Shropshire and Telford &Wrekin Sustainability and Transformation Plan

2016-2021

Version 5.0

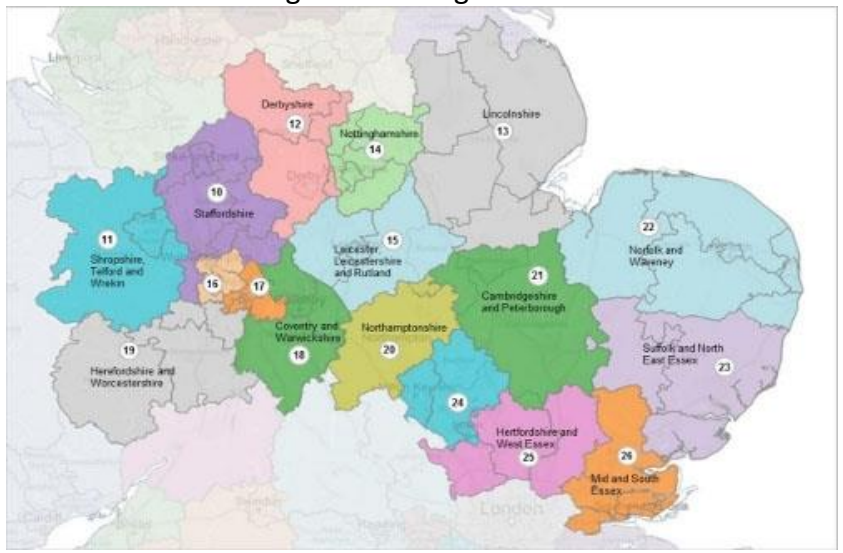
Version control

Date	Version	Notes
August 2016	V1.1	Initial draft compiled from June STP
December 14th 2016	V2.0	Discussion at STP Partnership Board. Prioritised actions. Timescales revised
January 11th 2017	V3.3	Discussed at STP Partnership Board. Additional actions agreed
January 25th	V4.1	Review of updated content by work-stream leads. Further amendments agreed
January 31st 2017	V5.0	Resubmitted incorporating changes and feedback from NHSE

Coverage

Geography

Midlands and East Region- NHS England



CCG boundaries

- NHS Telford & Wrekin CCG
- NHS Shropshire CCG

Local Authority Boundaries

- Telford & Wrekin Council: Unitary Authority
- Shropshire County 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
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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 County Council Telford & Wrekin Council Powys Teaching Local Health Board

Contents

Foreword

This plan is 'a work in progress' and sets out our approach to transforming our local health and care system across Shropshire and Telford &Wrekin . We have been working together as a health and care system to align our vision and approach for our population. Our aim is to materially improve the health and well being of the populations we serve by focusing on:

- Building support for people in our local neighbourhoods to choose healthy lifestyle choices
- Supporting patients to self-care and be actively engaged in managing their conditions

Providing access and support through joined up health, social care and wellbeing services.

Ensuring our services provide high quality care that is affordable and sustainable.

Since the October submission of our STP, a number of important changes have occurred in our system. Of particular note, the commissioners of healthcare in the Shropshire CCG catchment area are under severe financial pressure leading to a significant resource gap which is challenging our ability to meet the needs of some of our populations. In light of these changes we have reviewed our STP plan to consider whether our current plans are of sufficient ambition and scale to return our system to balance. It is clear to us that we need to urgently revisit a number of our key programmes to ensure we are taking the necessary actions to ensure our populations continue to have access to quality care that is affordable and sustainable. In particular we plan to:

Strengthen our plans to improve population health and community resilience

Review and redesign our place based plans (neighbourhoods) where neccessary to ensure we have robust models of integrated primary and community services to enable us to reduce the demand for acute based services across our county.

Revise our financial plan to describe how we will address Shropshire CCGs financial deficit position.

In recognition of our significant challenges, we have begun to strengthen our partnership arrangements to ensure that we have the necessary capabilities and governance in place to transform the health of the communities we serve.

Executive Summary

It is nationally agreed that in order for our NHS to continue to provide services for the future, changes need to be made now. In 2015, 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.

