Update to	**Boards, Governing Bodies and Local Authority meetings of Devon STP partner organisations**
Date	**April 2018**
Title	**Monthly Update Report on Devon's STP**

Introduction

The purpose of this regular report is to:

- *Provide a **monthly update** that can be shared with Governing Bodies, Board and other meetings in STP partner organisations.*
- ***Ensure everyone is aware** on all STP developments, successes and issues in a timely way.*
- ***Ensure consistency of message** amongst STP partner organisations on what has been endorsed at the Programme Delivery Executive Group (PDEG). All partner organisations in the STP are represented at senior level at PDEG.*

Content

This is the sixth Update Report, and covers developments from the ***PDEG meeting held on Friday, 20 April 2018***. Key items covered at PDEG this this month:

1. Northern Devon Healthcare Trust developments.
2. System development meeting with Regulators.
3. Organisational Development and Design.
4. Proposed Devon Strategic Outcomes Framework.
5. Health Navigator / economic modelling.
6. Acute Services Review:
    a. Service Delivery Networks – principles and indicative levels for approval.
    b. Acute Service Reviews – guiding principles for agreement.
7. STP Estates Strategy – next steps.

1. Northern Devon Healthcare Trust developments

Over the last three years, the various statutory health and care organisations in Devon have been working together as part of the STP to make best use of our resources for future sustainability, and to work towards better outcomes for local people.

We have made significant progress but despite this stronger collaboration, as a system we continue to face significant challenges, most recently in North Devon District Hospital.

Over several months, various colleagues have been involved in discussions about the Trust.

There was a constructive discussion regarding the issues facing Northern Devon Healthcare Trust at PDEG. It was felt that it was important that an agreed position statement highlighting the core themes and challenges at the Trust was agreed, and this has now been shared with STP leaders. This statement highlights that:

- We are taking a system approach to tackling the issues, ensuring sustainability and safety across Devon.
- There are very real quality and safety issues to be tackled and these are now being acknowledged and addressed.
- The difficulties in attracting medical staff to work in in North Devon have contributed to the quality and safety issues and are integral to developing service resilience and sustainability. We will take a system clinical network approach wherever possible, testing and developing our emerging system model. We will keep services as local as possible so long as it is safe and feasible to do so.
- There have been leadership and cultural issues at the Trust, but we are now seeing a new willingness to investigate and share issues and incidents. We want to make the most of this learning across the system, whilst also modelling good system relationships in the leadership support arrangements being developed with the RD&E.

Devon has built a collaborative model of system working, which has brought real benefits to date. The way the issues at Northern Devon Healthcare are being addressed builds on this successful model. There will be ongoing monitoring by commissioners and the STP Lead Medical Director, and updates will be given at future PDEG meetings.

2. System development meeting with regulators

STP leaders attend regular quarterly review with NHS England and NHS Improvement, and the most recent meeting took place on 11 April 2018 with Sophia Christie and Suzanne Tracey representing the Devon STP.

The review was positive and focused on strategic development and some of the challenges we face. The key themes and discussion points were as follows:

Strategic priorities

- Update on progress in establishing a new STP leadership team.
- Acute Service Review: given the positive work done by the Devon STP, there was a request for us to consider working with neighbouring counties to support them in managing resilient clinical delivery.
- There was a challenge for us to demonstrate that we are using best practice from elsewhere, particularly around elective demand management (such as ophthalmology in Oxford).
- While our challenges in primary care are recognised, there is a view that more progress in the roll out of the GP Five Year Forward View may be the solution to some of the problems in our most challenged areas.

Quality and Performance

- It was suggested that a review of what has worked well at Royal Cornwall Hospitals may help support improved A&E performance in Plymouth.
- There were concerns about RTT performance and low rates of dementia diagnosis.

Workforce

- It was felt that work on mental health workforce could benefit from including lessons from good examples in Bristol and Dorset.
- There was a discussion about the use of technology to create capacity and improve access and resilience – particularly for remote areas. There are NHS Global Digital Exemplars that we could learn from, particularly given that some are geographically close to Devon.

Finance

- It was recognised that Devon was building a good track record of developing rigorous and realistic plans, and a history of delivering on them.
- A review of what has worked on across the Devon STP was received positively, and it was suggested that there was value in sharing this across the rest of South West system.
- It was also noted that 'seasonality' was an issue in Devon and that we should clearly indicate where this was having an impact.

