C. How our STP meets key national priorities

We have been conscious of the need to tread an appropriate balance between (a) clearly setting out our major priorities (which we have sought to do in our main STP document) alongside (b) giving confidence that as we transform services we are doing so in a way that is consistent with major national strategies, standards and priorities – particularly those set out in the helpful 'quick guides' published by NHS England earlier this year.

This document is intended to support the latter of those goals, including sign-posting where in our main document or PIDs more detailed information is provided.

It covers the following areas:

- Simplify UEC system and deliver A&E and ambulance targets
- Improve mental health services
- Improve cancer services
- Improve services for people with learning difficulties
- Improve maternity services
- Strengthen primary care (including 7-day access to primary care)
- Implement 7 day hospital services
- Improve prevention
- Improve personalisation and choice
- Improve patient and staff safety
- Implement digital-aided care
- Achieve key access targets
- Provide a capable, efficiently deployed workforce
- Drive financial sustainability and efficiency

Finally, we have also referenced the original 10 STP questions as to provide continuity with our June 2016 Submission

Subject	Areas highlighted in 'quick guides and other STP guidance'	Where or how we have addressed it
Simplify UEC system and deliver A&E and ambulance targets (Q4.2)	1. Provide responsive urgent care services outside of hospital, ensuring care close to home a. More calls to ambulance resolved without conveyance to emergency departments. b. Urgent and emergency care services have greater electronic access to records, including advance care plans through an enhanced summary care record & 'special' patient notes. c. Increased use of frailty units and ambulatory care units, reducing hospital emergency admission rates and length of stay for urgent conditions and frail and/or older people (Q4.6). d. Stronger partnerships with care homes, homecare and housing providers to reduce avoidable admissions and delayed transfers of care (Q4.5). e. To succeed, footprints will also need to make progress on other policy areas including developing an enhanced primary care offer and improving community support for long-term condition management. 2. Single point of access for clinical advice (Q4.1) a. A 24/7 integrated urgent care service implemented in each footprint, including a clinical hub that supports 111, 999 and out-of-hours calls from the public and all healthcare professionals. b. Services marketed so patients understand what is available to them. 3. For people with more serious or life threatening emergency care needs, ensure treatment in centres with the best expertise and facilities a. UEC networks implement plans in all parts of the country to deliver objectives of the review for all ages, for both physical and mental health. b. Consistent pathways defined for UEC with equitable access, including designation of acute services and community urgent care facilities.	We have provided details on each of these standards in Section 4c of the main STP document except 1e, which is reflected in Section 4b of the main STP document. We have provided further details in the Project Initiation Documents (PIDs) for High Impact Area 3. We are confident that we are implementing all areas highlighted.
Improve mental health services	1. Improve access to and availability of mental health services and including hitting mental health waiting time standards: a. 50 per cent of patients experiencing their first episode of psychosis care within two weeks of referral b. 75 per cent of patients with depression or anxiety disorders needing access to psychological therapies are to be treated within six weeks of referral, and 95 per cent in 18 weeks (Q6.2)	We have provided details on points 1, 3 and 4, which are in Section 4b of the main STP document with further detail in the PID for High Impact Area 2. Regarding point 1a, we note that: • Nottinghamshire Healthcare Trust performance is improving month on month and was at 35% in August of this year