In Shropshire and Telford & Wrekin, our leadership team comprising of eighteen health ands social care organisations have been working together in partnership with our communities to develop local plans to address the causes of poor health and well being in our population. Our plan is a 'work in progress' and we have started to engage and communicate this with our patients, publics and partners, our workforce and our wider stakeholders to help us develop our plans further and to agree how to implement them in the best possible way.

The challenge we face is significant. Our services are not keeping pace with the changing needs of an ageing population and people with multiple long term conditions. It is becoming increasingly difficult to ensure local people have access to consistently high quality care that is affordable and sustainable. Local health and social care services are under severe financial pressure and we have a significant resource gap in part of our system which is challenging our ability to meet the needs of our populations. This plan sets out our strategic vision and our intention to work together to mitigate the growing demand, and cost, of providing care.

Our vision is materially improve the health and well being of our populations. Our focus is on addressing our 'triple challenges' which are:

- To address the wider determinants that result in poor health and well being in our communities
- To reduce unwarranted variations in care to ensure that everyone has the best outcome and experience of health and care possible
- We risk not being able to afford all the services our population need unless we take urgent action to avoid future costs and create a sustainable health and care system that helps our communities to thrive and prosper.

We want to prevent ill health where possible by making the most of the skills of local people and organisations, supporting people in our communities 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.

Our neighbourhoods will 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 patients with diabetes and other long-term conditions . patients who might otherwise have to go to hospital but who don't need emergency services; and patients who have recently been discharged from hospital. They would be the link between clinical and community care.

Executive Summary

For patients who do need acute 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 supporting this.

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 patients would need to go to hospital, and those who do would be discharged quicker.

It is clear to us that our current ways of operating are unsustainable. Under our plan, individual organisations and partnership will continue to make the improvements and efficiencies that are directly within their control but the overall scale of opportunity will be transformed by the our working together as a single system with a shared imperative

We have committed to work together to ensure our STP works in the best interests of local people. As a leadership team we have listened carefully to feedback and have acted accordingly to strengthen our partnerships and build our leadership capacity and capability to lead these changes. We have also enhanced our programme management infrastructure to provide us with the necessary structure, processes and tools required to deliver complex change. We will also be working with our regulators to secure expert advice and support where this is needed.

Working with the national and regional bodies and engaging with our communities, we will act with urgency to maintain momentum achieved through a accelerated STP process to ensure that each of our priorities delivers against our system objectives. We have listened carefully to feedback we have received from stakeholders and we recognise that we have to make some critical decisions about the way our services will be provided in the future and we accept that this will challenge existing models and approaches however we also acknowledge that these concerns must be managed if we are to achieve a sustainable and transformed health and care system for the people of Shropshire and Telford and Wrekin

Finally 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.

Our Vision

Our Vision: Section Summary

In this section we set out our ambition for how we want to transform health and care in order to meet the needs of people across Shropshire and Telford & Wrekin . We explain why we need to change because of our population growth, the changing profile of need, the difficulties in meeting quality standards, and limitations with our current workforce and finances.

- Our Vision and Objectives
- Our Population
- Our Challenges
- What's changing ?
- Our Case for Change

Vision and Objectives

Our Vision

- We have a unified vision to materially improve the health and well being of our populations. To achieve this goal we want our communities to be illness free and independent for as long as possible, provide community based integrated health and social care models of care; and when needed, ensure our patients receive the safest acute based services. To do this we want to transform our partnerships to bring unity of purpose across our health and social care sector .
- Key features of our plan will result in integrated technology and data moving freely across our system to support a placed-based delivery model, backed up by a one public estate philosophy which maximises the use of public assets to the full.
- We will work with our populations to improve public engagement and accountability and build social capital to enable us replace a sickness paradigm with wellness.
- We will use our scarce resources to focus on interventions and services that supports the prevention of poor health, early detection of disease and community based treatment where needed and possible. We believe this help us to reduce over reliance on our acute services.
- As employers of a significant number of local people in this area we also want to use this leverage to support economic prosperity in our communities

