Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin

Coverage

Geography

CCG boundaries

- NHS Telford & Wrekin CCG
- NHS Shropshire CCG

Local Authority Boundaries

- Telford & Wrekin Council: Unitary Authority
- Shropshire Council

Key Footprint Information

Name of Footprint and Number:	Shropshire and Telford & Wrekin (11)
Region:	Shropshire and Telford & Wrekin
Nominated lead for the footprint:	Simon Wright, CEO Shropshire and Telford Hospitals
Organisations within the footprint:	Shropshire Clinical Commissioning Group Telford & Wrekin Clinical Commissioning Group Shropshire Community Health NHS Trust The Shrewsbury and Telford Hospitals NHS Trust Robert Jones & Agnes Hunt Foundation Trust South Shropshire & Staffordshire Foundation NHS Trust ShropDoc Shropshire Council Telford & Wrekin Council Powys Teaching Local Health Board

Changes between June and October 2016

Shropshire and Telford & Wrekin Sustainability and Transformation Plan

Aims

1. To build resilience and social capital
2. Integrated care across the NHS and Social Care
3. More appropriate use of hospital care
4. Working as one health system
5. Sustainable workforce
6. Sustainable finances

Reconfiguration of Shrewsbury and Telford Hospitals *(Priority 1)*

- **To create one emergency care centre and one warm site mainly for planned care – to provide clinical sustainability, ability to deliver constitutional standards and achieve cost savings**
- **Strategic Outline Case approved**
- **Integrated Impact Assessment complete**
- **Senate Review commenced**
- **Public consultation due to start early 2017**

Development of Neighbourhood Working *(Priority 2)*

- **Essential to achieve the left shift of activity**
- **Integrates health and social care; physical and mental health**
- **Different models represent local situations in Shropshire, Telford & Wrekin and Powys. Local Authority leadership**
- **Key components are community resilience, prevention of ill health and the creation of Neighbourhood care teams**
- **Comprehensive review completed of evidence base for community resilience initiatives**
- **Neighbourhoods defined, based on General Practice**
- **High level modelling of implications for workforce and costs**
- **Pilot sites established at Bridgnorth, Oswestry, Newport and South Telford**

Review of Community Beds

- Beds looked at in the context of Neighbourhood working
- Includes Care Homes, Local Authority and community hospital beds
- Stocktake of Care Home beds complete
- Initial modelling of beds undertaken
- Due for completion – March 17

Estate Review Commenced

Review of MSK/Orthopaedics

- Identified as area of high expenditure
- Clinical review commissioned of current pathways
- Completion date -December

Making Best use of Resources *(Priority*

- **System financial position revised. 2020/21 deficit of £131.4m**
- **Transformation schemes identified but not complete**
- **Back Office Functions Case for Change submitted**
- **Intention to rationalise organisations**

Modelling of Activity Shift

- Developed from Future Fit business case
- Shifts 4215 non-elective episodes and 27,218 outpatient episodes away from hospital
- Indicative allocation of activity to Neighbourhood teams
- Analysed by condition and reviewed by Care Pathways group

Key Service Developments *(Priority 4)*

- **Mental health**
  - **Plans for 7 day working agreed**
  - **Delivery of national waiting time standards**
- **Learning Disabilities**
  - **New model for community provision agreed**
  - **Reduction in use of institution beds**
- **Childrens services**
  - **Emotional Health and Wellbeing service commissioned**
  - **New CAMHS model developed**
- **Cancer services**
  - **Plans agreed to achieve national standards**

Benefits for Patients

- Emphasis on preventing ill health
- Involvement of local communities in supporting vulnerable people
- More local services; less hospital visits
- Integrated service delivery – health and social care; physical and mental health
- Shorter waiting times in A&E and for inpatient treatment

Governance: Outcomes and milestones agreed; Implementation Plan Developed; PMO funding agreed; Governance revised

Narrative developed to explain how whole system is changing

Executive Summary

- It is widely agreed that in order for our NHS to continue to provide services for the future, changes need to be made now. In 2016, organisations were asked to work together to produce Sustainability and Transformation Plans (STPs) outlining how they are going to develop and deliver viable health and social care services over an agreed area. This also includes proposals for improving services for local people and making the most of advances in care and in technology.
- In Shropshire and Telford and Wrekin, councils, organisations providing NHS services and Clinical Commissioning Groups (who plan and buy health care and are led by GPs) have worked together to create our STP. Our starting point was a focus on communities and the need to work at a more local level to tackle the causes of poor health.
- The challenges we face are similar to those being experienced across the country. Demand on services continues to rise and outstrips the available funding, putting pressure on all services, especially hospitals, GP surgeries and social care. With a growing number of elderly people in our population, many having more than one long-term health condition, there is a greater need for certain services. Much of the area we cover is rural and that also presents problems.
- There is not enough money for us to continue as we are and we need to make changes to take full advantage of recent rapid progress in treatments and technology. Together we are trying to find where £74 million could potentially be used differently and more effectively to provide more care for the same money. Added to the proposals NHS providers have for saving £62 million through efficiency improvements, we should be in a good position at the end of the next five years to have services which are sustainable in the long term as well as meeting the public's healthcare needs more effectively.
- Together we are coming up with proposals to ensure people get the best treatment – whenever and wherever they need it. This involves looking at how existing services can be provided differently and how best we can share patient information to improve services. We have needed to take into account difficulties in recruiting nurses, doctors and other medical staff, particularly given our location.
- The causes of poor health are rooted in our communities so this is where we need to focus. Making the most of the skills of local people and organisations, supporting people to lead healthier lives, and promoting self-care are beneficial in their own right, as well as relieving pressure on the healthcare system. This is why our STP focuses on a more joined-up way of working, based on smaller areas we are calling neighbourhoods to prevent ill health and promote the support that local communities already offer.

These are the planned 11 neighbourhoods in Shropshire:

Bridgnorth North – 31,000 residents
Bridgnorth South – 25,000
Ludlow – 23,000
North East – 29,000
North West – 17,000
Oswestry – 35,000
Shrewsbury North – 43,000
Shrewsbury Rural – 18,000
Shrewsbury South – 39,000
South West – 20,000
Whitchurch – 25,000

There are a further four neighbourhoods in Telford and Wrekin:

TELDOC – 49,615 residents
South Telford – 45,427
Newport – 27,412
Group 4 – 59,155

Executive Summary

- These neighbourhoods would be used as the basis for providing health and care services for people who need professional help, but not hospital treatment. GPs, social care, community nurses, therapists and mental health workers would increasingly work together to provide a consistent range of services at a local level. These Neighbourhood Care Teams would be the first port of call for people with diabetes and other long-term conditions people who might otherwise have to go to hospital but who don't need emergency services; and people who have recently been discharged from hospital. They would be the link between clinical and community care.
- For patients who do need hospital care, we propose to create two centres of excellence, one specialising in emergency care and the other in routine surgery or planned care. We have involved 300 clinicians in developing the proposals for hospital services because they know what is best for their patients. Our aim is to improve the outcome for patients by using consultants and other resources most effectively. One central emergency centre would work closely with more local urgent care services. Most assessment, diagnosis and follow-up would be done closer to people's homes. Neighbourhood Care Teams would play an important role in this.
- All organisations have agreed to work together to make sure the STP works in the best interests of local people. We want to ensure that the approximately 470,000 people living in Shropshire and Telford and Wrekin understand these proposed changes, and are involved in designing new services. That is crucial to their success. We are committed to listening to local people and learning from feedback.
- We believe that making these changes would deliver clinical improvements and make the experience of using services better for patients. Communities themselves would be able to support vulnerable people, with the professional backing of Neighbourhood Care Teams where required. Fewer people would need to go to hospital, and those who do would be discharged quicker.
- The proposed changes to the organisation of hospitals, with more resources dedicated to emergency care and planned surgery, would improve clinical care and reduce waiting times.
- We have all vowed to work together to reduce duplication, freeing up resources to consistently provide the best possible care. Working together in this way across NHS, social care and the voluntary sector will ensure the best outcomes for the people of Shropshire and Telford and Wrekin.

The Context

The Priorities

The Enablers

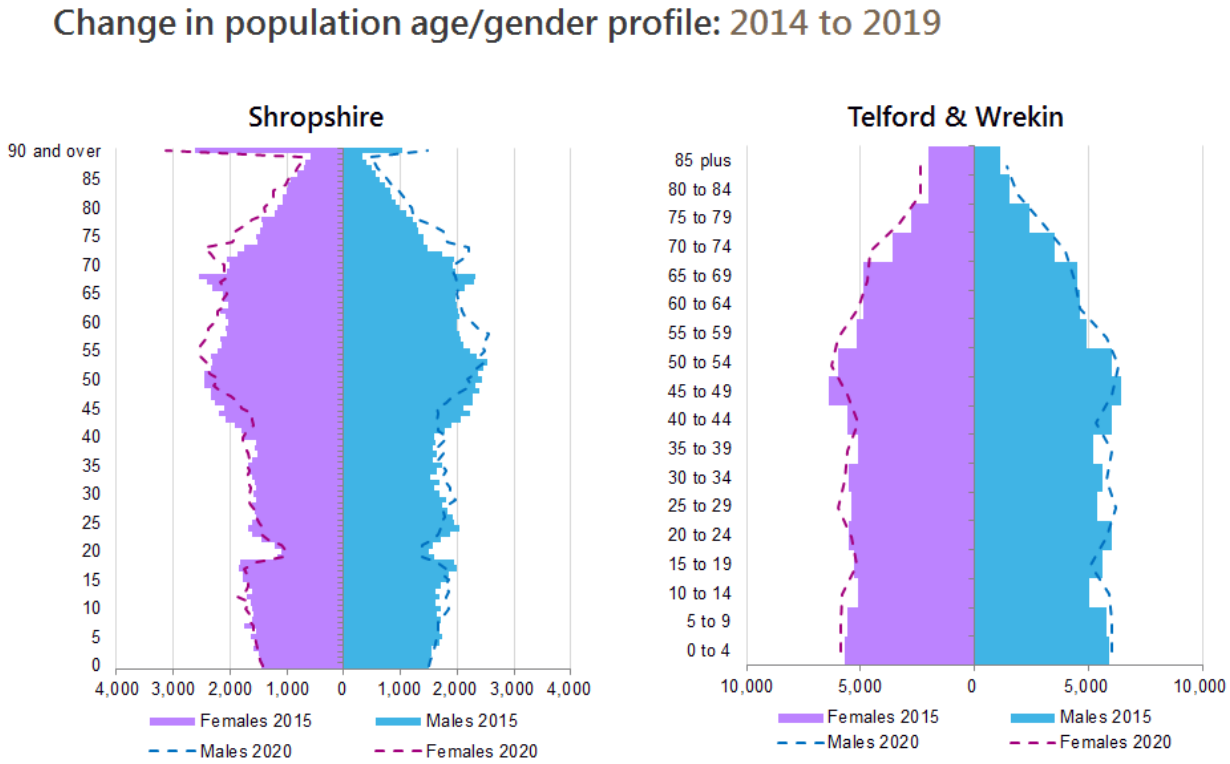
Implementation

Population

- The overall population within the footprint is approximately 470,000 people

- Telford & Wrekin CCG has a large, younger urban population with some rural areas. Telford is ranked amongst the 30% most deprived populations in England. The population is approximately 170,000 and due to grow to 180,000 by 2020; the percentage of people who are aged over 85 is set to increase by 130%.

- Shropshire CCG covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban aging populations. Shropshire has a population of approximately 308,000 which is set to rise to 320,600 by 2020.



The Strategy Unit
Midlands and Lancashire CSU
www.midlandsandlancashirecsu.nhs.uk

Sources: ONS Subnational Population Projections (2012 based) and Telford & Wrekin Local Authority

The causes of ill health are similar to many other areas

- Life expectancy rates overall have improved steadily in last decade across the footprint, although rates in Telford & Wrekin remain significantly worse than average and worse then those in Shropshire
- 60% of early deaths under 75 years (circa 640 deaths per year) are due to preventable cardiovascular diseases, cancers and respiratory diseases. Early death and survival rates for cancer in Telford & Wrekin are still worse than average
- Mental health, dementia and musculoskeletal conditions account for 26% of ill health
- A higher than average proportion of adults smoke in Telford & Wrekin, 20.7% of adults in Telford and Wrekin smoke (circa 32,000 smokers) compared to 15.3% in Shropshire (circa 38,088 smokers). Smoking-related deaths and hospital admissions are especially high in Telford & Wrekin as it maternal smoking (21.18%).
- Whereas in Shropshire levels of smoking in pregnancy are now similar to the national average at 12.5%
- An alarming majority of adults carry excess weight, 71.9% in Telford & Wrekin and 65.2% in Shropshire, which equates to an estimated total of 256,000 adults across the footprint who are at higher risk of cardiovascular diseases and certain cancers due to their excess weight
- Breastfeeding rates in Telford & Wrekin are low and excess weight in children aged 10-11 years olds is significantly worse than the England average at 36.21%, compared to 29.92% in Shropshire and 33.24% in England.
- Levels of adults are who are physically inactive, 28.1% in Telford & Wrekin and in Shropshire 24% - compared to 27.7% nationally, needs to be improved as it is estimated that almost half of type 2 diabetes cases can be attributed to obesity
- Around a quarter of adults, circa 92,000 people across the footprint are higher or increasing risk drinkers and in Telford & Wrekin alcohol-related death rates and hospital admissions are significantly worse than average, specifically for alcohol- related cardiovascular diseases and cancers. In Shropshire the rate of alcohol related road traffic accidents is significantly higher than the national average.
- Levels of diabetes have increased rapidly across the footprint in the past decade with the recorded prevalence doubling between 2004/05 and 2014/15 (from 3.5% up to 6.6%). On top of the 24,690 people with diagnosed diabetes, it is estimated that a further 47,000 people are at risk of developing diabetes in our population due to their excess weight, dietary habits and lack of physical activity.
- High blood pressure is a significant risk factor for chronic health conditions and 71,750 people in Shropshire, and Telford and Wrekin are currently diagnosed and recorded in primary care as having

What's changing?

Changes in our population

The welcome improvement in the life expectancy of older people is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This means the pattern of demand for services has shifted with greater need for services that support frailer people, often with multiple long – term conditions.

Medical workforce challenges

There are challenges emerging across numerous sectors of the clinical workforce. Recruitment and rostering of acute physicians and critical care staff across multiple sites is increasingly difficult and there is now a 15% vacancy rate in medical staffing in secondary care. Equally the recruitment of GPs, and the retirement profile of the more senior GPs, is making the future staffing of primary care services more problematic; add to this the high workload, and the popularity of General Practice as a career is reducing to a point where alternative models of care delivery need to be explored.

Changing patterns of illness

Long-term conditions are on the rise due to changing lifestyles; this means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community. Dementia will become an increasing pressure over the next few years. Our plans for the use of Big Data set out in the Digital Roadmap will help us to achieve this challenge.

Clinical and financial sustainability

The health community has to address a long-standing deficit in its finances. The changing patterns of population and the increasing costs of ever improving medical technology mean that without changing the basic pattern of services then costs will rapidly outstrip available resources.

The reduction in funding to adult social care in particular is impacting across our system.

Close working with the private, independent and voluntary sector has shown that they too are feeling under pressure.

Higher Expectations

Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services and both of these require a redesign given the inevitability of resource constraints. Achieving this will also require us to improve our sharing of clinical data across systems to ensure that there is no inequality of treatment across time zones.

Clinical standards and developments in technology

Specialisation in medical and other clinical training has brought significant advances as medical technology and capability have increased but it also brings challenges, not least in rising costs.

New approaches to the provision of care

There is an increasing recognition that non-clinical approaches have a crucial part to play in supporting people in the community and that voluntary and community organisations have an important role.

Engaging on the case for change

In November 2013 the system undertook a major engagement exercise with the public and clinicians under the national Call to Action for the NHS. The response was very clear in saying that the public wanted full engagement in thinking through options for the future and that nothing should be predetermined. Nevertheless, in the light of the factors described above, there was real consensus between public and clinicians about the following:

- An acceptance of there being a case for making significant change;
- A belief that this should be clinically-led and with extensive public involvement;
- A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives. We also know that around 20% of consultations in primary care are for a non-health need.
- A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but if we are to succeed we must avoid being constrained by history, habit and politics.

There was also a clear expectation amongst politicians and within NHS England that the health community would finally address longstanding issues of unsustainable local services and financial deficit.

Our Vision and Objectives

Our Vision

We have a unified vision for our population to be as healthy as possible. To achieve this goal we need to have the safest acute provision, independence into older age for the majority of our population and integrated delivery models; we need to develop shared learning and enviable reputations as employers of choice with a unity of purpose being seen and acted out across our health and care sectors.

We will embed social care and wellbeing into all health delivery and work with our population to establish social capital to improve public engagement and accountability, with wellness replacing a sickness paradigm.

Integrated technology and data moving freely across our system will support a placed-based delivery model, backed up by a one public estate philosophy which maximises the use of public assets to the full.

Our deficit reduction plan will track the transformational process and the changes necessary to support the investment shift into prevention, maintenance, early detection and treatment; this will allow a shrinking of secondary care provision.