3. Organisational Development and Design

A proposal to align system Organisational Design principles and Organisational Development to enable the delivery of an Integrated Care System in Devon was agreed at PDEG. The suggested approach will help to deliver our system ambition of closer integrated working to improve the health and wellbeing outcomes for the population of Devon, Torbay and Plymouth.

Up to this point the focus on Organisation Design (the physical structures and remits of organisations) and Organisational Development (the cultural and purpose elements of organisations) has been kept separately.

Bringing these elements closer together will increase the pace of change and ensure that organisational design decisions have integrity with the cultural elements that should be addressed through a new way of working.

An Organisational Development diagnostic was completed in November 2016 which recommended the alignment of organisational design and organisational development. The Organisational Design journey has been more visible to senior leaders with a number of workshops at Collaborative Board (January, June, September and November 2017) to define our overall partnership arrangements and our move to a new Accountable Care System.

PDEG endorsed that the Organisational Design Steering Group will agree the approach to align both of these vital areas, and will also design sessions to be held during May 2018, which will be led by an external expert facilitator.

4. Proposed Devon Strategic Outcomes Framework

PDEG were informed about the work to develop an integrated Strategic Outcomes Framework and were asked to agree that it is adopted by partners to be used and further developed during 2018/19.

It will complement the functions being developed through the strategic commissioning project, including a combined population profile and needs analysis across the STP (building on the three JSNAs), joint priorities and the development of a patient level data set. Further work will follow to:

- Agree three year trajectories incorporating the 2018/19 NHS operating plan requirements in year one.
- Implement a reporting cycle for the integrated strategic commissioning group.
- Review the outcome measures incorporated for mental health following completion of the mental health strategy and recommendations of the STP mental health programme.

The intended purpose, method and key features of the integrated Strategic Outcomes Framework are as follows:

- To establish a shared and core set of outcomes to inform working as an integrated care system across wider Devon, including strategic commissioning and all Local Care Partnerships (LCP), on progress against our strategic aims.
- The framework does not replace the accountability of individual organisations and the associated performance mechanisms.
- The strategic outcomes framework will form part of the overall system assurance framework including mechanisms for reporting performance delivery, quality, finance and enable exception reporting to the integrated strategic commissioner.
- The framework will be dynamic with the integrated strategic commissioner determining the priorities and relevant measures.

More work is being done to agree the range of indicators that are proposed to be monitored annually and monthly as part of the new Strategic Outcomes Framework.

5. Health Navigator – proactive health coaching

Torbay & South Devon NHS Foundation Trust has been in contact with Health Navigators to discuss the work they have been undertaking in Sweden for a number of years, and more recently with a number of CCGs in England. Health Navigators have had good success in enhancing health outcomes as well as making efficient use of health resources.

The Trust invited system colleagues from commissioning and provision to hear to hear more about the work of Health Navigators and discuss the opportunities their approach could have for the Devon System.

Proactive health coaching essentially uses a proactive risk stratification to proactively identify the 1% high users of urgent care that account for 35% of non-elective admissions and 53% of non-elective bed days on a predictive basis (daily) allowing for swift intervention. The service fits strategically with both our prevention and Integrated Care priority STP workstreams.

The evidence from the studies has seen a consistent and material reduction in A&E attendances (36%) and admissions (30%) as well as reduction in elective admissions (21%) for the cohort that were targeted.

The main benefit in 2018/19 is seen as creating capacity to stabilise and improve A&E performance and to reduce disruption to cancer and elective care pathways.

PDEG agreed that Liz Davenport, Interim Chief Executive of Torbay & South Devon NHS Foundation Trust, will lead as senior sponsor, and a project team will be established. Health Navigator will be commissioned to carry out the detailed planning and produce a service proposal.

6. Acute Services Review

Service Delivery Networks – principles and indicative levels for approval

The majority of Acute Service Review (ASR) phase one reviews have recommended the development of a 'network' solution as being a key enabler to deliver the recommended clinical proposals. PDEG agreed the final recommendations for 'Service Delivery Networks', and this is shown in ***Appendix One***.