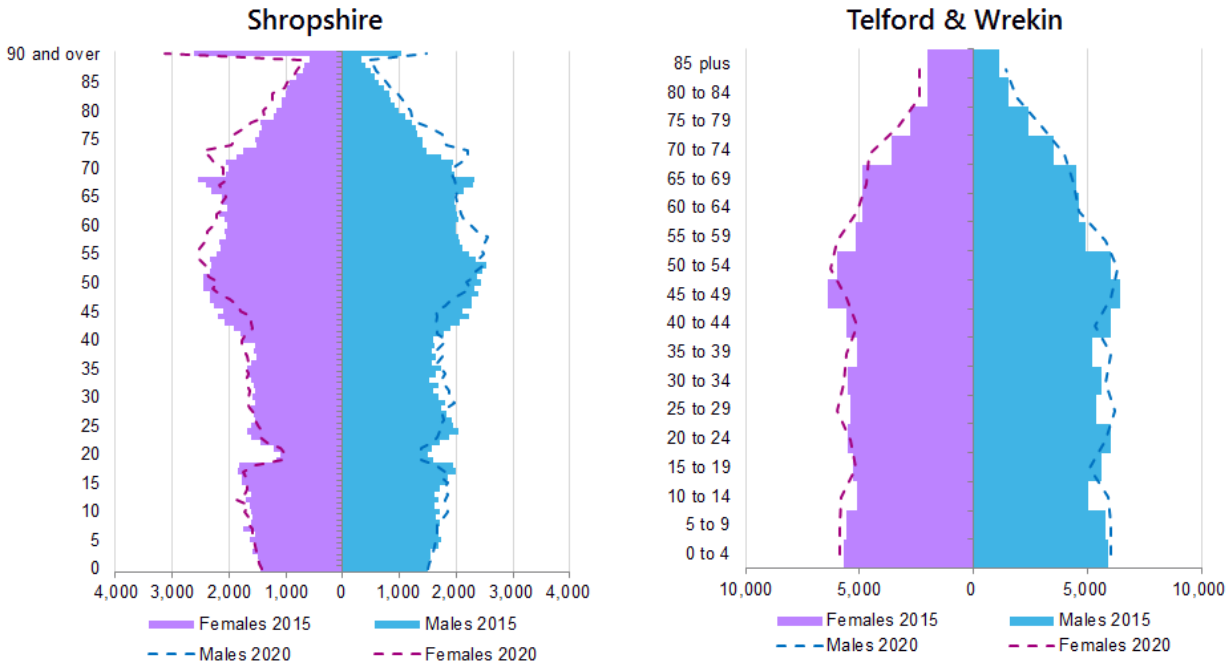
Our Objectives

- 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.

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.

Change in population age/gender profile: 2014 to 2019



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

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

Our Challenges

- Although life expectancy rates overall have improved steadily in last decade across the footprint, 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.

What's changing in our population?

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 the supporting people In the community and that voluntary community organisations have an important role.

Our Case For Change

In November 2013 our 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 Priorities & Plans

Our Priorities & Plans: Section Summary

As partners we have agreed a number of key priorities for wider engagement. In this section we set out how we intend to develop these and deliver our vision and in so doing tackle the gaps that exist in health and well-being, care and quality and finance and efficiency.

- Our priorities
- How will these priorities benefit our patients
- Priority one- To address the wider determinants of health and undertake prevention at scale
- Priority two -To develop and implement Local Place Based Models of Care - Neighbourhoods
- Priority three- To create a co-ordinated system of Acute Care to improve Quality and Sustainability of services
- Priority four- To build on existing collaborations of care such as the Transforming Care Partnership for Mental Health and Learning Disability Services.
- Priority five - To make best use of our scarce resources

Our Priorities For Shropshire, Telford & Wrekin

1 Prevention at scale

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.

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.

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

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.

3 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.

4 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.

