health challenges. At the same time, there is enormous pressure on health and social care budgets.

We are clear that these issues require us to think much more radically about how best to address the problems we face together, otherwise we will fail to support the needs of our Communities into the future. This document summarises the plans developed to-date to address these challenges across all our different communities in Cheshire and Merseyside and fall into 4 common themes:

- support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing;
- working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting;
- designing an acute care system for our communities that meets current modern standards and reduces variation in quality;
- making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes;

Much of this work is already underway at local level but there is also still much to do. The role of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside is to co-ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole Region in the future.



*Hani Shepherd*

## Executive Summary

Our submission in June identified the key challenges faced by the Cheshire and Merseyside STP, including:

- **high rates of diseases associated with ageing, including dementia and cancers;**
- **high rates of respiratory disease;**
- **early years and adult obesity;**
- **high hospital admissions for alcohol;**
- **poor mental health and wellbeing; and**
- **high rates of teenage conceptions.**

Furthermore our analysis confirmed that across the region there are significant service and financial challenges, either at individual organisational level or across whole economies. Health and social care services have grown and developed over time in fragmented, uncoordinated ways that do not meet the changing needs of our Communities. At the same time, there are significant pressures on health and social care budgets. Both these issues mean that we will fail to meet the future needs of our population and provide the standard of care they deserve without a radical change in current delivery. Continuing with current models of care provision will result in a gap in our finances of £908m by 2021 across the Region if we do nothing. This challenge has narrowed from the £999m in our June submission, reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

### ***We are clear on the ambition we have for the patients, staff and population of the C&M STP***

Our core purpose is to create sustainable, quality services for the population of C&M. This is effectively our ambitious blueprint to accelerate the implementation of the 5YFV across C&M.

Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

We have devised a portfolio of 20 programmes, each with clear objectives, scope and emerging governance structures – some are further ahead than others in developing their detailed plans.

***The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes.*** To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

### ***Maximising opportunities***

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

### ***The key themes we are pursuing***

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations.

***Delivery happens at LDS level,*** and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

### ***What stage are we at now?***

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

# 1 - Our starting point

## Our previous submission in June demonstrated a sound understanding of our issues, and a clear strategy for going forward

Our submission in June identified the key challenges faced by the Cheshire and Merseyside STP, including:

- *high rates of diseases associated with ageing, including dementia and cancers;*
- *high rates of respiratory disease;*
- *early years and adult obesity;*
- *high hospital admissions for alcohol;*
- *poor mental health and wellbeing; and*
- *high rates of teenage conceptions.*

Furthermore our analysis confirmed that across the region there are significant financial challenges, either at individual organisational level or across whole economies. *The 'do nothing' affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be £908m.* This challenge has narrowed from the £999m in our June submission, to £908m driven by the gap now reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

Clearly C&M isn't going to sit back and 'do nothing'. In addition to the work already underway within our three Local Delivery Systems (LDS) we identified the strategic STP priorities that would make our health and care system sustainable in the near medium and long term:

1. **Improve the health of the C&M population** (previously referred to as 'Demand Management' and 'Prevention at Scale') by:
  - *Promoting physical and mental well being*
  - *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*
2. **Improve the quality of care in hospital settings** (previously referred to as 'Reducing variation & improving quality in support of hospital reconfiguration') by:
  - *Reducing the variation of care across C&M;*
  - *Delivering the right level of care in the most appropriate setting*
  - *Enhancing delivery of mental health care*
3. **Optimise direct patient care** (previously referred to as Productive back office and clinical support services collaboration) by
  - *Reducing the cost of administration*
  - *Creating more efficient clinical support services*

After the existing LDS plans were modelled we forecast a surplus of £49m by 2021. However, these plans required further analysis and challenge to

convert them from sound ideas into robust plans.

## Our work since June has been focussed on the development of these 'sound ideas' into 'robust plans'.

We have created a portfolio structure that brings together twenty distinct, but interrelated programmes of work. Each of these programmes has developed clear objectives, is in the process of agreeing its governance model and are developing their plans for delivery. Each is at a different stage of maturity and this STP submission reflects this.

Our strategic STP programmes aim to provide guidance and clear principles about how we will tackle four key issues across the STP footprint:

1. Improving the health of the C&M population
2. Improving the quality of care in hospital settings
3. Optimise direct patient
  - a) Reduced administration costs
  - b) Effective clinical support services

These programmes are supported by eight clinical programmes looking to improve the way we deliver:

4. Neuroscience;
5. Cardiovascular disease (CVD)
6. Learning disabilities
7. Urgent Care
8. Cancer
9. Mental Health
10. Women's & Children's
11. GPs and primary care

There are five programmes that support and enable the above programmes:

12. Changing how we work together to deliver this transformation.
13. Finance
14. Workforce
15. Estates and facilities
16. Technology, including Digital
17. Communications and Engagement

Delivery of these programmes is at LDS level, each of which has a programme of work delivering improvements locally:

18. North Mersey
19. The Alliance
20. Cheshire and Wirral

**The overarching purpose of these programmes is to deliver on our purpose of creating sustainable, quality services for our population.**

## 2 - Our Cheshire & Merseyside strategy

*We are clear on the ambition we have for the patients, staff and population of the C&M STP*

Our core purpose is to create **sustainable, quality services for the population of C&M**. This is effectively our ambitious blueprint to accelerate the implementation of the 5YFV across C&M.

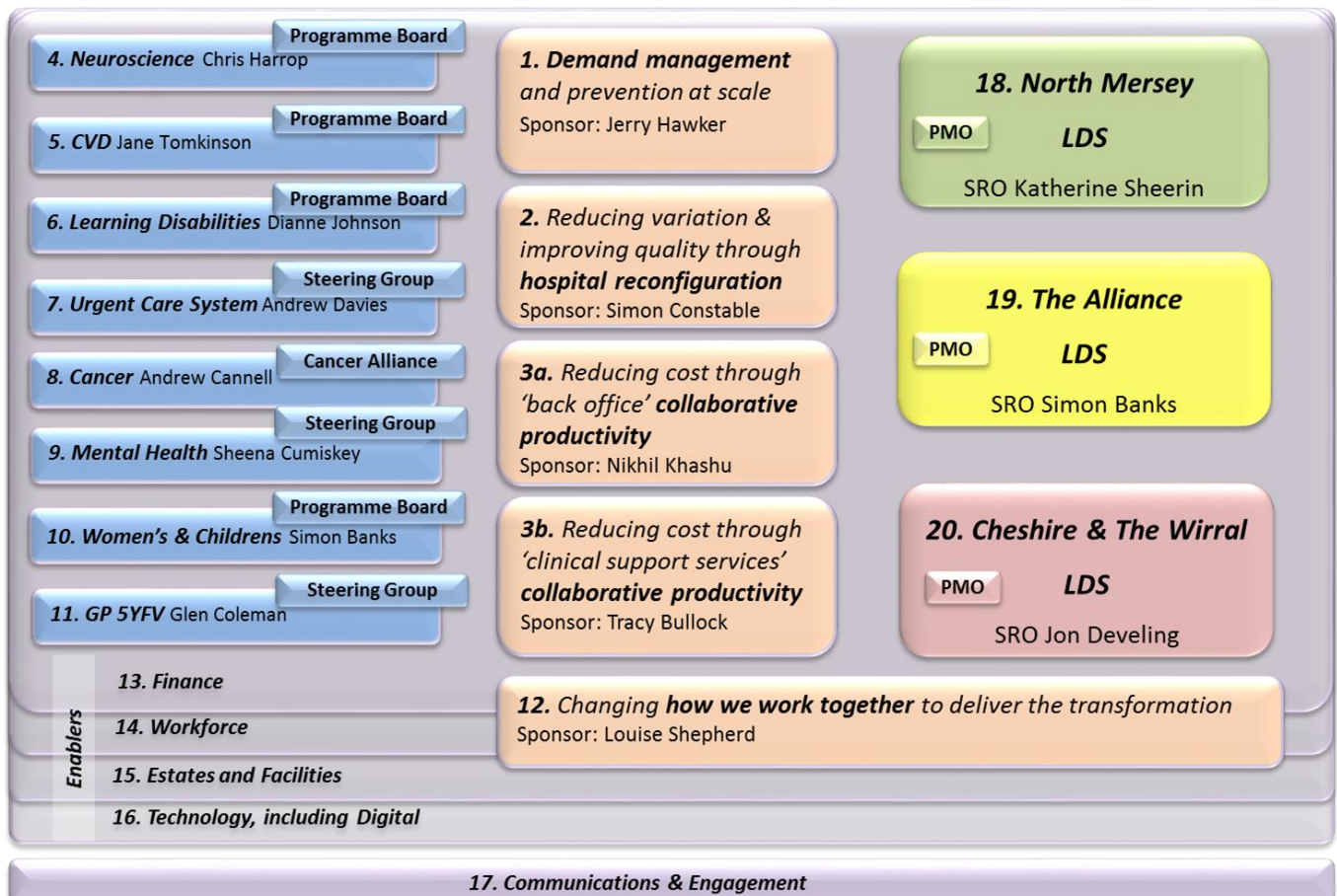
**Sustainable** means delivering services within the amount of finance made available to C&M for the provision of health and social care.

**Quality** means services that are safe, and deliver excellent clinical outcomes and patient experience.

### Doing the right things

The 20 programmes that form our delivery portfolio have been chosen as a direct consequence of the issues faced by C&M, and with a clear end goal in mind. These were noted in Section 1 and are regularly communicated by way of the graphic below:

Each programme is at a different point of maturity, and this is reflected in the later sections of this plan. As with any portfolio this is not unusual and there is no reason to get them all to the same place. However, there is an overarching process that each programme will go through and that the PMO will use to help assess progress.



## 2 - Our Cheshire & Merseyside strategy

### Clarity on responsibility

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

There are no budgets or quality standards held at STP level. Changes will directly impact organisations at level 1, with level 2 LDS plans providing oversight of progress, and, over time, a consolidated view of performance measures.

We have been really clear on the role of people at STP level, ensuring we are not duplicating effort.

**Level 1 STP** has a focus on:

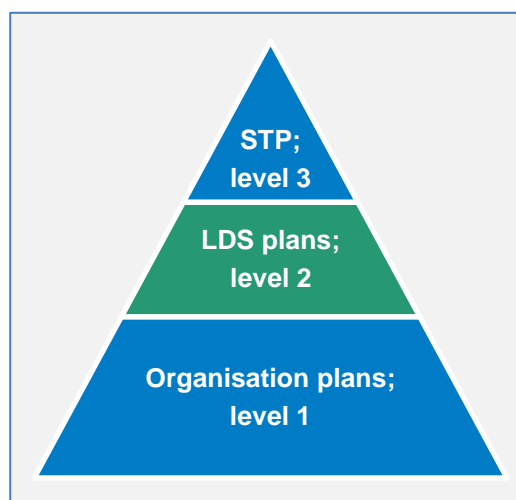
- **Economies of Scale** – what can be done at STP to create additional economies
- **X-LDS learning** – how can each LDS learn from each other
- **National benchmarking** – how is the STP doing compared to national benchmarks
- **STP wide system design** – design once, deliver locally – e.g. ACO/ACS framework
- **Governance** – agreeing and managing an STP wide approach
- **Assurance** – provision of assurance to STP lead, and ultimately NHSE
- **Performance** – responsibility for meeting and reporting against STP wide control totals
- **Communications and engagement** – consistent delivery of overarching key messages

Level 2 LDSs also have a clear role to play:

- **Locality strategy** – how this works in the LDS
- **Detailed delivery plans** - development and delivery of LDS plan
- **Monitor progress** – regular monitoring of plan
- **Reporting to STP** – progress reporting to STP
- **Financial control** – managing impact on finances

across LDS.

At Level 1 the responsibility is well known around meeting financial and quality standards. Currently it is only at Level 1 that a budget can be impacted. Level 1 organisations also have a clear responsibility to manage communications within their organisation and to their Boards/Governors.



### Maximising opportunities

Our approach to delivering improvements is that opportunities will be designed and delivered at the highest level of our triangle.

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

The emergence of an STP plan doesn't reduce the focus on organisational delivery at level 1 or their need for financial balance.

## 2 - Our Cheshire & Merseyside strategy

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

Managing a portfolio of 20 programmes is a significant undertaking and the dependencies between them need to be effectively managed.

### *Managing dependencies across the portfolio*

With twenty programmes of work there are many interdependencies that need to be carefully managed, such as:

- Effective management of demand on our healthcare system will influence the future configuration of where and how services are delivered;
- Future hospital service configurations will be driven by clear clinical strategies that place patients at the heart of any redesign;
- Very few changes can be made without the implicit inclusion of the Workforce, Estates and IM&T programmes

Section 6 will look in more detail at how the STP will deliver the transformation required.



# STP Interventions

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on the priority areas of focus that we believe will have the greatest impact on health, quality and finance.

Our challenges

<p><b>Demand for health and care services is increasing</b></p>	<p><b>Cheshire and Merseyside face different challenges as a consequence of its geography and demographics. There is therefore unacceptable variation in the quality of care and outcomes across C&amp;M</b></p>	<p><b>The C&amp;M system is fragmented resulting in duplication and confusion</b></p>	<p><b>The cost of delivering health and care services is increasing</b></p>
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Our priorities and areas of focus

Improve the health of the C&M population,		Improve the quality of care in hospital settings		Optimise direct patient care	
<p><b>1a. improving the provision of physical and mental care in the community (i.e.outside of hospital)</b></p> <ul style="list-style-type: none"> <li>• Agree framework to deliver via ACOs</li> <li>• Managing demand across boundaries</li> <li>• Joint commissioning and delivery models</li> <li>• Community risk stratification</li> <li>• GP Federations, Primary Care at scale</li> </ul>	<p><b>1b. Promoting physical and mental well being</b></p> <ul style="list-style-type: none"> <li>• Addressing primary prevention &amp; the wider determinants of health</li> <li>• Pan C&amp;M Alcohol Strategy</li> <li>• Pan C&amp;M High BP Strategy</li> </ul>	<p><b>2a. Reducing the variation of care across C&amp;M</b></p> <ul style="list-style-type: none"> <li>• Common standards, policies and guidelines across organisations at C&amp;M level</li> <li>• Standardised care across pathways</li> </ul>	<p><b>2b. Delivering the right level of care in the most appropriate setting; and enhancing delivery of mental health care</b></p> <ul style="list-style-type: none"> <li>• Common standards, policies and guidelines across organisations at C&amp;M level</li> <li>• SOPs and high level service blueprints for specialist services</li> </ul>	<p><b>3a. Reducing the cost of administration</b></p> <ul style="list-style-type: none"> <li>• Optimised workforce, reduced agency usage</li> <li>• Consolidated Procurement functions – an integrated Supply Chain Mgmt. function</li> </ul>	<p><b>3b. creating more efficient clinical support services</b></p> <ul style="list-style-type: none"> <li>• Consolidated clinical support services</li> </ul>

The impact of our plans

<ul style="list-style-type: none"> <li>• Reduction in A&amp;E attends and non-elective admissions</li> <li>• Reduced elective referrals</li> <li>• Reduced emergency bed days, and length of stay</li> <li>• Reduced re-admissions</li> <li>• Early identification and intervention</li> <li>• Delivery of care in alternative settings</li> <li>• Increased use of capitation-based and outcomes-based payments</li> </ul>	<ul style="list-style-type: none"> <li>• Improved clinical outcomes and reduction in variation</li> <li>• Improved performance against clinical indicators</li> </ul>	<ul style="list-style-type: none"> <li>• x-organisation productivity and efficiency savings</li> <li>• Reduced duplication</li> <li>• Reduction in temporary staff dependency</li> </ul>
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Governance and Leadership - Changing how we work together to deliver the transformation
Programme Delivery Structure
Communications and Engagement
Enablers – IM&T; Estates; Workforce

## 2.1 - Improve the health of the C&M population

### Introduction

We previously referred to this programme as 'Demand Management' and 'Prevention at Scale'.

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

### What are the objectives

- To maximise the benefits that C&M can gain from the improvement to its population's health.
- To provide the guidance and principles upon which the work around demand management and prevention will be delivered at LDS level.

### Why is this programme important?

The current challenges makes integration and consolidation across organisational boundaries a necessity. The NHS five year strategy sets out the ambition for this and local government leaders are keen to take a leading role in the integration agenda. Leading health economies are moving in this direction and they are delivering real reductions in hospital admissions; better population health through prevention; and 10-20% cost savings.

Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. It allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals.

Another important feature of the population health PIDs that have been developed is that as well as supporting the development of benefits over the next 5 years directly (from reduced hospital admissions / attendances etc), they will also play a crucial role in supporting the sustainability of the current STP. For example, by not addressing the real behavioural problems that excessive drinking can run the risk of creating future problems and dilute the positive impact that the current set of interventions are expected to have.

### What is the scope of the work

Improving the provision of integrated primary and community, health and social care (i.e. Out of Hospital)

1. A substantial range of schemes & interventions which can be broadly categorised as Prevention, CCG Business efficiencies (QIPP) and new Out of Hospital initiatives.
2. Promoting physical and mental well being to reduce the need for people to access care.
3. Developing an STP wide methodology and structure for tackling unwarranted variation in demand for care services and enabling effective delivery of the first two objectives.

### What is the structure of the programme?

1. Three STP prevention schemes will be delivered at LDS Level:
  - Alcohol Harm Reduction
  - High Blood Pressure
  - Antimicrobial resistance
2. Three high impact areas help manage demand, delivered at LDS level:
  - Referral management
  - Medicines management
  - CHC
3. Development of integrated primary and community, health and social care
4. Create a framework for the development and implementation for Accountable Care approaches (name of the chosen vehicle may be different but they are nationally known as ACOs)

The first phase of the programme has focussed on helping each LDS develop their plans and to verify the opportunity. This will now be taken forward at LDS level leaving the work at STP to focus on creating a framework to support development of ACOs and supporting the accelerated implementation (delivery) of high impact demand management initiatives (e.g. Right Care).

### How will the change be lead?

<b>Sponsor:</b>	Jerry Hawker
<b>Members:</b>	Eileen O'Meara (CHAMPS WG DPH Lead) Alliance – Leigh Thompson/Colin Scales Cheshire & Wirral – Tracy Parker-Priest North Mersey – Tony Woods Local Gov't – TBD Andrew Davies, Urgent Care CCT

## 2.1 - Improve the health of the C&M population

### Current Position

#### Management of demand

There is a strong symmetry across all three LDS plans and a further opportunity to share best practice and reduce inter-LDS variation. NHS England's referral management audit (template) suggests significant variation across three of the LDSs with respect to implementation of the eight high impact changes.

The high impact change areas being adopted across the LDSs include:

- Medicines management (**£66.6m**)
  - Referral management – implementation of eight demand management high impact changes for elective care (**£61.5m**)
  - Implementation of Right Care (**£42.5m**)
  - Continuing healthcare (**£16m**)
- (indicative values)**

These are predominantly flagged as business as usual efficiencies within CCG plans.

#### Prevention

Three population based prevention projects have been developed to support reductions in Alcohol abuse / harm, blood pressure and antimicrobial resistance (AMR).

The first two have identified benefits including reduced hospital admissions & “whole system impact” where appropriate (e.g. prevention of alcohol related violence). AMR will produce more long term impact.

All are key to the longer term sustainability of the STP i.e. doing nothing runs the risk of increasing our challenge post 2021.

The blood pressure team have identified a number of benefit scenarios associated with the level of increases in diagnosis rates. The table below shows the low end estimated net benefits i.e. based on a 5% increase BP diagnosis being achieved – these could be as high as £9.1m if the higher rates are achieved of 15%.