	2. Meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia (Q6.4). 3. Develop community services, taking pressure off inpatient settings. 4. Providing people with holistic care, recognising their mental and physical health needs.	• Nottingham City CCG is the lowest performing in the footprint and has provided additional funding to address this. A steering group meets fortnightly to implement action plan developed following recommendations from external review • Trust predicted to achieve target in Sept at 57% with City CCG improved to 25% Regarding point 1b, we note that all CCGs in the footprint currently meet both targets consistently. An additional provider has been commissioned within the City CCG to absorb increases in demand. Regarding point 2, dementia diagnosis rates for our footprint are in the top quartile (76.5%). Our ambition is to maintain this status. Local workplans are already in place and there are a number of integrated teams in place to support those with a diagnosis and their carers. For example, we have rolled out a Nottinghamshire-wide Intensive Recovery Intervention Service (IRIS), which is a 12 week intermediate care service delivered by a multidisciplinary care team (available 7 days a week) for older people with mental health problems or dementia to facilitate hospital discharge or prevent hospital or care home admissions.
Improve cancer services	1. Preventing cancer by addressing cancer risk factors – especially smoking; all areas should take steps to reduce national rate by the end of the decade. 2. Diagnosing more cancers early, increasing the proportion of cancers diagnosed at stage 1 and 2. STPs need to improve their cancer pathways as well as substantially increasing diagnostic capacity (especially imaging and endoscopy). These actions will result in fewer cancers diagnosed as an emergency, and an increase in one and five-year survival rates. By 2020, at least 95% of those with a suspected cancer should receive a definitive diagnosis or otherwise within 28 days (Q6.1). 3. Improving cancer treatment and care. By 2020, all patients should have access to high quality modern therapeutic services, such as personalised treatment informed by molecular diagnostics. They will be cared for during	We have provided details on point 1 in Section 4a of the main STP document. We have provided details on points 2 and 3 in Sections 4b and 4e of the main STP document. We have provided more detailed information on these points in the PID for Priority Project 5.3 of High Impact Area 5. Targets of achieving 75% one-year (all cancers) survival rates and diagnosis of 95% of cancers within four weeks form part of

	and after their treatment, benefiting from increased support to live well after treatment. Patients will have a better experience of their cancer care, with less variation across the country (Q4.3)	our strategy to improve cancer care. Key activities locally include: • Local support of the national *Be Clear on Cancer* symptom awareness campaigns • Increase screening uptake rates, particularly the focus on GP practices with low uptake populations • Focus on achieving early diagnosis initiatives for lung cancer, including the piloting of an MOT clinic encompassing awareness raising, and improving referral pathways for chest x-rays and CT scans • Increasing direct access to diagnostics for primary care • Implementation of non-specific symptoms multi-diagnostic centres • Continue the Nottinghamshire Cancer Pathways programme initiatives • Integration of genomic medicine into Cancer Strategy
Improve services for people with learning difficulties	1. Reduce reliance on specialist inpatient care by working with TCPs. By March 2019 no STP area should be planning for more than, 10-15 inpatients in CCG-commissioned beds and 20-25 inpatients in NHS England-commissioned beds per million population. 2. Deliver person-centred care and support by integrating public services such as leisure, employment support, health, social care, education and criminal justice; and increasing choice and control, including at the end of life, by extending the use of all forms of personal budgets and integrated personal commissioning. 3. Improve access to services to reduce premature deaths. A key driver of this is to ensure that GPs identify their local population on a learning disability register. People with a learning disability aged 14 and over on a GP's learning disability register should receive an annual health check.	Nottinghamshire is home to an NHS England Transforming Care Partnership. Our local plan aims to transform care and support for individuals with a learning disability and / or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging so that their care is focused on keeping people well and supported in their local community and that in-patient services are only used where community settings cannot provide safe and suitable alternatives to admission. When our transformation plan is implemented Nottinghamshire will have: • A whole systems approach across all commissioners. • Care and support redesigned to ensure that inpatient care is only used when it is the best place for the person concerned e.g. when it is mandated by the courts or for respite or assessment and treatment when community provision not possible. • Person-centred care and support planned and delivered to individuals consistently by providers.

		• An increased focus on the voice of the carer, relative and service user. • A 'whole life' preventative approach needed for care and support with a much greater emphasis on reducing the severity and frequency of challenging or offending behaviours from a young age and beyond into adulthood. We recognise in our gap analysis and plan to address the high numbers of inpatient admissions we are currently seeing for people with learning difficulties. We intend to drive forward our approach to person-centred care and intend to become an early adopter of Integrated Personal Commissioning. PIDs are being developed for submission to NHS England on 26 October.
Improve maternity services (Q6.3)	1. Personalised care, centred on the woman, her baby and her family, based on their needs and their decisions, where they have a genuine choice informed by unbiased information. 2. Continuity of carer, to ensure safe care based on relationships of mutual trust and respect, in line with the woman's decisions. 3. Safer care, with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place; leadership focussed on a culture of safety across organisations and investigation leading to honest and open discussions and learning when things go wrong. 4. Better postnatal care and perinatal mental healthcare, to address under provision in these two vital areas. 5. A culture of multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.	We do not provide specific focus on maternity services; however, we are committed to achieving national standards. Specifically, we will achieve our ambition to improve maternity services and reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries through: • Implementing the recommendations outlined in the national maternity review, *Better Births*, including a focus on personalised care, continuity of carer and safer care • Taking specific action to reduce stillbirths based on the *Saving Babies' Lives care bundle* elements • Integration of the two maternity units within the STP footprint, embedding consistent clinical care across the patch, adopting best practice from each unit and learning lessons (and improving practice) through regular and thorough review of stillbirths and neonatal deaths in Nottinghamshire

