DRAFT

Planned Care

Long Term Implementation

Plan

Prioritised Objectives	Anticipated year of delivery	Outcomes/Impacts	Level for delivery
Redesigning the way health care on a planned basis works so that patients and staff can access expert advice can be sought at the appropriate time without referral. Moving away from the traditional outpatients model of care and maximising the use of technology . **Outpatients transformation**	2029 with target of delivery of 1/3 reduction in face to face outpatients by 2024	Target of delivery of 1/3 reduction in face to face outpatients by 2024. Impact c 560k less face to face appointments	HCV supported by sub system and place plans

Prioritised Projects	Anticipated year of delivery	Level for delivery
Outpatients transformation		
1. Outpatients programmes - incl. national outpatients programme support	2019	Sub systems
2. Digital vision and enablers identified and built into strategy	2019	HCV

Sub System Project Hull & East Riding	Outcomes/ Impacts
National Outpatients Transformation Programme - Intensive	**NHSI Transforming outpatients – a system approach** Improve management of the pathways in and out of secondary care Reduce follow up backlog Review of best clinical practice and alternative methods of face to face activity GP/Consultant event to identify clinically lead opportunities for system wide solution (16th October 2019) Leading to the establishment of local clinical teams in a 100 day challenge model
Outpatients Transformation Programme	**Internal OPtimise project and business as usual**
Reduce follow up backlog Explore non face to face opportunities	Every contact within any outpatients service is meaningful and adds value to the patients experience Every contact with the outpatient services is the best use of resources and time for the service Services are designed to reflect national recommendations and local needs Delivery is sustainable for the long term
Reduce follow up backlog Explore non face to face opportunities	

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Outpatients transformation		
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Sub System Project North East & North Lincolnshire	Outcomes/ Impacts
National Outpatients Transformation Programme - Moderate	
Outpatient Transformation – 5 Year Programme	
7 Priority specialities: Cardiology, Colorectal, ENT, Gastroenterology, Ophthalmology, Respiratory, Urology	DNA rate reduction New: Follow-up ratio improvement ASI reduction Overall reduction in waiting list size Improved RTT Performance Zero follow-up Backlog Increased use of Advice & Guidance Reduction in Sis 30% reduction in face to face appointments Streamlined Administrative Processes

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Outpatients transformation		
1. Outpatients programmes - incl. national outpatients programme support	2019	Sub systems
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Sub System Project York and Scarborough	Outcomes/ Impacts
National Outpatients Transformation Programme - Moderate	**Rapid Expert Input.** Ensure patients receive the outpatient based care they need as promptly and efficiently as possible Reduce the administrative burden of managing referrals and booking appts for both primary & secondary care Reduction in unnecessary F2F appointments Introduce a simpler system for everyone to navigate Reduce duplication between primary & secondary care Improve communication between primary & secondary care Ensure we have sufficient capacity to continue to provide access to services in times of heightened demand Reduce the impact on the environment through reducing unnecessary travel
Outpatients Transformation Programme	
Patient Initiated Follow Up pilot in Rheumatology	Reduction in FU OP appointments Increase in the number of patients on PIFU pathway
Video Consultations in Diabetes & Cancer Care	Reduction in F2F OP appointments Increase in the number of patients alternative F2F pathway
Review of FU Long waiters (all specialties)	Reduction in FU backlog

Prioritised Objectives	Anticipated year of delivery	Outcomes/Impacts	Level for delivery
Redesigning the way health care on a planned basis works so that patients and staff can access expert advice at the appropriate time without referral to hospital. Moving away from the traditional outpatients model of care and maximising the use of technology . **Pathway redesign including , increasing access to First Contact Practitioners in Primary care and implementing National Back Pain Pathway across HCV and pathway change to support the Acute Services Reviews**	By 2024	100% population Coverage of access to an FCP across HCV	HCV supported by Place

Prioritised Projects	Anticipated year of delivery	Level for delivery
Pathway Redesign for example: MSK		HCV and Place
1. Implementation of National Back Pain Pathway across HCV	By 2024	
2. First Contact Practitioners – Primary Care Network recruitment	2020	
3. First Contact Practitioner - full population access – phased approach at place level	Phased from 2019	
Acute service reviews – cardiology, complex rehabilitation, neurology	2020	HCV