5 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 these priorities benefit patients

How our plan could benefit people in Shropshire and Telford &Wrekin:

- Redesign and investment in GP services by 2021 will result in extra GP appointments being made available. Children under 5 and adults over 75 will have enhanced access to GP appointments, meaning more people will be able to see a family doctor when they need.
- More people who turn up at A&E will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- Across Shropshire and Telford &Wrekin there will be additional home visits, clinics and appointments offered in local surgeries and health centres, as close to home as possible.
- By 2021, more people will be saved a trip to hospital for their outpatient care, with more treatment offered in local GP surgeries and health centres.
- By bringing all cancer services up to the standard of the best, cancer one year survival rates will increase in the Shropshire and Telford &Wrekin system.
- Common sense changes to the way our family doctors, hospitals and care services work together will reduce the number of people visiting A&E meaning faster treatment and care for the most seriously ill.
- By 2021, instead of having to be admitted as an emergency to hospital more people each week will be cared for in their own home or local community by doctors, nurses and paramedics.
- More patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and bloody pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.
- Our Acute Hospital reconfiguration will bring hospital services together in one place to treat more people in better facilities.
- By using our specialist NHS staff in a different way, patients who suffer major trauma, stroke, heart attack, or those who have cancer, kidney failure or breathing problems will receive the best treatment and care.
- Changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- By tackling waste, improving standards and working together, we can avoid a potential increase in health costs every year by 2021.

Priority one:
To address the wider determinants of health and undertake prevention at scale

Lead Sponsor – Clive Wright & Richard Partington

Prevention At Scale

All parts of our system are committed to addressing the wider determinants of ill health through a radical upgrade in prevention. This work will be undertaken at County and Local Neighbourhoods levels

- 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

- 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

Priority two:

To develop and implement local place based models of care - Neighbourhoods

Lead Sponsor – Clive Wright & Richard Partington

Our Overall Vision For Neighbourhoods

Shropshire, Telford and Wrekin Neighbourhoods Vision:

Our vison is clear to improve the health and wellbeing of our local populations. 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 . We will address the wider determinates of ill-health which 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.

Our Approach

We've listened to concerns of patients and public -

- **Providing more preventative care**; finding new ways to meet people's needs; and identifying ways to do things more efficiently.
- **Achieving a step change in population health & outcomes** through integrated, standardised, place-based services built around the registered list, which deliver both patient-centred and population-centred care, commissioned on the basis of outcomes not activity.
- **Enhanced access to primary care** with longer opening hours where this is needed
- **Improved support for people with a Long Term Condition**. Those being supported to live with a health condition (especially LTCs), need improved continuity of care. They need more consistent and proactive services that support them to manage their conditions and achieve their goals. They have needs (mental and physical) that are interdependent and that change, and they expect services to reflect these needs.
- **Better Coordinated Care**. Some, notably those with complex care needs, multiple co- morbidities, those with frailty and those nearing the end of life, need better coordinated care. We know that the majority of health spending occurs in the last years of a person's life, when many have complex care needs: These vulnerable people need the services that are supporting them to work closely together, integrating (rather than duplicating) care closer to home and improving the experience of it. Unfortunately, too many of these people are ending up in hospital in a crisis and being admitted to a hospital bed which potentially could be avoided with the right services in the community.

Analysis

Our understanding of local challenges draws on a substantial analysis of Shropshire and Telford & Wrekin's health services conducted during 20 15 and ongoing scrutiny of a wide range of clinical quality and safety data, clinical audit measures, patient and carer experience feedback and finances. We continue to update and deepen our understanding of the range and depth of challenges we face across our health and care system so that our plans are firmly focused on delivering positive change.

The Neighbourhoods Programme has built upon previous work in our system described as the **'Community Fit'** programme which was initially established in April 2015. This programme emerged from recognition in our system that there needed to be a fundamental shift of focus away from acute based towards community based care wherever possible.

An out of hospital work stream was therefore established alongside the Acute Services reconfiguration programme 'Future Fit'. The programme was designed to enable the development of a comprehensive range of community services to enable us to support people in their own homes for as long as possible, reduce avoidable hospital admissions and following an acute episode of care to return people back their their place of residence as swiftly as possible. The first phase of the Community Fit programme was designed to provide insight into the challenges facing the non-acute sector and to encourage stakeholders to consider how these challenges and those originating from Future Fit might be met.