Our Objectives

- To build **resilience and social capital** into people's environment so they have the knowledge and skills to help themselves to live healthier and happier lives enabled by current and emerging digital technologies.
- To develop a model of **coordinated and integrated care across the NHS, Social Care and the Voluntary Sector** that reduces duplication and places the patient and service user at the centre, ensuring parity of esteem. We intend to achieve this by connecting Health and Care systems ensuring that data flow freely to those who need to see it.
- To work as **one Health and Care system** to deliver for patients and citizens and develop a single shared view of the place-based needs of the population using advanced business intelligence capabilities.
- To develop a **sustainable workforce** that is fit for purpose, is supported by modern technology, and can deliver evidence-based care in new ways that suit user's lifestyles and where they live.
- To develop a transformed system of care that is **high quality, financially sustainable**, efficient and delivers on national standards all the time.
- To use evidence from around the world to develop excellence in care and **pioneering services** through the use of high quality research and use of new technologies.

The Context

The Priorities

The Enablers

Implementation

The Narrative

- There is widespread consensus that our health and social care services need to change if they are to be sustainable in future. Demand continues to grow and funding is not keeping pace, placing increasing pressure on all services – particularly hospitals, general practice and social care. Some of the ways in which patients are cared for needs to change to reflect changes in technology, changes in practice, and changes in the financial situation. All organisations need to ensure their services are delivered as jointly and efficiently as possible. This Plan sets out how we aim to achieve this in Shropshire, Telford and Wrekin over the next five years.

- The causes of poor health are rooted in our communities and as such the solutions need to be community based. Making the most of the skills and assets of local people and organisations *(community resilience)*; supporting people to lead healthier lives *(prevention)*; and promoting self-care are beneficial in their own right as well as relieving pressure on the NHS and social care. The starting point for our Plan, therefore, is to focus on fifteen *neighbourhoods* and provide a consistent approach to preventing ill health, as well as promoting the support that these local communities already offer to individuals

- The same neighbourhood structure will be used as a basis for providing health and care services for people who need professional help but for whom hospital is not necessary. GPs, social care, community nurses and therapists, community mental health workers and learning disability practitioners will increasingly work together as a single team to provide a consistent range of services at a local level. These *Neighbourhood Teams* will be the first port of call for people with diabetes and other chronic conditions; for people who might otherwise have to go to hospital but who do not need emergency services; and for people who have recently been discharged from hospital.

- For patients who do need hospital care, either because it is an emergency or because they need planned surgery or other treatment, the Plan creates two centres of expertise, one specialising in *emergency care* and the other in routine surgery or *planned care*. This aims to give better clinical outcomes by making best use of relatively scarce consultant time, as well as making financial sense. Specialist mental health and orthopaedic services will also be available locally.

- Explaining all these changes to local people and involving them in the design of the new services will be crucial to their success. The focus of other work - on the use of technology; the development of the workforce; and the use of the estate - must support the development of neighbourhoods and changes to hospital care.

- All organisations have agreed to work together to implement the Plan in acknowledgement that it is in the best interests of local people. However, the financial position is sufficiently serious that these changes to services will not, on their own, solve the problem and so the Plan also has a range of other actions that will need to be taken.

The priorities for Shropshire, Telford and Wrekin

1 To develop and implement a model for Neighbourhood working based upon:

Supporting individual communities to become more resilient. The causes of poor health are rooted within our communities and as such the solutions need to be community-based. Enhancing the assets and skills of local people and organisations, we will capitalise on the power of this rich source of social support to build individual and community resilience.

Supporting people to stay healthy. We will support people to lead healthier lives, empower patients through technology; and promote self-care in order to reduce the demand and dependency on our public services. Lifestyle patterns are complex and often interlinked and a combination of unhealthy lifestyle choices increases people's risk exponentially. It is estimated that middle aged people with a combination of unhealthy lifestyles are 4 times more likely to die in their next decade than those leading healthier lifestyles.

Developing Neighbourhood Care Teams. Preventing unplanned admissions to hospital and proactively supporting discharge from hospital are essential features of neighbourhood working. We will provide a quicker response from professionals at times of crisis to assess and treat patients in their own homes and provide short term therapy support to ensure people remain as independent as possible. People with long term health conditions will be supported to live their life to their full potential. We will ensure that health professionals and other local resources work together to seek out those who would most benefit as well as ensuring that patients can understand and, as far as possible, manage their own condition.

The community bed review. Neighbourhood working will require some access to locally provided beds for patients. At present these are provided through community hospitals, local authorities and care homes. As Neighbourhood working develops, the local provision of beds will be reviewed. The development and use of "virtual wards" will provide the vehicle for this initiative.

2 To re-evaluate hospital services

Acute reconfiguration. The Future Fit model for acute hospital care describes an urgent care network, within which one central emergency centre works closely with two urban urgent care centres and a number of rural services where urgent care is provided on a locality basis. For planned care, a central diagnostics and treatment centre will provide 80% of planned surgery whilst the majority of assessment, diagnosis and follow up will be performed closer to peoples' homes

Understand our secondary care expenditure. Shropshire appears to commission a high level of some treatments in comparison with the rest of England. Orthopaedic and musculo-skeletal (MSK) services is one such area. This service is organised across three hospital sites and through a number of therapy services. **The MSK and orthopaedic review** has been commissioned to ensure that the service is appropriate and as effective as possible. Other reviews will follow.

3 To continue to develop our other services

Services for people with mental ill-health or a learning disability; services for children; and cancer services are also developing rapidly. Mental health and Learning Disabilities are core to the development of Neighbourhood teams and will play a key role in the work of local teams. Psychiatric liaison and other specialist services such as Perinatal will play a an important role in ensuring that admissions to the acute hospitals are minimised. The health and care community is committed to ensuring that these continue to provide high quality care and are developed within the same philosophy as other services.

4 To make best use of our resources

Financial sustainability. The health and care community faces very significant financial challenges over the next few years. These have to be addressed whilst safeguarding the quality of services.

Reducing duplication. There is potential to reduce costs without affecting service provision by rationalising organisations, back office functions and estate costs; and by greater exploitation of IM&T

How will these priorities benefit patients?

We believe that achieving the changes this STP describes will deliver improvements in patient safety , clinical effectiveness and patient experience. In particular, changes to the configuration of hospitals will ensure that the concentration of resources dedicated to emergency care and planned surgery **will improve clinical quality and enable constitutional standards for waiting times to be met.**

The development of Neighbourhood working aims **to change the emphasis in the relationship between the public and the NHS** so that communities are able to support vulnerable people, with the professional backing of Neighbourhood Teams where required. Neighbourhood working also aims to ensure that **many people will no longer need to go to hospital and that delays to hospital discharge will be minimised**.

The unwarranted variations in clinical outcomes highlighted in the "Right Care" evidence packs tells us that we need to address the clinical effectiveness of the pathways we deliver. We will aim to **deliver consistently high standards of care** and to learn from best practice elsewhere, through, for example, RJAH's involvement in *Getting it Right First Time*

As expressed through our vision and objectives we aim to work collectively to deliver evidence based care and reduce duplication. This will happen as a result of the workforce developments and transformed systems of care which release capacity to consistently deliver care in line with constitutional standards. The objective of developing **co-ordinated and integrated care across NHS , Social care and the Voluntary sector** will address the quality concerns we have when patients experience delays in their journeys such as those measured through Delayed Transfer of Care data.

To improve patient experience , we are committed to listening and learning from feedback . Central to this will be the continued involvement of patients in service developments both large scale such as the engagement programme around Future Fit or as panel members on pathway review groups. The development of a **systematic approach to involving local people** is an aim in our 90 day plan.

Neighbourhood working

Neighbourhood working

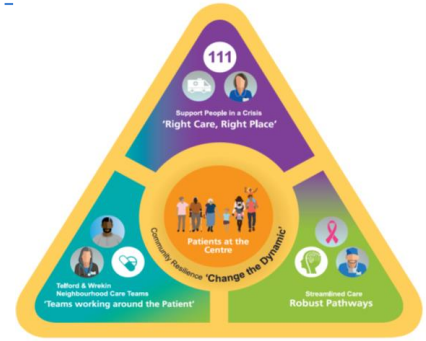
Shropshire, Telford and Wrekin Neighbourhoods Vision:

The HWB Strategies provide our vision: to be the healthiest, most fulfilled people in the country. To achieve this goal we need to replace the ill health paradigm with wellness and deliver place-based integrated health, care and community models that support independence into older age for the majority of our population. Integrated technology and data moving freely across our system will support the placed-based delivery models, backed up by an asset based approach and a one public estate philosophy which maximises the use of community and public assets to the full. These transformational changes will not only deliver better health outcomes for our communities but will support an investment shift into prevention, maintenance, early detection and treatment and reduce demand for secondary care provision, releasing hospital specialists' capacity to focus on the acutely unwell . This will only be achievable by working closely with our communities; by helping people take control of their own health and supporting communities to develop social action and resilience.

Together, we have recognised the opportunities for creating new ways of delivering care and front line services and also joining up social action, prevention activities and the currently fragmented care system to develop a wellness focussed and person centred system for our local population. We are now developing effective, collaborative relationships around this shared purpose that will enable us to move at scale and pace to deliver fundamental change.

Our neighbourhood care model will remove existing barriers to integration and bring together primary, community and mental health services and learning disabilities with local authority, voluntary and the independent care sector to deliver the right care in the right place and maximise the efficiency and effectiveness of local services. Our vision puts the needs of patients at the centre of our Neighbourhood model. This will operate in a more efficient, focused manner, steering away from bed based services to a more community centred style of care.

Together, we will replace the transactional nature of care provision across multiple teams and providers with integrated, flexible, responsive health and care teams, focussed on locality priorities and needs, providing our communities with the optimal outcome in the best value care setting. Our objective is to break down traditional boundaries between primary care, community and mental health services through the development of the Multi-Speciality Community Provider (MCP) model of care within our Neighbourhoods. We will focus on prevention and wellbeing by promoting shared management and self-care, allowing patients to continue living independently at home. We aim to move care out of hospitals to the community, wherever possible, and enable better access to, and continuity of care by aligning primary, community and mental health health and care teams, breaking down the existing barriers and providing integrated solutions to deliver improved health outcomes for our population. This will enhance clinical and service quality allowing more patients to be managed in the community. These expanded multi-disciplinary and multi sector community-based team will be complemented by the development of new clinical roles to coordinate care for people with frailty and long-term conditions.



Health Equity:

As we work together to improve the health and wellbeing of local people and to transform services, we want to also increase health equity. Not only is this an ethical imperative, it is also a financial one. Those in the poorest communities experience the worst health, largely due to the impact of social conditions on preventable risk factors such as smoking and obesity. To reduce premature mortality, narrow inequalities and improve health, there is a need to tackle both the preventable causes of ill health and the 'causes of the causes'. Key messages from the Marmot Review (2010) that we will apply as part of this approach are:

'Proportionate universalism' - the scale and intensity of our actions will be proportionate to the level of disadvantage

'Health through public policy' - we will use the policy levers available to us, through local government, the NHS, public and private provision, and communities, to support our prevention objectives

The causes of health inequalities *Source: National Audit Office*

Our Ambition

Our ambition is to work together in a person centred approach to reduce the need for treatment in our local population and to effectively treat in the lowest cost appropriate setting.

We have recognised that our future care system will need to be very different to current models of care and our Partnership's new care model for the future provides an opportunity to create a national exemplar of integrated, high quality, fit for the future Out of Hospital services. We aspire to create a Multi Specialty Community Provider as a vehicle for joint working as the removal of organisational boundaries will allow us to move away from a transactional based activity focus to an outcome delivery and improvement focus and will facilitate patient access to the right service, first time from the full range of health and social care services.

Case study: How community support for carers can support both the cared for and the carer

"I had difficulty in getting [father] to the doctor, as he was in denial that there was anything wrong with him … [father eventually] agreed to attend the memory clinic … specialist doctor … diagnosed Alzheimer's, offered medication, brain scan promised monitoring follow up appointments with the mental health nurse and suggested I get power of attorney. Good advice, but there it ended, no further support was offered at this point, or any suggestion of where support and guidance could be sought, and it was some months before I heard from that service again. I am an only child so the responsibility was all mine." (Nar. 4).

Fortunately this carer happened upon a display by the Alzheimer's Society and they made contact with them, which relieved a lot of stress and provided support. The stress relief manifested through a variety of factors, but being listened to and venting emotions appears crucial.

"Straight away, I felt understood and supported and could ask silly questions and felt less alone … advice on practical things (useful aids, strategies and finances) … 'Singing for the Brain' sessions … sharing my experience with other carers …opportunity to share experiences an concerns and relief of bottled up emotions which are hard to share with family members as guilt and helplessness gets in the way." (Nar. 4).

Source: Action Learning Programme based on story telling from patients, carers and staff, Shropshire 2016 NHSE

Learning for Neighbourhoods:
Routinely connecting clinical and community support will provide a host of opportunities to improve wellness for service users, and their carers, within their communities

Learning for Neighbourhoods:
Support found in communities such as outdoor partnerships can be an important component of improving mental and physical wellbeing

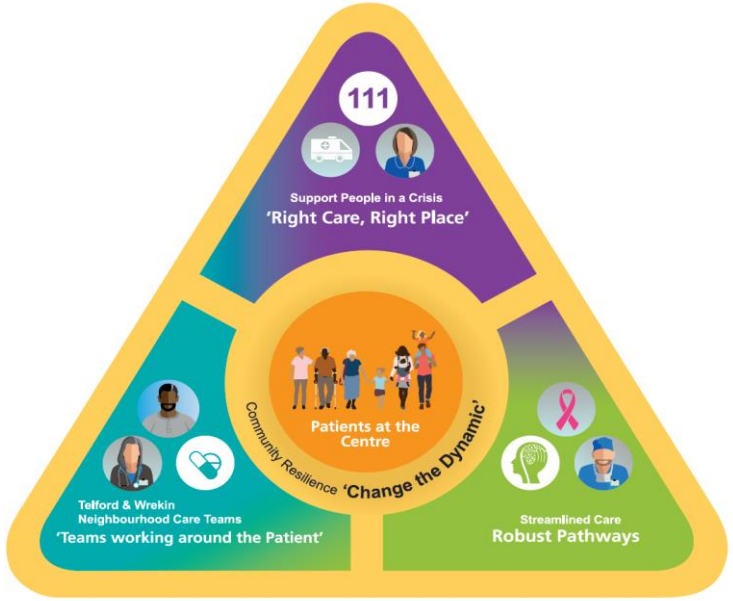
Holistic care–Mental/ Emotional/Physical Health:

The Neighbourhood programmes will focus on identifying opportunities where transformation can provide holistic care for patients and service users. One in three people with a long term condition also have a mental health concern. Addressing mental health as part of the overall health of people will be vital in reducing demand on services. Many community led schemes can support people, even with enduring mental health concerns. To support this ambition, there will be an enhanced IAPT service.

Case Study – mental health/emotional care:
Giles has been using mental health services continuously since 1999. During this time he has had four admissions with in-patient services. Throughout the past 16 years he has constantly struggled with his mental health problems and engaged in regular self harming as a coping strategy…Immediately prior to joining the Shropshire Wild Teams Giles was isolated and inactive and remained in his house for the majority of the week. He would keep his curtains closed throughout the day. When leaving the house he felt paranoia towards others. Giles reports he would regularly self-harm by cutting up to three times a week. CMHT intervention required weekly visits to his home to ensure his safety and to provide therapeutic support (above details collaborated by his current CMHT team). Since joining the Shropshire Wild Teams his situation has changed dramatically. He has not self harmed since joining the group and no longer requires weekly CMHT home visits. Giles reports his consultant psychiatrist commented that the SWT project was "just the sort of thing needed." Giles reports how much his mood has lifted and how the team provides an important focus for him…

Source: Outdoor Partnerships Annual Report, 2016

Neighbourhood working – Telford & Wrekin



The Telford and Wrekin Model of Care aims to promote:

- Community resilience
- Teams working around the patient
- Intermediate care

What is our approach to developing neighbourhoods?

- Building some prototypes around natural neighbourhoods.
- Optimising the total resource in the neighbourhood
- A community centred approach that increases access to community resources to meet health needs and increase social participation
- Supporting the development of strong neighbourhoods that can work collaboratively to take action together on health and the social determinants of health
- Needs to be locally determined and accept there are a variety of drivers for change and starting positions
- Incremental and organic change
- Support people properly to make the change (from front line staff to senior teams)
- Empower a broader spectrum of people to support the transformation, rather than the 'usual suspects'!
- Ensure we are embedding the principle of improved patient experience as one of our improved quality expectations

Telford and Wrekin - Community Resilience

Community Resilience

Vision and aims

Telford will have strong and connected communities. The community will drive the development of local assets and people will :

- Have friends and support networks
- Feel empowered to improve their own and their families health
- Things to do
- A feeling of being safe and belonging to their community
- Confidence to go and help and ask for help
- Centres or 'connecting points' to go to

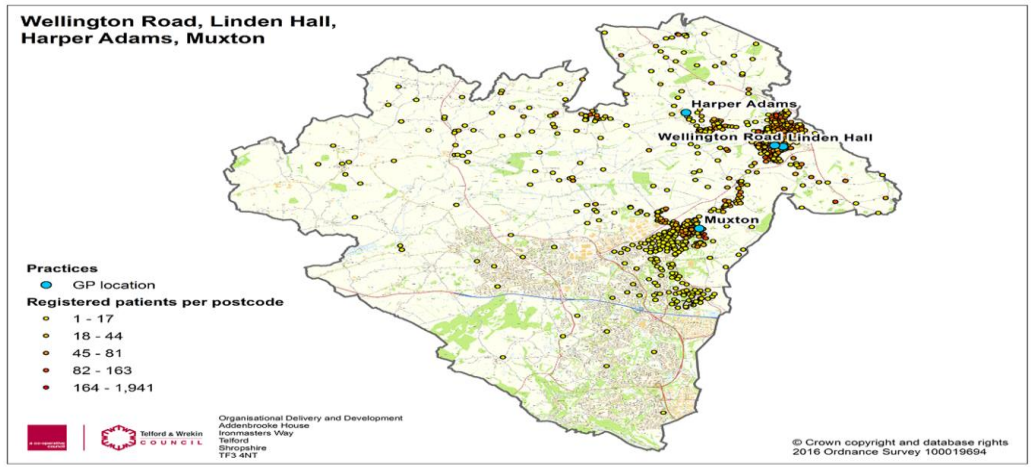
Why?