Delivery plans for these projects are noted overleaf

Prevention	Alcohol	Blood Pressure	Total benefit (2021)
Gross benefit	£13.65m	£9.5m	<b>£23.15m</b>
STP investment required	£2.45m	£2.5m	<b>£4.95m</b>
Net benefit at LDS level			
• C&W	£4.7m	£2.8m	<b>£7.5m</b>
• Alliance	£3m	£2m	<b>£5m</b>
• NM	£3.5m	£2.2m	<b>£5.7m</b>
<b>Total STP net benefit (2021)</b>	<b>£11.2m</b>	<b>£7m</b>	<b>£18.2m</b>

## 2.1 - Improve the health of the C&M population – alcohol prevention and High Blood Pressure Plans

Alcohol Prevention Project	Milestones
STP demand reduction (alcohol) steering group	<ul style="list-style-type: none"> <li>Establish a system wide leadership approach through the establishment of a CM cross-sector working group(s), networks and collaborations</li> <li>Detailed business case worked up</li> <li>Develop and continue to risk register</li> <li>Develop and implement a stakeholder engagement and communications</li> <li>Establish a data/outcomes working group</li> </ul>
Enhanced support for high impact drinkers	<ul style="list-style-type: none"> <li>Develop multi-agency approaches to support change resistant drinkers'</li> <li>Ensure the provision of best practice multidisciplinary alcohol care teams in all acute hospitals</li> <li>Review pathways and commission outreach teams</li> </ul>
Large scale delivery of targeted Brief Advice	<ul style="list-style-type: none"> <li>Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff offering brief advice and referring to local specialist services as required.</li> <li>Ensure screening and advice for Making Ever Contact Count includes evidence based alcohol IBA, and brief interventions such as high BP, smoking cessation, diet and physical activity.</li> </ul>
Effective population level actions	<ul style="list-style-type: none"> <li>Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards.</li> <li>Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners</li> <li>Ensure local partners collaborate to ensure efficient use of data and considerations of improvements, including: <ul style="list-style-type: none"> <li>Targeting interventions to prevent violence and reduce alcohol-related harm</li> <li>Targeting police enforcement in hotspot areas</li> <li>Use of intelligence in the license review process and targeting alcohol licencing enforcement</li> </ul> </li> </ul>

High Blood Pressure Project	Milestones
STP demand reduction (BP) steering group	<ul style="list-style-type: none"> <li>Detailed business case write up</li> <li>Risk register write up</li> <li>Stakeholder engagement and communication plan developed</li> </ul>
System Leadership approach	<ul style="list-style-type: none"> <li>System leadership approach is ensured in the delivery of the C&amp;M strategy</li> <li>Systematic triangulation and review of cross-sector patient safety measures is embedded into strategy dashboard</li> </ul>
Population approach to prevention	<ul style="list-style-type: none"> <li>Develop healthy local policy</li> </ul>
BP awareness raising campaigns	<ul style="list-style-type: none"> <li>Link with community pharmacies, community partners and voluntary sector partners and inform patients and communities of key messages</li> </ul>
Making Every Contact Count at scale	<ul style="list-style-type: none"> <li>Roll out MECC across primary and secondary healthcare settings, community pharmacies and with non-clinical community partners</li> </ul>
Blood pressure equipment	<ul style="list-style-type: none"> <li>Increase availability of BP machines and Ambulatory Blood Pressure Monitoring to meet local need</li> </ul>
Primary care education and training programme	<ul style="list-style-type: none"> <li>Develop education and training programme that utilises Sector Led Improvement principles</li> </ul>
Medicines Optimisation	<ul style="list-style-type: none"> <li>Increase uptake of Medicine Use Reviews and New Medicines Services on antihypertensive medicines</li> </ul>

## 2.1 - Improve the health of the C&M population – antimicrobial resistance

Project	Milestones
Ensure every Trust, Community Trust [including non-medical prescribers] and CCG has an AMR action plan	<ul style="list-style-type: none"> <li>Obtain assurances that every trust has an AMR action plan</li> <li>Obtain assurances that every trust has an Antimicrobial Stewardship Committee</li> </ul>
Implement back up prescribing for the treatment of upper respiratory tract infections	<ul style="list-style-type: none"> <li>Implement Back Up Prescribing via Practitioner-Centred Approach or Patient-Centred Approach</li> <li>Audit post implementation:               <ul style="list-style-type: none"> <li>Establish whether implementation in Accident and Emergency Departments, Walk-In Centres, Out Of Hours and with Non-Medical Practitioners is required. Consistency can be achieved by harmonising access to GP records.</li> <li>Prior to implementation, establish whether Healthwatch should be involved.</li> </ul> </li> </ul>
Engagement	<ul style="list-style-type: none"> <li>Pharmacy:               <ul style="list-style-type: none"> <li>Ensure consistent messages are given by all prescribers and all pharmacists.</li> <li>Ensure pharmacies support the AMR strategy as appropriate</li> </ul> </li> <li>Care Homes:               <ul style="list-style-type: none"> <li>Establish whether the Care Home Hygiene Award Scheme needs scaling up</li> </ul> </li> </ul>
Ensure AMR awareness, stewardship and training is delivered to all prescribers, non-medical prescribers and health care workers	<ul style="list-style-type: none"> <li>Target all prescribers (medical, non-medical, pharmacists) and consider including AMR in yearly mandatory training</li> <li>Ensure that training addresses and meets the PHE Antimicrobial prescribing and stewardship competencies</li> </ul>
Support public facing media campaigns to aid and inform about Antimicrobial Resistance	<ul style="list-style-type: none"> <li>Local authorities and CCGs engage with any national or international AMR campaigns and plan local activities to promote the initiative</li> </ul>
Implementation of AMR and Stewardship education at the primary and secondary level	<ul style="list-style-type: none"> <li>Utilise the free 'e-Bug' resource produced by PHE in all schools to encourage a generational change in the attitude to the use of antibiotics</li> </ul>
Identify a dedicated Community Microbiologist function to support AMR Stewardship	<ul style="list-style-type: none"> <li>Ensure protected sessions are available and establish whether these can be enhanced to a more proactive and accessible clinical advisor service for GPs and other antibiotic prescribers in the community</li> </ul>
Identify an Antimicrobial Stewardship Lead GP	<ul style="list-style-type: none"> <li>Establish how this resource can be identified and secured, assuming that the role doesn't exist already</li> </ul>
Ensure that every secondary care trust is implementing PHE Start Smart – Then Focus toolkit	<ul style="list-style-type: none"> <li>Obtain assurances that every trust has implemented the tool kit, including a ward-focused antimicrobial team</li> </ul>
Ensure that every GP Practice is implementing TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) (best practice recommendations)	<ul style="list-style-type: none"> <li>Obtain assurances that every GP Practice has implemented the tool kit</li> </ul>
Ensure every Trust and CCG has an Antimicrobial Pharmacist and ensure that they are provided with sufficient protected time to fulfil this role	<ul style="list-style-type: none"> <li>Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist</li> </ul>
Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	<ul style="list-style-type: none"> <li>Primary and secondary care formularies should dovetail</li> <li>Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance</li> </ul>

## 2.1 - Improve the health of the C&M population

### Development of ACOs

ACO's are one option for supporting the development of a standardised care model for non-acute care across the C&M Footprint that includes Primary, Community, Mental Health & Social Care with a view to driving & managing demand and pursuing population health management. We might want to look at this as a way of enhancing care for medically unwell and frail patients in particular, by integrating organisational arrangements, sharing clinical and financial risk across the system

**Ambition** - There is significant variation in the progress made on developing ACOs across the STP; most are at an elementary stage. St Helens has made the most progress having commissioned advisors to consider the options for an accountable care management system. Further work is required in most localities to fully define the vision and outcomes.

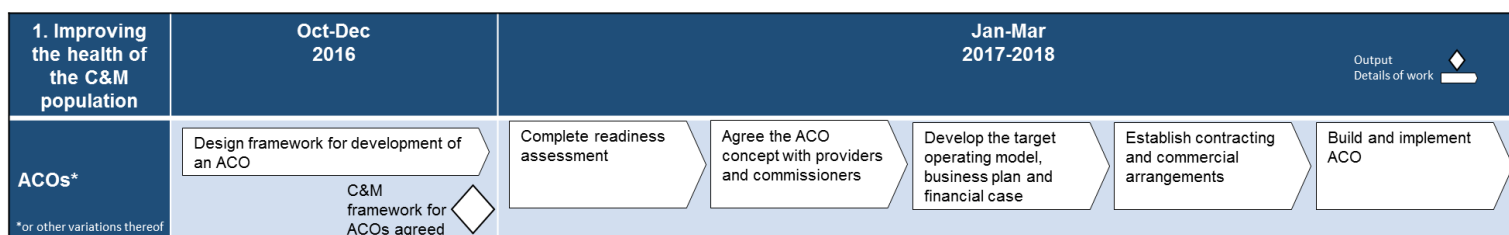
**Care Model** - Greater focus could be paid on ensuring primary care is at the centre of care models and ACOs are built on GP registered lists. Additionally, processes to engage primary care need to be determined. In parts of the system there is some ambition to build the ACOs around multispecialty community providers. The connection between ACOs and already established/proposed care models in some areas needs to be clearer e.g. the Caring Together programme in Eastern Cheshire.

**Delivery Model** - There is significant variation in the form of ACOs being proposed and developed across the STP. For instance, in some areas an 'accountable care management system' is being developed whilst in others a 'partnership' is envisioned. In almost all areas there is no defined operating model agreed and no delivery plans in place for implementation.

**Capabilities** - Learning should be shared as much as possible by those areas who are leading in the development of their ACOs. The process to understand the capabilities required for the successful implementation of an ACO is in place in some areas. Further work is required on the approach to sharing accountability amongst partners include risk and gain sharing.

There needs to be a real focus on the development of an STP wide framework to help design the right ACO model for each locality.

Each locality is at a different state of maturity – the potential plan below is an indicative view of the process and timeline that a more mature locality might aspire to.



### Plans

There are a number of next steps to follow on from the work:

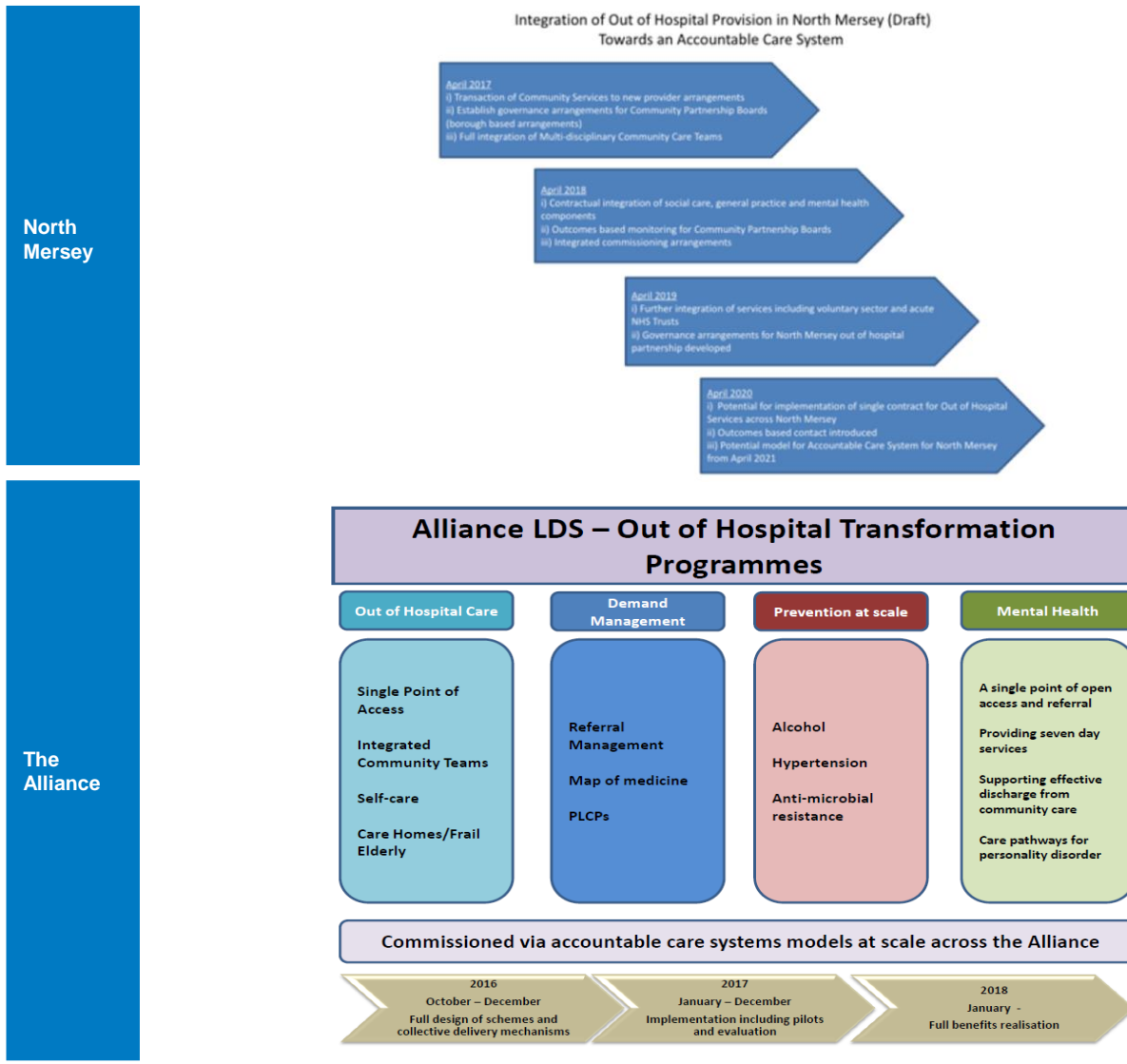
- Need to agree the relevant priorities of the projects and the associated investments.
- There is an immediate need to agree how benchmarking intelligence will be provided and utilised by end November.
- Each LDS should review existing plans against business intelligence to strengthen activity and financial modelling and assure schemes against benchmarked evidence to ensure that plans are targeted appropriately, by end November.

- The STP should identify a way to support each LDSP to stress test its business efficiencies (QIPP) schemes due to the significant financial variation, by end November.
- Develop a framework document to provide structured support to fast track potential exemplar ACOs and provide STP wide guidance and principles.

Much of this is to be delivered as part of the LDS plans, and features in their delivery plans, highlights of which are overleaf.

## 2.1 - Improve the health of the C&M population

Each LDS has plans that will tackle demand, enhance prevention, bring care closer to home and radically improve out of hospital care, the highlights of which are shown below. Full details are in each LDS plan that is within the supporting documents. By providing coordination, guidance, standards and clear principles, LDS's will learn from each other and C&M will achieve greater economies of scale.



The core C&W ambitions by 2020/21 are:

- Implement Cheshire and Merseyside Wide Prevention strategies in Hypertension, Alcohol, and AMR.
- Implement Cheshire and Wirral wide prevention strategies for Respiratory conditions and Diabetes.
- Implement Cheshire and Merseyside Wide Neurology, Cancer and Mental Health Programmes.
- Implement a Gain Share agreement with NHSE for specialised commissioning
- Embed integrated community teams by 2017/18 that include General Practice, Social Care and Community Services that will manage demand effectively throughout Cheshire and Wirral.
- Implement high impact demand management initiatives identified by NHSE through our current and ongoing QIPP Programme.
- Implement measures to reduce CHC expenditure by £8m
- Encourage and deliver better management of primary care prescribing (through self-care, over the counter status, repeat prescriptions)
- Continue to implement and optimise the benefit of sharing clinical information through the Cheshire (and Wirral) Care Record.
- Establish an approach to deliver Accountable Care Organisations across Cheshire and Wirral.

## 2.2 - Improve the quality of care in hospital settings - overview

### Introduction

We previously referred to this programme as 'Reducing variation and improving quality to support hospital reconfiguration'.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity. There is a strong need for a service line-by-service line review of the current acute care model, in order to generate the evidence and data required to inform an explicit decision to be taken on the locations of acute provision based through analysis of future patient flows.

### What are the objectives

- To maximise the quality of care delivered in hospital settings.
- To provide the guidance and principles upon which work around hospital services will be delivered at LDS level.

### Why is this programme important?

There is a wide variation of the quality of care across C&M – this is not acceptable and our population should expect the same quality service and outcomes wherever they live in C&M.

Hospital care is expensive – we should only be treating people in hospital when it is evidenced that their outcomes will be better by treating them there. Improving care is at the forefront of our STP ambitions, and delivering effective, safe and efficient care in hospital settings is a core principle.

### What is the scope of the work

There are two STP Level projects:

1. Technical solutions for the C&M system:
  - Critical decisions developed by specialist and technical expertise which exists already in the clinical networks or Vanguards for new models of care (e.g. Urgent and Emergency Care and Women's and Children's Health)
  - Agree the best clinical models across C&M and their detailed specification, which will include access issues, consideration of co-dependencies and the un-intended

consequences. This will be underpinned by the very best evidence base and specialist expertise.

- Pilot to then be expanded through all the specialities.
2. Reducing variation in outcomes
    - Clinical effectiveness is at the heart of the programme to reduce variation in clinical practice and outcomes across C&M.
    - Existing programmes of work such as Advancing Quality (AQ) and Getting it Right First Time (GIRFT) will be strengthened, standardised and harmonised.
    - Intra-hospital as well as inter-hospital variation will be considered
    - Workforce issues through people as well as processes will be standardised or harmonised at STP level to manage system as well as cultural issues through the assistance of Health Education England, the North West Leadership Academy and the Advancing Quality Alliance (AQuA).
    - An overarching principle will be achieving even modest improvements at scale over the whole C&M and reducing the variation that exists.

### How will the change be lead?

<b>Sponsor:</b>	<b>Simon Constable</b>
<b>Members:</b>	Alliance - Ann Marr Cheshire & Wirral - David Allison N Mersey - Steve Warburton/Fiona Lemmens Local Gov't - <b>TBD</b> Andrew Davies, Urgent Care CCT Simon Banks, Women & Children's CCT



## 2.2 - Improve the quality of care in hospital settings – delivery plans

To date, this thinking has largely been driven at the LDS level with little consideration of hospital reconfiguration across the C&M-wide footprint.

However, we believe there is benefit and the financial imperative to undertake this thinking at C&M level to deliver a consistent clinical service across the STP footprint.

We recognise that the current acute configuration within this footprint is unsustainable. This is perhaps most evident in Cheshire. The number of tertiary providers in Merseyside presents an atypical challenge and opportunity as well.

Given the importance and sensitivity of this area, our first task is to instigate a service by service review of the acute care model.

This will be a single programme of work that will run in parallel to the emerging LDS-led reviews and work undertaken by the NW Specialised Commissioning team.

Our view is that the definition and specification of the local District General Hospital will be sustainably supported through a network of specialist provider services, making a virtue of Merseyside's strong cohort of tertiary centres. This big idea is underpinned by health and social care integrated at the core.

The review will be undertaken rapidly with an outcome on the direction of acute provision being available for the next stage of consultation by March 2017 (subject to further discussion and agreement).

Work is underway with AQuA to identify from an international and national evidence base the areas in which reduced variation would give the maximum potential in addressing the quadruple aims of the 5YFV across the whole of C&M. The output of this work is expected in late 2016. In addition one of the early scoping pieces of work across the STP through the local delivery systems is to identify where there are already plans implemented or in train to reduce variation and/or implement hospital reconfiguration, to ensure that outputs and outcomes are known,

understood and assessed and adopted at pace and scale utilizing a range of clinical, managerial, patient and other change agents and supporting systems that are already in place.

The engagement strategy for this workstream is critical to its success in delivering against the quadruple aims of the 5YFV. The approach, with the appropriate level of programme management support and resource to oversee the progress of engagement, is to utilize existing networks of clinicians across primary and secondary care, other staff across the health and care system, and patients and carers to create a dialogue in the design of the priority work programmes (utilizing the intelligence identified above as an input) and identify, at a range of levels, change agents who have experience and are motivated to influence at a range of levels. So in addition to the necessary scoping of areas of focus for this workstream both in terms of existing improvement work in the STP area, and national/ international evidence base, we will undertake a piece of scoping around the existing engagement fora in order to enable face to face discussion about areas of focus. We see the STP Clinical Congress as a key engagement mechanism for clinical engagement along with existing networks of clinicians, particularly at and within LDS level. We will also, in conjunction with the STP workstream area around ways of working, explore the possibility of digital collaborative platforms to maximize engagement.

This review will focus on how acute provision will synergistically work within the construct of a demand management system (and potential ACO-driven environment), as well as embracing new technology such as tele-tracking to create individual control centres capable of having visibility across multiple providers who exist in a networked way. The review will consist of 2 phases of work as shown below:

### Nov - Jan

#### Phase 1 – Evidence generation & research

- Agree methodology & plan
- Formalise governance (clinical and non-clinical)
- Carry out service line reviews
- Capture and organise evidence

### Jan - Apr

#### Phase 2 – Analysis & outputs

- Design options for future acute care provision
- Build strategic outline case for each option including benefits and RoI
- Agree method for option selection
- Prepare for review
- Create delivery roadmap

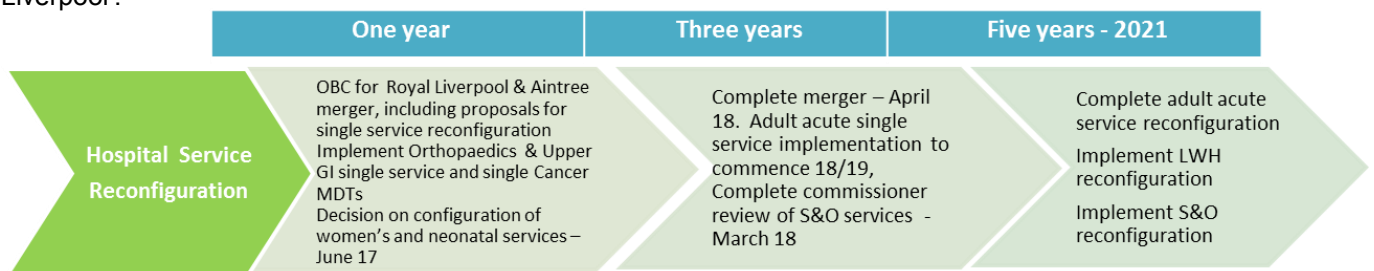
## 2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

### North Mersey

A more granular plan is included in the NM LDS plan. built from well established plans described in 'Healthy Liverpool'.