		Maternity services in Nottinghamshire are currently benchmarking their position against the recommendations published in Better Births and the elements in Saving Babies' Lives. This will form the baseline and working with key stakeholders, including mothers and families, we will develop plans to ensure recommendations are implemented in line with the timelines outlined in Better Births. Key work is focused on strengthening multi-professional working across the early years pathway to improve maternal mental health and post-natal care.
Strengthen primary care (including 7-day access to General Practice) (Q3)	1. Support and grow the primary care workforce a. Expand the workforce in general practice in line with the national objective to recruit 5,000 additional doctors and 5,000 additional clinical and support staff. b. Introduce new roles to support patients beyond traditional GP consultations, including 3,000 primary care mental health counsellors/therapists, physician associates and 1,500 clinical pharmacists in community settings. c. Retain the existing workforce, supporting professionals' health and wellbeing and giving primary care practitioners opportunities to develop. 2. Improve access to general practice in and out of hours a. People have easier and more convenient access to GP services, with the option to book appointments either in or out of hours (after 6.30pm weekdays, and weekends). 3. Transform the way technology is deployed and infrastructure utilised a. Patients benefit from new ways of interacting with services, providing alternatives to face-to face contact including the use of phone and online consultations. b. Primary care records shared across the local health economy, including community pharmacy, with the introduction of common standards, paperless transfer of notes and digital summary care records. Patients benefit from improved infrastructure and 'fit for purpose' premises. 4. Better manage workload and redesign how care is provided	We have provided details on point 1 in Section 6a of the main STP document with further detail in the PID for Priority 3 of the Workforce Enabler on building capacity, capability and resilience in the primary care workforce. We have provided details on points 2, 4b and c in Section 4b of the main STP document. We have provided a note on point 4a in Priority 1 of the PID for High Impact Area 2. We have provided details on point 3 in Section 4d of the main STP document. Primary care redesign is already in motion to operate at scale, integrate and provide care outside of hospital. For example, the Nottingham North and East Primary Care Home pilot (Nottingham North and East Community Alliance) and Principia Partners in Health Multispecialty Care Provider development are testing how primary care can operate at scale. The mid Nottinghamshire primary care hubs and the Greater Nottingham Urgent and Emergency Care vanguard are considering out of hospital models. Each area of our footprint is addressing one of the aspects needed to transform primary care and we have the opportunity to test, share and learn from each other as these

	a. Every practice benefiting from the use of the 10 High Impact Actions to release time for care. b. Most practices work collaboratively to capture economies of scale, improve quality, develop their workforce and provide enhanced services including extended in and out of hours access. c. Many go beyond this to form Multispecialty Community Providers (MCPs), a new clinical and business model to integrate provision of primary and community services based on the GP registered list, with a single budget and responsibility for their aspects of population health delivery.	models develop, and bring together the different elements to truly transform how primary care operates.
Implement 7 day hospital services	1. Timely consultant review: All emergency admissions have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital. 2. Improved access to diagnostics: Hospital inpatients have scheduled 7 day access to diagnostic services. Consultant-directed diagnostic tests and reporting available 7 days a week: within 1 hour for critical patients; within 12 hours for urgent patients; and, within 24 hours for non-urgent patients. 3. Consultant directed interventions: Hospital inpatients must have timely 24 hour access, 7 days a week, to consultant-directed interventions. 4. Ongoing review in high dependency areas: All high dependency patients (including acute medical unit, surgical assessment units and intensive care unit) seen and reviewed by a consultant twice daily, unless it is determined by a senior decision-maker that this would not affect the patient's care pathway; and consultant- directed ward rounds.	We have covered point 1 in Section 4c of the main STP document. We have provided details on point 2 in Sections 4c and 4e of the main STP document. Regarding points 3 and 4, NUH will be completing a large-scale clinical notes audit of compliance against these standards, which will be used to support a national baseline exercise across all Acute Trusts. This audit will be used to further identify where action and improvement is required, and the audit will be repeated on a 6-monthly basis to monitor this improvement. SFH is working to implement these standards by 2017.
	1. Targeted advice tackling unhealthy behaviours is provided at the point of care (Q1.3) a. Alcohol consumption is reduced and related hospital admissions are lowered by 2020/21, through implementation of system-wide targeted advice and care. b. Smoking prevalence is reduced (in line with the national ambition to reduce prevalence to 13%) and attributable hospital admissions in people aged 35+ lowered by 10% by 2020/21, by implementing a local, joined up approach to advice and care. 2. A healthier environment is created by health and care providers and local employers.	We have provided detail on points 1 and 2a in Section 4a of the main STP document. We have mentioned point 2c in Section 4a and have provided more detail on points 2b and c (staff wellbeing) in Section 6a. We have provided details on point 3a in Section 4b of the main STP document. We have provided details on point 3b in the PID for Priority 1 of High Impact Area 1.