- Traditional models of statutory services are no longer fit for purpose: They promote dependence, they are expensive and outcomes could be better
- There is a strong and growing evidence base about the importance of building confident and connected communities in improving outcomes for people
- Individuals benefit from contributing to the wellbeing of others
- Significant proof that poor health can be prevented or delayed
- Needs escalate and peoples health and wellbeing deteriorate because they don't have enough support in the community
- People depend on services because they have very limited alternatives in their own communities

Telford and Wrekin - Neighbourhood Care Teams

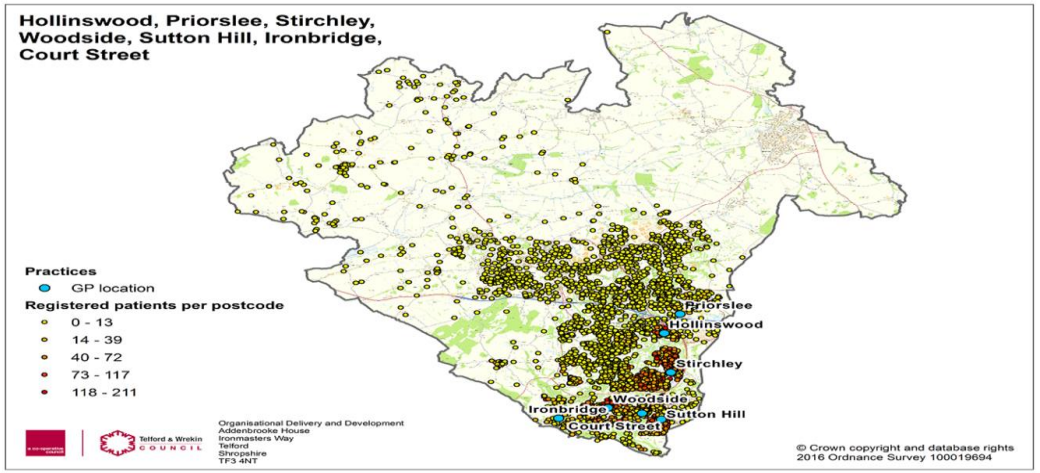
Telford Neighbourhood Care Teams
Vision and aims
People with an identified long term health condition will be supported to live their life to their full potential • The notion of care 'from cradle to grave' will be reinvigorated • Individual professionals will take responsibility for the delivery of as much care as possible, drawing on specialists where necessary • Professionals will work together to seek out those who would most benefit from an intervention/support • People will share their story once in a way that is right for them • People will understand their condition and how to deal with it and people will self care/self manage where possible • Carers will be supported
Why?
• We need a much greater focus on prevention • We need to find people earlier in their disease progression so they can manage their condition better, earlier • A greater number of people have become more dependent on statutory services • Current services tend to do things to and for people, rather than promoting self-management • Multiple individuals from different organisations are providing care for any one patient at any one time • The current way of working is not the most effective way of supporting people • We have lost a holistic nature of care by focusing on 'tasks'

Telford and Wrekin - Pilot sites



Newport Neighbourhood (pop. 33,000)
Priorities:

- Integration of nursing, therapy and care workforce and mental health and learning Disability professionals across a single area
- Utilise a different model of care based on Buurtzorg principles
- Align dementia related services with the practice and enhance early diagnosis
- Map and better utilise community assets (including local buildings)
- Develop the local offer within this market town, including range of diagnostics and outpatient clinics
- Better support to residential homes



South Telford Neighbourhood (pop. 44,000)
Priorities:

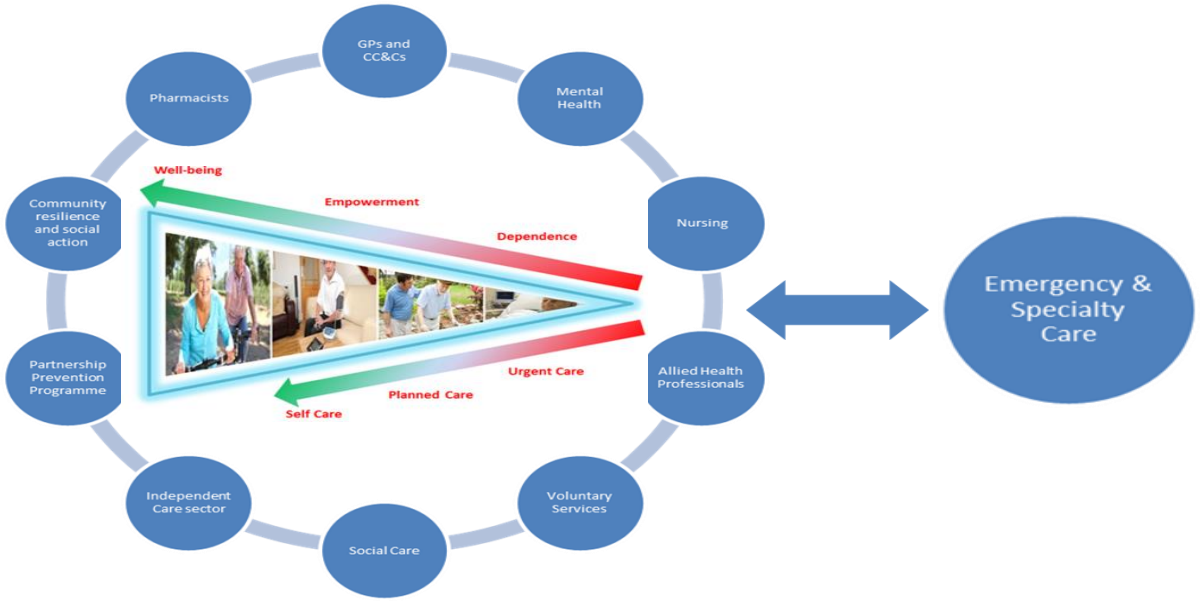
- Integration of health and social care teams
- Greater involvement of drug and alcohol services
- Consideration of those aged 0-5, initially through improved alignment of health visiting
- Implementation of creative support planning and other links with local authority teams

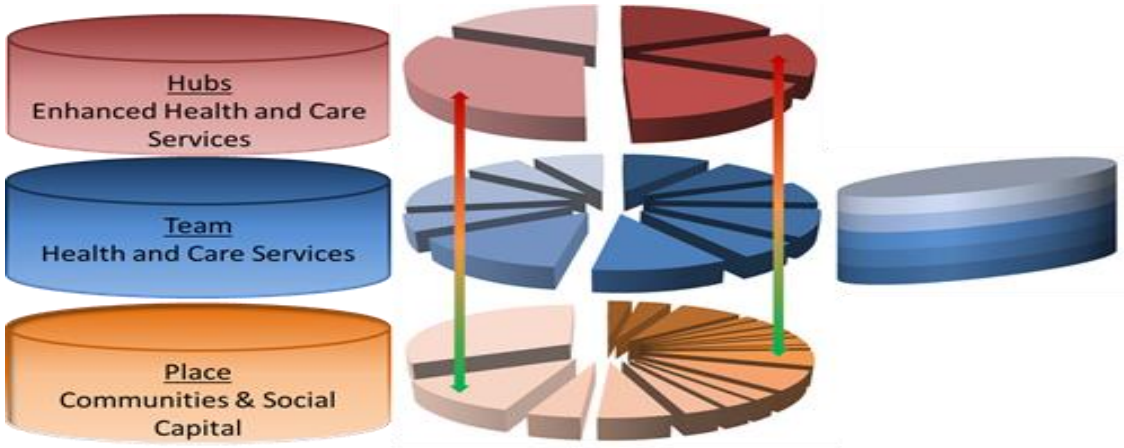
4 Neighbourhoods	
TELDOC	49,615
South Telford	45,427
Newport	27,412
Group 4	59,155

Neighbourhood working – Shropshire Council

Objectives

1. To build **resilient communities** and develop social action
2. Develop whole population **prevention** by linking community and clinical work – involving identification of risk and social prescribing
3. Implement **neighbourhood care models** including teams and hubs





Shropshire – Community Resilience and Prevention

What will it look like?

The Shropshire Neighbourhoods programme will use place based planning to reduce demand on acute and social care services by:

1. Building resilient communities and developing social action
2. Developing whole population prevention by linking community and clinical work – involving identification of risk and social prescribing
3. Designing and delivering neighbourhood care models
4. Creating alternatives to hospital admission by providing care closer to home

1. Building Resilient Communities

Volunteering and community initiatives exist in abundance in Shropshire. The **'Communities First, Service Second'** Resilient Communities Workstream will work to support and enable communities to help one another and promote positive, healthy life choices. They will support linking the clinical world to the community via developing the 18 place plan areas in Shropshire to:

- Further develop place based governance and delivery – cross-cutting across sectors and themes
- Develop hyper-local directories of activity and services
- Develop Networks of Community Connectors
- Support community prototyping developments – such as Oswestry
- Connect and support the wealth of volunteering and services that support people in the place where they work and live (these include C&CCs, Let's Talk Local Hubs, C&YPS Early Help hub of services, volunteers to support these, local voluntary groups, community activity)

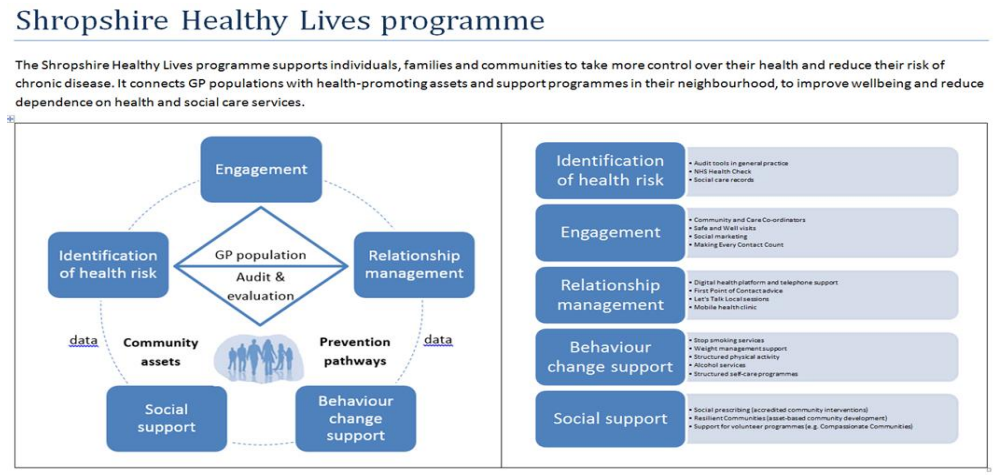
2. Partnership Prevention Programme: Healthy Lives

Bringing about population level behaviour change through a suite of prevention activity that reduces the burden of ill health and disease in Shropshire. The programme's objectives are:

- Implement a system wide prevention programme
- Proactively identify health risk and connect people to the right level of support from across the community and neighbourhood care model to address that risk
- Maximise the impact of preventative activity in reducing the demand on acute and social care services
- Help people to remain independent at home and improve population level health and well- being in Shropshire

The programme includes:

- Social Prescribing
- Diabetes and CVD Prevention
- Falls Prevention
- NHS Health Check
- Future Planning , Housing and Fire Service Safe and Well Visits
- COPD and Respiratory Prevention
- Carers and Dementia Support
- Mental Health and Learning Disability



Shropshire Council – Neighbourhood Care Teams

3.Neighbourhood care models

The Scope of Care to be delivered in the Neighbourhood Care Model includes;

Urgent Care - Supporting people in crisis with access to rapid response care and interventions in their home or a community setting, including MH Crisis & Home Treatment

Supporting patients who have accessed Emergency Care to return to their home as soon as clinically appropriate

Planned Care - Supporting the left shift from acute to community settings, delivered though lower cost workforce models

Prevention and Maintenance Care - Supporting people living with more than one health issue or co-morbidity at the same time to live well with chronic conditions thereby preventing or delaying complications

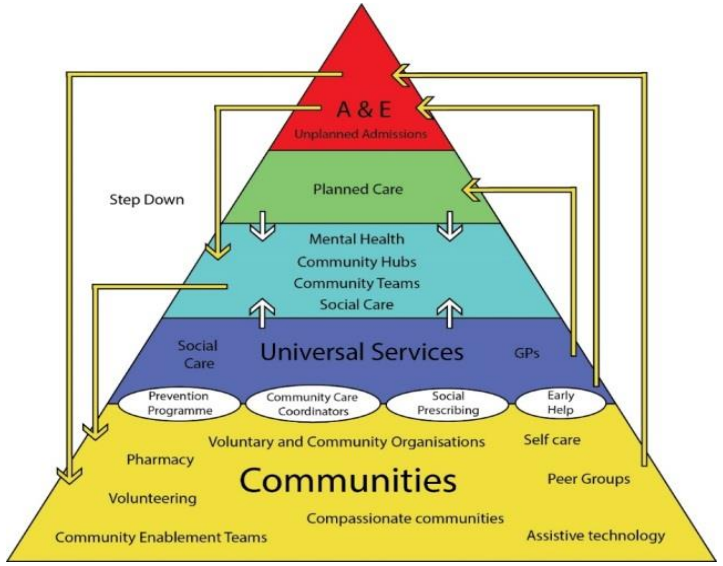
We recognise that the development of fit for purpose neighbourhood care models will require a bottom-up approach of locality co-production and will involve a wide range of different stakeholders from across our System. We have therefore agreed the guiding principles to support the development of place-based models of care that will deliver consistent outcomes and standards for local populations.

Model of care

- Seamless service delivery across both place based and whole pathways of care with a focus on prevention, early intervention and improved outcomes.
- Integrated health and care teams to support a flexible response to our communities' health and care needs and ensure local service sustainability.
- Extended healthcare teams offering rotational opportunities for staff to work across patient pathways and traditional service and organisational boundaries. This not only supports recruitment, retention and career development for staff but also ensures clinical service sustainability through a flexible workforce that can respond to variation in demand and capacity.
- Frailty management through cross-system mechanisms to support the frail to remain independent and out of hospital including specialists integrated with out of hospital teams to optimise patient care and ensure that patients are looked after in the most appropriate setting including the community.

What will be different?

- Our integrated care delivery model will be shaped by our communities, patients and their carers. We will build on our existing engagement mechanisms to ensure comprehensive patient engagement so that we know our communities' perceptions about what would improve their quality of life and use their ideas to create a care model which meets their priorities.
- Our integrated care delivery model will enable us to use our resources more flexibly across care teams to ensure we have capacity to meet demand in the most appropriate care setting and respond to variation.
- Our integrated workforce will support local GPs and primary care resilience with timely access to out of hospital multidisciplinary healthcare teams, including mental health and learning disabilities, that are responsive to local need and priorities.
- Our integrated workforce will significantly improve system resilience with staff multi-skilled to be able to work across organisational boundaries.
- Our Partnership and integrated structures will provide educational and development opportunities for all staff to facilitate local health and social care system talent management and improved recruitment, retention and career development
- Our information and communication systems will support a shared patient record, transferable and visible to all care providers. We will further develop our IT and governance arrangements to support this.
- Our Population Health Management approach will enable urgent care provision in out of hospital settings, where appropriate, will support admission prevention and will reduce demand for acute healthcare services.



Shropshire Council - progress and work plan

The rural nature of Shropshire provides a potentially positive environment for the wellbeing of the people living and working in Shropshire. This needs to be better valued and harnessed. Equally the rural nature of the county presents challenges of access and delivery that are a significantly influencing factor on the development of the Neighbourhoods strategy and delivery.