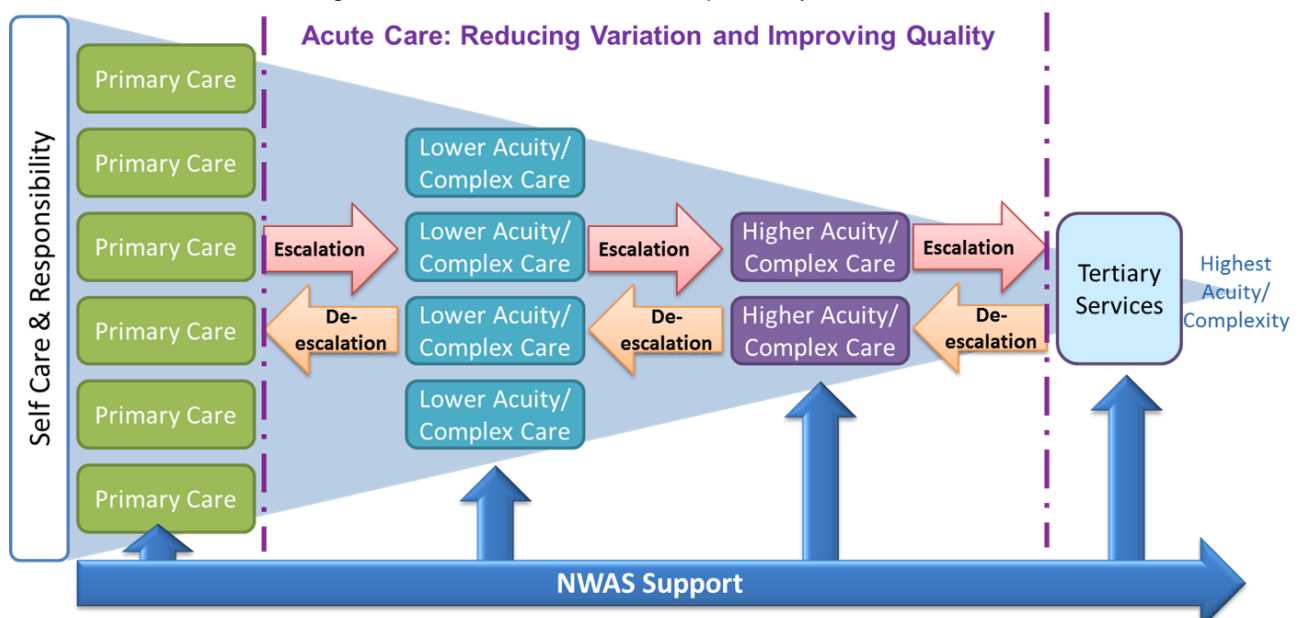
### Review of Services at Southport & Ormskirk NHS Trust

NHS Southport & Formby CCG will lead a review of the services provided by Southport and Ormskirk NHS Trust, the outcome of which is to ensure long term clinical and financial sustainability and to meet the particular needs of this population. The review process will be conducted by a multi-stakeholder partnership that will develop a case for change which will inform plans for the future of these services.

- Process, Governance and Stakeholder Mapping (Jan-March 2017)
- Case for Change (April-June 2017)
- Pre-consultation engagement (July-September 2017)

### The Alliance

The Alliance has developed a vision for hospital reconfiguration, and started to develop a range of options. A plan for the assessment and design of these services will be completed by December.



## 2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

### Cheshire and Wirral

C&W have a short term plan to rapidly address variation and reconfigure hospital services across Cheshire and Wirral

2. Improving the quality of care in hospital settings	Oct 2016	Nov 2016	Dec 2016 <small>Output Details of work</small>
<b>Project Management</b>	Review and refresh project management arrangements		
<b>Clinical Variation</b>	Confirm methodology and any required support		Confirm cost improvement quantum and trajectory
		Development of implementation plan	
		Confirmation of clinical governance arrangements across ACOs and hospitals	
<b>Hospital Reconfiguration</b>	Development and appraisal across each hospital sub system of options for hospital and service reconfiguration		Confirmation of preferred hospital and service reconfiguration option
	Confirm future configuration of women's and children's services in Cheshire and Wirral	Confirm implications of preferred option in terms of service portfolio, size/activity, SOPs and management arrangements	
		Confirm HR, IM&T and estate implications of reconfiguration	
			Confirm cost improvement quantum and trajectory
<b>Operational Planning</b>			Development of implementation plan
			Production of operational plans for 2017/18-2018/19

### Hospital Services in Eastern Cheshire

The Caring Together programme is a well-established transformation programme within Eastern Cheshire. The programme aims to improve the health and wellbeing of the local people by implementing enhanced integrated community care supported by clinically and financially sustainable hospital services.

Extensive modelling work has been completed and indicates that transforming just one segment or service of the local health and social care economy will not be sufficient to address the challenges the economy is now facing. Instead a system-wide solution is needed. The Caring Together Programme Board met with system regulators (NHS England and NHS Improvement) on 17 October 2016 and agreed to complete financial modelling on two care model options

The two options are based on clinical and financial sustainability of hospital services at East Cheshire Trust, (and the impact on neighbouring Trusts) taking into account clinical dependencies of managing either low risk or medium to low risk patients and the impact these options have on the development of enhanced proactive community care.

The financial modelling of the two options builds on decisions already taken in 2016/17 including Dermatology Services transferred to Vernova CIC in January 2016 and Stroke Services transferred to Stockport NHS Foundation Trust in October 2016. The intention is to transfer high risk General Surgery to Stockport NHS Foundation Trust from April 2017.

The modelling of Options 1 and 2 including capital requirements and potential impacts of tariff plus payments/MFF will be completed by the end of 2016 with the findings being presented to the Caring Together Programme Board and NHSI/NHSE for a final decision in early 2017.

## 2.3a - Optimise direct patient care – reduce the cost of administration

### Introduction

We previously referred to this programme as 'Back Office'.

While performance improvements within organisations remain important, we are making a move to longer term transformation and strategic planning across the health and care economy.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations. The ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.

### What are the objectives

- Reduced spend in the Back Office will enable additional spend and effort to be directed towards front line services.
- Cost reduction in Back Office is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services.
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system.
- Improve links and engagement with stakeholders to ensure that reconfigured services meet both corporate and clinical need.
- Identify the required changes to ways of working and to organisational culture to enable delivery of collaboration.
- Create an engaging and rewarding place to work, operating flexibly across structures and ensuring staff are able to build a broad framework of skills and experience
- Ensure that Back Office operations are sufficiently flexible to meet changing needs of the organisations in the footprint

### Why is this programme important?

The Carter Review made clear that we can no longer

rely on traditional efficiencies and cost improvement programmes within single organisations.

Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries. This is how real efficiencies are identified and how greater economies of scale can be delivered.

Values - Where appropriate, Back Office services will be maintained within the NHS to provide wider economic benefit to communities in Cheshire & Merseyside region.

### What is the scope of the work

For all Back Office services, the ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.

The projects that will delivered are to be prioritised on the basis of deliverability, scale of benefit and time to transform.

Projects can be described in two ways:

- Transactional savings leveraging economies of scale and best in class approaches and models across the patch
- Procurement at category level, then built up to a cluster approach at LDS and then STP level

### How will the change be lead?

<b>Sponsor:</b>	<b>Nikhil Khashu</b>
<b>Members:</b>	Alliance – Andrea Chadwick, WHH Cheshire & Wirral – Tony Chambers North Mersey – Aidan Kehoe Local Gov't - TBD

## 2.3a - Optimise direct patient care – reduce the cost of administration

### Delivery

The 'Plan on a Page' below is a summary of the more detailed plans that are included in the Appendices.

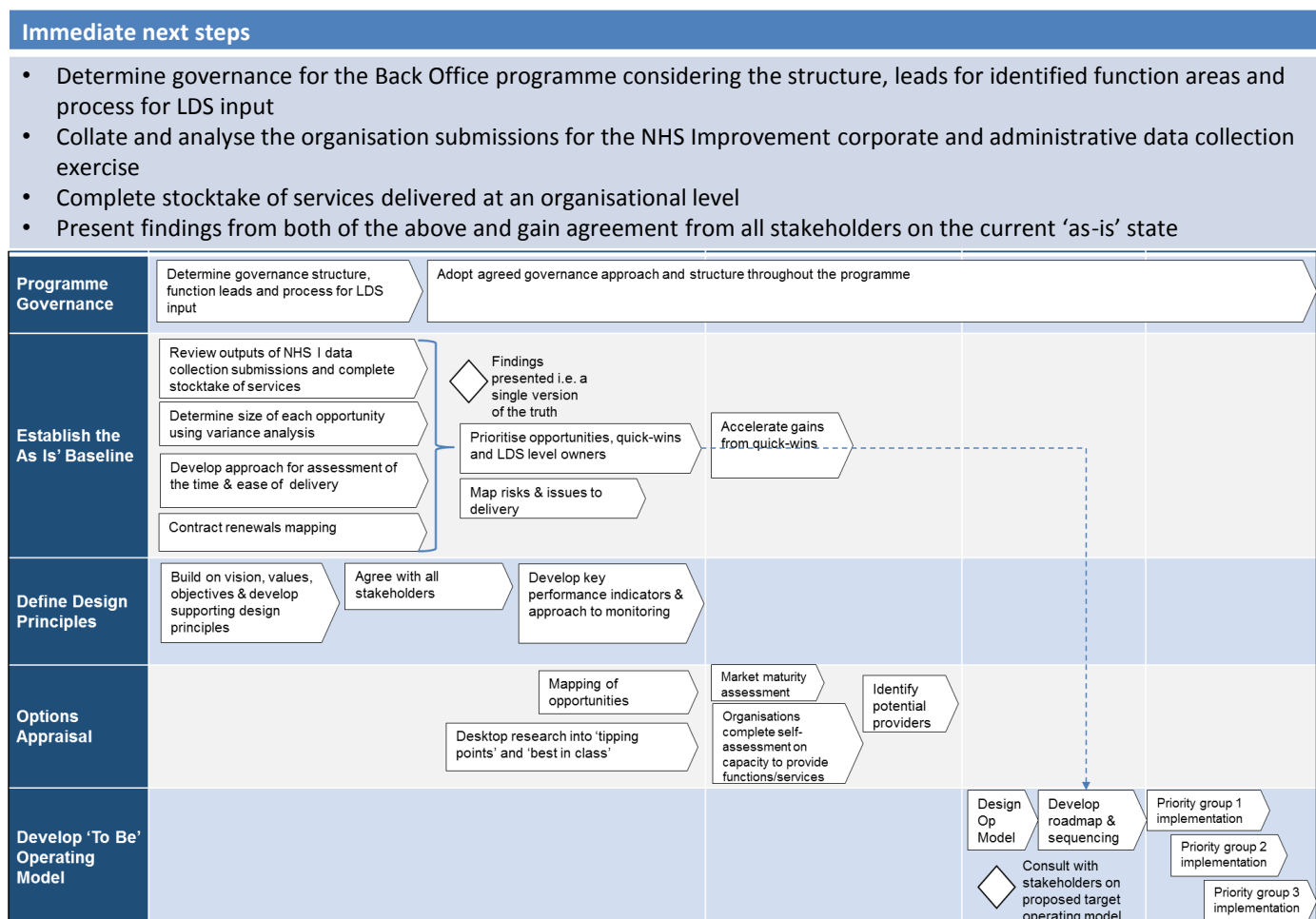
There is a clear opportunity to create some early wins in this programme, though there are risks and challenges - the key challenge being the capability and capacity to deliver within the timescales.

The main enablers for the Back Office programme will be:

- Breaking down department or Trust silos and ensure open communication and sharing of data.
- Sharing lessons learnt and good practice swiftly and openly
- Investment in required technology and systems.
- Balanced focus across business as usual and future state development – being future focussed according to the needs of our stakeholders.

### Proposed Governance Arrangements

- The existing Back Office Steering Group is to become the Back Office Programme Board
- Back Office SRO is a member of the Steering Group representing the 3 LDSs, with a remit to challenge, drive and support the LDSs in the delivery of the programme and where appropriate, escalate issues or opportunities to STP Membership Group for consideration
- LDS Back Office leads / SROs will be part of the Programme Board
- Governance at the level of the LDS leads for the functional areas will be determined as part of the next phase of work.



## 2.3b - Optimise direct patient care – efficient clinical support services

### Introduction

We previously referred to this programme as ‘Middle Office, or Clinical Support Services’.

The vision is to deliver cost effective, efficient and commercially sustainable Clinical Support Services which can be transformed to deliver improved services to front line services across the STP footprint.

### What are the objectives

- Reducing variations in practice / services across the STP footprint area and develop a set of standards which every service can comply with irrespective of *how* they are delivered (e.g. either via a “network” arrangement or a single managed service).
- Reduced spend by delivering increased efficiencies generated by Clinical Support Services operating differently across the C&M footprint, enabling additional spend and effort to be directed towards front line services.
- Cost reduction in Clinical Support Service areas is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system
- Reduction of on call rotas through better / increased use of digital enablers

### Why is this programme important?

The Carter Review, and indeed Lord Carter’s review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if these services are consolidated on a regional basis.

Therefore, there are a range of future collaborative models which we are considering across the different support services in C&M, ranging from, for instance, setting up a single wholly owned subsidiary organisation for manufacturing and dispensing medicines, to outsourcing dialysis services to a satellite dialysis provider.

### What is the scope of the work

- Radiology
- Pharmacy
- Pathology

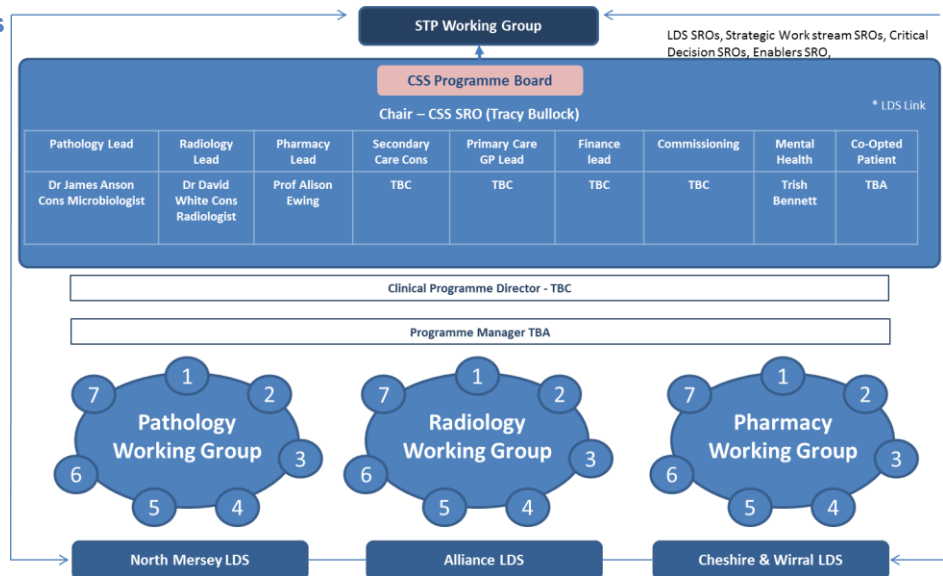
The ambition is to collaborate at STP level wherever possible and to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint

### How will the change be lead?

<b>Sponsor:</b>	<b>Tracey Bullock</b>	
<b>Members:</b>	Pharmacy:	Karen Thomas, Prof. Alison Ewing
	Pathology:	Dr James Anson
	Radiology:	Dr Dave White

## 2.3b Optimise direct patient care – efficient clinical support services

### Proposed Governance Arrangements



### Delivery

The principle is collaboration across the entire STP but recognising that this will be a journey starting with programme based collaboration at STP level in the first 18 months of the programme, building to full STP collaboration where appropriate between 18 and 36 months or even longer in some cases.

The 'Plans on a Page, below and overleaf, are summaries of the more detailed plans that are included in the Appendices.

3b. Optimise direct patient care: Clinical support services- Radiology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019	Output Details of work
Collaborative reporting arrangements	Develop project scope and review 'as is' model		
	Identify how working practices might need to be changed to promote a change in reporting arrangements	Consult on the proposed business case proposal	
	Agree new design principles	Examine governance and HR requirements to support proposed new model of care	
	Identify and evaluate options for future delivery arrangements		
	Develop new operating model and a business case		
	Determine investment costs required to ensure IT systems are compliant across the footprint		
Flexible reporting arrangements – home reporting	Identify how working practices might need to be changed to promote a change in reporting arrangements	Increased use of honorary contracts	
	Agree new design principles	Examine governance and HR/legal issues in support of changing practices	
	Identify the options for future delivery arrangements	Introduce trials of home reporting arrangements and carry out evaluation of results	
	Identify any infrastructure/IT costs to support/facilitate home care reporting arrangements	Expansion of home reporting across the C&M footprint	
	Carry out gap analysis of how future reporting arrangements compare to current and identify potential investment costs		
Flexible reporting arrangements-establishing 'hub and spoke' units	Consideration and development of new operating model including establishment of a central management team charged with managing requests for work/balancing demand with capacity in system	Examine implications of introducing honorary contracts to allow flexible working arrangement across Trusts	
	Explore flexibility/use of honorary contracts to support flexible working arrangement across Trusts	Establish central reporting hubs to allow group involvement in speciality reporting	
		Consolidation and expansion of radiographer role extension	
Greater collaboration around procurement	Carry out audit of equipment which is regularly purchased by type, manufacturer and value	Commence the procurement of standard range of interventional radiology equipment	
	Identify when larger items are due for replacement and synchronise purchasing schedule	Central procurement of contrast media	
	Standardise range of equipment lines	Central procurement of imaging technology	
	Establish a single managed service via a lead Trust/supplies team to lead the negotiations with potential suppliers about the range of items required and agree potential discounts		

## 2.3b Optimise direct patient care – efficient clinical support services

Delivery, cont.

3b. Optimise direct patient care: Clinical support services- Pathology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019	Output Details of work
LDS consolidation and partial centralisation (phase 1)	Alliance merger consolidate further with Warrington	Develop Project Implementation Boards to implement agreed business cases	
	North Mersey LDS to complete consolidation by merger of Regional Genetic Service into LCL and examine the potential merger/centralisation of Alder Hey pathology service into LCL		
	Cheshire and Wirral- to review collaborative models feasible between the current collaboration and CoCH & Wirral. Identify options for further consolidation/centralisation of services		
	Identify current unsustainable services and opportunities across C&W/C&M for short term sustainability		
	Identify IT and support system investments required vs financial/sustainability benefits		
STP wide/C&M single managed service	Develop business cases		
	Commence scoping of potential future strategic direction of services including development of baseline position (costs, staffing, service and performance issues)	Review potential governance models that could best support an STP single managed service	
	Look at demand and capacity and site options to accommodate any further centralisation options	Review governance arrangements that could support the operation of the above solution and clarify performance of services required	
	Undertake workshops and engagement sessions with key stakeholders to define a well understood and agreed set of design principles that could govern future change with specific focus on the use of increased collaborative working arrangements. Define which processes are suitable for delivery through a more consolidated function versus those that should be retained within local hospitals / LDS level	Review and discuss potential vision and models with stakeholders to seek buy-in and support	
		Consider how this supports the acute service reconfiguration model which evolves from the STP work	
		Undertake an options appraisal of the best solution and identify the relevant costs and benefits associated with this for the C&M footprint area	
		Examine the potential for novation of contracts over time	

3b. Optimise direct patient care: Clinical support services- Pharmacy	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019	Output Details of work
Medicines information	Develop project scope	Implement new operating model and establish and transfer services	
	Identify and evaluate options		
Aseptic service	Develop project scope and clarify investment/support costs	CEO/STP sign off	Establish a communication plan
	Establish 'as is' position- audit what is currently provided at each site and identify those areas that could be centralised and what would need to remain under local direction		Evaluate estate's capacity/capability to meet potential transfer of services
	Agree vision ('to be' operating model) and establish design principles		Develop business case to support service proposal
			Develop stakeholder engagement plan and engage key stakeholders
Clinical Pharmacy Templates			Finalise options
	Develop project scope and clarify investment/support costs		Develop implementation plan
	Establish 'as is' position- Assess what is currently done and how pharmacists/technicians currently spend their time delivering these functions		Commence roll out of proposed service moves
	Identify what a good pharmacy service looks like		Design templates for pharmacists and technicians and agree new standards of working
	Establish patient pharmacist contact criteria eg when a patient would see a pharmacist, how long consultation should take (average)		Undertake a gap analysis- compare proposed solution with the 'as is' situation and develop a case for change
Forging links with the community Pharmacy	Establish criteria which would support a medicines review for a technician		Develop a shared medicines management training programme via e-learning package
	Develop project scope and clarify investment/support costs		Staff side engagement and consultation
	Establish vision of the proposed future state		Establish potential opportunity for improvement across the STP footprint from moving to the new operating model
	Undertake assessment of current pharmacy dispensing arrangements across every Trust in the C&M footprint and how they are funded		Set KPIs to inform performance management and to adhere to standards
	Explore legal implications of the proposed operating model		Develop service specification and obtain professional advice
Formulary management and application	Evaluate potential options/commercial vehicles to support the proposed venture/operating model		Develop tender arrangements to secure preferred partner
	Review current plans/proposals being developed in C&W in short term for proposals to cover the five existing Trusts in the area		Develop appropriate legal documentation to support the proposed commercial partnership arrangement
	Undertake assessment of staffing costs		Determine new governance arrangements
	Agree, if applicable, a wider vision and target operating model prior to regional centres being established		Set up new commercial vehicle(s) with proposed community pharmacy partner
	Consider proposed governance arrangements to support proposed model		Consult with stakeholders on proposed single sit solution and how this will work
			Implement single formulary arrangement with the advent of the Regional Medicine Optimisation Committee coming on line for the North West area



## 2.4 - Mental Health

### Introduction

Mental disorder is responsible for the largest proportion of the disease burden in the UK (22.8%), which is larger than cardiovascular disease (16.2%) or cancer (15.9%). One in four adults experience at least one diagnosable mental health problem in any given year. *Mental health problems represent the largest single cost of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.* In England, if you have a serious mental illness, you are twice as likely to die before the age of 75 years. On average, you will die 15-20 years earlier than other people.