A standard Service Level Agreement to support these network services has been produced. This will be introduced during 2018/19 to support Level 2 and Level 3 Networks. The guiding principle is that the service will be provided in the best interests of current and future patients. This may include:

- Access times.
- Provision to be as local as possible and as specialised as necessary.
- High quality of care and high standards of clinical practice.
- Continuity of care.
- Operational and financial efficiency.
- Service sustainability, including workforce sustainability.

Service Delivery Networks will maintain the original ASR mandate at their core:

- Address inequalities in the health of the population of Devon and improve outcomes via timely and responsive treatment and care that delivers reduced variation in clinical outcomes
- Improve service quality and sustainability in the interest of an equal standard of care (not individual organisational interests).
- Address the current 'post code lottery' where some people in Devon wait longer for treatment and care than others depending on where they live.
- Not focus on the future of individual hospitals in the current system, but will seek to ensure that no single service change destabilises any hospital.

A set of principles developed by key stakeholders, confirm that Network provision should:

i. Follow the STP guiding principle that services should be provided locally where possible and centrally when necessary to the delivery of 'best care for Devon'.
ii. The service delivery, if cross organisational, delivers greater benefit in terms of safety, effectiveness and affordability of care than any potential for adverse impact of the essence of vertical integration that has been the cornerstone of the approach to place based delivery of care
iii. Ensure that service users across all parts of the STP have access to the same established interventions (and new interventions as they are commissioned). Providers in the network who have specialist resource must be willing to share that resource to achieve this, and providers who do not have appropriate specialist skills must develop networked arrangements with other providers so that their patients are not disadvantaged.
iv. Pre-planning will form the basis of all collaboration unless by exception of requests for short term mutual support.
v. Each Service Delivery Network will review its services holistically to prioritise the patient/service pathway.
vi. In any collaborative venture the organisations have a shared responsibility in relation to timely access for the placed based populations which benefit from the service.
vii. The principles of acute service/hospital collaboration and networking should focus on sustainable and affordable services from a clinical/operational and financial perspective with underpinning good governance to assure safe care.
viii. All partners will take the learning from previous experiences of what works well, and not so well, when operating cross-organisational service delivery arrangements/networks in order to ensure that future arrangements deliver the maximum benefits.
ix. The developing mutual aid and network papers will be used as tools to support collaboration.
x. Service management and infrastructure costs should be reduced as part of the redesign where there is an opportunity to do so.

Guiding principles for future Acute Service Reviews

PDEG also agreed a set of Guiding Principles, which will be used for all future Acute Service Reviews. These 10 principles are as follows:

i. All Acute Service Reviews will be clinically-led and have at their heart the 'triple aim' of the NHS Five Year Forward View, with an additional 'fourth principle' about improving the experience of our staff :
    a. Improving the health of the population.
    b. Improving the quality of care delivery.
    c. Achieving better value by reducing the cost of care.
    d. Improving the experience of staff working in our system of care, making their jobs challenging but satisfying and increasing the attractiveness of a career in the Devon health and social care system.
ii. The managerial lead for the ASR Review will work in an organisationally-neutral way.
iii. Transparency is important at all stages – trust is fundamental.

iv. Each review will establish a Working Group which is responsible for ensuring progress is made in accordance with the Project Mandate and for ensuring clinical opinions are fully understood and built into any outcomes.
v. A clinical lead from each affected provider should be identified at an early stage to act as a key point of contact for that organisation and to be part of the Working Group (although this many of the responsibilities may be delivered via e-mail communication and teleconference rather than creating an excessive burden of meeting attendance).
vi. A Project Mandate should be produced for each ASR Review and be approved by the Working Group. This will include the scope of the review, outline review timetable and key priorities.
vii. Reviews will be supported by data rather than opinion. The data requirements should be agreed by the Working Group and noted in the project mandate.
viii. The STP Technical Variation Group will be used to produce and/or validate activity and performance data (including GIRFT and Right Care) to ensure data quality and consistency. Additional service specific data sources such as national audits may also be used, but these will need to be validated by clinicians within the service. Workforce data should be produced and/or validated by the HR Directors' Group. Financial data will be produced and/or validated by the Deputy Directors of Finance Group.
ix. Until the Project Mandate is formally approved, those involved should guard against speculation about service reconfiguration. For example, any suggestion that the review might lead to a major relocation of services could set hares running and create unnecessary concern – with no organisational or system wide agreement of this as a possible outcome.
x. Whilst ASR reviews are across both ASR and planned care programmes some shared functions should support all projects to provide consistency in content and timing. These should be communications and engagement, BI, finance and workforce. Any service reconfiguration proposals should be considered by the ASR programme group and SRO with then a combined process to navigate the NHS England Strategic Sense Check.