Resilient communities - Progress to date

- **Active and effective VCS** – at risk from reducing grant/contract funding
- **Active community groups** - need support to thrive
- **Formal and informal volunteering** – needs strategic development
- **Care & Community Co-ordinators** - based in GP practices to assist patients and signpost services
- **Compassionate Communities** – volunteer befriending service to help people with long term illnesses stay in touch with the local community
- **Let's Talk Local hubs** – offer support and advice on issues such as loss of independence, isolation, role of carers, benefits advice etc
- **Everybody Active Towns** – to encourage physical activity
- **People2People** Carers project
- **Early Help Strengthening Families** – Shropshire's Troubled Families initiative

Resilient Communities - implementation

- 4 pilot areas implemented, roll out for rest of county ongoing
- Development of Oswestry as pilot for linking community activity with social prescribing and service redesign (Autumn 2016)
- Assessment of community resilience using toolkit – strengthening weaknesses and filling gaps

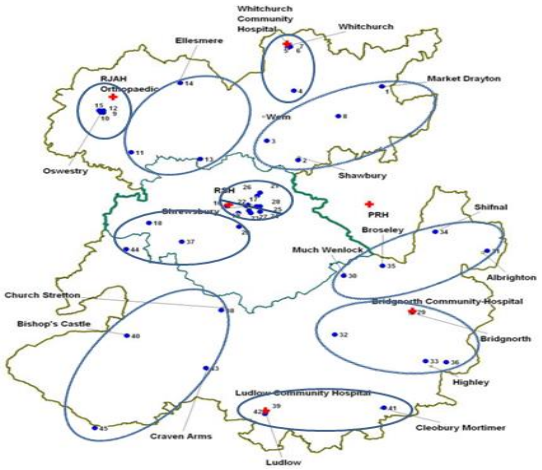
Social Prescribing model development – September 2016

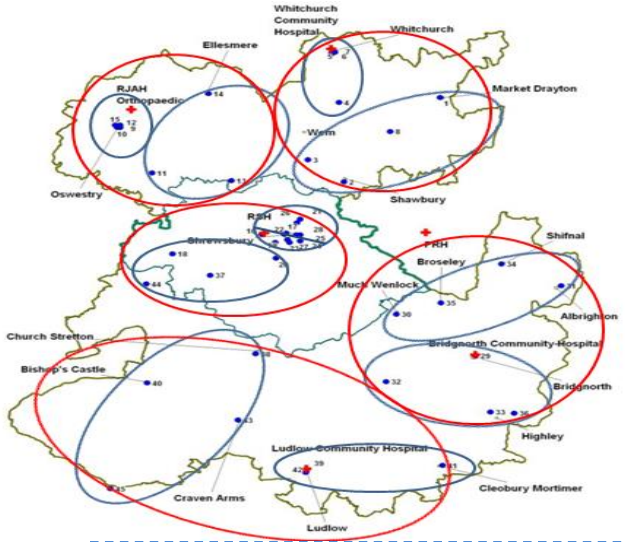
- Engagement with GPs, VCS, and all stakeholders Autumn 2016
- Pilot November 2016
- Roll out Spring 2017

6 Key Additional Programme Areas

- Pilot Diabetes & CVD Prevention– Oswestry Autumn 2016
- Mental Health – Suicide prevention strategy (in development)
- Safe and Well visits – January (T&W and Shropshire)
- Future planning – Autumn 2016
- Carers/ Dementia/ UTIs – all age carers strategy and action plan November 2016
- Falls Prevention – roll out of Community PSI (start Autumn 2016), New Service Specification (April 2017), link to Fire Safe and Well

Shropshire Council - Neighbourhood Care Teams and Hubs





Neighbourhood teams provide:

- Planned Care
- Condition specific pathways (Frailty/CKD etc)
- Long term condition management
- Interface between teams and Social Capital/Voluntary Sector (step up & step down)
- Point of Care Testing
- End of Life
- Domiciliary Care
- Early intervention for Mental Health conditions

Community Hubs provide:

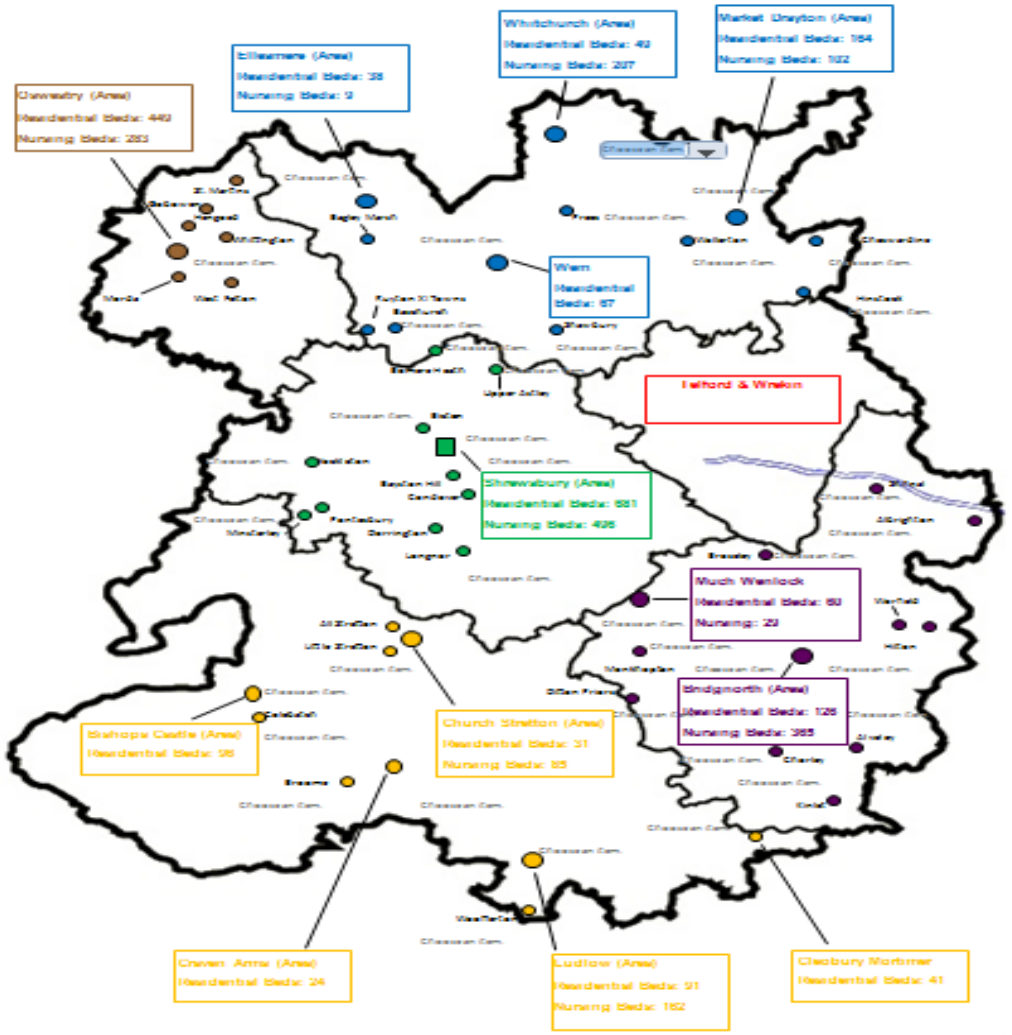
- Same Day response
- Unplanned and or an Increase Care/Support
- Expert advice & reassurance
- Rural Urgent Care (MIU/DAART/Ambulatory Care)
- ICS – Admission avoidance
- Therapy coordination/pathways
- Specialist Nursing Teams
- Mental Health/ Learning Disability Specialists.
- Comprehensive Geriatric Assessment
- Point of Care Testing
- Diagnostics

Neighbourhood team population	
Bridgnorth North	30543
Bridgnorth South	24881
Ludlow	23155
North East	29175
North West	17068
Oswestry	34523
Shrewsbury North	42555
Shrewsbury Rural	18223
Shrewsbury South	39154
South West	20261
Whitchurch	24261
Grand Total	**303799**

Review of community beds in Shropshire

Neighbourhood working will require some access to locally provided beds for patients. This will enable care to be delivered in the most appropriate environment and improves quality of care for patients . At present these are provided through community hospitals, local authorities and care homes. As Neighbourhood working develops, the local provision of beds is being reviewed. The stages in the review are:

- Complete stocktake of all non-NHS beds in the community – September 2016 (complete)
- Complete analysis of projected activity shifts from hospital by condition – Sept 2016 (complete)
- Agree most appropriate ways of meeting current and projected activity in the community – Oct 2016
- Model number of beds needed at hub level to meet projected demand
- Model clinical and financial sustainability of different options – Dec 2016
- Agree future model for beds in the community – March 2017

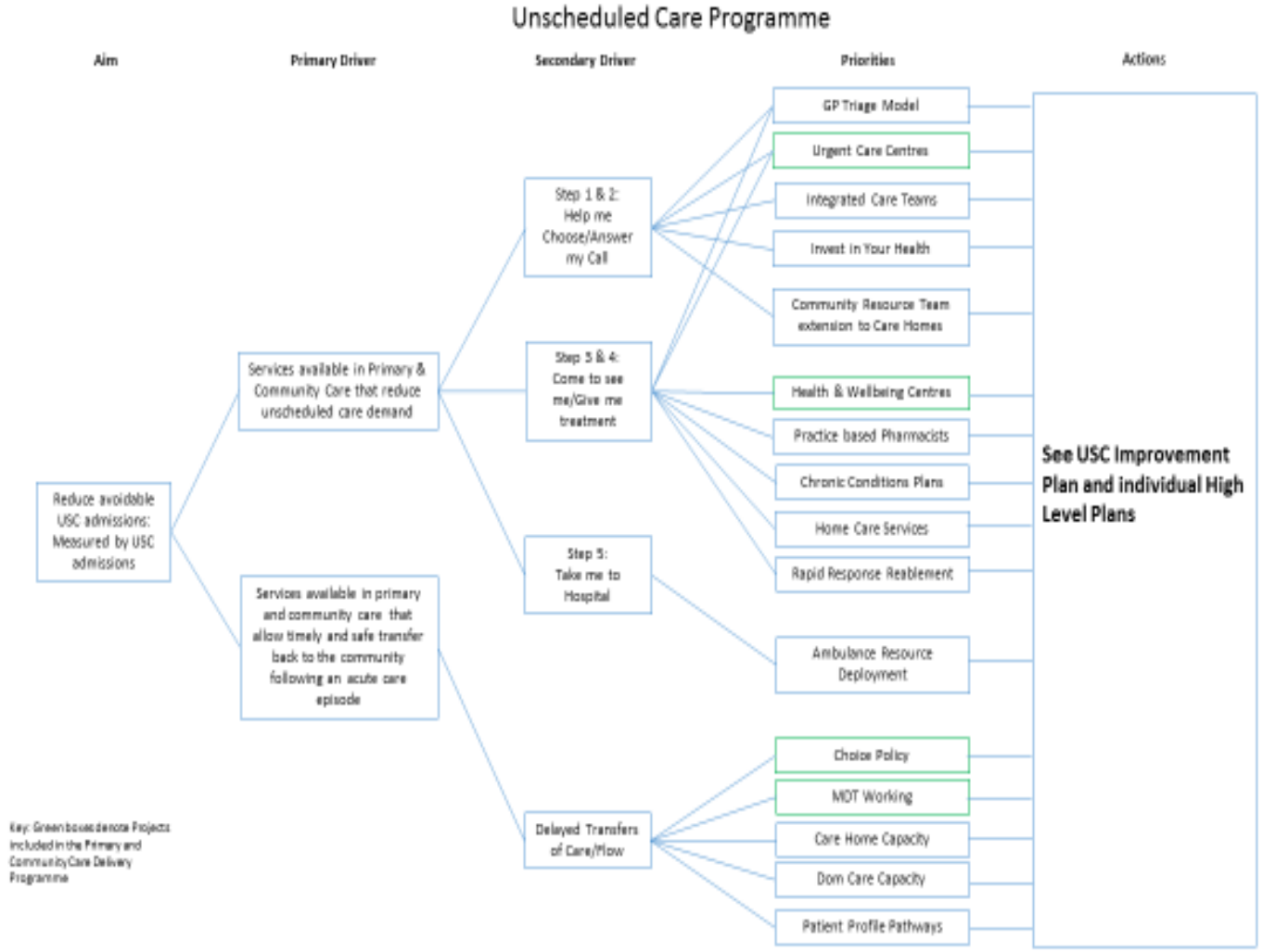


Neighbourhood working – Powys

Radical realignment of resources to support community working already achieved.

Health Board resources now *equally split between primary care, community and secondary care*.

Secondary care activity at Shrewsbury reduced by 10% in first 5 months



Radical upgrade in prevention – everybody's business

In addition to the preventative work that is built in to the Neighbourhood model, there is a need to ensure that all parts of the system are committed to prevention

Objectives

- Systematic delivery of lifestyle advice, signposting and referral – the NHS and the Community
- Tackle the obesity epidemic through a whole-systems approach
- Upgrade the NHS role in tackling alcohol harm
- Deliver expectations for improving cancer survival
- Improve the presentation, detection, treatment & management of preventable cardiovascular disease

Progress to date

- LHE cancer survival plan has strong prevention focus
- Neighbourhood models embedding prevention and social prescribing
- Neighbourhood Pathways incorporating prevention
- Smoke Free SaTH work commenced
- Alcohol liaison service under review
- Piloting Healthy Lifestyle hub in-reach in outpatients
- Population-level analyses to identify disease risk factors

Milestones

- Develop whole-systems plan for excess weight
- Agree MECC plus programme
- Scope diabetes prevention programme
- Deliver primary care quality improvement plans
- Hold alcohol summit
- Deliver screening and immunisation improvement plans

Outcomes

- Preventable and avoidable mortality rates
- Smoking-related and alcohol related admissions
- Emergency admissions from stroke
- Reduced length of stay for diabetes patients
- Screening and immunisation programme uptake
- Reduce variation in GP management of cardiovascular disease

Local Authority leadership in Neighbourhood working

Shropshire Council

Neighbourhood workstream chaired by Council Chief Executive

Committed to supporting its contribution to prevention for the next 18 months

But significant risks in future:

- National proposal to change funding arrangements for Public Health and Attendance Allowance makes financial planning difficult
- Councils have to set legal budgets resulting in severe cuts. In future, this could include cuts to preventative services
- The proposal on local Business Rates would mean Shropshire losing £12m of Public Health funding
- Attendance Allowance is an open-ended cost pressure and likely to have a clear impact on health services – such as the ability to discharge patients from hospital

Telford and Wrekin Council

Neighbourhood workstream chaired by T&W Chief Executive

£80m savings achieved over 6 years with a further £30m to be achieved in16/17 & 17/18.

- Focus on solving problems and promoting social responsibility to reduce demand
- Reimagining the way we do things
- Re-focussing the work that we do and contributing to Neighbourhood work
- Supporting work to build resilient communities and maximising the use of community assets
- Providing some universal services which prevent problems arising in the first place
- Retaining a workforce to work with our most vulnerable children families and adults
- A focus on safely reducing demand away from higher tier more expensive services
- A clear outcome focus

Supporting Primary Care

General Practice provides the building block for Neighbourhood Teams. Providing support is a fundamental part of the model

Objectives

1. To ensure that patients have the knowledge, skills and confidence to manage their own health and health care
2. To develop active Patient Participation Groups (PPGs) to support practices to deliver the Primary Care Strategic Priorities
3. To support new models for sustainable Primary Care - addressing inequalities by attracting a multidisciplinary skilled workforce via a workforce strategy, to increase patient access, supported by excellent IT infrastructure and Estate
4. To ensure that Primary Care is resourced to identify and manage those health conditions highlighted as a priority by public health and the increasing number of patients with complex health conditions
5. Promote and develop a culture of continuous improvement and shared outstanding practise
6. Develop a formal stakeholder communication and engagement plan to support the delivery of the Primary Care Strategic priorities
7. Develop a long term financial plan to support the delivery of the Primary Care Strategic priorities

Progress to date

- Formal quarterly reporting to Primary Care Committees
- Primary Care Needs Assessment Undertaken
- Review of all PPGs across the County
- Shropshire wide Primary Care Workforce audit process commenced
- Primary Care Estates Plan being progressed
- Primary Care IT Roadmap approved
- Transformation bids submitted to NHSE to resource IT and Estates projects – outcome expected early September 2016
- 12/17 practices in Telford and Wrekin are now working in 3 clusters/localities to secure sustainability (5/17 practices are being offered individual practice support)
- The development of Practice clusters are being progressed in Shropshire
- National Practice resilience programme underway with the support off NHSE
- Practices have attended training sessions to understand their referral data better (via the Aristotle system)
- Shared learning from Care Quality Visits has commenced
- New Quality and Improvement assurance process has commenced
- Primary Care Communication and Engagement Plan submitted for approval to Primary Care Committee
- Primary Care Financial plan approved by Primary Care Committee
- Pilot for Social Prescribing outlined for approval
- Review of Primary Care Access in and out of hours has commenced

Key Milestones

Full work-plan developed to delivery Primary Care Strategic Priorities with key milestones are monitored by Primary Care Committee on a quarterly basis.
High level key milestones include:

- September 2016 – Outcome of national Primary Care Transformation Fund process, communications plan for Primary Care approved for implementation
- October 2016 - clear understanding of cluster working and outcomes, all practice have active PPGs, draft Primary Care MDT workforce strategy in place
- November 2016 – Social prescribing pilot to commence

Outcomes

- Patients supported equitably in the Community by sustainable GP Practices leading a neighbourhood approach to care enabling disease prevention, wellness and healthy lifestyles and the ability for patients to self-manage their long term conditions safely
- Patients and Stakeholders will better understand Primary Care and how it aligns to the wider STP
- Improved Access in Primary Care will be delivered