People with long term illnesses suffer more complications when they also develop mental health problems, increasing the cost of care by an average of 45%. For example, £1.8billion additional costs in diabetes care are attributed to poor mental health.

Two thirds of people with mental health needs are seen in primary care. Local GP registers indicate that 9 out of the 12 CCGs in Cheshire and Merseyside have a higher number of adults with depression than the England average. The number of people on Cheshire and Merseyside GP registers with severe mental illness is also higher than the England average and over 50% of Cheshire and Merseyside CCGs have been flagged for having a high prevalence rate of dementia.

Additional funding to support the transformation of mental health services will include centrally-held transformation funding and allocations via CCGs. It is assumed that an appropriate share of national monies will be made available and that this investment will rise to at least £57.9m in Cheshire and Merseyside by 2020/21. Evidence provided within the Centre for Mental Health Economic Report indicates that significant savings across the health and care system will outweigh the investment needed to deliver services.

### What are the objectives

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases;
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

A C&M Mental Health Programme Board will be established to oversee nine workstreams to facilitate delivery of these key objectives. The Board will identify workstream owners and confirm timescales for delivery of all workstreams.

### How will the change be lead

Sponsor:	Sheena Cumiskey
Members:	Alliance – Simon Barber C&W – Sheena Cumiskey North Mersey – Neil Smith / Joe Rafferty

## 2.4 - Mental Health

### Delivery

Three priorities have been identified for early implementation:

- Eliminate out-of area-placements
- Develop integrated clinical pathways for those with a personality disorder
- Enhance Psychiatric Liaison provision across the footprint and establish Medically Unexplained Symptoms (MUS) service

The nine projects below have been developed to deliver the objectives. Detailed plans for each workstream are currently being prepared.

A Mental Health plan on a page is included overleaf to provide the headline phases of work.

Project	Impact	'Workstream'
<b>Children &amp; Young People's (CYP) MH</b>	Increased number of CYP receiving community treatment; reduced use of inpatient beds; improved outcomes for children with conduct disorder leading to savings in the public sector, mainly the NHS, education & criminal justice	<ul style="list-style-type: none"> <li>• Community access</li> <li>• 24/7 crisis &amp; liaison</li> <li>• School age screening &amp; education</li> </ul>
<b>Perinatal MH (PMH)</b>	Improved identification of perinatal depression & anxiety; improved health outcomes; reduction in adverse impact on the child (which account for >70% of total long-term costs to society);	<ul style="list-style-type: none"> <li>• Build PMH capacity &amp; capability</li> <li>• Improve screening programmes &amp; access to psychological therapy</li> </ul>
<b>Adult MH: Common MH Problems</b>	Relieve pressure on General Practice, reduce A&E attends & short stay admissions. Target most costly 5% of patients with medically unexplained symptoms (MUS)	<ul style="list-style-type: none"> <li>• Increase access to psychological therapies</li> <li>• Develop Medically Unexplained Symptoms Service</li> </ul>
<b>Adult MH: Community, Acute &amp; Crisis Care</b>	Reduced bed days, lower rates of relapse, reduced admissions and lengths of stay Reduced use of MH services and improved outcomes	<ul style="list-style-type: none"> <li>• Early Intervention in Psychosis</li> <li>• 24/7 Crisis Resolution &amp; HTT</li> <li>• All-age MH Liaison in acute</li> <li>• Increase GP screening &amp; access</li> <li>• Scale up IPS employment services</li> <li>• Improve psychological therapies</li> </ul>
<b>Secure Care Pathway</b>	Prevent avoidable admissions & support 'step-down' and ongoing recovery	<ul style="list-style-type: none"> <li>• Improve pathways in &amp; out of secure care</li> </ul>
<b>Health &amp; Justice</b>	Fewer GP consultations, hospital admissions & inpatient MH treatment	<ul style="list-style-type: none"> <li>• Expand access to liaison &amp; diversion services</li> </ul>
<b>Suicide Prevention</b>	Main benefits relate to non-public sector costs relating to the individual and the family	<ul style="list-style-type: none"> <li>• Suicide Prevention</li> </ul>
<b>Sustaining Transformation</b>	Prevent avoidable admissions, reduce length of stay, improve community access and eliminate out-of-area placements	<ul style="list-style-type: none"> <li>• Care pathways</li> <li>• Workforce MH</li> </ul>
<b>Dementia Care</b>	Increase dementia diagnosis rates & create dementia-friendly health & care settings	<ul style="list-style-type: none"> <li>• Implement commitments from PM's Challenge on Dementia 2020</li> </ul>

## 2.4 - Mental Health – plan on a page

9. Mental Health		2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
<b>Enablers</b>	Output Details of work	Establish Transformation Board				
		Identify BI capacity & capability to complete baseline assessments & provide ongoing support / delivery of schemes				
		Confirmation of funding as per 5 YFV for MH				
<b>Children &amp; Young People's (CYP) Mental Health</b>	Community access	Design	Implementation	Post-implementation phase. PDSA		
	24/7 crisis & liaison	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Screening of school children & provision of parenting programmes	TBC				
	Develop school based mental health curriculum (social & emotional learning)	TBC				
<b>Perinatal Mental Health</b>	Build PMH capacity & capability and improve screening programmes & access to psychological therapy	Recruitment	Full implementation	Post-implementation phase. PDSA		
<b>Adult Mental Health: Common MH problems</b>	Increase access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Develop a specialist Medically Unexplained Symptoms (MUS) service	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Provide collaborative care for long-term conditions & co-morbid MH		Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Early Intervention in Psychosis	Implementation	Post-implementation phase. PDSA			
	24/7 Crisis Resolution & HTT	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Deliver all-age mental health liaison teams in acute hospitals	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Armed forces community MH		Baseline assessment, design & implementation	Post-implementation phase. PDSA		
	Increase GP screening & access		TBC			
	Scale up IPS employment services		TBC			
	Improve access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Supported housing step-down facility		TBC			
	Improve pathways in & out of secure care		TBC			
	Expand access to liaison and diversion services		TBC			
	Suicide Prevention	Design	Implementation	Post-implementation phase. PDSA		
	Care pathways (multi-phased)	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
			Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Workforce MH		TBC			
	Implement the 18 commitments outlined in the Prime Ministers Challenge on Dementia 2020	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		

# 3 - Embedding the change locally

Please see separately attached LDS plans in full



## LDS Plans

The previous section has described the programmes of work at the STP level, together with the LDS's contribution to them. Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

The strategic programmes that will drive transformation across C&M are not new or particular to C&M. They are issues that health economies have tackled over many years but so often failed to deliver on.

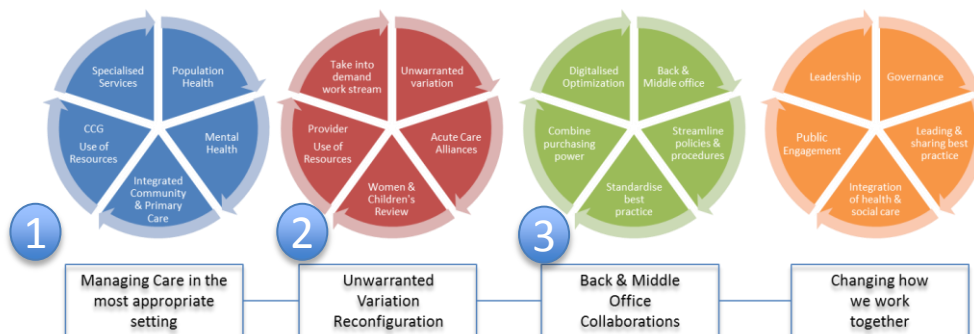
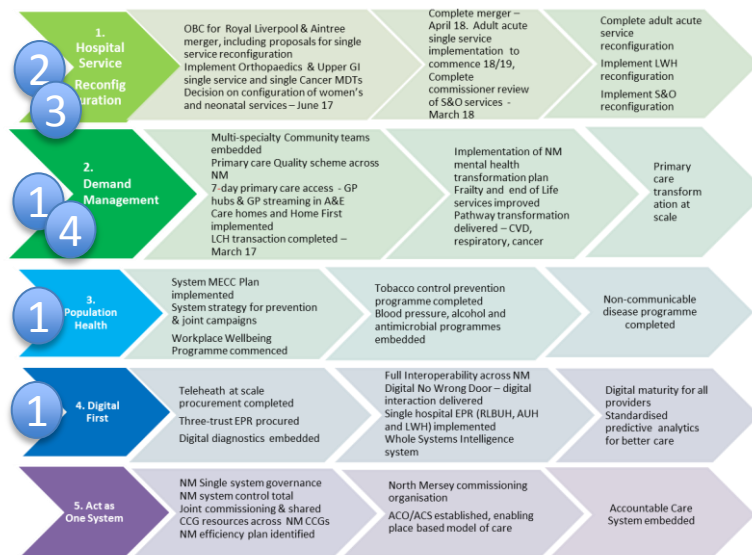
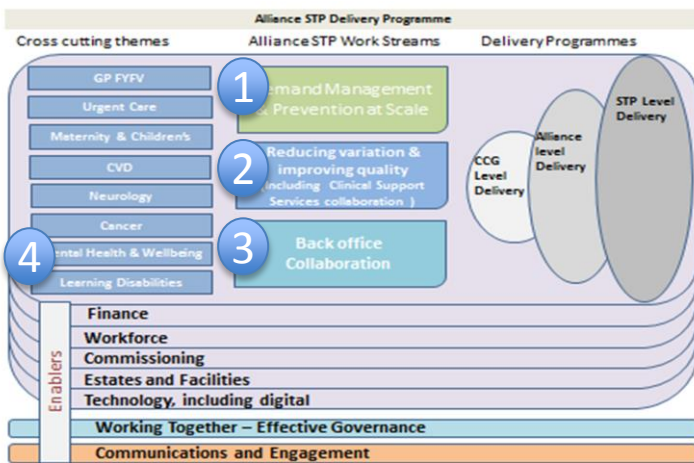
However, there is now an compelling need to deliver on these ideas that have been developing. This is reflected in the plans of the three LDSs. All three have already put in place programmes to help improve out of hospital care, to reduce the demand on our acute hospitals and to persuade people that they need to take responsibility for their own health.

Acute hospitals in each LDS have started work on aligning and sharing services, including clinical service lines, and in North Mersey, merger discussions are at an advanced stage. There is also a, mixed, history of back office collaboration and working together on city and county wide issues.

Over the following pages we have summarised the key programmes being developed in each LDS, together with their delivery plans.

The graphics below illustrate the overall alignment of LDS plans with the STP's strategic programmes:

- 1 Demand Management,
- 2 Variation and Hospital Reconfiguration,
- 3 a) Back Office, b) Clinical Support Services, and
- 4 Mental Health



### 3.1 - Alliance approach and plans

The Alliance LDS has aligned its transformational work streams and delivery structure to mirror that of the C&M STP to ensure that delivery will be at the most appropriate level – organisational, LDS level or STP footprint.

Since the June submission the Alliance has gained a greater understanding of the potential service models that will transform services and achieve long term financial sustainability.

This plan represents options and models of transformation for the local health system that have been developed by the member organisations and are still subject to wider engagement and where necessary formal consultation with stakeholders.

Alliance LDS – Transformation Plan on a page				
Transformation Programmes	Schemes (subject to consultation)	Benefits	Net Saving	Year (full benefits delivered)
<b>Prevention at Scale</b>	Alcohol Blood Pressure AMR	Improved population health Less MRSA	£3.5m	2019/20
<b>Out of Hospital Care /Demand Management (Inc. Mental Health)</b>	<ul style="list-style-type: none"> <li>Referral Management</li> <li>Single Point of Access</li> <li>Integrated Community Teams (Virtual Ward, Intermediate Care, Discharge to Assess, Rapid Assessment)</li> <li>Self-care – Tele-health, Telemedicine, Meds Management</li> <li>Care Homes/Frail Elderly</li> <li>Mental Health</li> </ul>	Contain predicted growth in; <ul style="list-style-type: none"> <li>A&amp;E Attendances</li> <li>NEL Admissions</li> <li>OP Appointments</li> <li>Elective &amp; Day case procedures</li> </ul>	£52.5m	2018/19
<b>Acute Care - Reducing Variation and Improving Quality (Inc. Clinical Support Services &amp; Estates)</b>	Single Acute Service Models <ul style="list-style-type: none"> <li>Urgent Care</li> <li>Elective Care</li> <li>Maternity and Children's Clinical Support Service</li> <li>Collaboration</li> <li>Pathology</li> <li>Radiology</li> <li>Pharmacy</li> <li>Estates</li> </ul>	<ul style="list-style-type: none"> <li>Improved outcomes</li> <li>Reduced LoS</li> <li>Reduced premium/agency costs</li> <li>Improved efficiency (Carter metrics)</li> <li>Achieve access targets</li> </ul>	£30.1m	2020/21
<b>Back office Collaboration</b>	Payroll Transactional HR Procurement Financial services	<ul style="list-style-type: none"> <li>Reduce overhead costs</li> <li>Reduce variation and duplication</li> </ul>	£15.5m	2020/21

The Alliance is still developing its programme of work and the detailed plans that explain how delivery will be effected.

In addition to the core programmes shown above the Alliance is working closely with the Clinical programmes and have clear objectives with regard Urgent Care, Women's and Children's, Elective Care and Clinical Support Services

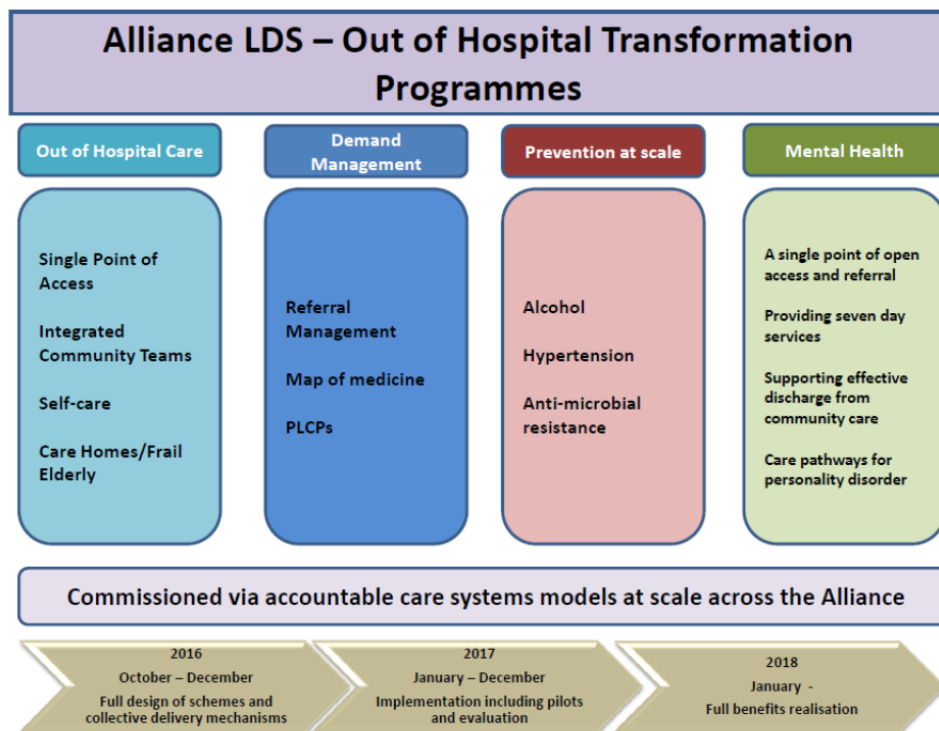
Over the page are the models and frameworks they have developed for developing improved out of hospital care and also improving the quality of acute care.

### 3.1 - Alliance approach and plans

Improve the health of the C&M population by:

- Promoting physical and mental well being
- Improving the provision of physical and mental care in the community (i.e.outside of hospital)

Out of hospital care is a key component of the future vision for services across the Alliance. The individual CCGs have already started to develop plans and the challenge now is for the commissioners to come together and work collaboratively to scale up the ambition and impact of these plans to impact on the overall sustainability of the LDS. This is a complex programme of work that has 4 core elements as shown below:

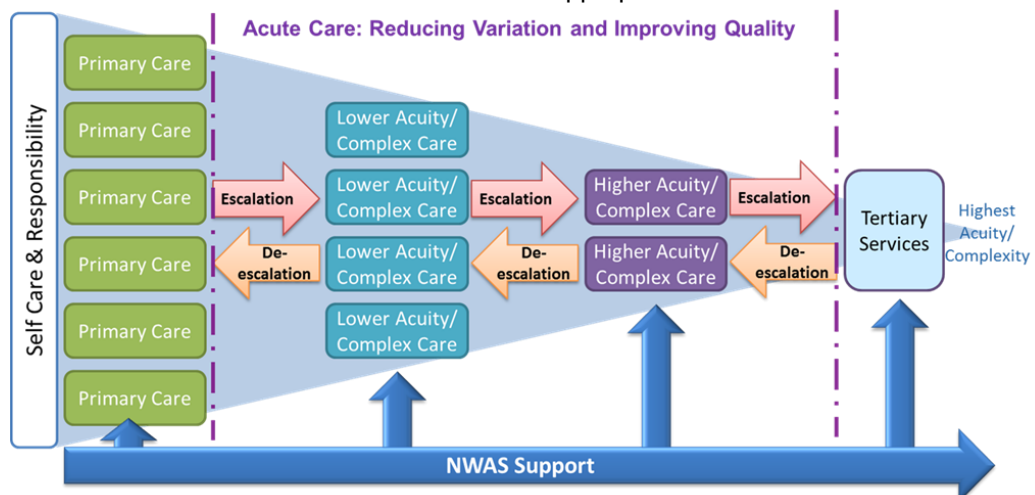


Improve the quality of care in hospital settings by:

- Reducing the variation of care across C&M;
- Delivering the right level of care in the most appropriate setting
- Enhancing delivery of mental health care

- More streaming of patients depending on their acuity and complexity
- The highest acuity care can be delivered on fewer sites with the appropriate facilities
- Site specialisation to suit that patient cohort with the appropriate resources and facilities
- NWAS streaming patients to the site/service appropriate to their need

The Acute Providers will work together to develop a new model of working, including:



### 3.1 - The Alliance plans - Demand management

Projects	Change Delivered	Outcomes
Quality Referral Management	Single quality referral management system across the Alliance LDS managing demand using Map of Medicine and generic pathways agreed between the acute hospital sites. Utilisation of Map of Medicine and greater scrutiny of PLCP.	Impacts Acute Outpatient Activity and Acute Elective and Day Cases Activity For Acute Outpatient: 20% activity reduction (equiv. 150,000), and £22.5m gross saving in FY202/21 For Acute Elective and Day cases: 4% activity reduction (equiv. 7,000) and £7m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Single point of access	Single clinical governance regime and infrastructure which enables access to the appropriate level of support in a variety of settings for patients and professionals in instances of unscheduled care	Impacts Acute Elective and Day Cases Activity and Acute Non Elective Activity For Acute Elective and Day Cases: 5% activity reduction (equiv. 5,000), and £5m gross saving in FY202/21 For Non Elective: 6% activity reduction (equiv. 5,000) and £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Integrated community management teams (virtual ward)	Integrated services involving social care which not only involves the work of professional teams but also integrated information systems and the sharing of patient and client information; this also supports discharge by linking into SPA - including domiciliary care and care homes.	Impacts Acute A&E Activity and Acute Non Elective Activity For Acute A&E: 4% activity reduction (equiv. 15,000), £1.8m gross saving in FY2020/21 For Acute Non Elective: 5% activity reduction (equiv. 5,000), £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Medicines Management Optimisation	Reduction in primary care medicines management spend	£4m gross saving in FY2020/21 0-1 year timeframe for benefits delivery
Telehealth and telecare	Identifying individuals to support better self care to provide them with IT equipment in their own home to monitor their conditions to reduce emergency admissions	For Acute A&E: 4% activity reduction (equiv. 15,000) and £1.8m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Rapid response/ rapid assessment	Rapid response and assessment team respond quickly to urgent requests at home, with one of the boroughs employing a community geriatrician	Acute A&E Activity: 3% activity reduction (equiv. 10,000) with £1.2m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Prevention	STP-wide strategy to reduce the prevalence of alcohol-related conditions or episodes and impact on primary and acute	