Place Projects	Outcomes/Impact
East Riding FCP's in place across all PCN's 19/20 Back pain pathway ER – capture from ME Charter HUTHT – MRI referral form to reduce Lumbar spinal MRI referrals in line with back pain pathway	100% coverage In place 2021? Diverting 30% patients from GP's No of MRI referrals reduced by 50%
Hull HUTHT – MRI referral form to reduce Lumbar spinal MRI referrals in line with back pain pathway	No of MRI referrals reduced by 50%
York MRI referrals (referral form and GP postcard) to reduce Lumbar spinal MRI referrals in line with back pain pathway FCP – roll out PCN's	No of MRI referrals reduced by 50%
Scarborough MRI referrals (referral form and GP postcard) to reduce Lumbar spinal MRI referrals in line with back pain pathway FCP – roll out PCN's	No of MRI referrals reduced by 50%
North Lincolnshire Pilot FCP's through to 2020.	Diverting 30% patients from GP's
North East Lincolnshire	Diverting 30% patients from GP's

Prioritised Objectives	Anticipated year of delivery	Level for delivery
Increasing support for people to manage own health. Supporting healthier choices ,prevention, early diagnosis & treatment improving patient outcomes & experience with a focus on : • **Diabetes**	2024	HCV and sub systems

Prioritised Projects	Anticipated year of delivery	Level for delivery
Diabetes delivery 1. NDPP delivery 2. MDFT delivery 3. Treatment Targets 4. Structured Education 5. Glucose monitoring 6. Low Calorie Diet	1. Ongoing 2-4 19/20 with sustainability plans in place from 20/21 5. 2019 6. 2019	1. HCV 2. Humber and VOY/SR 3. H/ER and VOY/SR 4. H/ER/VOY/SR/NEL 5. Place 6. Hull and East Riding subsystem
Development of HCV vision and delivery plan for diabetes aligned with regional and national vision	2019	HCV

HCV WIDE	Outcomes/ Impacts
The Humber Coast & Vale (HCV) Partnership are part of wave 3 for the National roll out of the NDPP.	This plugs the intensive behaviour change support gap in GP services recommended in NICE guidelines. The contracted number of Individual Assessments (IA's) for HCV is 5,357 (Jul'18-Jun'20). HCV intervention places for the 3 years from August 2020 are 5,221. This will be phased as follows Yr1 3,655,Yr2 4,438,Yr3 5,221

HUMBER CCGS	Outcomes/ Impacts
MDFT	The MDFT aims to reduce the high rates of amputations Is there any ambition set re how many by when?

North East Lincs CCG	Outcomes/ Impacts
Structured Education	DESMOND extended to include prevalent population. increase numbers of prevalent population attendees

Hull & East Riding	Outcomes/ Impacts
Structured Education Low Calorie diet local pilot	Focus on individuals who are considered the most vulnerable and at risk of complications: any targets for numbers of people accessing?

York and Scarborough	Outcomes/ Impacts
Structured Education MDFT Treatment Target	Focus on individuals who are considered the most vulnerable and at risk of complications: any targets for numbers of people accessing?

Prioritised Objectives	Anticipated year of delivery	Outcome/Impacts	Level for delivery
Increasing support for people to manage own health. Supporting healthier choices ,prevention, early diagnosis & treatment improving patient outcomes & experience with a focus on : • **Cardio Vascular Disease prevention** • **Cardiac services** (also aligns with redesign objective)	2024	Prevention of 4500 CVD events if HCV achieve the PHE ambitions by 2021 Within 3 years: - 260 heart attacks and 390 strokes through optimal treatment of diagnosed hypertensives and 390 strokes through optimal treatment of high risk AF patients. With a financial opportunity calculated by NHS RightCare of up to £14m.	HCV and Place