Acute Reconfiguration

Reconfiguration of Acute Services

Objectives

- The model for acute hospital care describes a balance of acute hospital service provision within the county. The plan would see two vibrant hospitals , one being the site for consolidated Emergency Care (with a single Emergency Department and single Critical Care Unit) and one for Planned Care (with a Diagnostic and Treatment Centre and the majority of elective care). Duplication of services would be reduced. However, outpatients, diagnostics and centres providing urgent but not specialist emergency care would be provided at both sites. It may be possible to designate the Urgent Care Centres as local A&E Centres.
- The programme is primarily focused on the reconfiguration of services between Shrewsbury and Telford hospitals to improve outcomes for patients, improve their experience and deliver safe and sustainable services in the county. The Outline Business Case will describe the options for the delivery of two balanced hospitals with improvement and investment at both RSH and PRH.
- The Neighbourhood model of care is an essential element of acute reconfiguration in enabling the left shift from acute to community provision

Progress to date

- The Strategic Outline Case for the reconfiguration of services between Shrewsbury and Telford hospitals has been approved by the Boards of SaTH and the two CCGs. The CCG's approval was conditional on a number of issues being addressed in development of the FBC
- Work continues to be clinically led with widespread involvement and engagement of staff, patients and the public
- Department level Task and Finish Groups are ongoing and in partnership with Technical Advisers have reviewed key clinical adjacencies, pathways and workflows to develop architectural plans for OBC
- Best practice guidance and evidence continues to be used in the development of all plans and thinking
- A rural urgent care prototype has been established at Bridgnorth to help understand the extent to which urgent care needs can be addressed in rural situations
- Internal patient pathways have been developed that have driven the facility and workforce needs. System wide groups have been established for 6 long-term conditions to support the shift from acute to community care and will help inform the work of the Neighbourhood teams

Key Milestones

- External review of option C2 (separation of Women and Children's from Emergency Care) – September 2016
- Clinical Senate Review November 2016
- Draft OBC December 2016
- Pre-consultation Outline Business Case to NHS Boards – November 2016
- Gateway Review – November 2016
- Public consultation – Jan-Mar 2016/7
- Decision on OBC – May 2017

Acute reconfiguration – the benefits for patients

A single purpose built Emergency Centre:

- Better clinical outcomes with reduced morbidity and mortality
- Bringing specialists together treating a higher volume of critical cases to maintain and grow skills
- Ensure greater degree of consultant delivered decision making and care
- Improved clinical adjacencies through focused redesign
- Improved access to multi-disciplinary teams
- Delivery of care in environment for specialist care
- Improved recruitment and retention of specialists

Within the balanced site proposal, patients would benefit from:

- Being cared for in their nearest hospital as much as possible for their acute service needs – Urgent Care, Outpatients, Diagnostics and some inpatient specialties
- Receiving planned care within a defined service separate from emergency care
- Improved pathways between primary and secondary care providers delivering a seamless patient pathway.
- Timely access to care through the achievement of national standards
- Improved access to an enhanced range of services within the county i.e. Cardiology

Modelling the changes

- By 2020/21, modelling suggests that at least 4,215 non-elective admissions will be able to be managed locally through the Neighbourhoods. This is 8.6% of all non-elective admissions.

This has also been analysed by condition:

	n	%
cardiac disorders	999	24
paediatric medicine	983	24
strokes, TIAs and other disorders of the nervous system	493	12
respiratory disease	446	11
disorders of the digestive system	270	6
infectious diseases, poisoning	179	4
other	845	20
TOTAL	**4215**	**100**

So that the Clinical Pathway Groups can redesign the way in which care is delivered within the Neighbourhoods

27,000 hospital outpatient appointments will be managed in the community

Both analyses enable high level estimates to be made of the workforce required and pattern of investment.

The modelling assumes:

- Reductions in delayed discharges and LTC admissions
- 7 day working in Medicine
- Continued shift to Day Case and Ambulatory Care and from Day Case to Outpatient Procedures
- Plans based on improved occupancy and 50% single rooms
- Distinct pathways based on patients clinical need and protected delivery of planned care
- Delivery of telehealth solutions to support redesigned pathways and ways of working

Indicative activity levels have been calculated for each team and hub for each of the four years of implementation

Bridgnorth Community Hub				
Year	Community team intervention	Prevention	Community Resilience	Cumulative Activity Shifted
2017/18	124	-	-	124
2018/19	247	-	-	247
2019/20	334	37	-	371
2020/21	420	74	-	494

Clinical Pathway Development

(To test that the shift of activity from hospital to community can be delivered in clinically appropriate ways and with the right staff)

Objectives

1. Develop and agree the 'end to end' clinical pathway for:
   - Diabetes,
   - Heart Failure,
   - Chronic Kidney Disease,
   - Respiratory,
   - Preventing Falls and Fractures and
   - Frailty
2. Quantify the activity shift assumptions from the agreed pathway and confirm against acute activity assumptions in the SOC
3. Quantify the workforce requirements of the agreed pathway and quantify any gaps and resultant workforce development needs
4. Map against co-morbidity, including mental health

Progress to date

1. Pathway design guiding principles agreed.
2. Membership of multi-stakeholder task and finish groups confirmed
3. Task & Finish Groups have met in August for Diabetes, CKD, Heart Failure, Preventing Falls and Fractures and first draft pathway circulated to members for comment.
4. Agreed Respiratory Pathways will progressed through the established LHSE Respiratory Group and their programme of Right Care work other than Paediatric Asthma which has a task and finish group established and has met twice.
5. Frailty stakeholder workshop held.
6. Working with CSU to determine consistent approach to activity modelling for community offer

Key Milestones

1. Agree guiding principles for pathway development.
2. Establish multi-stakeholder task and finish groups including patient reps
3. Establish links with CCG commissioners to ensure all previous and current related pathway development work is incorporated
4. Pathways drafted and shared with wider stakeholder groups to 'sense check' before sign off
5. Pathways agreed and signed off by Clinical Design Group
6. Activity shift assumptions defined, agreed and any variances from acute SOC activity assumptions quantified
7. Workforce requirements to deliver the pathways defined including the skills and competencies to deliver

Target timescale for final draft – end of October 2016

Outcomes

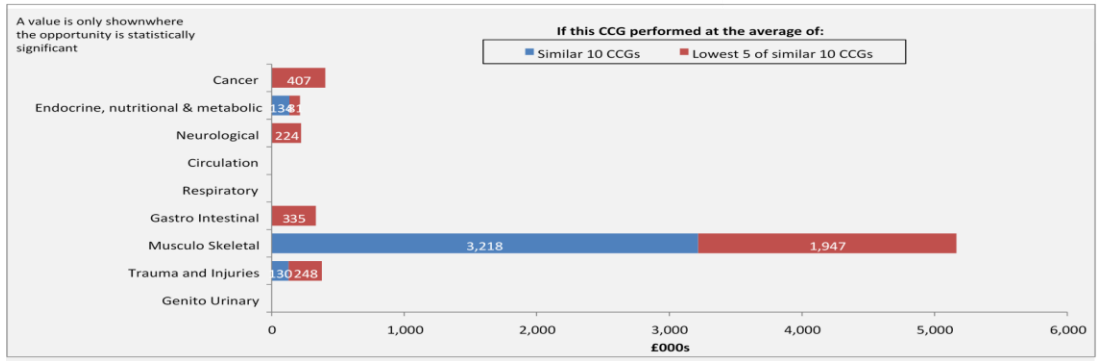
1. 'End to end' pathways agreed for 6 patient condition groups through prevention to end of life (where appropriate) that describe the community offer in support of the Futurefit acute reconfiguration
2. Pathways are deliverable and sustainable in terms of workforce and finance

Maintain wellbeing/prevention (pre-diagnosis)	Early diagnosis, treatment and care planning	Condition stable, maintenance and management	Condition unstable, deteriorating, acute crisis	End of life

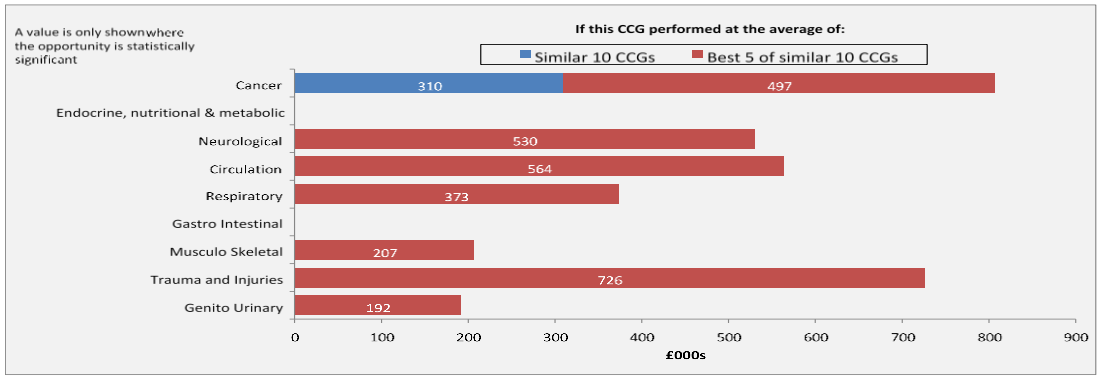
Understanding our expenditure

Shropshire

How different are we on spend on elective admissions?

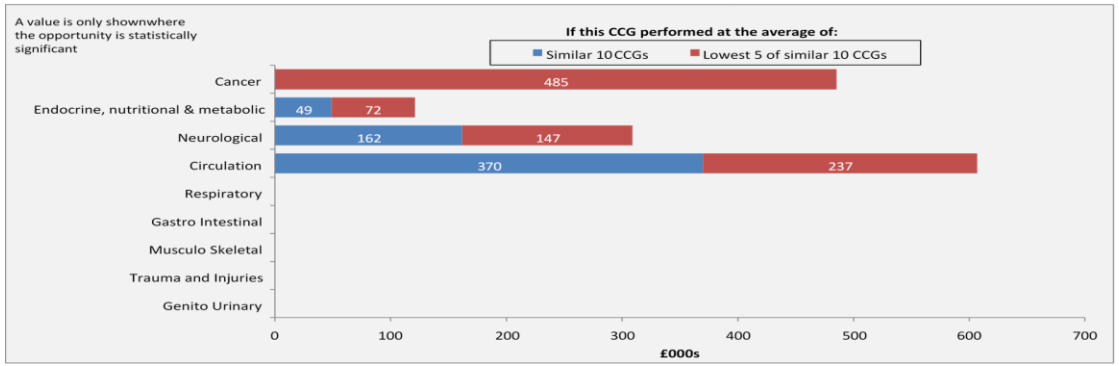


How different are we on spend on non-elective admissions?

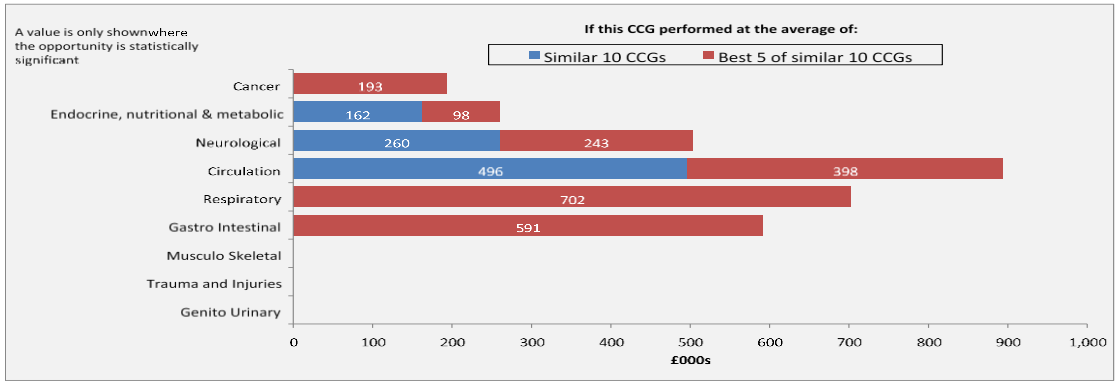


Telford & Wrekin

How different are we on spend on elective admissions?



How different are we on spend on non-elective admissions?



Orthopaedics stands out as an area of high expenditure. Project plans for Respiratory and High Intensity Users also developed

Source: Commissioning for Value, October 2016

Understanding our expenditure: The Orthopaedic and MSK Review

Objectives

The current provision of orthopaedic and musculo-skeletal services across Shropshire and Telford and Wrekin is fragmented and split across a number of locations.

This review considers the current provision of Orthopaedic and MSK services and the future service models needed in 2020. The main focus will be planned work but the fragmentation of therapy provision across specialist, acute, primary and community services will also be considered

It will cover the population of Shropshire, Telford and Wrekin and the provision based out of Shrewsbury and Telford Hospitals NHS Trust and Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust. It will also consider related services provided in primary care, community services and the independent sector.

Key Milestones

- Dec 2016 – Phase One report to be completed by end of December

Progress to date

The Terms of Reference for the Review have been agreed and the work commissioned.

Phase One will –

- Assess current and future demand for Orthopaedic and MSK services for Shropshire and Telford and Wrekin populations and an analysis of how this will change in the light of future demographic change
- Understand this demand in the context of available benchmarking data and historic performance, considering demographic and non-demographic changes.
- Provide a high level assessment as to how this demand could be more appropriately managed in future in the light of best practice and the implications of this for specialist, acute, community and primary care providers
- Assess the risks to provision taking in to account constraints of the workforce, estate and current capacity
- Assess the potential of current providers to either gain or lose market share through competition from outside the county
- Assess the quality of the current service taking in to account the views of CQC, external reviews, commissioners, specialist commissioners and other quality data
- Assess the clinical, operational and financial viability of the current services
- Identify the scope for any economies that could be made whist safeguarding the quality of service

Developing other services

People with mental ill-health

Objectives

- To work towards parity of esteem between physical and mental health , improving the quality of care for patients
- To implement the Five Year Forward View for Mental Health
- To promote good mental health
- Working in partnership with all organisations , voluntary, private and public
- To co-produce services/pathways with people with lived experience of services, their families and carers
- To ensure support is available to help people to help themselves
- To ensure support is available at the earliest opportunity to reduce the likelihood of escalation and distress and support recovery
- Effective Crisis pathway in place
- Proactive support for those within criminal justice system
- Effective services delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives
- New payment mechanism in place to support effective outcomes

Progress to date

- Joint mental health strategy
- Plans in place to develop 24/7 mental health support
- Access and recovery targets for IAPT achieved
- RTT early intervention psychosis service
- System for monitoring out of area placements
- Rehab pathway under review
- Dementia strategy and action plan
- CQUIN to develop agreed clinical outcome measures
- All age psychiatric liaison in place 7 days a week 12 hours a day
- Third sector led employment event held
- Mental health stakeholder forum in place

Outcomes

- To have more people recovering from mental ill health
- Reduced stigma of mental health
- People access support (voluntary sector and primary care services) and reduced numbers requiring secondary mental health services
- Crisis pathway available 24/7
- No out of area placements for in patient care unless very specialist care required
- Hospital liaison in place for acute mental health, children and young people, substance misuse and dementia
- Referral to treat times aligned to physical health response times
- Increased employment rates for those with severe mental illness
- Increase in peer support in mental health
- Outcomes measured and reported for mental health services
- Payment mechanism in place that has an outcome payment for an agreed % of contract
- Reduction in suicide rates

Key Milestones

Five Year Forward View Local Commissioning Strategy	October
Comprehensive needs assessment	April 2017
CCGs signed up to Time to change (Good mental health in workplace)	April 2017
IAPT access rate of 16% with recovery rate over 50%	April 2017
CBT available face to face and on line	June 17
RTT for early intervention psychosis 50%	September 17
Reduction in Out of area acute Mental health in patients	Q4 16/17
Second Sec 136 suite	April 2017
Plan for 7 day working April 17	April 17
Implemented 7 day working	September 17
Clear articulation of crises pathway	December 16

People with a Learning Disability

Objectives

- To improve the quality of care by ensuring people are cared for in an environment that is safe and secure
- Working in partnership with all organisations , voluntary, private and public
- To co-produce services/pathways with people with lived experience of services, their families and carers
- To improve the life chances of people with LD
- To improve the physical health of people with LD
- To ensure specialist support is available for those with profound and complex health needs
- To support people, with LD/autism with behaviours that challenge as close to home as possible.
- To support people in their own homes where possible
- To ensure reasonable adjustments are made when people with a LD are admitted to acute care
- To develop an integrated approach to learning disabilities commissioning across NHS and local authority

Progress to date

- TCP plan written collaboratively across whole footprint
- CCG commissioned beds within target
- Case written to support development of an intensive home care team
- Intensive support team for challenging behaviour in place
- Care and treatment review procures in place
- At risk of admission register and support mechanisms in place

Key Milestones

Reduction in NHS England commissioned beds	Commence Q2 16/17 within national targets by 2018/19
West Midlands Quality care review undertaken to understand management of patients in an acute ward	April 17
New model of community learning disabilities service in place	September 17

Outcomes

- 7% of people with an LD who are on the GP registers are offered an annual health check
- Care and Treatment reviews held for all people who are at risk of admission or who are admitted to an inpatient bed
- Personal health budgets offered and supported to people with a LD
- Reviews undertaken for all people with an LD who die (unexpected or expected) to understand how care could be improved
- Within national target for CCG and NHS England commissioned in patient beds for LD/ autism with behaviours that challenge

Children and Young People

Objectives

- To implement a comprehensive CAMHS service with reduced waiting times and raised awareness of children's mental health issues amongst professional and other staff
- To develop an integrated paediatric model of care which provides the Right Care approach to include continuity of care and services closer to home.
- Special Educational Needs and Disabilities (SEND) Education, Health and Care Plan effective care delivery.