### 3.1 - The Alliance plans - Variation and hospital reconfiguration (1/3)

Projects	Change Delivered	Outcomes
<b>Urgent Care System – model of care 1</b>	S&O will consider options for new models of A&E delivery. 3 Trusts will have a Type I - 24hr A&E, but through shared rotas and federation of staff premium payments would be reduced by x% Modelling of staffing rotas and new working patterns/processes will improve productivity	Reductions in the consultant on call cover and presence Reduction in the use of locums /agency by (x%) Productivity improved through the use of best practice Alignment with commissioner interventions
<b>Urgent Care System – model of care 2</b>	S&O will consider options for new models of A&E delivery 3 Trusts will have a 24hr A&E High acuity patients will be transferred to the Emergency centre (for example: stroke, heart attack, compound fracture, burns, emergency dialysis, some trauma, GI Bleeds) By federating staff and remodelling of staffing rotas and new working patterns/ processes will improve productivity and reduce premium payments Alignment with commissioner demand management interventions	Accelerated flow through departments to achieve more optimal performance Reduction in the use of staff premium payments by x% Consultant presence and cover will reduce on call payment Activity transfer of x patients per year (one site) Increase in bed capacity of x y beds to freed up. Redistribution of elective activity to other centres (TBD)
<b>Urgent Care System – model of care 3</b>	S&O will consider options for new models of A&E delivery . 1 Trust will have a Type I - 24hr A&E, 2 trusts will re-profile opening hours with activity flowing to other 24/7 centres Alignment with commissioner demand management interventions	Reductions in the consultant cover from 3 to 2 on call covering 3 sites. Reduction in the use of locums /agency staff by x% Activity transfer of 8,700-20,000 patients per year (one site) Increase in bed capacity of 80-150 beds required/freed up. Redistribution of elective activity to other centres (TBD)
<b>Stroke Services</b>	The Acute vision is for Whiston to be the Hyper Acute provider for the LDS support by a 1 in 8 rota. (All Trust have lost some consultant establishment recently so this needs to be address first) Single point of contact and standardise referral process All ESD teams to have equal access to discharge plans for proactive discharge planning Single CCG lead for ESD and Community for cross organisational services Development of Unified ESD and Community teams.	Single provider for Hyper Acute, support be 3 acute units and community teams Consistent approach across the Alliance Patients repatriated to local centre A x% reduction in premium payments



### 3.1 - The Alliance plans - Variation and hospital reconfiguration (2/3)

Projects	Change Delivered	Outcomes
<b>Paediatric Services Review</b>	<p><b>Alignment with Vanguard Proposals for a 'Single Service'</b></p> <p>Move from 3x level 2 units to:            2x high acuity units &amp; 1 lower acuity unit or            1x high acuity units &amp; 2 lower acuity unit or            Higher and Lower levels of Acuity</p> <p><b>Acute Inpatient Unit – 24hrs</b>            Paediatric A&amp;E 24hrs            GP hotline            Outpatients            Rapid access clinics            HDU            Inpatient unit            Neonates: Level 1/2            Community home nursing sup.            Day case surgeries            Anaesthetic cover</p> <p><b>Short Stay Unit – 12hrs</b>            Paediatric A&amp;E            GP hotline            Outpatients            Rapid access clinics            Neonates : level 1/2            Community home nursing sup.            Day case surgeries            APNPs            Safe transfer to AIU</p>	<p><b>High Quality</b>            Resources, facilities and the care delivered in each site is tailored to the patient cohort treated            ALL hospitals will be required to attain Quality and Safety standards.</p> <p><b>Safe</b>            Specialist consultant resources will be concentrated on the highest acuity patients            Evidence shows that the more times a surgeon performs a procedure, the better the outcome.            Focusing the delivery of highly specialist care in fewer locations means that our professionals will gain the volume and breadth of experience to deliver excellent quality care</p> <p><b>Accessible</b>            Better access to Primary care will alleviate pressure on services.            Streaming the highest acuity cases to a Red Hospital means a Green hospital can deal efficiently with lower acuity demand            Staffing levels will be standardised and ALL hospitals will be required to attain standards. This means quality care will be delivered in ALL our hospitals</p> <p><b>Sustainable</b>            This model proposed is a more effective use of EXISTING resources</p>
<b>Maternity Services Review</b>	<p><b>Alignment with Vanguard Proposals for a single service</b></p>	
<b>Elective Services Review &amp; Productivity Review</b>	<p>Improvement in LoS benchmarked against Better Care Better Value            Ward Closures based on reductions in DTOC            Premium pay reductions resulting from the application of standardised care pathways            Benchmark against upper quartile and within the Alliance to move to the most productive amongst peers and best in class</p> <p>Exploration of a Factory Model for simple high volume procedures such as:            Orthopaedics            Ophthalmology            Plastics            These could be scheduled for day case and short stay &lt;72hrs procedures at t Treatment Centres            Alignment with commissioner demand management interventions</p>	<p>BCBV</p> <p>Reduction in DTOC</p> <p>Reductions in Premium Payments</p> <p>Reduction in bed days            Reduced number of delayed transfers of care            Reduction in costs            Alignment with commissioner demand management interventions</p> <p>Reduction in variation of care and outcome            Higher productivity levels            Improved utilisation of theatres            Lower length of stay</p>

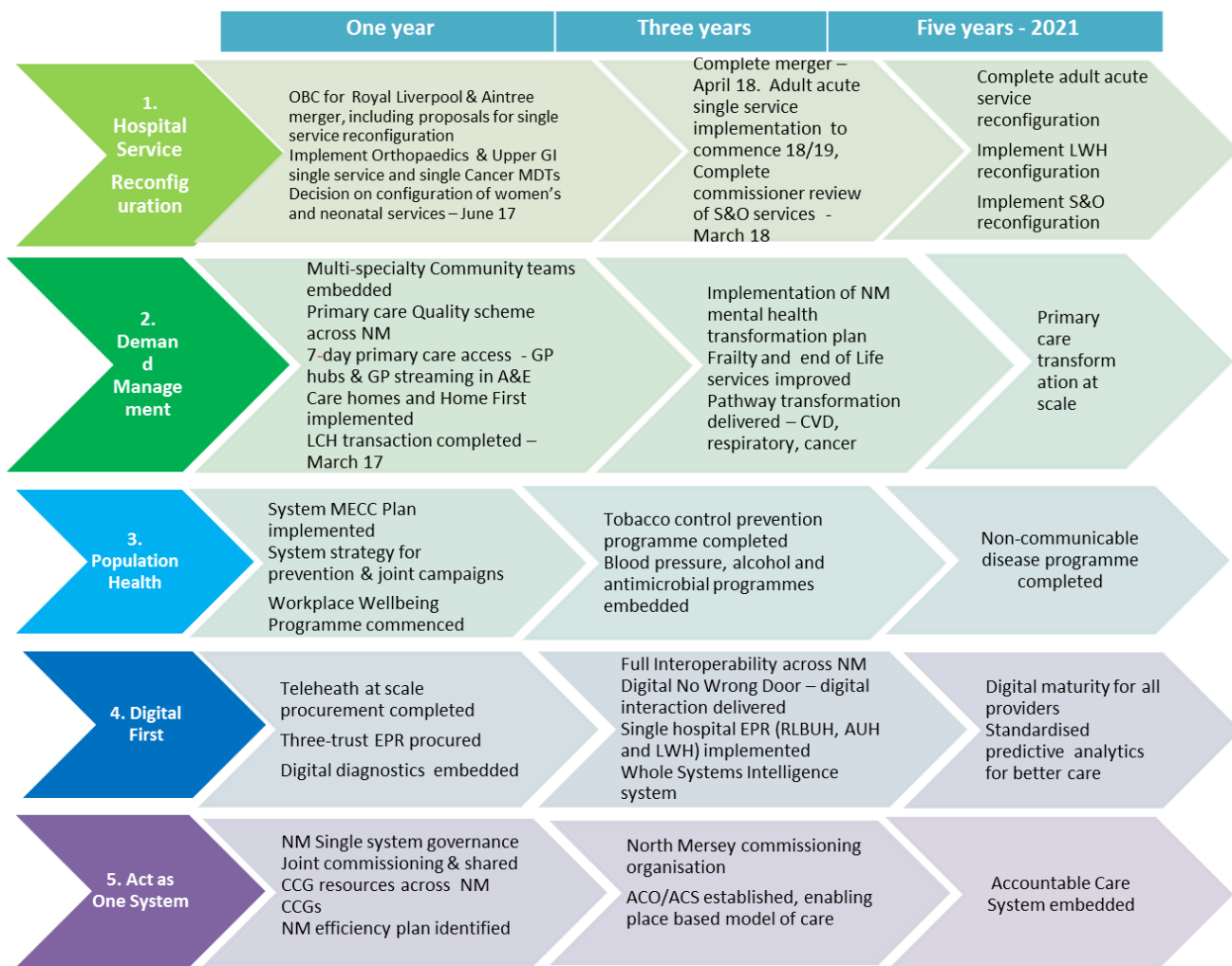
### 3.1 - The Alliance plans - Variation and hospital reconfiguration (3/3)

Projects	Change Delivered	Outcomes
<b>Sub-scale Services Review</b>	<p>Federate services to make them more clinically sustainable and reduce the premium payments , see above</p> <p>Urology; Dermatology, Rheumatology; Diabetology, Orthodontics; Respiratory Medicine; Acute Medicine, Geriatric Medicine</p>	<p>Clinically Sustainable Services</p> <p>Reduction in on-call rotas</p> <p>Reduction in premium payments amounts to around £4.7m</p> <p>Alignment with commissioner demand management interventions</p>
<b>Pathology</b>	Moving from a Bi-partite arrangement between STHK and S&O to a tri-partite arrangement to include WHH	<p>Lower unit costs</p> <p>Reduced investment required</p> <p>Increased productivity</p> <p>Consolidation of staffing levels</p> <p>4% reduction in costs year on year</p>
<b>Pharmacy</b>	<p>Opportunity to outsource/ create a JV for outpatient dispensary</p> <p>Alignment with STP Review, sub regional solution likely</p>	<p>VAT advantages</p> <p>4% reduction in costs year on year</p>
<b>Radiology</b>	Alignment with STP Review, sub regional solution likely	4% reduction in costs year on year

## 3.2 - North Mersey approach and plans

The North Mersey plan builds upon and joins-up established transformation programmes; including *Shaping Sefton* and *Healthy Liverpool*, which was established in 2013 in response to the city's Mayoral Health Commission. The commission's ten recommendations recognised that such was the extent of poor health outcomes, and the relentless pressures on resources, that only a whole-system approach to

the transformation of health and care would succeed. The commission's insight and mandate to the local NHS and partners to deliver change has given the North Mersey delivery system a three year head start in identifying and now delivering the whole system transformation plans that are set out in the Cheshire and Merseyside STP. It is represented by this 'Plan on a Page':



Each of the programmes above has a delivery plan that clearly lays out the projects that are being mobilised, the expected outputs and outcomes and forecast benefits.

Overleaf are North Mersey's plans for each of these programmes

## 3.2 - North Mersey plans for hospital reconfiguration

Programmes	Projects	Outputs	Start Date	End date
<p><b>Single service system-wide delivery for adult acute services</b></p> <p><u>Plan</u> SOC completed OBC commenced Project plan in development</p>	<p>Reconfiguration of 35 adult acute services across RLBUH, AUH and LHCH, to establish single service, system-wide services. Detailed service reconfiguration plan to be set out in an Outline Business Case, currently in development</p>	<ul style="list-style-type: none"> <li>Single service pathways across all adult acute services</li> <li>Single clinical workforce for adult acute services across 3 trusts</li> <li>Site rationalisation across 4 to 5 hospital sites in the city</li> </ul>	April 2016	March 2021
<p><b>Merger of the Royal Liverpool, Aintree and Liverpool Women's Hospitals</b></p> <p><u>Plan</u> As above</p>	<p>Establish a single organisation from 3 NM trusts - RLUH, AUH and LWH</p> <p><u>Milestones:</u></p> <ul style="list-style-type: none"> <li>Strategic Options Case – approved by boards, June 16</li> <li>Outline Business Case – to be completed June 2017</li> <li>Joint HLP and trust PMO to be established, Nov 16</li> </ul> <p>Full Business Case and approval by regulators and mobilisation for a new trust by 1<sup>st</sup> April 2018</p>	<ul style="list-style-type: none"> <li>Single trust to deliver the majority of adult acute service in the city from April 2018</li> </ul>	April 2016	March 2018
<p><b>Reconfiguration of women's and neonatal services</b></p> <p><u>Plan</u> Project plan completed and delivery on track (see below)</p>	<p>Women's and Neonatal Review. The objective is to achieve clinical and financial sustainability through a reconfiguration of the services provided by Liverpool Women's FT NHS Trust.</p> <p><u>Milestones:</u></p> <ul style="list-style-type: none"> <li>Pre-consultation engagement – completed Aug 16</li> <li>PCBC – Oct 16 – completed</li> <li>Assurance process – Sept – Nov 16</li> <li>Public consultation Jan17</li> <li>Decision May/June17</li> </ul>	<ul style="list-style-type: none"> <li>Reconfiguration of services which address the clinical and financial challenges of delivering these services, as set out in the Review Case for Change</li> <li>Improved access to essential co-dependent acute services, for example blood transfusion services, associated surgical expertise, diagnostics, interventional radiology etc</li> <li>Increased scope for involvement in and patient benefits from research and innovation</li> <li>Reduced transfers of care</li> <li>Protecting the future delivery of specialist services within the city</li> </ul>	Jan 2016	Decision: May 17
<p><b>Neuro Network Vanguard</b></p> <p><u>Plan</u> Programme plan</p>	<p>The programme objective is for a clinically and cost effective comprehensive whole system neuroscience service.</p> <p>People with neuro or spinal problems will receive the appropriate clinically effective care to assured standards, wherever they live, via local access points, and have an efficient and person centred experience.</p>	<ul style="list-style-type: none"> <li>Integrated, high quality neuro, rehabilitation and pain pathways across Cheshire &amp; Merseyside, delivered via a hub and spoke model of care</li> <li>More care delivered in community settings</li> </ul>	2016/17	2020/21
<p><b>Southport &amp; Ormskirk NHS Trust Review of Services</b></p>	<p>The objective is to achieve clinical and financial sustainability facilitated by a review of the services provided by Southport and Ormskirk NHS Trust.</p> <p><u>Milestones:</u></p> <p>Establish formal commissioner led major service review in a multi-stakeholder partnership.</p> <ul style="list-style-type: none"> <li>Process, Governance and Stakeholder Mapping (Jan-March 2017)</li> <li>Case for Change (April-June 2017)</li> <li>Pre-consultation engagement (July-September 2017)</li> </ul> <p>Further milestones will follow in accordance with NHSE published "Planning, assuring and delivering service change for patients"</p>	<ul style="list-style-type: none"> <li>Expansion of current integrated care organisation strategy. Emphasis on partnership, standardised pathways and self care in the community and primary care setting.</li> <li>Reconfiguration of services which address the clinical and financial challenges, as determined by the Reviews "Case for Change"</li> <li>Implementation of specialist commissioned strategy for the North West Regional Spinal Injuries Centre</li> </ul>	January 2017	July 2018

## 3.2 - North Mersey plans for demand management – community 1/2

Programmes	Projects	Outputs	Start Date	End date
<b>Integrated Multi-disciplinary Community Teams</b>	Delivering proactive care through multidisciplinary teams operating on neighbourhood footprints of 30-50k. MDT to include general practice, community nursing, mental health, social care and a range of relevant care professionals relevant to an individuals' care.	<ul style="list-style-type: none"> <li>Reconfigured integrated multi-disciplinary teams operating on smaller neighbourhood units of 30-50k</li> <li>Shared records platform</li> <li>Single multi-agency assessment process (GATE Framework)</li> <li>Single point of access</li> </ul>	2015	March 2018
<b>Primary Care Transformation</b>	Transformation of primary care aligned to the GP Forward View and forming an essential component of the Community Model of Care  Adoption of the Liverpool GP Specification across NM	<ul style="list-style-type: none"> <li>Increased integration of services across primary care</li> <li>Improved workforce capacity and skill mix</li> <li>Improved optimization of prescribing solutions</li> <li>Standardised approach across the NM footprint</li> </ul>	June 2016	March 2019
<b>Primary Care Demand Management in Acute</b>	<ol style="list-style-type: none"> <li>Addressing activity at the front door of NM AEDs through the provision of GP streaming</li> <li>Developing capacity and utilization of primary care through the creation of primary care hubs in the community for routine and urgent care 7 days a week</li> </ol>	<ul style="list-style-type: none"> <li>Increased capacity to provide same day access to routine and urgent primary care 7 days per week</li> <li>Urgent delivered closer to home</li> <li>Increased integration of the urgent care system</li> </ul>	Jun 2016	TBC
<b>Effective Discharge Plan</b>  Borough specific plans in operation.	Implementation of whole system approach to support effective discharge for patients into community/home care. Focus on discharge to assess to deliver required assessments and reablement services in the patient's home (or community facility).	<ul style="list-style-type: none"> <li>Agreed pathways across whole system for discharge to home/community</li> <li>Consistent protocols across the NM system</li> <li>Clear system of escalation</li> <li>Increase in levels of domiciliary care provision</li> <li>Integration of health and social care resources</li> <li>Single assessment process</li> </ul>	Oct 2016	Mar 18
<b>Organisational Transition</b>  Decision October 2016 (New provider in place by April 2017)	Transition of community services to new provider arrangements, delivering a new specification aligned to the NM community model.	<ul style="list-style-type: none"> <li>Enabler to embed the new model of care for out of hospital services</li> <li>Financial sustainability</li> </ul>	Jan 2015	Apr 17
<b>Mental Health Plan</b>  Implement pan NM approach to Mental Health. Plan to be developed.	North Mersey Mental Health Health Transformation Board has been established. <ul style="list-style-type: none"> <li>Agreement of approach to implement new model for mental health care including:</li> <li>Integration with physical health services</li> <li>Implementation of new national standards/requirements</li> </ul> Merseycare delivery of 5 year financial plan	<ul style="list-style-type: none"> <li>Integration of mental health into community model of care</li> <li>Financial efficiencies</li> </ul>	July 2016	Mar 2021
<b>Enhanced Care Home Model</b>  Plan Elements in operation within South Sefton. Implementation within Liverpool from November 16.	Delivering proactive care through multi-disciplinary teams to provide regular MDT reviews in older peoples care homes. Introduction of telehealth with 24/7 access to a clinical telehealth hub	<b>Outputs</b> <ul style="list-style-type: none"> <li>Introduction of telehealth into care homes</li> <li>Increase in the uptake of telehealth and telecare</li> <li>MDT approach introduced</li> <li>Increase in the numbers of people with a Comprehensive Geriatric Assessment</li> </ul>	Nov 2016	Mar 2018

## 3.2 - North Mersey plans for demand management – community 2/2

Programmes	Projects	Outputs	Start Date	End date
<b>Cardiology</b>  <b>Plan</b>  North Mersey delivery plans in place and on-track	Whole system approach to delivering a single service delivery for cardiology services aimed at improving value from cardiology spend and improving outcomes. Six workstream areas: <ul style="list-style-type: none"> <li>• Chest Pain</li> <li>• Cardiac Rehab</li> <li>• Breathlessness</li> <li>• Heart Rhythm</li> <li>• Healthy Imaging</li> <li>• Prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in Consultant to Consultant referrals</li> <li>• Reduction in Outpatient appointments</li> <li>• Reduction in duplicate diagnostics</li> <li>• Reduction in inter-hospital transfers</li> <li>• Strengthening business continuity to support 7 day working</li> </ul>	Oct 2015	Mar 2018
<b>Respiratory</b>  <b>Plan</b>  Plan in place but to be reviewed in line with wider North Mersey delivery arrangements	Development of a new model of integrated respiratory care with city wide delivery	<ul style="list-style-type: none"> <li>• Single service pathways across all adult respiratory services.</li> <li>• Single clinical workforce for all adult respiratory services across the City</li> </ul>	Jan 2016	Mar 2018
<b>Children</b>	Redesign of children's service infrastructure across multiple partners and sectors with a focus on integrated, community based services; primary care / general practice, community services, social care, CAMHS, education and voluntary sector. At the core is a proactive approach to health, wellbeing and care delivery, focused on children and families, utilising the Levels of Need and the Early Help tools. Prime focus on prevention and early identification of need via universal services.	<ul style="list-style-type: none"> <li>• There is a clear set of objectives for this programme and a clinical blueprint is being developed to underpin the integration of teams &amp; services.</li> </ul>	Oct 2016	TBC
<b>Telehealth and Assistive Technologies</b>  <b>Plan</b>  Delivery plan to be reviewed in line with revised North Mersey delivery arrangements. Currently in procurement to deliver scale requirements.	<ul style="list-style-type: none"> <li>• Significant scale up of the telehealth programme across North Mersey</li> <li>• Telehealth procurement route and specification complete; new contract enabling scale up to be implemented in December 2016 to March 2017.</li> <li>• Clinical technology hub embedded in community service, with amended specification.</li> </ul>	<ul style="list-style-type: none"> <li>• Full telehealth monitoring for patients with COPD, Diabetes or Heart Failure with a risk of admission above 25% and also pass the clinical suitability gateway.</li> <li>• Provision of 'light touch' and self care telehealth systems and apps for patients below 25% risk and for a wider range of diseases.</li> <li>• North Mersey wide clinical engagement and referral routes established to take advantage of economy of scale.</li> </ul>	Apr 2016	Mar 2019