Prioritised Projects	Anticipated year of delivery	Level for delivery
• Delivery of RightCare priority re the optimisation of treatment for AF in place in high risk practices • Delivery of RightCare priority re optimisation of treatment of Hypertension • Development of HCV vision and delivery plan for CVD aligned with regional and national vision (using the North CVD framework to shape as active members of the North CVD Group • Healthy Hearts Website and communication plans • CVDPREVENT audit • PCN - CVD prevention and diagnosis specification 1 of our projects will provide strategic support to PCN's to decrease variation and support use of CVDPREVENT Cardiac services • Community cardiology services • Heart Failure • Cardiac rehab	2019 2020 2021 2024	HCV and place HCV and Place Place HCV and Place

HCV WIDE	Outcome/Impacts
• Identify variation in opportunities for improvement in population groups • CCGs implement RightCare national priority initiative for CVD (AF & Hypertension) (19/20) • Hospital trusts to implement PH48 and complete baseline audit & develop action plan • Consistent communication messages and healthy hearts website - launched August 2019 • Implement CVD MECC with Humberside Fire & Rescue launched August 2019 • CCG/ GP practice participation in National AF programme • Standard community cardiology specification supporting place delivery including heart failure services • Cardiac Rehab – working with Respiratory workstream to look at expansion alongside pulmonary rehab	Prevention of 4500 CVD events if HCV achieve the PHE ambitions by 2021. Within 3 years: - 260 heart attacks and 390 strokes through optimal treatment of diagnosed hypertensives and 390 strokes through optimal treatment of high risk AF patients. With a financial opportunity calculated by NHS RightCare of up to £14m.Total CCG targets for 19/20 (SH) Outcomes from community specification to add plus numbers for expansion cardiac rehab

Sub System Project Hull and East Riding	Outcome/impact
BHF Blood pressure pilot in pharmacies	

Sub System Project York and Scarborough	Outcome/impact
Review of community heart failure services -scoping workshop Sept 19 RightCare NPI – population health analysis with LA and PH including ward level inequality analysis • Population health analysis will be a subsystem key piece of work. Supported by RAIDR tool.	Creation of integrated service model to improve patient experience and outcomes. Deliver NICE 2018 recommendations Improved pathway and patient outcomes Positive impact on unplanned admissions and LOS Hypertension • VOY (824pts) SR (317pts) AF • VOY (112pts) SR (15pts)

Sub System Project East Riding	Outcome/impact
Agreed plan for 19/20 and 20/21 including increasing detection rates, support to self care and complementary services, demand management, reducing likelihood of cardiac episode or stroke	By 2023/24 Heart failure 110 fewer Stroke – 28 fewer

Sub System Project Northern Lincolnshire	Outcome/Impact

Sub System Project North East Lincolnshire	Outcome/Impact

Prioritised Objectives	Anticipated year of delivery	Level for delivery
Increasing support for people to manage own health. Supporting healthier choices ,prevention, early diagnosis & treatment improving patient outcomes & experience with a focus on : • **Respiratory**	2023	HCV and sub systems

Prioritised Projects	Anticipated year of delivery	Level for delivery
Respiratory 1. Development of plans supported by RightCare as part of the regional plan for early detection and diagnosis, structured education, medicine use, expansion of pulmonary rehab services, and response to pneumonia 2. Development of HCV vision and delivery plan for respiratory aligned with regional and national vision	2019	• Right care target per CCG (SH)

HCV Wide	Outcomes/ Impacts
Pulmonary Rehab • Systems to identify how to increase PR referrals • Targeted investment in certain sites in 2020/21 with further roll-out 2021/22 • PR QOF indicator 2020/21 • Opportunities to test combined PR & CR models	• Most CCGs have an opportunity to improve PR completion rates • All CCGs have an opportunity to improve the number of patients offered PR
Spirometry Training • Spirometry guidance 2019/20 • Expand quality assured spirometry Targeted funding to increase spirometry training 2020/21 • PCNs to support via diagnostic hubs	• All CCGs have provided spirometry training – *variable take-up* • East Riding, Hull and NE Lincolnshire have an opportunity to improve diagnosis using spirometry • Hull, Scarborough & Ryedale, North Lincolnshire are providing ARTP training/ needs assessment
Smoking Cessation • Targeted investment to develop NHS-funded smoking cessation services in certain sites in 2020/21 and further roll-out 2021/22 onwards	• All CCGs have an opportunity to improve the numbers of smoking quitters
Prescribing • PCNs to provide patient reviews for SABA inhalers	• No baseline information

Sub System Project Hull	Outcomes/ Impacts
Lung Health Checks (Hull only) Physio into Care homes (H&ER)	Early diagnosis – no saving in year - no's diagnosed? Reduce hospital visits for respiratory patients by how many?