Clinical leadership for reviews will be via the designated programme clinical leads however it is recommended that reviews identify:

- A senior clinical leader from within Devon System from outside the clinical specialty area, willing to check and challenge.
- Clinical leads from each STP organisation providing particular service.
- Input from external clinical specialty expert.
- GP representative (provider and commissioner view).

Each review should identify:

- A clinical lead.
- A management lead.
- Project manager/support.
- Business Intelligence, workforce, finance, communications/engagement, digital and quality enabler support to be sourced via main programme.

7. STP Estates Strategy update

All STPs have been requested to submit an STP Estates Strategy and Wave 4 Capital Plans to NHS Improvement, NHS England and the Department of Health and Social Care by 16 July 2018. Indications are that they may require submissions earlier on 30 June 2018.

It is critical that the STP Estates Strategy is fully integrated with and enables the wider STP service strategy and clinical configuration.

The STP capital bid submission also includes the opportunity to submit IT capital bids that would not be covered by the NHS England provider digitisation fund. For this reason it is proposed that a process for developing the Digital strategy and digital capital bids is run in parallel to meet the capital bid submission deadline of 30 June 2018.

Detailed guidance relating to Wave 4 STP bids has been released, and the main points are as follows:

i. The STP submission will be the single point of access for funding. STPs are to lead in prioritising individual bids as part of an overall STP Estates Strategy submission.
ii. The STP must submit an STP wide estates strategy with no separate ICS submissions. Any ICS capital bids should be prioritised within the STP Estates Strategy.
iii. STPs should ensure that all capital projects are included for sign off, regardless of the proposed funding source, even if funding is intended via private finance.
iv. All schemes where public capital is requested need to be prioritised by the STP, regardless of whether the lead organisation is a Trust, Foundation Trust (including SWAST), CCG, NHS England for primary care, NHS Property Services or Community Health Partnerships.
v. Capital bids should include primary care projects.
vi. Capital bids can include equipment and also IT bids which are not covered by provider digitisation. For example, bids for pathology networks or telemedicine are acceptable, but bids relating to Electronic Patient Records are not.
vii. The STP capital allocation is up to 2022/23 so all the capital should be planned to be spent within this period, with a majority spent by 2021/22.
viii. Capital will not be made available for those schemes not identified as a priority by the STP.
ix. Bids for public capital must also include any schemes where funding is intended via Local Authorities or pension funds.
x. If a scheme is genuinely wholly self-funded and does not require any approval, a capital bid does not need to be submitted. However, the scheme should still be included in the Estates Strategy so that the totality of STP plans can be understood.
xi. Successful bids will be announced in November 2018 but funding will not be released until 2018/19. It is highly unlikely that many, if any, large schemes with a capital ask > £100m will be approved or announced as part of this process.
xii. All capital will be subject to business case production and approval (this also applies to Wave 3 bids awarded to T&SDFT and PHNT).
xiii. All public capital bids will be assessed against six criteria:

- Deliverability.
- Patient benefit and demand management.
- Service need and transformation.
- Financial sustainability (ability of the STP or organisation to absorb the additional capital).
- Value for money.
- Strength of estates strategy (including level of stretch on disposals).

xiv. Schemes which replace current assets can be transformational. For example theatres and wards as long as the model of care delivered from those is significantly improved through the delivery of the scheme (e.g. length of stay, reduction in referrals).

xv. Reducing backlog maintenance should be one of the priorities in the STP estates strategy.

xvi. Schemes will be assessed based on the value for money impact across the entire system, not just on one organisation. Where a provider led scheme has a clear commissioner impact that is not modelled this is likely to be challenged.

xvii. It is highly unlikely any scheme which does not achieve significant savings will be awarded funding.

xviii. The level of stretch on land disposals will be a key consideration in the STP bid assessment process.

xix. Disposals should also account for staff housing needs, in particular delivering the expectation that staff will be offered right of first refusal on affordable housing generated through the sale of surplus NHS land.

A four stage process is proposed for ensuring all documentation is submitted by the 30 June 2018 deadline.