## 3.2 - North Mersey plans for demand management – population health

Initiatives	Projects	Benefits	Start Date	End Date
<b>Non-communicable disease prevention strategy for North Mersey</b>	health policy initiatives that make the healthy option the default social option.	<u>Outcomes</u> <ul style="list-style-type: none"> <li>Improved health outcomes</li> <li>Reduced emergency admissions</li> <li>Improved quality of life</li> <li>Reduced years of life lost</li> </ul>	Jan 2017	March 2021
<b>Making Every Contact Count (MECC)</b>	NM MECC Plan to be developed – Dec 16 Phased implementation plan across all providers	<u>Outcomes</u> <ul style="list-style-type: none"> <li>Improved health outcomes</li> <li>Reduced emergency admissions</li> <li>Improved quality of life</li> <li>Reduced years of life lost</li> </ul>	Sept 16	March 17
<b>Tobacco control</b>	Prevention programmes for young people Smokefree areas Reduce outlets selling tobacco and licencing Implementing PH guidance 48 on Smoking: acute, maternity and mental health services	<u>Outputs</u> <ul style="list-style-type: none"> <li>Stop smoking pathway adopted across all disciplines, which includes electronic referral to the stop smoking services</li> <li>Number of staff trained</li> <li>100% of patients with recorded smoking status &amp; given brief advice</li> <li>50% of smokers electronically referred to community stop smoking service &amp; 50% achieve a 4-week quit</li> </ul> <u>Outcomes</u> <ul style="list-style-type: none"> <li>% reduction in smoking-related hospital admissions</li> <li>Improved health outcomes</li> <li>Reduction in smoking prevalence</li> </ul>	Apr 17 Apr 17 Oct 17	Ongoing Mar 18 Sept 18
<b>Workplace Wellbeing Programme</b>	Develop programme, charter and accreditation framework Roll out across NHS and care system first Extend to NM workplaces	<u>Outputs</u> <p>Numbers of accreditations and reaccreditations achieved Evidence within 6 months of accreditation through audit of hospitals as health promoting environments e.g.</p> <ul style="list-style-type: none"> <li>Increase in physical activity programmes at work</li> <li>Increase in vending machines using healthy foods and drinks</li> <li>Longer term measures - 6 months/1 year</li> <li>Reduction from an agreed baseline - sickness absence, staff turnover</li> </ul> <u>Outcomes</u> <ul style="list-style-type: none"> <li>Improved health outcomes</li> <li>Reduced hospital admissions</li> </ul>	Dec 16	March 18

## 3.2 - North Mersey plans – digital roadmap

Programmes	Projects	Benefits	Start Date	End Date
<b>Digitally Empowered People</b>  <b>Digital No Wrong Door &amp; Assistive Technology</b>  <u>Plan</u> Digital no Wrong Door plan in development  Telehealth scale up in procurement phase	<b>Digital No Wrong Door</b> <ul style="list-style-type: none"> <li>Digital No Wrong Door; enabling people to interact digitally and online with the health and care system, as well as supporting population health Programmes</li> </ul>	<b>Digital No Wrong Door</b> <u>Outputs</u> <ul style="list-style-type: none"> <li>A single source and platform to access information, advice and services</li> <li>Online consultations with care providers and online appointments.</li> <li>Use their choice of device and app to manage their care</li> <li>Patients to be enabled to use assistive technology to manage their care and interact with professionals, and to access information about their own health and conditions to support them to self care.</li> <li>Establish a workforce that is digitally skilled with the appropriate technology and culture to enable effective working through technology.</li> </ul>	16/17	18/19
	<b>Assistive Technology</b> <ul style="list-style-type: none"> <li>Establish a range of assistive technologies that can be deployed across North Mersey in primary care, community and acute settings. This work supplements the demand management plans for deployment at scale.</li> <li>Support integration and interoperability with clinical systems for improved intelligence, referral mechanisms (to increase scale and sustainability) and clinical decision making.</li> </ul>	<b>Assistive Technology</b> <u>Outputs</u> <ul style="list-style-type: none"> <li>Increase in available technology</li> <li>Wider range of conditions supported by assistive tech</li> <li>Interoperability with clinical systems</li> </ul> <u>Outcomes</u> <ul style="list-style-type: none"> <li>Further reduced emergency admissions</li> <li>Improved patient experience</li> <li>Improved health outcomes</li> <li>Improved access to digital services</li> </ul>	16/17	18/19
<b>Connected Health and Social Care Economy Plan</b>  Plans fro all lines developed sharing agreements in place EPR procurement for 3 trusts in progress	To ensure that information is available to the right people, in the right place, at the right time Delivery of Information Sharing Framework <ul style="list-style-type: none"> <li>Digital maturity transformation of all H&amp;S Care providers</li> <li>Interoperability Programme –joining up key systems to deliver information sharing framework</li> <li>Single Adult Acute Hospital EPR (3 trusts)</li> <li>Maximisation of technology in Community Care Teams</li> <li>Consolidated Infrastructure; enabling work across sites and better patient access</li> </ul> <b>Delivered through implementation of the Merseyside Digital Roadmap</b>	<u>Outputs</u> <ul style="list-style-type: none"> <li>Every health and social care practitioner will directly access the information they need, in near real time, wherever it is held, digitally on a 24x7 basis.</li> <li>Consolidated and rationalised Electronic Patient Record systems moving to a common system for out of hospital care and a common system in our hospitals with interoperability between the two.</li> <li>Duplication and paper processes will be removed.</li> <li>Standardised, structured, digital clinical records across all providers in the pathways of care.</li> <li>No patient will need to 'repeat' their story.</li> <li>All health and social care professionals record clinical information in a consistent way, digitally, at the point of care, by 2018/19.</li> <li>All clinical correspondence between professionals caring for patients is sent digitally and integrated into core clinical systems by 2017/18.</li> <li>Community care teams can integrate for person-centred care with technology that "just works", by 2017/18.</li> <li>Individuals interact with their care services digitally should they choose to by 2018/19.</li> <li>All clinicians can order diagnostic tests electronically and view share diagnostics results around a patient by 2016/17.</li> <li>Single Service Teams have a single EPR to operate as a team by 2018/19.</li> </ul>	15/16	18/19



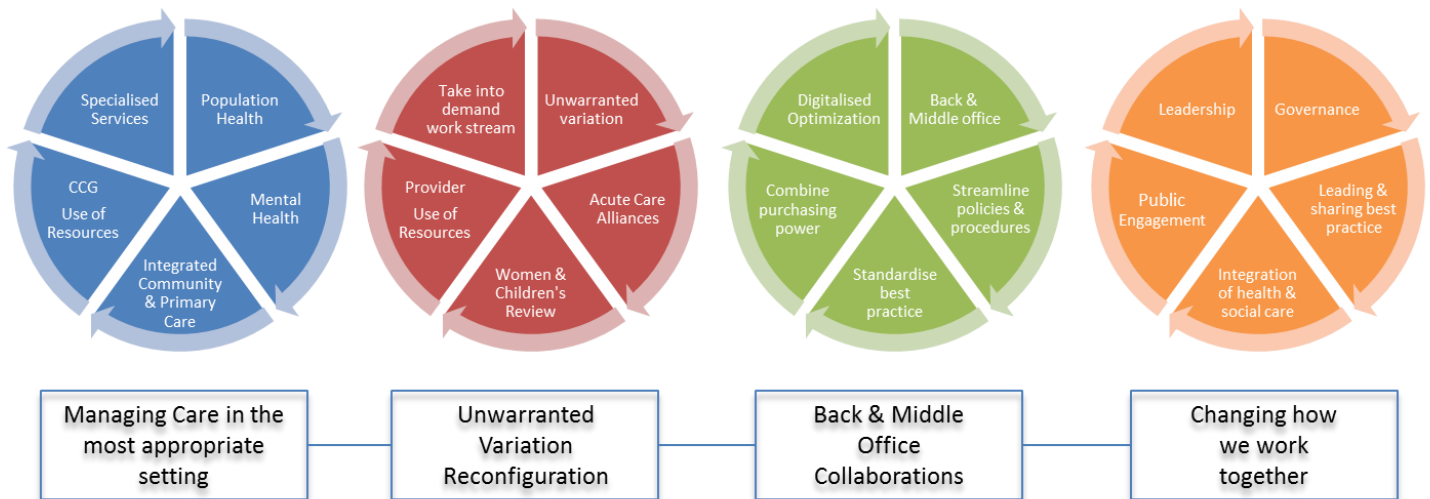
## 3.2 - North Mersey plans – act as one

Programmes	Projects	Outputs	Start Date	End Date
<b>Single-System Governance</b>	<p>Establish North Mersey system governance for strategic oversight, delivery of the LDS Plan and input into STP delivery. Healthy Liverpool Leadership Group to extend to NM.</p> <p>Financial Governance; establish governance framework for single-system accountability for managing financial risks and benefits, to achieve NM control totals and financial balance by 2021.</p>	<ul style="list-style-type: none"> <li>Robust, embedded governance model to enable whole-system accountability and decision-making</li> <li>Financial risk sharing to achieve system control total</li> </ul>	July 16	Oct16
<b>Commissioning Arrangements</b>	<p>Objective: to establish the optimum commissioning arrangements to deliver NM LDS Plan:</p> <ul style="list-style-type: none"> <li>Establish joint commissioning programmes, with clear lead roles and resourcing across NM CCGs, Local Authorities and NHS England</li> <li>New organisational arrangements for NM commissioning; reflecting Devolution and ACS plans.</li> </ul>	<ul style="list-style-type: none"> <li>Integrated commissioning model across health and social care for North Mersey system</li> <li>Single commissioner in organisational form</li> <li>Place-based strategic commissioning plan for North Mersey to enable transformation</li> </ul>	July 16	March 18
<b>BAU Efficiency Programme - Organisational</b>	<p>Develop a detailed NM plan for Level 1 BAU efficiencies for:</p> <ul style="list-style-type: none"> <li>Royal Liverpool</li> <li>Aintree</li> <li>Liverpool Women's</li> <li>Alder Hey</li> <li>Walton Centre</li> <li>Liverpool Heart &amp; Chest</li> <li>Clatterbridge Cancer Centre</li> <li>Merseycare</li> <li>Liverpool Community Health</li> <li>Liverpool CCG</li> <li>South Sefton CCG</li> <li>Southport &amp; Formby CCG</li> </ul>	<ul style="list-style-type: none"> <li>Organisational BAU efficiency plans for every NM provider</li> <li>Merger of three adult acute trusts with associated efficiencies</li> </ul>	July 16	March 2021
<b>Collaborative Efficiency Programme – North Mersey</b>	<ul style="list-style-type: none"> <li>Develop North Mersey plan for back office, clinical support and non-viable services</li> <li>Implementation of plan – prioritised &amp; phased</li> </ul>	<ul style="list-style-type: none"> <li>North Mersey plan aligned for collaborative efficiencies, aligned and part of wider C&amp;M STP plan</li> </ul>	July 16	18/19
<b>Accountable Care System</b>	<p>Explore options for the development of an Accountable Care System to support the radical step change required to manage demand and improve health outcomes.</p> <p><u>North Mersey System Control Total</u></p> <p>The North Mersey Leadership Group has agreed to explore the submission of an expression of interest for a North Mersey system control total, which would be submitted to NHSE by 31.10.2016 in line with the opportunity set out in the NHS Planning Guidance.</p>	<ul style="list-style-type: none"> <li>Establish an accountable care system/organisation with the right geography and scope, providing optimal model for improved outcomes and sustainability.</li> <li>Whole pathways of care managed across provider and commissioner boundaries</li> <li>Establish a sustainable financial model for shared benefit and risk</li> </ul>	Oct 16	Marc19

### 3.3 - Cheshire and Wirral approach

We have identified four priorities to make our health and care system sustainable in the near, medium and long-term. To transform our services, we need to reduce demand, reduce unwarranted variation and reduce cost. To comprehensively address these we must prioritise the areas that we will have the greatest impact to our system. Based on our knowledge of our

local challenges, and as a result of engagement across the system, we have identified the following four priorities:



#### Demand Management

1. Prevention £14m
2. Integrated OOH £37.9m
3. QIPP/BAU £26m
4. Accountable Care £3m
5. Specialised Services £30m

**Total £110.9m**

#### Variation / Reconfiguration

1. Variation £11m
2. Provider Chain £8m
3. Women & Child £2m
4. Accountable Care £3m
5. Model Hospital/BAU £107

**Total £144m**

#### Back & Middle Office

1. Back & Middle Office £3.75m
2. Streamlining £1.4m
3. Best Practice £1.2m
4. Combined P'Power £22.5m
5. Digitalisation £1 m

**Total £28.8m**

#### Ways of Working

1. Outcomes Commissioning £1m
2. Patient based need £1m
3. Systems Leadership £1m
4. Collaborative working £2m
5. Learning partnership £1m

**Total £6m**

The following pages provide further detail of the projects and outputs these programmes will drive. We still have a lot to do in respect of determining:

1. Capability & Capacity at STP and LDSP level
2. Full development of schemes and 'business cases'
3. True impact of each of the PIDs on each other.

(Critical interdependencies /impact and activity assumptions – STP and LDSP.

4. Robust Governance driven bottom up that GBs and respective Boards and LA recognise and be part of (including local leadership groups)
5. Capital requirements needed to be refined and better linked to benefits realisation.

### 3.3 - Cheshire & Wirral plans for demand management 1/3

Projects	Change Delivered	Outcomes
<b>Alcohol Strategy (NHS, Las. Police, Community and Voluntary sector)</b>	<p>System wide interventions to reduce alcohol related harm:</p> <ul style="list-style-type: none"> <li>• Social Marketing Campaigns</li> <li>• Schemes to restrict high strength alcohol sale</li> <li>• Cumulative impact policies (reduced opening hours)</li> <li>• Children and Young persons interventions to reduce alcohol use.</li> <li>• GP Screening and life course setting approach.</li> <li>• 7 day alcohol care team within acute hospitals</li> <li>• Alcohol assertive outreach teams</li> </ul>	<ul style="list-style-type: none"> <li>• Per 100 alcohol dependent people on treatment planned reduction of 18 AE visits, 22 hospital admissions saving approximately £60k</li> <li>• Cost benefit ratio £1-£200 per £1 spent</li> <li>• Assertive outreach services expected to return £1.86 per £1 invested.</li> </ul>
<b>Hypertension</b>	<p>Implementation of the Pan Cheshire Hypertension Strategy: a model of care that focuses on empowering patients and communities, enhancing the role of community pharmacies in detecting and managing high BP, and high quality BP management in primary care (including reducing variation in care).</p> <p>For Cheshire and Merseyside up to 800 heart attacks and strokes could be prevented per year through optimising blood pressure treatment alone.</p>	<ul style="list-style-type: none"> <li>• If all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths.</li> <li>• It is estimated that a 15% increase in the adults on treatment controlling BP to &lt;140/90 could save £120m of related health and social care costs nationally over 10 years.</li> </ul>
<b>Implementation Accountable Care Partnerships/Orgs across CW plus introduction of strategic commissioner.</b>	<ul style="list-style-type: none"> <li>• Introduction of 4 ACO/Systems across Cheshire and Wirral</li> <li>• Budget Alignment on population outcomes</li> <li>• Risk Sharing Arrangements across commissioning and delivery of services as per ACO.</li> <li>• Delivery of new contract mechanism.</li> <li>• Clear operating model</li> </ul>	Improved population health management that improves peoples experience and outcomes from care services with available resources.
<b>QIPP Referral Management</b>	Implementation of referral management schemes across Cheshire and Wirral.	Reduction in non-elective referrals
<b>QIPP - Prescribing</b>	Encourage and deliver better management of primary care prescribing (through self-care, over the counter status, repeat prescriptions)	Reduction in prescribing spend
<b>Respiratory Strategy</b>	Implement a Cheshire and Wirral Integrated Community Respiratory Service; building on the development of the LTCs Community Model of Care. It is anticipated this transformational approach to respiratory care will deliver a system saving £2m by 2021.	<p>Fewer hospital visits, fewer unplanned primary care visits (&gt;1000 Emergency Admissions Avoided)</p> <ul style="list-style-type: none"> <li>• Easier and earlier access to care and support</li> <li>• Earlier, evidence-based treatment e.g. pulmonary rehab</li> <li>• Improved data sharing across Wirral health care economy</li> <li>• Improved diagnosis and case finding (undiagnosed population &lt; England Avg 2.91% (&lt;7,800))</li> <li>• Consistent approach to care</li> <li>• Better case management</li> <li>• Improved targeting of services to meet population need</li> <li>• Earlier identification of people with certain respiratory conditions</li> <li>• Improved knowledge and awareness of population</li> <li>• Improvement of lifestyle factors e.g. reduced smoking/higher quit rates (&lt;18 per 100,000)</li> </ul>
<b>Diabetes Programme</b>	<p>Implement at scale a national evidence-based diabetes prevention programme capable of reducing not only the incidence of Type 2 diabetes but also the incidence of complications associated with Type 2 diabetes; heart, stroke, kidney, eye and foot problems.</p> <p>Deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.</p>	<p>It is forecast that over 56,000 Cheshire and Wirral residents suffer from Diabetes Mellitus and a further 99,000 residents suffering from non-diabetic hyperglycaemia.</p> <p>Assuming programme growth to 5000 patients, Cheshire and Wirral LDP anticipate an annual saving of over £500k per annum by 2021 with significant additional wider-systems savings resulting from a reduced incidence of diabetes.</p>

### 3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes
<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>• Prevention and Early Detection</li> <li>• Better MH Care for people with Physical conditions.</li> <li>• Improved services for people with severe MH Conditions</li> </ul>	<p>Reducing variations in clinical practice – through the development of consistent care pathways, developing standard approaches to key processes such as assessment, access, discharge and caseload review.</p> <p>Improving patient safety – including a commitment to ‘zero suicide’</p> <p>Improving effectiveness – through a focus on care pathways with clear outcomes and evidence-based practice</p> <p>In year 1, a priority will be the establishment of fully functioning mental health liaison services across Cheshire and Merseyside</p> <p>Cost of investment to be clarified</p>	<p>Reducing pressures on acute physical services</p> <p>Improving outcomes in mental health</p>
<p><b>Specialised Commissioning</b></p>	<p>Newly formed commissioning delivery body Cheshire and Wirral single approach to reducing the £35m overspend in specialised commissioning</p> <p>Gain share to be developed with NHSE</p>	<p>Referral pathway improvement to ensure services are patient centred and outcome based.</p> <p>Improve productivity and value of these services.</p>
<p>High Impact Community Based Integrated Care Schemes:</p> <ul style="list-style-type: none"> <li>• Integrated Community Teams</li> <li>• New Models of Primary Care</li> <li>• Long Term Conditions Management</li> <li>• Intermediate Care</li> <li>• Care Homes Support</li> <li>• Intermediate Care Development</li> <li>• Integrated Discharge Processes</li> <li>• Community Services MCP</li> </ul>	<p>Delivery of four Transformation Programmes across Cheshire and Wirral will see the expansion of out of hospital care services.</p>	<ul style="list-style-type: none"> <li>• Reductions in non elective admissions.</li> <li>• Reductions in Length of Stay</li> <li>• Reduction in DTOC</li> <li>• Shift in activity from acute to community sector.</li> </ul>
<p><b>Neurology</b></p> <p>The Neuro Network neurology model aims to achieve a clinically and financially sustainable integrated neurology service by enhancing the community support, clinical pathways and advice and support for primary and secondary care.</p> <p>The spinal model is to implement a whole system spinal services network, integrating the two key components of the national Spinal Transformation Project:</p>	<p>Delivery of 7 day acute inpatients, specialist diagnostics, subspecialty/MDT clinics, access to neurosurgery, specialised pain and rehabilitation</p> <p>DGH satellite services from visiting neurologists plus support: outpatient clinics, weekday ward consultation service, supported from the centre by:</p> <ul style="list-style-type: none"> <li>• acute referral pathways</li> <li>• 7 day advice line</li> <li>• telemedicine</li> <li>• second opinion/specialist neuroradiology reporting via PACS</li> <li>• Community: nurse clinics, nurse specialist support, homecare drugs, home telemetry, supported from the centre by:</li> <li>• GP referral pathways</li> <li>• ready communication between community and specialist neurology services for advice and practical help</li> <li>• Standards and clinical governance: common standards across network delivered services, with a single clinical governance structure, developing and using clinical outcomes as available.</li> </ul> <p>A network for the provision of spinal surgical procedures, managed from the centre with partner services in secondary care, working to common standards, and outcome measures, with MDT discussion of complex cases and all specialised surgery undertaken in a centre fully compliant with national specialised serviced standards. This may include a single service model for spinal surgery in North Mersey; Implementation of a single whole system patient pathway through a network of all providers of spinal services, with common and audited service standards and outcome measures.</p>	<p>It is projected to save up to £3.2m a year recurrently by 2020-21 compared with the do nothing scenario.</p> <p>Hospital services reconfiguration: with its single service system wide delivery, providing a specialist centre well placed for future consolidation, and networks of specialised providers and hub and spoke models to improve collaboration across tertiary and secondary care; and this is reinforced in:</p> <p>5. Acting as one: which specifies a single service spinal model, moving within the planning period to a single site.</p>