Improve prevention	a. Prevalence of obesity is significantly lower due to improved approach to food and catering in health and care settings and the implementation of the Government's forthcoming Childhood Obesity Strategy (Q1.1). b. Employment of people with long-term conditions (LTCs) is improved, so the gap between the overall employment rate and the rate for people with LTCs is reduced, as a result of a more supportive work environment for people living with a LTC, with a focus on people with mental health needs and/ or learning disabilities. c. The health and wellbeing of staff employed by health and care providers is improved through meeting the three indicators outlined in the 2016/17 CQUIN (Q2.3). 3. Improved patient pathway, from early action to better management. a. More patients with diabetes, hypertension, atrial fibrillation and hypercholesterolaemia have their condition diagnosed and optimally managed, through an enhanced use of pharmacies and community settings (Q1.2). b. Number of injuries due to falls in people aged 65+ are lowered, with admissions due to falls decreasing by 10% by 2020/21, through improved and better coordinated preventative services. c. Reduction in avoidable hospital admissions due to preventable disease (Q1.4).	We have provided details on point 3c (reducing demand on hospitals through disease prevention) in Section 4a.
Improve staff and patient safety (Q7)	1. Support a culture of safety for patients and staff a. Improved incident reporting and continued improvement of a safety culture, demonstrated by increased reporting rates and improved responses to NHS staff survey safety culture questions. b. Participation in a local patient safety collaborative and other relevant initiatives encouraged, supporting the delivery of improvement. c. Implementation of all relevant national patient safety alerts issued by NHS Improvement. 2. Improvements in patient safety to reduce avoidable mortality a. A Standardised retrospective case record review (RCRR) methodology used by clinicians to review the care of patients who die, facilitating learning from care delivered. b. Problems in care highlighted by RCRRs are addressed through development and implementation of detailed improvement plans.	Regarding point 1, our trusts are participating in the national Sign up to Safety Campaign and have identified priority areas to focus improvement. Each priority area has an ambition to increase reporting and reduce avoidable harm and have improvement plans, owned by a workstream, which are monitored bi-monthly by the Patient Safety Sub-Committee and summarised in the Quality Priority Report for the Quality Committee. To support the Sign up to Safety Campaign there are additional enabling workstreams and NHCT, for example, launched the 'Say It, See It' Campaign to encourage incident reporting in September 2016. SFH is engaged in a Board Safety Programme and the Patient Safety Collaborative's Safety Climate Programme for Emergency Departments and Maternity. In addition, there is a ward-based Patient Safety Culture