Progress to date

- 0-25 Emotional Health and Wellbeing service. Includes crisis support, CBT, Systemic Family Treatment, training for professionals and better access for Looked After Children. Tender across both CCGs issued in August 2016
- Redesign of neurodevelopmental pathways. Reconfiguration of existing CAMHS service to reduce waiting times
- Developmental programmes for workers in universal services
- Eating Disorder service, jointly commissioned with South Staffs CCGs and provided by SSSFT. Current caseload is 119; anticipated to increase by 100 referrals pa
- All age Psychiatric Liaison service. Hospital based to support children attending A&E or admitted with emotionally related disorders
- Perinatal Support programme to train professionals to recognise early signs of emotional problems
- Cross-cutting programme to provide robust needs analysis and approach to record keeping, engagement and transition
- Future Fit, Clinical pathways group, developing a 'Paediatric asthma pathway' for the Shropshire health economy.
- SEND self assessment gaps/areas for improvement identified and action plan in progress action.

Outcomes

- Reduced waiting times for assessment by CAMHS service
- Comprehensive Eating Disorder service
- Reduced hospital attendances and admissions for children and young people .
- Robust health response to EHCP including performance monitoring of providers.

Key Milestones

- **Implementation of the CAMHS programme**
- **0-25Emotional Health and Wellbeing service.** Tender approved and new service commences Q4 2017
- **Paediatric Asthma Pathway** - Pathway and supporting business case to be developed by 30 September 2016.
- **SEND -** Action plan in progress to respond to gaps/areas requiring improvement by January 2017.

Cancer Services

Objectives

- Develop health economy wide cancer strategy based on National Cancer Taskforce priorities
- Expanded service with Care Closer to Home
- Workforce development to meet future demand including 3rd sector involvement, volunteer and HEE training roles
- Use of Digital Health solution to develop new whole population models of care

Progress to date

- SaTH Cancer services strategy approved by Trust Board
- Proof of concept of digital health solution for chemotherapy and prostate cancer follow up
- Commissioner support in principle for care closer to home
- Increase in palliative medicine provision

Outcomes

By 2020:

- achieve definitive diagnosis of cancer within 28 days
- achieve 1 year survival of 75% for all cancers
- improve uptake for screening
- Offer digital health follow up to all cancer patients
- Build on new models of care through innovation to be a Centre of Excellence and employer of choice

Key Milestones

- 2016 Q4 : briefing paper to expand diagnostic capacity in radiology and endoscopy to inform business cases
- 2016 Q3: implementation of NG12
- 2016 Q4: Contemporary workforce strategy
- 2017 Q4: redesign cancer pathways to increase earlier diagnosis and improve care
- 2017 business case for cancer unit Powys
- 2016/17: 100K Genome Project strategy group established . Eligible patients enrolled 2017
- 2018: establish increased service provision Powys, business case for increased provision Telford
- 2018: Capital replacement Linac

The Ten National Priorities

1. **Preventing ill-health and moderating demand** *(see slides on Neighbourhood working and Prevention)*
   - Whole system plans for obesity and diabetes under development
   - Alcohol service under review and Alcohol Summit scheduled
   - Social prescribing pilot underway
   - Healthy lifestyle hub in outpatients
2. **Engaging patients, communities and staff** *(see slide on Engagement)*
   - Significant public engagement already undertaken as part of Future Fit
   - Step change in self care developed as key component of Neighbourhood working
3. **Investing in General Practice** *(see slide on Primary Care)*
   - National Practice resilience programme underway (with NHSE)
   - Primary care financial plan approved; Primary care workforce audit underway
   - Cluster working being developed through Neighbourhood working
4. **New models of care** *(see slides on Neighbourhood working)*
   - Neighbourhood working integrates health and social care with an emphasis on prevention and community resilience aimed at providing less hospital-based urgent care
   - Combined 111/OOH service goes live in November 2016
5. **Performance against core standards** *(see slides on Cancer and Quality)*
   - Reconfiguration of hospital services is intended to support delivery of A&E and RTT waiting times
6. **Key clinical priorities** (see slides on Mental Health services and Cancer)
   - Changes to mental health services will deliver waiting time targets
   - Cancer survival rates
   - Dementia diagnosis standard being achieved in Shropshire, but not in T&W
7. **Improve quality and safety**
   - Service Improvement Plan in place to deliver 7 day hospital services against the 4 clinical standards. Significant progress will be made with reconfiguration of acute services
   - Most providers rated good
   - Anti-microbial prescribing performs well in both CCGs
8. **Using technology to accelerate change** (see slide on Digital Strategy)
   - See Digital Roadmap
9. **Developing the workforce** (see slide on workforce)
   - Reconfiguration of hospital services will significantly reduce agency spend
   - Multi-disciplinary teams a key component of Neighbourhood working
   - New workforce roles being developed in conjunction with LETC
10. **Achieving financial balance** (see slide on Achieving Financial Balance)
    - Provider efficiency set at 2%
    - Financial sustainability plan still requiring further development
    - Activity growth to be moderated as a result of Neighbourhood working

Making best use of our resources

The financial challenge

	Commissioners	Providers	Total
Structural Deficit	(18.7)	(17.0)	(35.7)
Inflation/Demography cost pressures	(54.8)	(41.0)	(95.8)
Local Health System Deficit	(73.5)	(58.0)	(131.4)
QIPP savings LHE Providers	32.1	(32.1)	0.0
QIPP savings (other)	45.4	0.0	45.4
Provider Trust Efficiency Programme		45.2	45.2
Carter Review Savings		8.8	8.8
Transformation	4.0	(36.0)	(32.0)
Use of Transformation savings		6.5	6.5
Reconfiguration		15.1	15.1
Community Hospitals		3.8	3.8
Orthopaedic Rebasing		3.9	3.9
Repatriation		6.0	6.0
Rationalisation of services		4.0	4.0
External Transfer	1.5		1.5
	5.5	3.2	8.7

- Before actions – Scale of deficit is £131.4 million
- Transformation savings required - £32.0 million
- Transformation savings/funds identified are £40.7 million, generating health economy surplus of £8.5 million
- Underused Transformation funds of £26.5 million.

Addressing the Financial Challenge

	2017/18	2018/19	2019/20	2020/21		SAVINGS 2017/18 - 2020/21	MOVE 1 YEAR
Provider CIP	13.3	10.6	10.6	10.7	45.2	116.8	148.7
Carter Review	2.2	2.2	2.2	2.2	8.8	22.0	28.6
Use of Transformation Funds			6.5		6.5	13.0	19.5
Hospital Reconfiguration	2.0	2.0	2.0	9.1	15.1	27.1	40.3
Community Hospitals	0.7	0.9	1.0	1.2	3.8	8.7	11.8
Orthopaedic rebasing	0.8	0.9	1.0	1.1	3.8	9.0	12.0
Repatriation	1.5	1.5	1.5	1.5	6.0	15.0	19.5
Hospital Sites Rationalisation				4.0	4.0	4.0	8.0
External Transfer	0.4	0.4	0.4	0.4	1.5	3.8	4.9
	20.9	18.5	25.2	30.2		219.4	293.3
						73.9	

Finance

- The financial position of the CCCG/Provider organisations over the period 2017/18 is summarised in the table below.

		SATH	RJAH	Shropshire Community	Telford & Wrekin CCG	Shropshire CCG
		£000s	£000s	£000s	£000s	£000s
2017/18		-6,063	-83	1,139	-100	-19,400
2018/19		-2,778	76	1,268	-100	-13,600
2019/20		-14,143	-368	470	0	-6,212
2010/21		3,865	-709	85	7	5,519

Significantly the inflation/demographic and QIPP savings assumptions made by the three local health provider bodies are fully reconcilable with the financial plans as constructed by commissioners.

- In the two years 2017/18 and 2018/19 each of the providers, with the exception of Robert Jones and Agnes Hunt Orthopaedic Foundation Trust, present a financial position consistent with their respective control totals as issued by NHSI. Robert Jones and Agnes Hunt Orthopaedic Foundation Trust differs because of an outstanding requirement to address concerns relating to the application of the revised 2017/18 tariff. Commissioner finance plans in the two years 2017/18 also agree with issued control totals.
- In the construction of these plans, both commissioners and providers recognise that in setting contracts for the 2017/18 and 2018/19 years, further discussions will need to take place to confirm the precise impact of QIPP savings and also outstanding contractual issues.

Capital requirements

A key component of the

- LHE financial recovery plan; and
- Trust Sustainable Services Programme

is the need to comprehensively reconfigure services between the Trust's two hospital sites.

The capital costs associated with the reconfiguration of hospital sites has been established at a maximum of £311 million. This sum supports the direct capital costs relating to the reconfiguration of services and also the essential 'backlog' work that also has to take place in order to make the reconfiguration possible.

The capital cost at maximum is profiled as follows:

		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Capital required		7	50	76	138	21	21	311

As can be seen the level of funding required over the period 2017/18 – 2020/21 amounts to £269 million. A further £42 million occurs over the years 2021/22 – 2022/23 to complete the programme.

Capital Requirements (Cont'd)

The Trust recognises that the availability of capital resources nationally is challenging and so is actively reviewing opportunities through which it may become possible to reduce the scale of capital required.

Within the above diagram, a sum of £20 million is included to support the reprovision of facilities management activities. Ultimately, in determining the most appropriate procurement mechanism for the capital development, it may become possible to source such services from a partnering organisation. Doing so could see capital development being sourced through such a partner.

Additionally, the Trust is also examining possibilities to develop joint venture partnership arrangements with private partners. Such an approach offers the potential to share capital responsibilities and in doing so offers a potential solution (in full or part) to the issue of capital financing. Pursuance of such an approach however is likely to be dependant upon the legal ability of the Trust to enter into such an arrangement. Accordingly, the Trust is presently sourcing legal opinion.

Reducing duplication

Objectives

To reduce costs and increase operational resilience without affecting service provision by rationalising;

- Organisations where there is a clear view that sustainability is served better in a different form,
- back office functions,
- estate portfolio; and
- by greater exploitation of IM&T

Key Milestones

- **October 2016**
  Define ambition for consolidating Back Office functions.
- **November 2016**
  Set up the appropriate governance structure to engage relevant partners to develop a Business Case for further amalgamation and submit to NHSE

Progress to date

- The health community has set a target to reduce Back Office Functions cost by £1.8m (inc Pathology)
- Payroll, Purchasing/Supplies, Estates (cleaning) already shared between SaTH, ShropCom and RJAH
- Scoping exercise has highlighted areas that may warrant further consideration and these cover clinical process consolidation as well as traditional back office.

Outcomes

- Reduce costs by £1.8m through greater sharing of functions
- Fewer organisations to reduce overhead costs and increase efficiency
- Greater resilience to support services which directly provide patient care

The Context

The Priorities

The Enablers

Implementation

Workforce

Objectives

To ensure the planning, recruitment and development of an engaged, talented and compassionate workforce for the future system.
To develop a sustainable future workforce who are equipped to meet the needs of our communities.

Outcomes

- A system integrated workforce plan
- A system workforce transformation plan
- Joint Leadership Development
- The development of consistent behaviours to support a strong culture
- Supporting people through change through a transparent and people focussed approach
- Making Shropshire a great place to work
- Strong educational system
- Enabling financial plan, delivery of new models of care and new ways of working
- A workforce equipped to change and develop with changing population needs

Progress to date

- New Workforce Work stream established to recognise scope of STP and refocused ambition. Absorbing previous Future Fit work.
- Workshop held to agree purpose, focus, early opportunities and measures of success.
- Reinvigorated stakeholder engagement through new work stream.
- Agreement to work as a system to develop Health and Wellbeing programmes to support vision of the Healthiest population on the planet.
- Agreement that bold decisions will need to be made to secure a sustainable workforce.
- Partner in successful Nurse associate pilot bid with multiple providers and Wolverhampton University.
- Through Local Workforce Action Boards (LWAB) agreed opportunities for collaboration with Staffordshire STP. Including Bank proposal.
- Agreement for system approach to Apprenticeships, developing a future workforce for health and social care. This will support the impact of the Levy.
- Development of Integrated Workforce Plan for frail and elder patient pathway.
- NHS Elect funding to support system leadership through integrated planning and transformation.
- STP Leaders undertaking system leadership development supported by NHSI. Supporting Health and Social Care leaders to work differently.
- Over 1,000 staff trained in Virginia Mason Institute Accelerated Transformation Programme

Key Milestones

90 Day

- Work plan to be created based on value stream needs.
- Action plan to up scale of new roles for example Advanced Clinical Practioners (ACP) and Nurse Associate. We know now we need new roles , therefore through a home grown approach development needs to be further progressed.
- Progression of Apprenticeship model for the STP.
- Early opportunities for collaboration to be undertaken e.g. Health and Wellbeing.
- Drivers for bank and agency across STP being shared and agreement on actions needed.
- To support back office function review.
- Principles of workforce plan to be agreed that includes transformation and is bold and brave.
- Scope a development plan to support better use of technology by up skilling our workforce and communities.

Approach of the Workforce Work stream

The Workforce Work stream has agreed an approach to integrate with the four value streams. Workforce professionals will be deployed to support the needs of the value stream. For example a workforce transformation specialist may be required to support innovation; New roles and ways of working. However over time the need will change to an Organisational Development Specialist to support teams working together. Task and finish groups will support this work and the Work Stream will ensure focus, pace and that duplication is avoided. The Work stream believes it needs to sit in the heart of the development as opposed to removed from it. We are adopting a business partner approach.

Workforce changes

Changes in the acute workforce

Workforce Summary

Staff Group	Establishment at 31/03/2016 WTE	Option B Scale of Change WTE	Option B WTE	Option B Saving £000s	Option C1 Scale of Change WTE	Option C1 WTE	Option C1 Saving £000s
Non Medical							
Registered Nursing, Midwifery and Health visiting staff	1,415.62	-114.00	1,301.62	-4,310	-106.00	1,309.62	-4,014
Allied Health Professionals	262.97	-53.93	209.04	-1,489	-53.93	209.04	-1,489
Other Scientific, Therapeutic and Technical Staff	345.81	-12.64	333.17	-168	-12.64	333.17	-168
Support to Clinical staff	1,396.02	-84.63	1,311.39	-1,857	-80.63	1,315.39	-1,766
Non-Clinical	964.48	-90.00	874.48	-2,924	-90.00	874.48	-2,924
Total Non Medical	**4,384.90**	**-355.20**	**4,029.70**	**-10,748**	**-343.20**	**4,041.70**	**-10,362**
Medical							
Consultants	282.00	8.50	290.50	1,237	8.50	290.50	1,237
Middle Grade	276.00	-6.00	270.00	-464	-6.00	270.00	-464
Junior	90.00	-10.00	80.00	-450	-10.00	80.00	-450
Total Medical	**648.00**	**-7.50**	**640.50**	**323**	**-7.50**	**640.50**	**323**
Total Non Medical and Non Medical	**5,032.90**	**-362.70**	**4,670.20**	**-10,425**	**-350.70**	**4,682.20**	**-10,039**
Other Efficiencies				-8,572			-8,572
Grand Total Workforce Efficiencies	**5,032.90**	**-362.70**	**4,670.20**	**-18,997**	**-350.70**	**4,682.20**	**-18,611**

In order to deliver the clinical model the workforce will increasingly be:

- §Treating higher acuity patients on the emergency/ acute site as a matter of routine
- §Working more autonomously and delivering a more complex case load
- §Working in more flexible ways across traditional professional groups
- §Developed to support new roles required
- §Smaller in numbers Up-skilled to take on extended roles
- §Required to use new technology to deliver clinical care and non-clinical services
- §More routine working new patterns of employment e.g. 24/7 on site presence, 7-day working and delivering routine services in the evening and at weekends

Changes in the Neighbourhood workforce

Workforce changes in the community (estimated)

The Buurtzorg model suggests that between 8 – 10wte community nurses are required per 10,000 head of population to support the delivery of care needs in out of hospital settings. For the population of Telford and Wrekin and Shropshire, this would be equivalent to 376wte based on the lower end of the range, 8wte per 10,000, and a 470,000 population.

There is currently a budget for 232wte community nurses for our STP footprint which reflects nurses' actual paypoints and enhancements. This means that the community nursing workforce would need to expand by 144wte to meet the needs of our populations. It is critical that any opportunity to use different roles or ways of working are fully developed for example the opportunity that the Nurse Associate role brings or multi skilled workers.

We believe that there is an opportunity to phase investment in the community nursing workforce expansion over three phases. We have calculated that the delivery of the 4215 non-elective spells through extended admission avoidance and urgent care delivery in community settings will require an additional 53wte, based on 11 hours community nurse input per admission avoided (including face to face care, administration and travel) and also 08:00 to 20:00 service availability to respond to local demand for urgent care in the rural settings.

2 further investment phases of 46 and 45wte will enable the community nursing service to deliver the extended range of activities including proactive long term condition management and targeted prevention. It is also anticipated that the full investment will support primary care resilience through the provision of additional capacity to meet demand so that we can appropriately redistribute inappropriate demand for local GPs and deliver the right care by the right person.