### 3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes
QIPP - Thresholds and PLCV: Cheshire and Wirral review of PCLV (incl. joint consultation)	Extension of treatments not funded via CCG.	Reduction in demand for treatments
Cheshire and Wirral Cancer Strategy:	<p>Targeted interventions to address areas of low screening uptake, Reconfiguration of complex surgical and non-surgical cancer services.</p> <p>Reconfiguration and rationalisation of the number and function of MDTs.</p> <p>Focus on improving the key worker arrangements for cancer patients and roll out the Recovery Package, Diagnose or exclude cancer within 28 Address together our capacity, workforce and organisational bottlenecks, which are preventing delivery of the 62 day cancer standards.</p>	<p>Seeking to improve early stage cancer detection rates, associated with better survival and lower cost impact.</p> <p>To limit emergency presentation rates during treatment and the follow-up costs of delivering cancer care respectively.</p> <p>days by creating multi-disciplinary diagnostic centres and new pathways for patients with vague cancer symptoms.</p>
Operational Control Centre For Risk Stratified Population	Using integrated IT and shared patient records to target and manage the top 5-10% users of healthcare services. By using a centralised control facility to signpost and direct appropriate care services to those who need it the most, managing their conditions more effectively in the community and reducing inappropriate hospital admissions.	<ul style="list-style-type: none"> <li>• Effective and personal communication with a vulnerable cohort of patients across Cheshire and Wirral in a coordinated manner.</li> <li>• Improved navigation of Vulnerable Patients through Health and Social Care systems</li> <li>• Improved clinical outcomes for Patients</li> <li>• Reduction in variation and ability to control demand.</li> </ul>
Cheshire Shared Care Record	Development of Cheshire and Wirral care records	Enabler for key measures in all workstreams
Implementation of CHC Collaborative Commissioning:	<ul style="list-style-type: none"> <li>• Improving the quality of service delivery</li> <li>• Improved joint working with LAs and across CCGs</li> <li>• Improved team metrics (reducing sickness and turnover rates)</li> <li>• Comprehensive PUPoC assessments</li> </ul>	<ul style="list-style-type: none"> <li>• A planned reduction in outstanding reviews</li> <li>• Delivery of targets, (i.e., 28 days)</li> <li>• Reducing the number of dispute cases</li> </ul>
Primary and Community Demand Avoided through investment	<ul style="list-style-type: none"> <li>• Delivery of a range of physical and mental health initiatives designed to deliver care closer to home and reduce demand on acute services.</li> <li>• Introduction of new models of primary care and community care.</li> </ul>	<ul style="list-style-type: none"> <li>• Reductions in non elective admissions.</li> <li>• Reductions in Length of Stay</li> <li>• Reduction in DTOC</li> <li>• Shift in activity from acute to community sector.</li> </ul>

### 3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
Organisational structures and system architecture	Single C&W strategic commissioner 4 ACOs Single hospital collaborative	Structures support integrated approach to management of variation  Enabler for V3
Development of strategic alliance with Cerner and subject matter expert	Single IT/ informatics platform to support management of variation Access to global thought leadership/ expertise in management of variation	The right IT and information flows to support management of variation / optimum approach to management of variation  Enabler for V3
Development of common approach to IPC (inc. management of multi drug resistant organisms) and medicines management/ creation of single pathology service/ creation of single radiology service/ cessation of procedures of limited clinical value	Standardisation of middle office service delivery	Optimal use of clinical support services clinically and financially  Delivery
Development of model care pathways	Model care pathways (across primary, secondary and social care) for high cost/ high volume diagnoses  Standardised care pathways  Reduced length of stay	Optimum management of high cost/ high volume diagnoses. Priorities Reduced length of stay <ul style="list-style-type: none"> <li>• Pneumonia/ upper respiratory tract infection</li> <li>• COPD</li> <li>• Cardiac disease (HF and MI)</li> <li>• Acute abdomen</li> <li>• Alcohol</li> <li>• Ophthalmology</li> <li>• Orthopaedics</li> <li>• Dermatology</li> </ul>
Improved system performance to match best decile NHS England performance	Local indices for admissions, overnight stays, ALOS, admissions for ACS conditions and conditions not usually requiring hospitalisation, A&E attendances, OPD referrals and follow ups match NHS England best decile.	<ul style="list-style-type: none"> <li>• Management of demand in appropriate setting will produce a range of between £30-£60m However, impact on presenting demand</li> <li>• Model impact to understand extent of overlap with demand management.</li> <li>• Minimalist use of secondary care</li> <li>• LDS changes in activity and bed base as follows:</li> </ul>
Creation of standard package of ACO based 'local medical services'	Alignment of local medical services with ACOs and reorientation to support community/domiciliary based preventative care  List of local medical services: <ul style="list-style-type: none"> <li>• Frail older people's services (including dementia)</li> <li>• Palliative/ EOL care</li> <li>• Neurology (inc stoke rehab)</li> <li>• Rheumatology</li> <li>• Diabetology</li> <li>• Respiratory medicine</li> <li>• Cardiology</li> <li>• Alcohol treatment services</li> <li>• Minor Injury &amp; Illness Unit</li> <li>• Endoscopy (screening)</li> <li>• Oral surgery</li> <li>• Ophthalmology</li> <li>• Nephrology</li> <li>• Haematology</li> </ul>	Improved health, wellbeing and independence of local residents  Enabler for managing demand

### 3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
Remapping of ECT elective and emergency care models	Agreed long term models for elective and emergency care in mid and south Cheshire based on strategic relationship with University Hospital of South Manchester and Stockport FT Emerging clinical model (depending on savings generated): ED downgraded to MIU staffed by GPs, elective care at MGH provided by ECT and UHSM/ Stockport, residual inpatient focus on care of older people; women's and children's services networked with south Manchester/ Stockport providers	Clinically and financially sustainable services with a cost saving to be determined
Remapping of MCH elective and emergency care models	Agreed long term models for elective and emergency care in mid and south Cheshire based on strategic relationship with University Hospital of North Midlands: MCH cannot see any robust clinical links with CoCH or WUTH being sustainable given travel times and population distribution	Clinically and financially sustainable services with a cost saving to be determined
Consolidation of Acute Care Alliance between CoCH and WUTH – Development of Clatterbridge Hospital as South Mersey Elective Care Centre (SMECC)	SMECC provides all elective inpatient care for CoCH and WUTH	Clinically and financially sustainable services
Consolidation of Acute Care Alliance between CoCH and WUTH – creation of integrated low and high dependency units for women's and children's services	Creation of single service across CoCH and APH sites: one site hosts high dependency unit; other site hosts low dependency unit	Clinically and financially sustainable services
Cheshire and Wirral dermatology service	Creation of single dermatology service for LDS	Clinically sustainable service  Anticipated savings to be identified and worked through
Specialised / 3° services	The provision of Maxillo facial services Oesophago-gastric services, plastic surgery to 3° providers in Manchester, Wirral and Liverpool	Clinically sustainable service. Anticipated savings to be identified and worked through

### 3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Payroll Workforce	1 Cheshire Occ Health 1 Cheshire Payroll CCG Admin	A single centralised payroll will reduce duplication, staff numbers, improve efficiency and responsiveness, and standardise processes.
Model Hospital & Delivery of BAU Targets	Model Hospital (LOS) Model Hospital (Theatre Utilisation) Model Hospital (New Opat Models) Model Hospital (Other efficiency gains)	Delivery of Provider BAU targets Delivery of higher quality service for patients. New O/P Models
Payroll Process Streamlined	1 consistent process for all client organisations.	Fewer errors and queries.
Payroll Product Standardisation	Single payroll supplier across 6 providers and new ACOs	Reduced software licensing costs and
Procurement Workforce	Move from 6 procurement departments to 1 hub & spoke services in organisations	Reduced cost of overheads and staffing. Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Procurement Purchasing Power	Single contracting and purchasing activity on behalf of 6 organisations rather than one.	Procurement cost savings at scale. Greater purchasing power, standardisation and consistency. Compliance with Carter recommendations.
Library Service	A single library service for Cheshire and Wirral	More efficient service Cheshire and Wirral focus
Occupational Health	1 Cheshire and Wirral Service	Clinical Sustainability
Occupational Health Streamlining of Process	Single OH management.	Reduced duplication of localised management.
HR Workforce	1 Cheshire and Wirral Service	Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
HR streamlining process	1 Cheshire and Wirral service	Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Comms and Engagement	1 Cheshire and Wirral service across all 6 current organisations	1 consistent approach. Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
1 Litigation service	1 Cheshire and Wirral service  In house lawyers providing legal advice and guidance, rather than high cost external legal firms.	1 consistent approach Reduced cost. Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Workforce	Centralising and reconfiguring Finance workforce	10% cost savings. Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Processes Transactional Services	Single accounts and transaction processes for Cheshire and Wirral	Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Pathology	Scale up the service for across Cheshire and Wirral	Automated processes scaled up to provide a service that is more cost effective and efficient. Sustainability of service and approach and consistency of approach Workforce savings Better Process



### 3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Capital Estates Planning and Hard Facilities Management	Scale up the services	Regional Estates Team Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Workforce	1 Business Intelligence Function CSU not required or utilised for this purpose	CCG and Provider teams merging Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Processing and Coding	Coding still required for national information submissions, but now of reduced necessity for local contracting given move to block contracts and system control totals.	Reduced duplication, staff numbers, improve efficiency and responsiveness, and standardised processes. Economies of scale.
Utilities management approach across Cheshire and Wirral	One bill for utilities – electricity, gas, water.	Reduced overall cost of utilities. Single supplier for 6 organisations. Economies of scale and consistency. Intelligent energy procurement.
Teletracking	Asset tracking of all 4 Hospital sites, plus 2 community trusts and mental health providers.	Better matching of resources and capacity to demand. Enables 4 hospital providers to operate as one for deployment of all resources. Reduced duplication, improved efficiency and responsiveness.
Pharmacy	1 Pharmacy Approach	Back and Middle Office efficiency savings Actions scoped out in PID
Agency Cost Reduction	Reduction in Agency Staff use by investment in substantive roles where required and using a joint strategy as 1 organisation approach	Net £2m reduction in agency staff cots in CW by 2021 Investment required of £8m Payback £10m
CCG Business As Usual QIPP and CIP	The top 10 QIPP Initiatives that are mandated.	BAU delivery.
CCG Business as Usual QIPP CHC and Funded Nursing Care	Cost reduction from Cheshire and Wirral approach	Harnessing collaboration to reduce cost of CHC Packages and FNC

### 3.3 - Cheshire & Wirral plans - ways of working

Projects	Change Delivered	Outcomes
Shared Care Records	All our providers will have the ability to access shared care records in a local setting and face to face with the patient in real time. Avoiding Duplication	Improved and consistent patient care across the system  Reduces cost due to patients not being lost in system.
Real time data	A single digitalised platform that we will facilitate a population health management approach.  When integrated with respective risk stratification tools and the shared care records this will manage the rising risk of future patients	A preventative approach that will identify patients at risk and enable supportive intervention before the patient's needs become urgent.
Outcome based commissioning	Outcomes-based commissioning seeks to solve the issue of how financial flows and the commissioning process can best support quality and efficiency improves across the health care system.	Clear outcomes associated with all service areas, which will increase the clarity and therefore quality of provision.
Meeting patients' needs	Costs can be reduced significantly if patients are at the heart of decision making and that clinical decision making is based on outcomes with incentives aligned to doing less rather than more work.	Patients will be engaged at all levels, from shaping NHS plans to the development of services around patient need, and in decisions about their own individual care.
Clinical and Systems leadership	A new and heightened role for clinical networks, clinical leadership and multi-disciplinary working.  A single Cheshire and Wirral approach to OD and cultural change with public sector and NHS Leadership Academy and Health Education England.	Improved communication and information sharing across the system.  System leaders and staff who fully support and are engaged with system leadership. Connect into the systems leadership work from Planning guidance
Collaborative working	Alliances, driving out costs to critical mass benefit of procurement at scale we will examine opportunities for integration both vertically within local systems and horizontally across providers	A system that works effectively and efficiently, driving out duplicated processes and costs (savings identified elsewhere)
Accountable care.	Commitment to providing accountable care into all 4 geographies within Cheshire and Wirral	Care Systems that will focus on system benefit and change rather than organisational benefit.
CW Health & Social Care Teaching & Learning Partnership	support the creation of a sustainable local supply and the ongoing development of existing staff	workforce development to underpin national and local priorities – e.g. reception and clerical staff training and support leaders to develop system wide transformation skills

## 4 - Closing the Cheshire & Merseyside financial gap

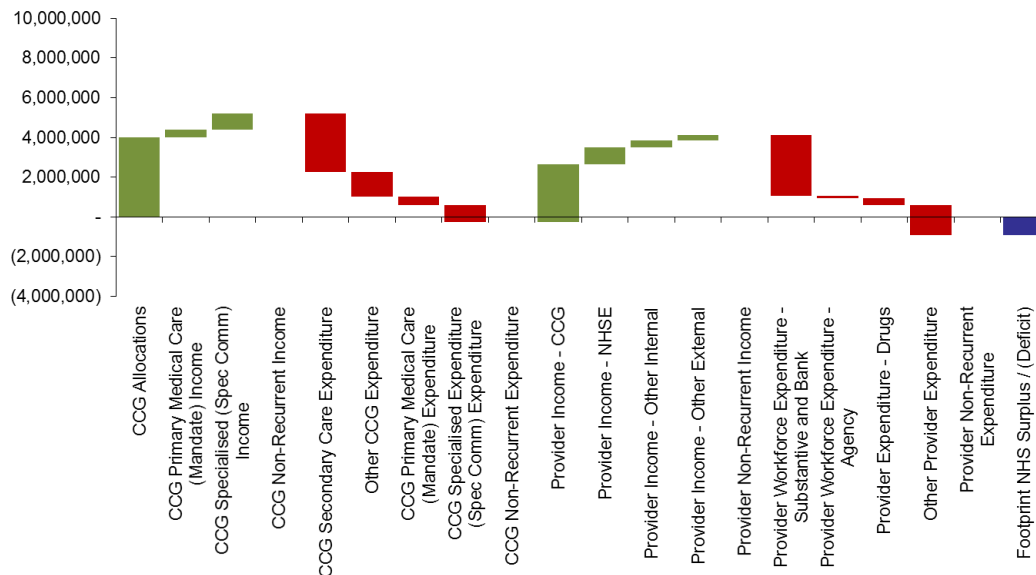
### Financial Gap – current position

The ‘do nothing’ affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be **£908m**, as illustrated below. The drivers of the affordability gap is a growing population that accesses health care more often, and are – positively – living longer but often with one or more long term conditions.

This challenge has narrowed from the £999m in our June submission, to £908m driven by the following:

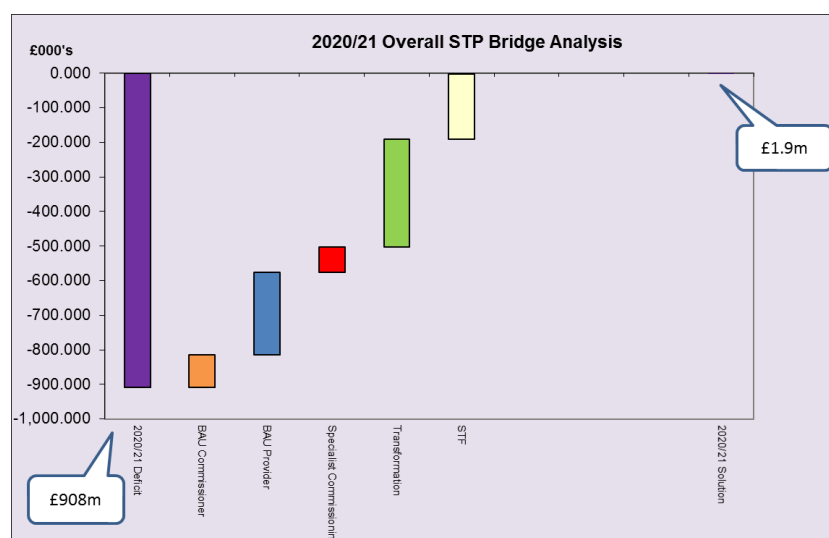
- The gap now reflects the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan
- The remaining gap now reflects the four year period 2017/18 – 2020/21

However, there is still risk associated with the delivery of organisation’s 2016/17 financial plans, which at this stage may not fully reflected within the forecast gap.



### The ‘Do Something’ position

After the impact of our transformation solutions, our business as usual and specialist commissioning efficiencies, and the expected STF funding the ‘do something’ gap is £1.9m, as illustrated below:



### Risks to delivery

- Whilst the plans at this stage show a balanced position there is still a significant amount of further planning required on many of the solutions before we could present them as robust and with confidence of delivery
- We will continue to pursue further solutions in order to provide a contingency for when the current plans do not deliver the levels of savings currently forecast in the plan. In particular the focus will be on extending the opportunities in the strategic programmes at STP level.

## 4 - Closing the Cheshire & Merseyside financial gap

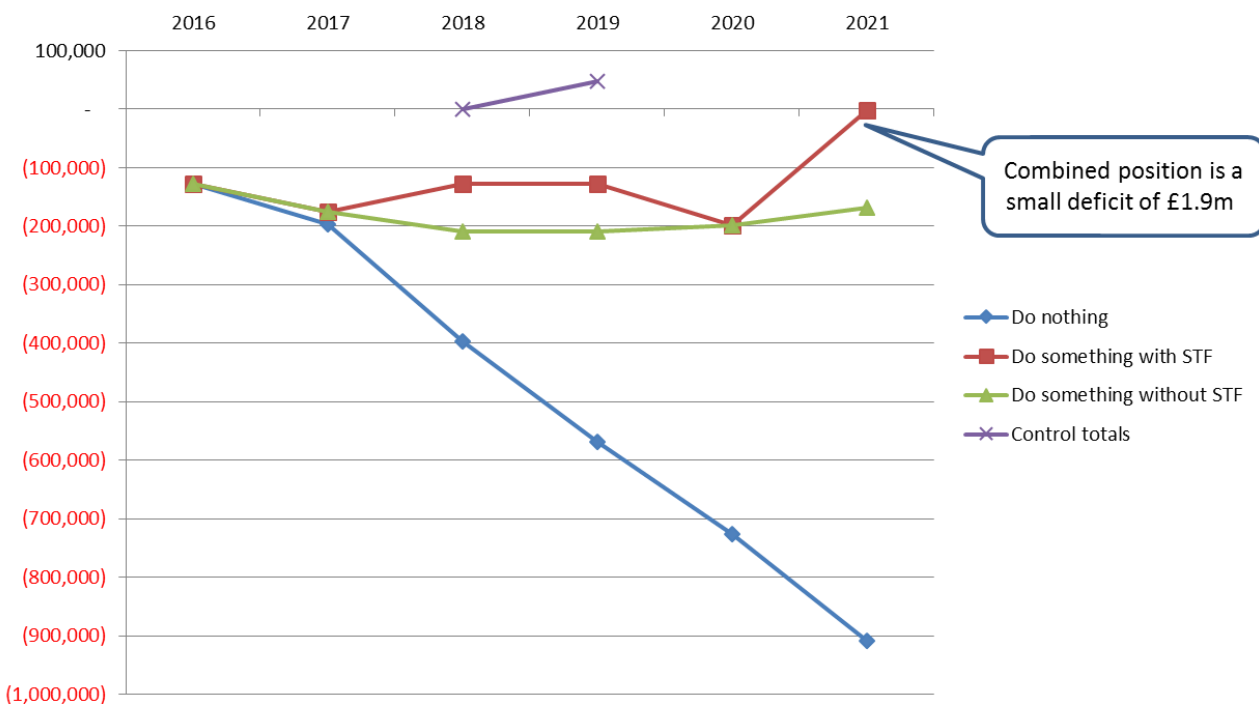
### Capital

- We recognise that these plans are heavily dependent upon capital – up to £755m additional funding requirement in current plans as shown below. However we recognise there is still significant work to do before these high level requirements are turned into robust business case ready solutions. In particular to fully articulate the cost/benefits associated with the proposed investment.
- We also understand that Capital funding is extremely limited and that we will need to focus investment in those schemes that provide the most beneficial impact on our STP plans. In doing so we recognise that there may be schemes that do not get approved and the STP will therefore the benefits will also need to be reassessed.

Capital	£000s
<b>Do Nothing</b>	
Locally funded	726,150
Business case funding approved	150,785
Other funding source	47,634
<b>Funding identified/approved</b>	<b>924,569</b>
<b>Funding <u>not yet</u> approved/identified</b>	
Do Nothing	387,012
Do Something	368,232
<b>Total funding not yet identified/approved</b>	<b>755,244</b>
<b>Grand Total</b>	<b>1,679,813</b>

### Pace of Change

Whilst we are forecasting balance in 2021, the profile of our solutions reflect that many of the benefits are forecast to be achieved in the latter half of the plan. Therefore the current financial plan does not demonstrate delivery of the aggregate Control Total across Providers and Commissioners for both 2017/18 and 2018/19. We will need to do further work to identify where pace can be increased, and to ensure that we are capturing all the quick wins that might be available.