	3. Appropriate use of antibiotics and improvement in infection prevention and control a. Appropriate antibiotic prescribing among primary and secondary care clinicians, including reduced overall prescribing and broad spectrum antibiotic prescribing. Unwarranted variation identified and reduced and best practice spread within and across footprints, for example adoption of the Start Smart Then Focus and TARGET guidance. b. Demonstrable improvement in infection rates through prompt identification and modification or removal of infection risk factors, earlier diagnostics and appropriate treatments, a 50% reduction in inappropriate prescribing and compliance with the Code of Practice (2015) for the prevention and control of infection and related guidance.	Programme supported by NUH, which delivers a Safety Climate survey to staff based in a clinical area and supports bespoke interventions to identify and improve key areas. This is linked to a ward accreditation programme focussed on safety. A Governance Support Unit and Director of Assurance oversee incident reporting and investigation. A Serious Investigation tracker is reviewed weekly by the Executive Team and all outstanding reports are reviewed monthly at Divisional Performance Management meetings. For specific details on reporting, NUH, for example, has an above average rate of reporting (39.85 per 1000 bed days). The majority of reported incidents are no (76.5%) or low (22.4%) harm. Trusts in the footprint have a robust policy in place to manage all safety alerts. NUH monitors implementation of NPSA alerts through its Clinical Effectiveness Committee, and NHCT employs the Ulysses Risk Management System with a Patient Safety Sub-Committee to review compliance with previously issued patient safety alerts. Regarding point 2, NUH, for example, has a robust Mortality Reduction Plan in place, which is based on case note review and analysis of relevant data. NHCT has developed a Mortality Surveillance Improvement Plan which is monitored by the CIRCLE Group (Critical Incident Review Creating a Learning Environment). The Trust has undertaken an analysis of deaths, the outcome of which has informed this plan. The hospital-standardised mortality ratio at SFH has been within the normal range for over 9 months with no difference between weekday and weekend mortality. There is a daily consultant

		presence at the weekend in key medical specialities with access to key diagnostic tests. The Sepsis Team at the trust have embedded sepsis screening and bundle compliance across all areas delivering a significant improvement in Sepsis mortality which is now amongst the top 30 performing acute trusts nationally. There is also an electronic mortality proforma with level 1 (no avoidable factors) or level 2 (potential avoidable factors) outputs. Each service is mapped for completion of mortality reviews with a trajectory to achieve 100% by April 2017. These are in line with expected national requirements. All level 2 deaths are reviewed at the Management Steering Group and learning/themes identified. Every Serious Investigation has an Action Plan signed off by the Division with clear owners and timelines. The completion of actions is reviewed on a database via Datix and the Governance Support Unit reviews this with divisions and reports monthly to the Patient Safety and Quality Board. Regarding point 3, a consistent approach to antibiotic prescribing and resistance rates will be adopted to address variation within Nottinghamshire and contribute to the global effort. We will develop an STP footprint approach to Governance and Leadership for antimicrobial resistance and healthcare-acquired infections.
	Demonstrate how Local Digital Roadmaps will be taken forward. Priorities: 1. Digital maturity in secondary care providers is significantly increased a. Patient information is recorded once, digitally, at or close to the point of care. b. Clinicians alerted promptly to key patient events and changes in status, supported by knowledge management and decision support tools c. Improved management, administration and optimisation of medicines, availability of assets and effective staff- rostering.	We have provided details on points 1, 2 and 3 in Section 4d of the main STP document with further detail in the PID for High Impact Area 4 Delivering technology enabled care is a High Impact Area in our STP and an established programme is already in place to drive transformation; Connected Nottinghamshire. Our STP our vision is to build upon the significant progress we have made through Connected Nottinghamshire and maximise the use of

Implement digital-aided care (Q8)	2. Information is digital (paper-free) and flows between primary, secondary and social care providers seamlessly a. Patient information at the point of care is available digitally (irrespective of where it was recorded), on a secure, timely and accessible basis. b. Transfers, referrals, bookings, orders, results, alerts, notices and clinical communications are passed digitally between organisations. c. Telehealth and collaborative technologies being used to deliver care in new ways. 3. Patients, carers and citizens use digital technologies to manage their health and wellbeing a. Patients digitally book and manage their appointments, request and manage their prescriptions and consent to share personal information. b. Patients can view, understand and contribute to their digital record, and manage how this is made available to family and carers. c. Approved digital tools and applications used across care settings to facilitate: care planning and shared decision making; education and access to resources; monitoring and feedback on health and wellbeing; and administration of personal budgets.	technology. Our Local Digital Roadmap (LDR) has been developed together with our STP.
Personalisation and choice	1. PHBs and integrated personal budgets, including NHS and social care funding, are available to everyone who could benefit (in line with Mandate requirements) (Q2.2) a. In each footprint at least 1-2 people per 1,000 of the population has a PHB or integrated personal budget incorporating NHS funding. PHBs should be in place: i. to deliver NHS Continuing Healthcare and continuing care for children; ii. for people with high cost packages of support e.g. people with a learning disability; and iii. in specific areas where the model will deliver a positive impact e.g. in wheelchair iv. services and end of life care. b. People have the support they need to successfully manage their PHB, with choice over how it is used.	Regarding point 1, engagement and self-activation are key to the delivery of our plan. We are particularly interested in maximising the use of direct payments and personal health budgets from 19.9 per 100,000 to at least 1,050 citizens utilising personal health budgets by 2021 (approximately 100 per 100,000). We have provided details on our commitment to points 2 and 3 in Section 4b of the main STP document.