Estates

Objectives

To ensure that the healthcare estate meets the needs of patients, service users, staff, carers and visitors to acute, community, mental health and primary care services delivered to the people of Shropshire and Telford and Wrekin.

- That estate is accessible, efficient and safe.
- That the opportunity to develop the overall healthcare economy is critically and invasively assessed to offer best models in accordance with best business case practice. One Public Estate bid for funding to undertake option appraisal and feasibility work to rationalise the healthcare estate
- To create a One Public Estate infrastructure that brings together all public sector estate planning across the public sector for Shropshire, Telford and Wrekin and recognises the potential for community assets to be used as a base for service delivery.

Outcomes

- An integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- Reduction in estate
- Reduction/removal of backlog maintenance
- Estate aligning with and utilising the OPE agenda
- Utilisation aligned with Carter review
- Reduction in annual revenue costs
- Flexible estate that will enhanced a dynamic healthcare economy

Progress to date

- One Public Estate bid for funding to undertake option appraisal and feasibility work to rationalise the healthcare estate
- Data collection exercise and continued population of electronic asset management system.
- NHS Property Services Estates Workbook complete (October 2016) with summary of existing projects and draft implementation priorities
- Working group including Directors of F&E, CCG's and NHSPS
- Shropshire One Public Estate bid receives £60,000 funding

Key Milestones

- Completion of data capture exercise.
- Overarching and adopted estate strategy aligning with the estate outcomes and key STP outcomes
- Agree priorities
- Feasibility/option appraisal models with supporting financial overview
- Outline rationalisation plan.
- Outline business case
- Detail rationalisation plan.

Digital Engagement Group

Objectives

1. Paper-free at the point-of-care (by 2020)
2. Digitally-enabled self-care
3. Real-time analytics at the point of care
4. Whole system intelligence to support population health management and effective commissioning, clinical surveillance and research

Key Milestones

1. Establishing the Programme Management Office.
2. Ensuring that there are CCIOs in each organisation to support delivery of this LDR.
3. Identifying the project leads and ensuring that projects are suitably resourced.
4. Agreeing the delegated authority of the DEG with the STP Partnership Board.
5. Identifying resources to support the development of the business cases.
6. In developing the business cases, identifying the revenue consequences, the return on investment and broader benefits of each project.
7. Agreement of fund for individual projects

Progress to date

- Digital Roadmap developed
- Sub-group structure agreed:
  - Information governance
  - Clinical Reference Group
  - Design Authority
- Additional capacity commissioned

Outcomes

By 2020 we aim to have:

- An integrated care record across our economy (starting with end of life by March 2018)
- Patients as co-authors of their record. Contributing and interacting with their record, approving access, booking appointments, repeat prescriptions etc.
- Data Sharing agreements in place to enable our vision of a paperless NHS at the point of care. We expect agreements to be in place by March 2017.
- Universal capabilities significantly delivered by March 2018
- Tele Health at scale 2016-2020.
- Collaboration locally and regionally – standards, infrastructure, procurements, large projects like big data population health analytics.

The Context

The Priorities

The Enablers

Implementation

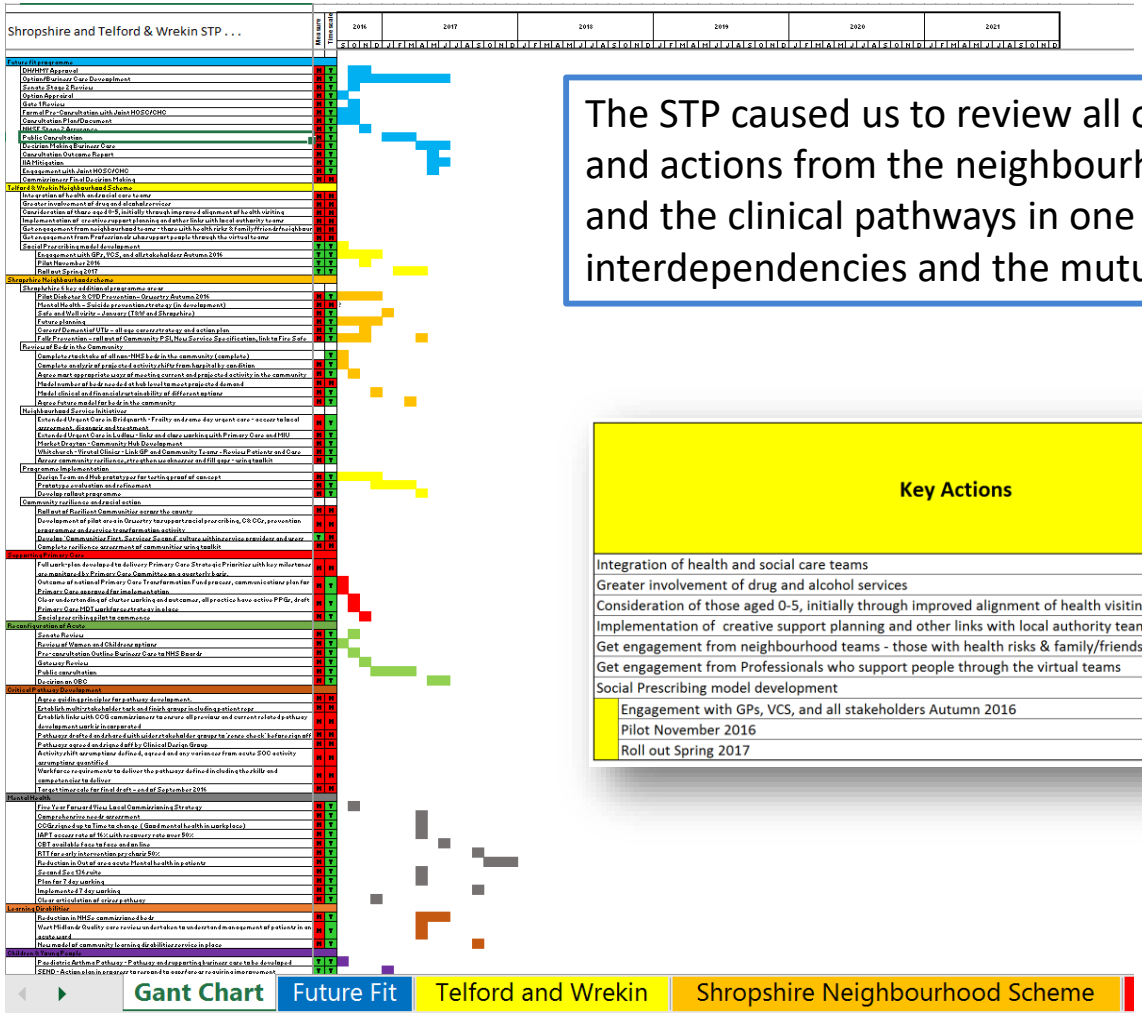
Plan to implementation and the next 90 days . . .

Our ‘plan to implementation’ aims to create transparency by working up ‘the effect’ of each scheme - to ensure we have the right deliverables and timing between the neighbourhood and the acute developments. Together these deliver the end game of sustained transformation. This helps to determine the required delivery from the clinical pathways and from the frontline, at the same time as specifying the enabling functions that will be needed.

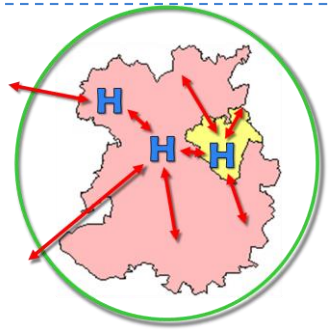
The 90 day plan widens the clinical discussion, increases transparency and creates grip. This will provide footprint assurance for the transformation of our health and care services.

Most importantly, by doing it in this way, we are creating a ‘frontline to footprint’ language, understanding and measurement – to generate united thought, language and action, and inducing a culture that makes the plan sustainable.

A transparent view – mutual accountability



The STP caused us to review all of the schemes, initiatives and actions from the neighbourhood work, the acute plans and the clinical pathways in one place, to understand the interdependencies and the mutual benefits.



Key Actions	Timescale	Measures	Benefit	Numerical Measure	Enabling Work Streams: Communications /Citizens Panel	Estates & Transport	Clinical Reference Group	Finance & Governance	Workforce	IM&T
Integration of health and social care teams	N	N								
Greater involvement of drug and alcohol services	N	N								
Consideration of those aged 0-5, initially through improved alignment of health visiting	N	N								
Implementation of creative support planning and other links with local authority teams	N	N								
Get engagement from neighbourhood teams - those with health risks & family/friends/neighbours	N	N								
Get engagement from Professionals who support people through the virtual teams	N	N								
Social Prescribing model development	Y	N								
Engagement with GPs, VCS, and all stakeholders Autumn 2016	Y	N								
Pilot November 2016	Y	N								
Roll out Spring 2017	Y	N								

Enabling Work Streams

Communications /Citizens Panel | Estates & Transport | Clinical Reference Group | Finance & Governance | Workforce | IM&T

Using the transparency of the ‘whole footprint’ we have begun to determine the requirements needed from the enabling workstreams to implement the clinical and non-clinical pathways, that will deliver the neighbourhood schemes and the sustainability of the acute scheme.

Frontline to footprint – making it sustainable

Cost *(£)*:
Clinical pathways and any associated investment yet to be finalised and agreed
£71k implementation costs for tiered community diabetes model in Central Shropshire

Return on Investment *(£)*: £298,000 NEL , OPFA £84,000, OPFU £161,000

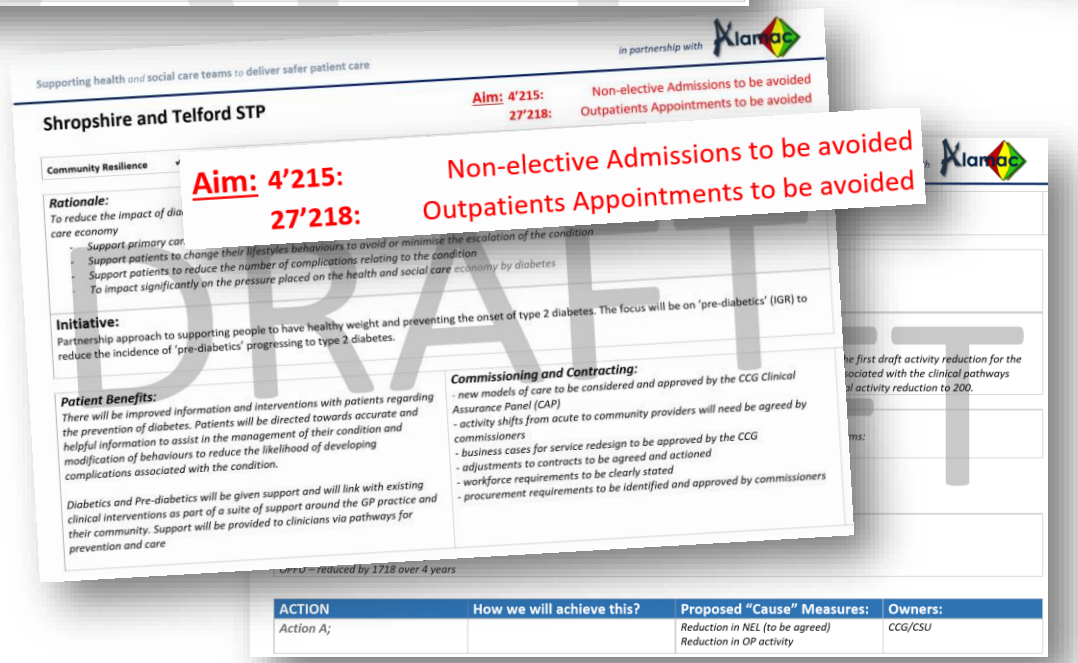
ROI has been calculated on the basis of the NHSE unit cost for NEL set out in the Better Care Fund Guidance of £1490. The first draft activity reduction for the diabetes workstream has been estimated at 99 by the FutureFit programme related to acute reconfiguration activity associated with the clinical pathways work. This would be at least matched by the planned community resilience models bringing the first draft estimated total activity reduction to 200.

Enabling Work Stream Support:
Implementation of pathway redesign and community models will require support from the following enabling workstreams:
IT, Informatics, Communications, Estates, HR & Workforce & Finance

Measurement

"Effect" Measure Description:
Decrease NEL Admissions related to diabetes by 200 over the STP period
OPFA – reduced by 420 over 4 years
OPFU – reduced by 1718 over 4 years

Each pathway and scheme considers the 'effect', timescale, patient benefit, cost, return, (all captured in a uniform way) so that the delivery of the plan is manageable, measurable and founded from a clinical and patient perspective.



In this way the frontline feeds the delivery of the STP. These changes are then, more likely, to be sustained. Yet, it can be seen, the transformational 'goal' of the STP is universally aimed for, and owned, across the footprint.

Milestones and outcomes . . .

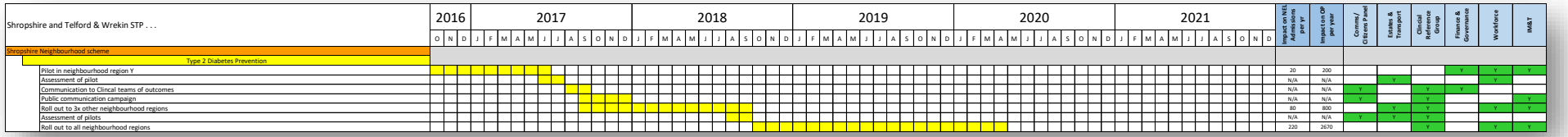
Community Prescribin...
272 KB

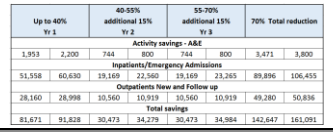
Care Networks STP Ca...
267 KB

Paediatric Asthma STP...
272 KB

Diabetes Cause and Eff...
273 KB

Bridgnorth Prototype S...
267 KB



Scheme/initiative		Non-elective admission avoidance				Out patient avoidance				Comms/ Citizens Panel	Estates & Transport	Clincial Reference Group	Finance & Governance	Workforce	IM&T
		2017/18	2018/19	2019/20	2020/21	2017/18	2018/19	2019/20	2020/21						
Owner	**Rural Urgent Care Prototype - Bridgnorth**	124	247	371	494	*200*	*1000*	*1700*	*2000*	Y	Y	Y	Y	Y	Y
NCM - SHROP	***Rationale:*** *Left shift of acute activity to community management (where clinically appropriate) to support the delivery of the activity and capacity assumptions within the Futurefit acute hospital reconfiguration*	Patients from GP practices in Bridgnorth North and South account for 12% of the total NEL to SaTH each year. Applying this 12% to the total required reduction in emergency admissions of 4215 equates to 494 emergency admissions avoided for Bridgnorth North and South. Of these it is projected that 420 will be delivered by community team intervention which equates to 8 per week.								Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4		
Owner	**Developing Wellbeing Care Networks**	*0*	*8*	*10*	10	*0*	*0*	*1800*	4000	Y	Y	Y	Y		
NCM - SHROP	***Rationale:*** *To respond to the health and social care demands of an ageing population and an increasing number of older people living with dementia it is necessary to build capacity within the care sector and identify alternative ways of providing care and support at home and within communities.*	• Reduction in NEL admissions from homes and care homes by 10 (£23,000) • Reducing care home placements from home as alternatives to hospital conveyance (£80,000) and ultimate reduction in use of Recovery beds • Reduction on permanent placements of 1 (£26,000) • Reduction in the use of Recovery 2 beds (£80,000 identified above)								Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4		
Owner	**Telford and Wrekin Community Prescribing**									Y	N	Y	Y		
NCM - Tel&W	***Rationale:*** *Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.*	A Social Return on Investment (SROI) study of Bristol's Wellspring Healthy Living Centre social prescribing project showed that for every pound invested in social prescribing there was a £3 social return including savings from: reduced GP attendance; prescriptions; secondary care and specialist referrals; savings from a return to employment; and adoption of caring roles.								Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4		
Owner	**Diabetes Neighbourhood Prevention Scheme**	*0*	*50*	*100*	200	*100*	*750*	*1500*	2138	Y	N	Y	Y		
PRE - Shrop	***Rationale:*** *To reduce the impact of diabetes on the health and wellbeing of people in Shropshire and the financial burden this condition places on the health and social care economy*	200 over the STP period OPFA – reduced by 420 over 4 years OPFU – reduced by 1718 over 4 years								Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4		
Owner	**Neighbourhood Paediatric Asthma pathway**	0	164	225	287	0	338	465	592	Y	Y	Y	Y		
NCM - SHROP	***Rationale:*** *The county of Shropshire is an outlier for respiratory related paediatric emergency admissions with activity increasing year on year (NHSE RightCare Commissioning for Value Focus Pack, April 2016).*									Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4	Year 1 Year 2 Year 3 Year 4		
Totals		**124**	**469**	**706**	**991**	**300**	**2088**	**5465**	**8730**						

The collation of the work is now 'real' with milestones, outcomes, resources and owners for each scheme and will be qualified and assessed through the 90 day plan to ensure the assumptions are agreed and the enabling workstreams are able to create plans for the next 4-5 years.

90 Day Plan . . .

STP Schemes

. . . proposed impact of each scheme 'in the round'

Strategic Modelling

. . . are the schemes delivering enough?