### Next Steps

In addition to addressing the issues noted above our focus now will be on strengthening the financial modelling through development of a demand and capacity model at STP level. This will enable us to more accurately and quickly reflect the impact of our solutions through a more thorough understanding of the drivers of costs across the system.

## 5 - Delivering the change

Successful delivery of transformation this size requires:

- *Governance enabling decision making*
- *Strong leadership*
- *Robust programme management*

### Governance

A successful governance structure will enable leaders to govern with confidence, making timely decisions using high quality management information

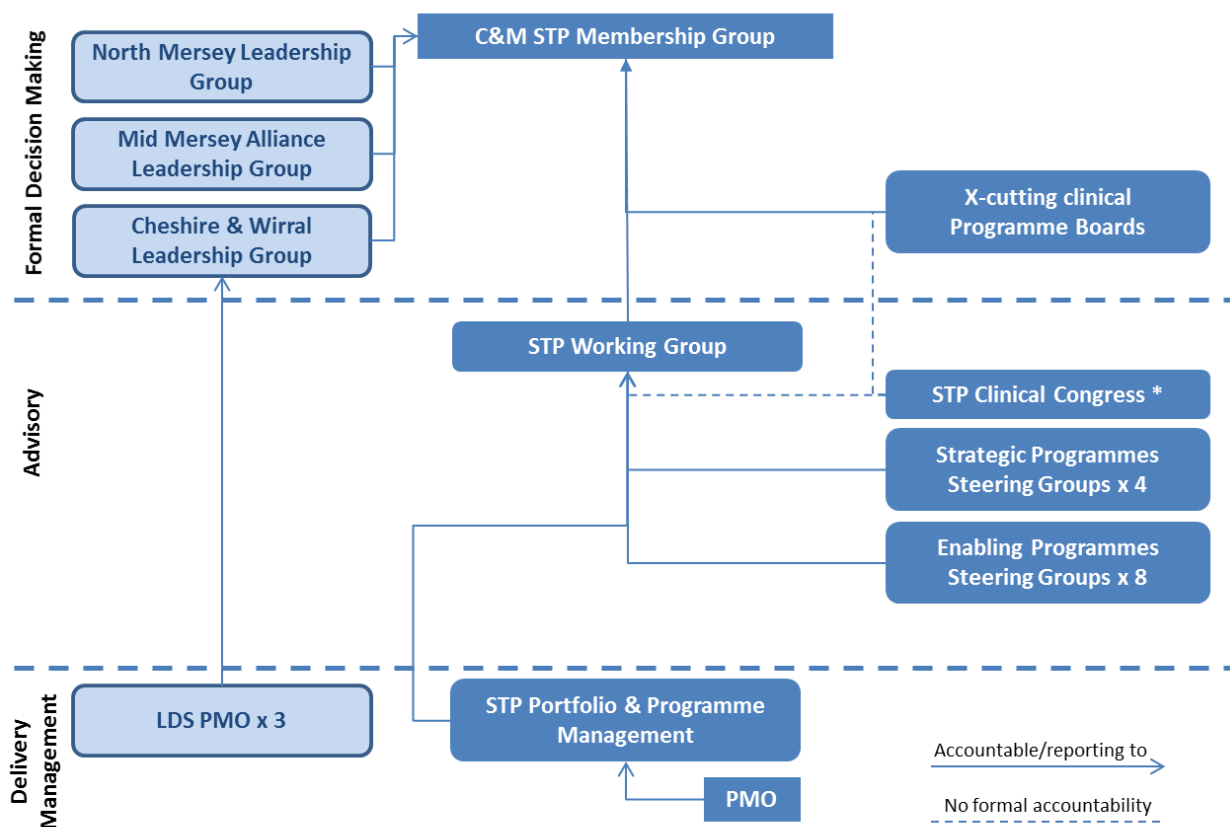
Effective governance of a programme is fundamental to successful delivery and alignment with the STP strategy and direction, and are built on some key principles:

Each LDS already has its own Governance arrangements that will underpin the STP, and be responsible for the delivery of local programmes of work.

We will look to define governance arrangements early and comprehensively as this will create clear roles and responsibilities at all levels and allow for effective and timely decision making throughout the transformation plan.

We have drafted a Memorandum of Understanding and shared this with the STP Working Group. Once approved this will provide a sound footing to move forward from.

The current governance structure is shown below. This will be developed by the Membership Group in the short term so that Terms of Reference and membership details are agreed across C&M quickly.



\* The Clinical Congress constitutes the clinical leadership of the member organisations (medical and nursing directors) and will be led by the STP Clinical Advisory Group which is the clinical advisory group to the STP Working Group. All of the three local delivery systems, four strategic workstreams and eight cross cutting themes will have a nominated senior Clinical Lead/Sponsor who will represent their workstream, their organisation, their sector, and their local delivery system and will also be expected to take a 'holistic'

clinical view across the whole STP. The STP Clinical Advisory Group will be chaired by Dr Kieran Murphy, NHSE Medical Director (C&M).

## 5 - Delivering the change

### The ambitions within the STP will only be delivered under strong leadership

A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level, while having a national network.

These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace.

### Leadership and Organisational Development

The aim of this section is to set out the forms of leadership and leadership development required to implement, sustainably realise and maximise the impact and benefits of the Cheshire and Merseyside Sustainability and Transformation Plan for the citizens of the region. In particular, to realise the benefits of inclusive, integrated service design, delivery and on-going development, that has the potential to significantly contribute towards improved population health and the reduction of health inequalities. STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm. What makes most sense for patients, communities and the taxpayer should always take priority over the narrower interests of individual organisations.

### Context and Drivers

The context and drivers for change and new forms of leadership and leadership development within the region are both complex and diverse including factors, such as, both the national agenda, as expressed in the 'Five Year Forward View' and the region's, political, economic, social, demographic, legislative, technological, geographical, physical, industrial, agricultural, commercial, educational and service sector history and current architecture, infrastructure and landscape.

The opportunities and challenges within the region's, sub-region's, cities, sub-cities, rural and urban environments are incredibly diverse and distinctive. However, all share the vision of a healthier population for all. A vision within which: -

- the assets and talents of local communities and populations are rigorously harnessed
- health inequalities are proactively addressed
- the promotion of health and well-being is the primary focus
- health and well-being services are integrated, resilient, culturally appropriate and sustainable

### Regional Leaders

This vision requires regional leaders able to act, engage, learn, influence, challenge, develop, initiate and sustain change within differing volatile, uncertain, complex, ambiguous and diverse environments (VUCAD). We need to identify, develop, support and future proof inclusive, culturally competent leaders to become more impactful 'place' based, collaborative system leaders, implementing and continually developing fully integrated health and well-being strategies and services. This strategy to then support leaders to articulate and 'live' the ambitious Cheshire and Merseyside vision, and gain 'buy in' towards/for it from a range of stakeholders.

### Conclusion

Twenty-first century leaders are expected to be VUCAD leaders; Cheshire and Merseyside leaders are no different. They are expected to respond to these environments by providing vision, understanding, clarity, and adaptability, to possess a VUCA approach, to fully immerse themselves in place, to work in place with individuals, groups and communities with an asset based approach, harnessing the talents of all diverse stakeholders, listening to and learning from differing perspectives, responding with agility and humility, whilst remaining personally resilient. Acting at all times as Inclusive Leaders, Cheshire and Merseyside leaders do and will work with others to ensure the successful achievement of the Cheshire and Merseyside STP, promoting innovation, creativity, entrepreneurship and inclusive, sustainable growth.

A Cheshire and Merseyside leader is and will be fulfilling an exciting, demanding, innovative and often challenging role and will need differing levels, forms and opportunities for development. This STP will work with the NHS North West Leadership Academy (NHS NWLA), and other agencies, to support the development of leaders and the region's leadership community, spanning Cheshire and Merseyside leaders within, across and beyond organisations, systems, and place. It is recognised that the NHS NWLA's experience developing, supporting, stretching, growing and caring for a diverse and inclusive leadership community can support the Cheshire and Merseyside leadership community in the vital role of supporting new and existing leaders to excel in role, to excel in new 'bigger' roles, to excel in identifying new talent and in making the region's health and well-being services world leading.

## 5 - Delivering the change

### Robust Programme Management

The Cheshire & Merseyside STP comprises a significant number of programmes. Programmes are about managing change, with a strategic vision and a route map of how to get there; they are able to deal with uncertainty about achieving the desired outcomes. A programme approach should be flexible and capable of accommodating changing circumstances, such as opportunities or risks materialising. It co-ordinates delivery of the range of work – including projects – needed to achieve outcomes, and benefits, throughout the life of the programme.

A programme comprises a number of projects. A project has definite start and finish dates, a clearly defined output, a well-defined developmental pathway, and a defined set of financial and other resources allocated to it; benefits are achieved after the project has finished, and the project plans should include activities to date, and both measure and assess the benefits achieved by the project.

For a portfolio of this size and complexity, the illustrative model below tells us that successful delivery is wholly dependent upon having the right set of capabilities in place. Any significant weaknesses in the capability generated to deliver projects, at any level of the programme, are likely to impact negatively upon delivery.



The aim is to ensure that the right people are in a team and a clear and transparent project resourcing process is in place; this will mean that ways of working are understood.

### Project Management

All members of the project teams must be committed to the vision and plan; moreover, impacted stakeholders should be willing to put in the additional effort required to deliver the programme. The use of milestone trackers, with enough detail to monitor on a weekly basis, and that are understood and agreed by the project lead and team, is critical.

### Accountability

There must be clear accountability for project delivery of benefits (including savings) and the consequences of non-delivery understood. The work-stream lead is accountable for project delivery as delegated to them by the Executive Sponsor for each project.

### Document Sharing

An intranet knowledge base should be established for the projects that comprise the programme. The use of the programme 'SharePoint' facility is an efficient and effective medium for joint viewing arrangements for documents, specifically workbooks, as well as maintaining good configuration (version) control.

The project teams will be responsible for ensuring that the latest version of the project documentation is always available on the SharePoint site. The access to the workbooks in terms of editing rights will be restricted to the Programme Assurance Framework, work stream and project team members.

### Training & Development

The Programme Assurance Framework will promote exemplars of best practice project documentation. All staff completing these documents should be trained (by means of on-the-job training) during the development phase of that project.

### Progress Meetings

Each project team will be expected to meet with the Programme Assurance Framework on a monthly basis. The objective of the meeting will be to gather evidence to ensure that the assurance update to the programme dashboard is based on documented evidence and is factually correct.

The conduct of the meeting will be based on a comprehensive review of the project documents as the evidence base. The progress meeting will also be an opportunity for the project to raise any issues for which the assistance of the Assurance Framework/Steering Group may be required to address to 'unblock' the route ahead.

The Programme Assurance Framework will ensure that there is a sufficiently formal process in place to ensure that any assurance reports are produced for governance meetings. This will support the embedding of an appropriate accountability framework and the provision of escalation reports, by exception, to the sub-committees; this latter process will form part of the role of the Programme Assurance Framework.

### Programme Dashboard

The Programme Dashboard is intended to enable the governance bodies a more qualitative view of the development and implementation of projects. It will provide cues to focus executives on the strategic issues that require a degree of anticipation, like communications with stakeholders, or problems that need unblocking, for example questions relating to financial investment. The Programme Dashboard will also assist with the monitoring of milestones, KPIs, financial status and risks. Specifically, the dashboard reporting allows executive sponsors to review all of their projects easily, at a glance. Furthermore, it will include a responsibility matrix – given the complexity of the programme - identifying the key staff needed to deliver the project and identifies the dedicated resource required.

## 5 - Proposed resources required

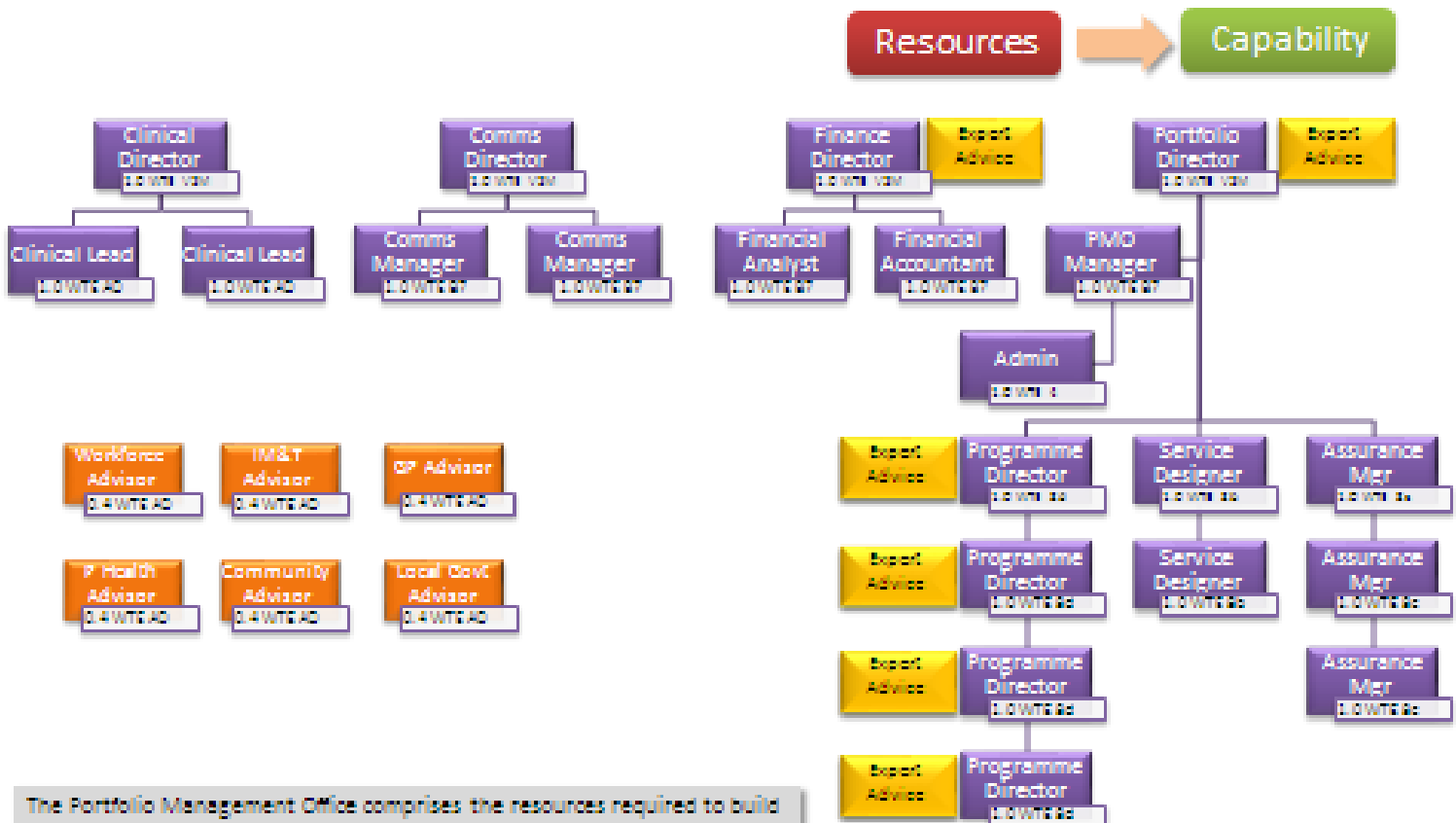
The current proposals before the Cheshire & Merseyside STP Working Group are shown below. The resource and skill mix may come from a number of sources and the capability sets will need to change as programmes mature through the gated phases.

The Portfolio management Office will reside at the centre of the STP, as the engine room, meeting the demands and requests of external stakeholders while directing and assuring the programmes (as appropriate and cognisant of local governance arrangements) that fall within the agreed scope of the STP.

Similar structures will need to be agreed and mobilised, where they do not already exist, for the work of the Local Delivery Systems and each of the programmes within the Portfolio.

### Portfolio Management Office

### Delivering the change



The Portfolio Management Office comprises the resources required to build the capabilities necessary to cement both assurance of Local Delivery Systems while delivering C&M Wide (cross-cutting) programmes



## 5 - Proposed communications and engagement plan - subject to further work and detailed discussion, including with individual governing bodies

### Introduction

Our communications & engagement strategy sets out the approach to communicating the STP across Cheshire & Merseyside and engaging in an open & honest manner, with patients, public, staff and stakeholders. Stakeholders are recognised in terms of their level of interest and influence, and the corresponding level of engagement and communication is applied to enable each audience to have the opportunity to comment on proposed changes to health service provision.

This STP is a 'live' document that is subject to regular revision throughout the programme, and recognises and documents the work that has already taken place and is still ongoing at a local level. Much engagement work has already taken place to support area transformation plans such as 'Healthy Wirral', 'Healthy Liverpool' and 'Connecting Care' and this work is currently in the process of being scoped and logged.

The plan has been developed in collaboration with the Communication & Engagement Leads for each of the three 'Local Delivery Systems', providing a joined up, partnership approach across the region, and utilising all available channels to reach stakeholders.

### What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

This is why we are taking time to create an STP that is worthy of consideration by the public, patients, clinicians and the wider health economy and why the STP itself is still expected to go through a number of changes and adaptations – beginning with a phase of review and revision after the 21st October.

An initial period of pre-engagement will follow this date - setting the scene, considering and communicating available options and making sure that we are having the right conversations with the right people. The conversations that we have started about this process are extremely valuable and we will continue to engage with all of our stakeholders.

### Engagement & Communications Objectives

The communications and engagement strategy has a number of over-arching aims. It is based on the three LDS areas being the "engine room" for developing and implementing any plans for transforming services. At a Cheshire and Merseyside level a joint Communications and Engagement Steering Group will be established to oversee the following:

- Establish standards for communication and engagement with members of the public, NHS staff and other stakeholders, taking into account the needs of any groups of people with protected characteristics, so that local people have the opportunity to contribute to discussions about NHS services. These standards will build on existing good practice and draw on expertise from partner organisations
- Where there is a need to formally consult with the public, staff and stakeholders on options for making major changes to services, ensure that standards of best practice are adhered to. Provide peer support, advice and guidance to support this and if necessary seek external expertise
- Build on existing good practice in order to transform how the NHS engages with members of the public, staff and stakeholders for the future.

### Our Local Delivery Systems

A joint calendar will be created for the three LDS areas, identifying key milestones, which will be dependent on the priorities for each area. Communications and engagement activity will be planned to support these milestones. Where appropriate this activity will take place across LDS areas.

A senior communications and engagement lead has been identified for each LDS. Each lead will be responsible for overseeing the co-ordination of activity in their LDS area, providing strategic advice and guidance to their LDS chair and delivery board and will be a member of the Cheshire and Merseyside wide communications and engagement steering group.

### STP Key Messages

- All health and social organisations across Cheshire and Merseyside are committed to delivering sustainable services that deliver the best care for local people
- We need to think differently about how we deliver services to meet the changing needs of our population
- We know we need to use our limited resources wisely, to meet the demands on the system and stay within our allocated budgets. By working together we can plan our services to deliver the maximum benefit for patients

## 5 - Strategic Risks

**Financial Sustainability challenge.** Since the June 2016 submission of the Cheshire & Merseyside STP, we have taken the opportunity to commence some initial steps to create a common standard of assurance across the footprint. What we have since received in the STP Working Group is a set of high level assurance assessments, both documented and verbally, which demonstrates that our current plans are extremely unlikely to close this gap.

The size of the current gap is an estimate and more work to agree the future assurance framework is yet to be completed. However, two dimensions can be described in that: firstly, the current level of planning has no level of contingency (indicatively 25-50%) that would normally be associated with programmes of this size and complexity ; secondly, the robustness of the 'plans' and associated risks regarding measurability, capability and deliverability all serve to make us discount the current value of the whole by a figure of 30% equating to some £300m.

**Decision-making.** As we stated in our June submission, while there is an emerging clarity about what needs to be done to deliver system-wide change, the challenge of delivering the decisions to effect this should not be underestimated. The strategic aim of the STP to deliver a work stream entitled 'How We work together to Make it Happen' is progressing but now needs to accelerate to agree the draft Memorandum of Understanding that has been circulated, define the governance bodies going forward (evolving the current Membership Group, Executive Group and Working Group) and cement the growing relationship with local Authorities. In due course, it is likely that a number of the decisions required may face public resistance and political challenges. We therefore need to have mature and well oiled governance mechanisms to receive and involve the concerns of our staff and our communities with their representatives.

**Internal capacity.** The issue of the capacity and capability needed to generate and coordinate detailed design and the delivery of the STP has still to be resolved. Attempting to deliver a change programme of this scale without freeing up key members of staff from other duties, or without bringing in additional resource, is destined to fail. The lack of transformation capacity and expertise released from within the system will result in momentum being lost. We are at a watershed moment and the Membership Group has recently agreed to consider all requests for capacity and skills in the light of insufficient progress being made to exploit the goodwill and discretionary efforts of all those contributing to this plan to date.

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