	2. IPC is a mainstream model of care for people with highest health and care needs, planned and delivered with partners in local government and the voluntary sector a. Core service components of the IPC model are in place for target cohorts in each locality, underpinned by contracting and payment mechanisms that enable personalised care. b. Peer support and community capacity is harnessed and coordinated better with formal care services, to support self-care for the IPC cohort. c. People with the highest needs have routine access to person-centred care and support planning, including integrated personal budgets that blend funding from health and social care. 3. Patients make meaningful choices about whether, where and how they receive their healthcare a. Patients are able to say: i. I have discussed with my GP/ healthcare professional different options and pros and cons including, where appropriate, whether to have treatment. ii. I was offered a choice of where to go for my care or tests, as appropriate.	
Self-care (Q2.1)	1. Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices a. Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action. b. Patients and clinicians are supported by decision aids to help people think through the pros and cons of different care, treatment or support options. 2. Care planning and self-management is hardwired into how care is delivered a. Meaningful care planning takes place for people with long-term conditions or ongoing care needs which guides the choices and actions of the patient and her/his professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or carers.	Self-care features in many of the High Impact Areas of our STP. We provide more detail in Section 4a of the main STP document and the PIDs for High Impact Area 1.

	b. People living with long-term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing, including: i. Self- management education: formal education or training so people develop knowledge, skills and confidence to manage own health and wellbeing ii. Peer support: people supporting each other to understand their condition(s) and to manage its impact iii. Health coaching: to help people set goals and take action, improving their health and lifestyle iv. Group based activities: activities that encourage healthier living and reduce social isolation (e.g. exercise classes or community choirs). 3. Social action beyond the NHS helps people improve their health and manage their wellbeing a. The STP area works with their local authority to support the local population in building community capacity and resilience. b. Social prescribing is widely provided by primary care and whole population care models. c. Strong partnerships between the NHS and voluntary groups deliver health prevention and support for patients, carers and their families. d. STPs employ asset based approaches: community- based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing.	
Achieve key access targets (Q5)	1. A&E 4 hour waits 2. Ambulance response times 3. Referral to treatment times	We aim to achieve the 95% target for A&E 4 hour waits by 2017/18 (see Section 2 of the main STP document for our current performance). Details on how we will do this are provided in Section 4c of the main STP document, the PIDs for High Impact Area 3 and in Section 5b of the main STP document where we outline details of our proposed acute service reconfiguration. We aim to have 75% of Red 1 and 2 calls responded to by an ambulance within 8 minutes (see Section 2 of the main STP document for our current performance). Details on how we will

		do this are provided in Section 4c of the main STP document and the PIDs for High Impact Area 3. We aim to improve the consistency in performance of referral to first treatment times across the footprint. For example, we intend to maintain or reach at least 85% of cancer cases to have <62 day waiting time from referral to first treatment for every CCG in the footprint. Details on how we will do this are provided in Section 4e of the main STP document and the PIDs for High Impact Area 5.
Provide a capable, efficiently deployed workforce (Q9)	1. Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values 2. Integrated multi-disciplinary teams to underpin new care models 3. New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice	We have provided detail on workforce in Section 6a of the main STP document where it is identified as a key enabler of the other workstreams. Our workforce strategy encompasses plans to reduce agency spend, and recruiting and retaining a workforce that meets our needs. The development of new care models as part of our Vanguard and Pioneer programmes include the development of both vertical and horizontal multi-disciplinary teams. The development of new roles will be explored through our innovative health and social care university. We have provided further details on this theme in Appendix G of the STP document.
Drive financial sustainability and efficiency (Q10)	1. A local financial sustainability plan 2. Credible plans for moderating activity growth by c.1%pa 3. Improved provider efficiency of at least 2% p.a. including delivery of Carter Review recommendations	A detailed financial analysis has been undertaken. Details of the underlying assumptions and details of provider efficiency are contained in Section 5c of the main STP document as well as Appendix E. We have provided further details on the financial planning in Appendix E of the STP document.