Cause & Effect Measures

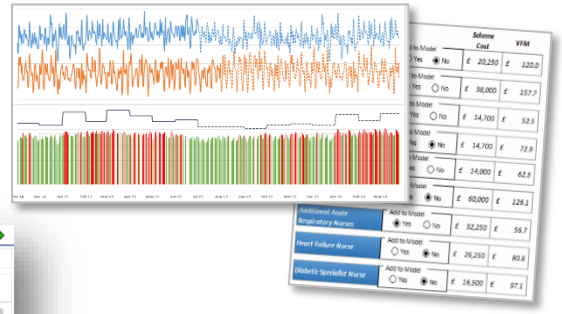
. . . captured on a daily basis

Assurance & Performance of Schemes

. . . daily, weekly, monthly reporting

Day 1-30

Much of this has already been done and is built off the clinical foundation of the future fit work

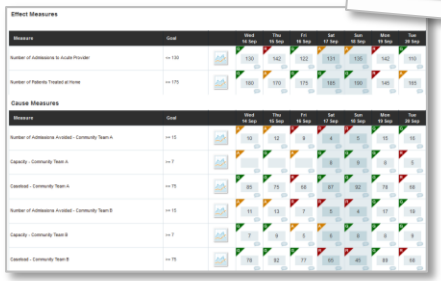


Day 1-60+

This is a model which captures all of the initiatives, incentives and interventions through the pathways and schemes – in one place. It shows projected assumptions, alongside, cost and expected return

Day 30 – 90+

Where daily, footprint transparency and grip is required to provide assurance



Day 60 – 90+

These reports provide the STP Board assurance of delivery against assumption

The 90 day plan will:

- Build upon the foundations and programmes of the clinically led FutureFit work
- Produce holistic enabling workstreams that will truly 'enable' implementation
- Continue the delivery of the plan founded upon clinical pathways
- Provide frontline to footprint measurement and grip with unified language and action
- Create a frontline founded plan for cultural 'buy-in', and therefore, sustainability
- Present whole system transparency and grip of expected outcomes to deliver the aims of the STP
- Deliver daily assurance of the transformation required through the implementation of the plan
- Give the STP Board visibility of operational, workforce, quality and financial measurement
- Initiate a delivery mechanism that is transparent, sustainable and gives assurance of delivery

Specifically, we will …

- Confirm our QIPP plans
- Develop contracts for 17/18 and 18/19 in support of Neighbourhood working and acute reconfiguration
- Ensure wider clinical support for STP
- Implement internal and external communication of STP
- Review left-shift activity modelling
- Complete MSK/orthopaedics review
- Complete community beds review
- Develop consistent business cases for acute reconfiguration and Neighbourhood working
- Finalise public/patient engagement proposals
- Review commissioner/provider organisational landscapes

Communicating the Plan

Communications and Engagement Overview

Aim

To create opportunities for an open, transparent, two-way communication and engagement system between patients, the public, carers, clinicians, stakeholders and individual local health organisations to ensure that the plans and their implementation are robust and meet the needs of the communities

Key outcomes

- Secure public understanding of the case for change recognising not everyone will like the implications
- Effective delivery of engagement with key stakeholder groups
- Evidence early and robust engagement and where appropriate consultation
- Where consultation is required ensure statutory responsibilities and legal requirements are met including Brown and Gunning principles
- Robust evidence of activities and responses of stakeholders
- Workforce engagement and support
- Effective reporting and risk management

Governance

The Communications and Engagement Group workstream is required to:

- Agree with the STP Partnership Board, through the STP Operational Group, a strategic approach to communications and engagement to support Acute Services and Neighbourhood workstreams
- Take delegated responsibility from the STP Partnership Board, through the STP Operational Group, for implementation of the agreed strategic approach and be held accountable for its delivery
- Develop a programme approach to delivery and routinely report on progress, risks and resource usage to the STP Operational Group
- Ensure attendance at the STP Operational Group and (as appropriate) at the Acute Services and Neighbourhood workstreams

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

NHS

Health and Care Communications and Engagement

Engagement

Presentations/networking with:

- Patient groups
- Healthwatch Shropshire and Healthwatch Telford & Wrekin
- Powys Teaching Health Board
- Health and social care networks
- Local Joint Councils
- Young health champions
- Senior citizens forums
- Parish Councils
- Cabinet / members
- Health and Wellbeing Board

Deliberative events

- 10 events in six locations
- 300+ participants

Pop up stands

- 68 events
- 38 locations
- 203 x direct feedback
- Increased brand awareness
- Positive workforce engagement
- 500+ people added to the mailing list

Consultation preparation (Future Fit)

- Process established to consult stakeholders on consultation methods
- Consultation survey preparation
- Consulting with Consultation Institute on best practice and legal guidance

Stakeholder management

- Fortnightly flash report to senior managers issued
- Regular group and one-to-one briefings
- Parliamentary/Cabinet briefings
- Programme bulletin / Newsletter
- Internal briefings ahead of key news
- Political profiling

Media

- 250+ media enquiries handled
- 53 press releases issued
- 30 rebuttals from the media groups
- Daily media monitoring
- Regular media briefs
- Media training and messaging sessions delivered to senior professionals
- Several case studies created and published

Clinical and Workforce Engagement

- 300+ clinicians and patients involved in co-creation of Model of Care underpinning STP workstreams
- 6 senior clinician champions supporting Future Fit
- High levels of GP and voluntary sector engagement in pilot sites for Neighbourhoods
- Monthly workforce briefings at Telford & Wrekin and Shropshire CCG's.
- Regular briefings at PRH/RSH
- Workforce engagement during pop up stands
- 10 SOC specific pop up stands to date

Strategic Communication

- Representation at Future Fit Programme Board
- Advising STP Partnership Board via Communications and Engagement Workstream
- Key messaging framework
- Brand positioning
- Report writing
- Pre-board briefings

Digital

Website

- Website established Dec 2013
- 13,717 visits to date
- 70.3% visits as a result of twitter hits

Blogs

- 13 blogs on key themes - travel times, long term conditions, clinical design report summary and programme of change

Twitter

- Twitter established in July 2014
- 1024 followers
- 1367 tweets sent
- Average monthly reach over 10,000 accounts

Facebook

- Facebook launched in Mar 2016
- 1077 page likes
- Average weekly reach of 4000 people

Social Sign In

- Run pre-scheduled twitter campaigns
- 75 pop up stand campaign posts
- 274 clicks to NHS Future Fit website
- 234.2k total potential reach
- 148 re-tweets/shares
- 32 likes

Animation video

- Viewed 9000+ times

Communications PMO

- Workstream governance
- Planning and presentations
- Archiving and evidencing activity
- Continual updating of activity plans
- Financial reporting and management
- Support and advice - The Consultation Institute
- Benchmarking
- Facilitating external meetings
- Risk management

Marketing and Market Research

- Pull up banners, leaflets, clinical design summary, mailing list, comment cards etc
- Promotional items - plasters, hand sanitizer, pens
- Simple infographic and explanation of Urgent Care Centre services poster

Equality and diversity monitoring

- Supporting Integrated Impact Assessment
- Investigating gatekeepers to "hard to reach" groups
- Running and engaging with equality focus groups
- Legal and governance advice

Contact lists

- 1890 stakeholders now on mailing list

Branding/Advertising

- Series of adverts in local newspapers
- Shropshire Star reach 98,146 people
- Telford Journal reach 61,541 people

2 x telephone surveys

- Scientific data collection
- Telephone interviews with residents living in Shropshire (60%), Telford & Wrekin (31%) and East Powys (9%)
- Survey results include responses from approx 3000 people

Communications and Engagement Overview

What is an STP?

An Sustainability and Transformation Plan (STP) is a local health and social care five year plan. There are 44 planning areas across England. Health and care organisations in Shropshire and Telford & Wrekin have come together to create a shared plan. Together we will work together to support people to look after their own health and that of their friends and family.

Acute Services (Future Fit)

- The outcome of this programme will transform acute hospital services making them fit for at least the next 20 years
- The programme is led by local clinicians with input from patients and local authority partners
- Future Fit will modernise and transform the way our hospital services interact with neighbourhood services to support more patients to maintain independence in their own homes
- The design of services will attract NHS professionals and address recruitment and retention issues

STP aim is to provide:

- Local people with the knowledge and skills to live healthier happier lives
- Safe and sustainable health and social care service
- Support for people to maintain independence in older age
- Job roles in health and social care that are attractive to potential recruits and keep people highly skilled
- A way to deliver high quality and affordable health and social care

Neighbourhoods

- The outcome of this programme will be to give local people the skills and information they need to lead healthy happy lives
- When people do need care and support, teams will integrate to meet their needs
- The programme will strengthen neighbourhood based services so that most care can be delivered in or as close to home as possible
- Engagement with local communities, groups, representatives and clinicians is critical to developing the right solution for each neighbourhood

Stakeholders and Risk Management

Key Stakeholders Groups

Patients, Service Users, Members, Public, Communities, Voluntary and community organisations

Case for change and communications on delivery models with feedback and involvement required to inform plans

Media

Promote case for change and key principles of programmes. Encourage fair and balanced reporting through positive media relations

Workforce

Ambassadors for plans and key advocates for case for change; involvement includes feedback in ideas development and engagement/consultation planning

Key Risks	L	C	LxC	Mitigation
Failure to gain and sustain support from clinicians to be visibly leading the programme; thus dwindling clinical and public support, and undue burden on small number of leaders.	5	4	20	Work with most senior clinicians in each sponsoring organisation to help identify and develop spokespeople
Failure to comply with Gunning Principles & Brown principles and related legislation & guidance on consultation and engagement in England and Wales	5	4	20	Programme Board to approve consultation plan which complies with specified requirements.
Failure to agree a process when diverging off plan. Risk includes inability to implement a timely plan to meet best practice standards with no subsequent ownership	5	4	20	To implement the Engagement and Communication Strategy and subsequent plans. Additional focus includes creation and maintenance of risk register.

Partners

Engagement throughout to ensure case for change and options for services are understood. Feedback to be iterative element of engagement journey and key learnings to be gathered around gateway reviews and assurance

Political

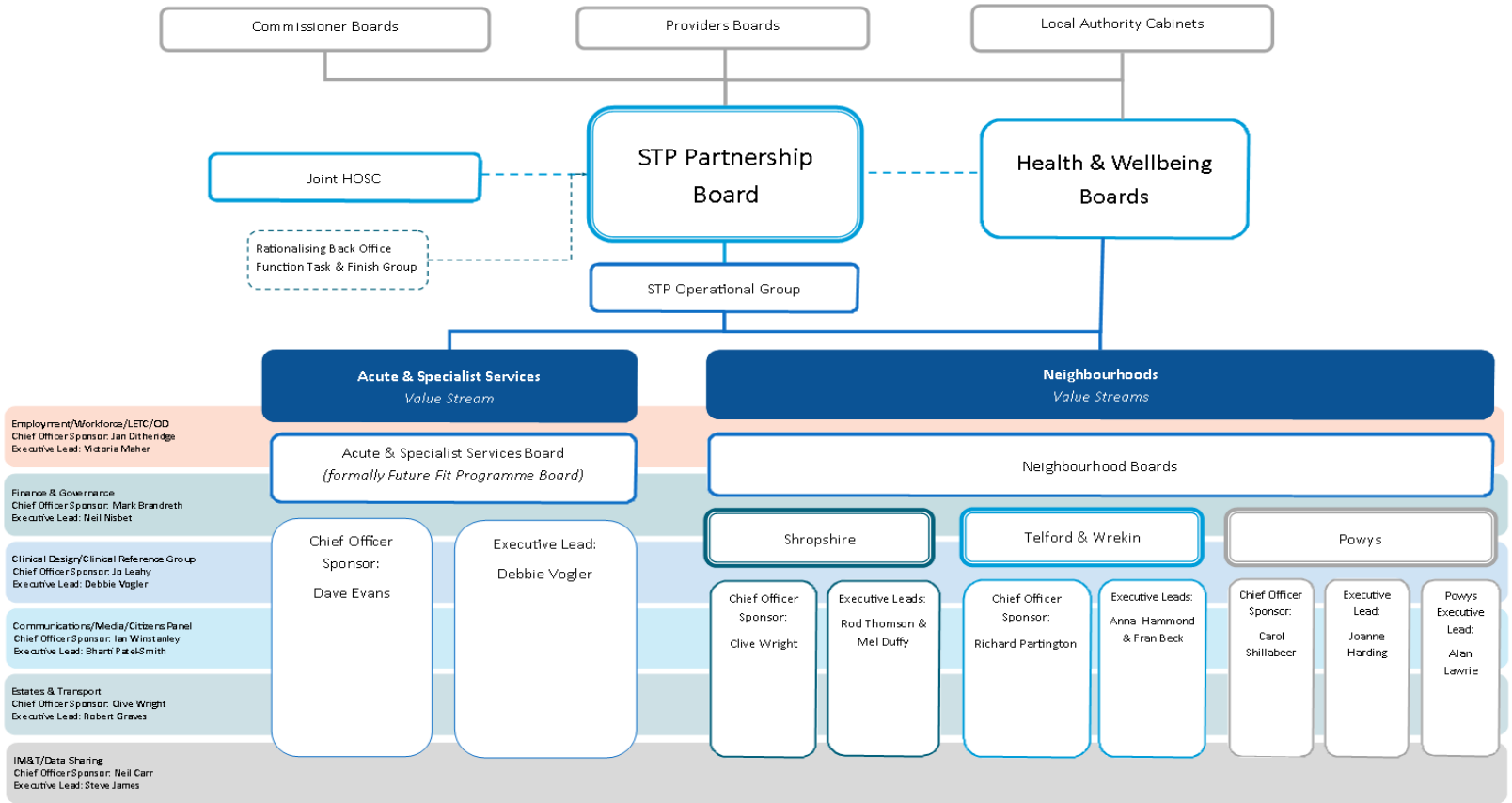
A group that need to be kept informed and engaged upon key milestones. Councillors key for community outreach meanwhile MPs for decision making

Governance

Governance

Shropshire, Telford & Wrekin
Sustainability and Transformation Plan

STP Governance Structure



Governance and Leadership

- Partnership Board brings together Chief Officers from all NHS providers and commissioners and the two local authorities.
- Compact agreed that sets out how the Partnership will work – being adopted by all NHS Boards and the two Health and Wellbeing Boards (*appendix 1)*
- Operational Group brings together the Executive leads from each of the four value streams and six Enabling Groups.
- Virginia Mason Institute Accelerated Transformation Programme adopted throughout SaTH
- All Terms of Reference being agreed
- Financial support for the STP agreed between all organisations. Permanent Programme Director being appointed together with supporting team.
- Executives from all organisations participating in Transformational Leadership programme

Key risks to the programme

Risk	Description	Mitigation
Delivery	Poor history of large scale transformation	New teams in place
	Lack of dedicated PMO function at system level	Commitment of all organisations to fund small PMO
	Unwillingness to adapt to non-clinical approaches	Communications Strategy will emphasise
Financial	Anticipated savings may not materialise	PMOs in place in CCGs and Providers
	Unable to obtain capital funding for changes	Alternative sources for capital under discussion
	Local Authority funding to continue Neighbourhood working	Local Authorities have committed to continue support for the medium term
Workforce	Recruiting and training appropriately skilled staff	Workforce Group articulating changes that will be needed
Political	Political support for proposed changes	Ongoing active engagement strategy
Regulatory	Regulatory bodies enforce individual organisational performance	Single control total for the system under consideration
Public	Public support for proposals	Development of Neighbourhoods provides opportunity for positive messaging
Clinical support	Clinical support for proposals	Ongoing clinical engagement through Design Group

Appendix 1 - STP Compact

- The overarching purpose of STP is to create a patient centered, sustainable system of health and social care. By implementing STP we learn how to collaborate to deliver care to an ageing population with less overall resource.
- We recognize the work that lies ahead will take discipline and a long-term commitment. In the end ***Shropshire, Telford and Wrekin will be the healthiest population in the country.***
- We recognize achieving this vision will require unprecedented levels of trust, cooperation, collaboration, and working across traditional boundaries.

The purpose of our compact is to support this partnership way of working. The elements are:

GIVE - In our work together, we all agree to:

- Address hard issues ["lance boils"] in constructive ways
- Avoid defensive reactions – listen to feedback
- Say what we need to say in the meetings not outside
- Keep our commitments to this group
- Think and work upstream; invite participation, don't hand others fully baked solutions
- Be transparent regarding data/finances
- When it comes to the money, align our behavior so that all organisations have positive bottom line within five years
- Share knowledge with each other
- Seek to understand the impact of decisions your organisation takes on others
- Demonstrate commitment to this work to our boards and staff. Inform them regularly using agreed-to talking points.
- Be disciplined about meeting start and stop time
- All take responsibility for successful meetings (not just the chair)

We expect to GET:

- Results including system surplus, 7 day/week care, the services our population needs delivered here
- Aligned outcomes
- Collective power and influence
- Robust meetings, constructive conversations
- Better decisions and greater confidence in our decisions
- More resilience and mutual support
- Trust that agreements we make to each other will be followed through
- Able to learn from failures or shortfalls and thereby accelerate progress

These outcomes should be indicators that our agreements are being lived and we are willing to modify our "gives" as necessary to make progress relative to these outcomes