Prioritised Objectives	Anticipated year of delivery	Outcome/Impacts	Level for delivery
Long Term Plan statement: Increase identification of respiratory disease, increase referrals for pulmonary rehabilitation, concentrating on opportunities to improve care and management for patients in deprived communities.	2020-2021	1. Increase the number of people receiving an accurate diagnosis using quality assured spirometry performed by a ARTP trained health professional 2. Increase the proportion of people with COPD who are diagnosed comparing recorded prevalence with predicted prevalence 3. Reduce unscheduled activity (ED attendances, admissions and re-admissions) 4. Increase the number of patients referred to pulmonary rehabilitation, take-up rates and compliance 5. Enhance patient's quality of life, improve understanding and management of own condition	HCV and Place

Prioritised Projects	Anticipated year of delivery	Level for delivery
Respiratory		
1. Detect and diagnose respiratory problems earlier	2020-21	Place
2. Expand access to pulmonary rehabilitation services	2020-21	Place
3. Receive and use the right medication	2020-21	HCV and Place
4. Improve the response to patients with pneumonia	2020-21	Place
5. Treating tobacco dependency	2021-22	HCV and Place
6. Structured patient education and self-management programme	2020-21	HCV and Place

HCV WIDE	Outcome/Impacts
1. Review COPD registers to improve accuracy and detection rates 2. CCGs to review current PR services and models 3. All CCGs roll-out or increase the uptake of MyCOPD app 4. Programme of inhaler-technique training (including pharmacists) 5. CCGs and providers to take-up the SDEC Community Acquired Pneumonia CQUIN 6. Increase flu and pneumococcal vaccine uptake – particularly for at risk groups 7. Development of well-being pop-up clinics/health checks/frailty clinics to increase engagement in the most deprived wards 8. Identify local champions for smoking cessation services and promotion of local services 9. Increase quality assured spirometry training and provide support to PCNs in the development of diagnostic hubs	1. Increase the number of patients accurately diagnosed with COPD 2. Increase referrals to PR, take-up and completion rates 3. Increase appropriate prescribing, reduce inappropriate and wasteful prescribing 4. Reduce avoidable admissions for low severity pneumonia patients by 40% (based on COPD audit) 5. Reduce impact on winter pressures 6. Reduce unscheduled activity (admissions and A&E attendances) 7. Reduce re-admissions for exacerbation of COPD by 24% (based on COPD audit) 8. Increase vaccination take-up in at risk groups 9. Improve patient health outcomes, improve patients understanding of own condition, improve self-management 10. Increase the number of patients referred to stop smoking support and the number of successful quitters

Sub System Project York and Scarborough	Outcome/impact
Clinical review of inhaler technique video's from Asthma UK and Rightbreathe Hold a Respiratory PTL session Explore a follow-up/hot clinic model for asthma and COPD patients with for re-attenders to ED/provide follow-up	Improve inhaler techniques Reduce avoidable admissions

Sub System Project Hull and East Riding	Outcome/impact
Lung Health Checks Increase knowledge of pulmonary rehabilitation via PTL Develop a plan to meet the 5 year national target (90% completion rate for PR) Encourage the use of telehealth	Increase number of patients diagnosed with COPD Increase pulmonary rehabilitation take-up rates Improve self-management, health outcomes and quality of life

Sub System Project Northern Lincolnshire	Outcome/Impact
Work with practices and PCNs on anticipatory care planning, scoping a community respiratory service and access to steroid packs Commission health checks with RDaSH for patients with a mental health problem Targeted case finding engaging with at risk groups, deprived areas, drugs and alcohol cohorts and the homeless Review a combined cardiac and pulmonary rehabilitation service model Explore working with local breathlessness clinics	Reduce avoidable admissions Improve self-management, health outcomes and quality of life Provide targeted support towards deprived areas and reduce inequalities