- Stage 1: Paper to April 2018 PDEG requesting confirmation of overall approach and governance.
- Stage 2: Paper to May 2018 PDEG with draft STP Estates Strategy and draft prioritisation of capital bids. PDEG to confirm agreement to prioritisation or make any amendments as necessary.
- Stage 3: Paper to June 2018 PDEG with final STP estates strategy, final prioritised capital programme and draft bid templates completed. PDEG to sign off Estates Strategy, prioritised capital programme and draft bid templates.
- Stage 4: Mid-June to Mid-July 2018: Individual Trust and CCG Board approvals of STP Estates Strategy, prioritised capital programme and final bid templates, prior to 16th July.

A Capital Prioritisation Panel be established which consists of individuals with a broad range of clinical and STP workstream skills who can represent the whole STP rather than individual organisations. This panel will have two specific tasks: placing all STP public capital bids in a numbered priority ranking for submission to the May 2018 PDEG meeting; and undertaking a quality assurance review of the completed bid templates for all prioritised schemes prior to the June 2018 PDEG meeting.

Appendix One

Proposed Levels of Service Delivery Networks

LEVEL 1
Service Quality and Effectiveness Network
All networks include the entire service MDT, representation on the network would be via a designated lead for the service.

Core characteristics:

- Discussion of cases, peer review for specialist advice and support on the care of individual patients.
- Mentor support for learning and improvement for individual clinicians
- Best practice reviews and Guideline development.
- Peer comparison of processes, pathways and outcomes to agreed priority service improvements.
- Consideration of mental health pathways in either support of or an alternative to elements of the current physical health pathways.
- Identification of areas of service which may benefit from more integrated delivery between providers (SOPs to establish process for escalation of identification and process for agreeing any SLA).
- Analysis and benchmarking of financial cost of delivering service at provider and Devon level against upper quartile peer organisations with a continual review of efficiency opportunities.
- Host provider to designate a clinical lead with appropriate administrative support. The clinical lead's Trust would normally host the network and provide appropriate administrative support, with this clinical and administrative time apportioned across the participating Trusts.
- Annual learning and improvement summary (potentially via peer review) to host Trust MD for sharing and discussion through the Medical Directors network meetings and with Commissioner via standard quality assurance processes.
- Accountability for service delivery, performance monitoring and clinical governance of the Trust-specific service retained by the individual Trusts.

LEVEL 2
Service network with cross-site delivery of all or some provision of service
This network would be appropriate where there are services where one or more Trusts do not have the capacity or capability (workforce, infrastructure, etc) needed to deliver that service to the standards required and may have to contract with another Trust to secure that capacity for part or all of the service that they are commissioned to deliver. This may require workforce to travel to provide the service on another site, or patients to travel to another hospital to receive the service.

Core characteristics:
(To include all functions described at Level 1)
Plus:

- The network would develop and broker agreements on the cross site solutions required, which could include joint (cross Trust) appointments and shared rotas.
- A contractual agreement would be put in place between Trusts for provider A purchasing service capacity from provider B.

- Accountability for quality standards, governance, complaints, performance retained by purchasing provider where they provide the majority of the service pathway.
- Collaborative agreement on subspecialty areas for provision on a specified (potentially single) site via a 'host Trust' arrangement for that element of the service – the host Trust then assumes the accountability for and governance of that element of the service and the commissioner contracts for that service element from that Trust.
- Host provider to designate a clinical lead with appropriate administrative support. The clinical lead's Trust would normally host the network and provide appropriate administrative support, with this clinical and administrative time apportioned across the participating organisations.

LEVEL 3
Lead provider network – one budget, full accountability
This network would be appropriate where the total service for Devon is delivered by a single/lead provider and should be commissioned directly from that provider. The specification will detail the access requirements (where to be delivered and how) and the Lead Provider will need to subcontract for the infrastructure required from other Trusts.

Core characteristics:
(To include all functions described at Level 1)
- Contract income for the total service and singular accountability for quality, performance and governance.
- Provided through a single organisation/lead provider.
- Employer of all staff who deliver the service commissioned, and responsible for deploying these staff to meet the access requirements defined in the commissioning specification.
- Directly accountable via Lead Provider to commissioner (Devon-wide Strategic commissioning function).
- Provider will designate a clinical lead with appropriate administrative support. The clinical lead's Trust would normally host the network and provide appropriate administrative support, with this clinical and administrative time apportioned across the participating providers.