HCV Prioritised Objectives	Anticipated year of delivery	Level for delivery
Effective and efficient use of **medicines** in line with best practice /evidence (benchmarks spend/outcomes)	Ongoing	All levels

HCV Prioritised Projects	Anticipated year of delivery	Level for delivery
Medicines optimisation		
1. Development of HCV Pharmacy leaders group and MO plan	2019	HCV
2. Networking and sharing of best practice	2019	HCV and Place
3. Agreement of Avastin position	2019	HCV and Place
4. Development of workforce strategy that links to local implementation	2019-2020	HCV and Place
5. Primary care campaign encouraging self care	2019	HCV and Place
6. Work towards closer alignment of APCs, across STP	2019-2020	HCV and sub-system
7. Waste: Managed repeats - Third party ordering of Rx's (primary care)	2019-2020	HCV and Place

Humber CCG Work towards closer alignment of APCs, across STP	Outcomes/ Impacts
1. OptimiseRx – Clinical decision support software optimisation	In year projected savings: £749,733.54
2. Pharmaceutical rebates – CCG approved rebates	In year projected savings: £371,159.48
3. Biosimilars opportunity utilisation	In year projected savings: £1,245,224.65
4. PbR High cost drugs/Blueteq implementation	Assurance around appropriate use of relevant to PbR excluded/high costs drugs.
5. Alignment of CCG QIPP plans	Costed within CCG plans - Alignment of work plans and sharing of best practice

Secondary Care	Outcomes/ Impacts
For secondary care All 3 acute trusts will continue to work together as part of the regional networks, including • Efficient procurement via MOPC (workplan in place) • Patient safety via national and regional MSO networks • Anti-microbial stewardship via regional group Engaging with the national review on aseptics and deciding if the STP patch is an appropriate network to be taking this forward Workforce – engaging with HEE to ascertain what is being delivered by HEE at STP level Workforce- joint posts – looking at more system wide posts (eg with PCN's) and other work to improve recruitment and retention Consultant Pharmacist posts be developed at sub regional level. Continued development of TCOM Sharing good practise and avoiding duplication	

HCV Prioritised Objectives	Anticipated year of delivery	Level for delivery
Effective and efficient use of **medicines** in line with best practice /evidence (benchmarks spend/outcomes)	Ongoing	All levels

HCV Prioritised Projects	Anticipated year of delivery	Level for delivery
Medicines optimisation		
1. Development of HCV Pharmacy leaders group and MO plan	2019	HCV
2. Networking and sharing of best practice	2019	HCV and Place
3. Agreement of Avastin position	2019	HCV and Place
4. Development of workforce strategy that links to local implementation	2019-2020	HCV and Place
5. Primary care campaign encouraging self care	2019	HCV and Place
6. Work towards closer alignment of APCs, across STP	2019-2020	HCV and sub-system
7. Third party ordering of Rx's (primary care)	2019-2020	HCV and Place

Sub System Northern Lincolnshire	Outcomes/ Impacts
Alignment of QIPP and CIP plans with NEL/NL & NLaG North Lincolnshire APC (Including joint shared care work) Development of joint workforce plan DOACs TCAM	Standardised approach to QIPP, sharing of best practice Effective local decision making processes in relation to medicines commissioning and guidelines Development of a sustainable pharmacy workforce In year savings: £44,204 Annualised savings: £1,187,000

Sub System Hull and East Riding	Outcomes/ Impacts
Hull & East Riding APC, covering shared care frameworks produced; joint formulary work. TCAM	Effective local decision making processes in relation to medicines commissioning and guidelines Reduction in hospital admissions (thereby releasing capacity, & improving pharmaceutical care for patients)

Sub System York and Scarborough	Outcomes/ Impacts
Implement PINCER North Yorkshire APC TCAM Joint trainee pharmacist and technician post between primary and secondary care Development of MO to domiciliary and care home patients Introduction of outpatient antimicrobial service across the patch to allow patients to be treated at home	Effective local decision making processes in relation to medicines commissioning and guidelines Reduction in hospital admissions (thereby releasing capacity, & improving pharmaceutical care for patients)