The aim of this phase of the programme was to provide insight into the challenges facing the community sector to enable the development of an appropriate set of out of hospital solutions. In particular we wanted to:

- Develop an enhanced understanding of the common ways in which patients use health and social care services in Shropshire Telford & Wrekin
- Undertake a detailed analysis to guide our thinking about the potential to reorganise care in this area- particularly for those patients with contact with more than one sector.
- Access information and intelligence to support considerations about the packages of community support that might substitute for acute care packages.
- Project Deliverables & Scope
- To summarise the level and nature of activity currently taking place in the out-of-hospital health and care sectors
- To estimate the likely impact of demographic changes on the demand for health services in these sectors.
- To create a patient-linked dataset to provide insight into the patterns of patients' health service use across multiple sectors
- To develop a taxonomy or classification of patients based on their patterns of healthcare use.
- To summarise the assumptions in the Future Fit activity models about the movement of activity out of acute settings
- To assess of the current and potential contribution to Community Fit of voluntary sector organisations in Shropshire, Telford and Wrekin.

Findings

Approximately 5% of current inpatient spells might be avoided in the future. This assumption amounts to about 3 admissions per practice per month. Approximately half of these would be avoided as a result of a public health intervention, with smaller proportions avoided through the provision of community/primary care alternatives and policies/thresholds.

Approximately 19% of current acute bed days might be avoided in the future – approximately 30 beds days per practice per month – through the provision of public health interventions and community / primary care alternatives in broadly equal measure.

Approximately 8% of current outpatient attendances could be avoided through improved policies and thresholds.

Approximately 1% of current A&E attendances could be avoided – though the provision of public health interventions and community / primary care alternatives in broadly equal measure.

The Community Fit workstream recommended that the STP programme board ensures that:

- the Clinical Design workstream, use the data analysis and in particular the taxonomies work to drive the development of a refreshed integrated community model, building on existing developments already underway.
- the Clinical Design group brings in additional expertise to boost its membership (e.g. voluntary sector, social care, mental health, community reps) use the intelligence gained from Community Fit phase 1 to describe the neighbourhood models of care closer to home.
- Taking a steer from the Clinical Design Discussions, 'bottom-up' redesign discussions are facilitated on a locality basis between all stakeholders, service-users, patients and service providers to coproduce the Community Fit plan for their locality.
- Relevant STP and Future Fit workstreams, in particular Deficit Reduction but there may be others, takes due consideration of the important and helpful analysis from Community Fit phase one.
- All workstreams are supported to use the Community fit analysis as a resource to inform ongoing design work and test models of care; we suggest a half day workshop to review the modelling is scheduled to facilitate this.
- Building on the successful work with the board of the GP Federation, secure agreement and funding to enable GP data sharing with a view to repeating the data analysis and matching later in the year to enable a more comprehensive overview to inform the development of the neighbourhood workstream, including CHC and primary care data.
- Work is rapidly completed to clarify the governance of workstreams to align approaches and avoid duplication; reviewing the membership of relevant groups to confirm fitness for purpose.
- Voluntary sector focus – establish feasibility of incorporating NHS number for voluntary sector organisations – scope the potential to pilot this.

Developing our Neighbourhood Model - Overview

Our statement of purpose: We have drawn upon our analytical work alongside the extensive engagement with our patients to build up our neighbourhoods model. We have developed a framework for neighbourhood working that recognises that our constituents need a wide range of services some of which will be common to large numbers of patients across all our neighbourhoods whilst others will be more specialist applying to smaller numbers of patients to meet the needs of specific communities.

- The main groups of services that will be developed and delivered through our neighbourhoods are:
- Greater support to stay well and self care
- Being part of resilient communities as a way of avoiding social isolation and helping others to do the same
- Enhanced access to care. The number of patients able to get an appointment 'to see or speak to someone here' at a time of patients choosing is decreasing The majority of our patients want enhanced access to Primary Care.
- Improved support for patients with long term conditions
- Better co-ordinated care

The **three Neighbourhoods; Shropshire, Telford &Wrekin and Powys** will be responsible both for the population registered with its constituent practices but also the population that lives, works, learns and plays in its agreed geographical place.

- working with the community to understand and interact with their perspectives on need and wants
- detailed understanding of overall patterns of health, healthcare and social care at a citizen and population level to identify opportunities for improvement and optimisation for 'better value'
- detailed understanding of the capability and capacity of local assets for health and care, including the voluntary sector
- collaborative working locally across statutory and voluntary sector agencies to ensure joined up care, real alternatives to hospital care and sustainable local provision wrapped around primary care on a 24/7 basis as needed. Opportunities must be created for practice and community staff in particular to have regular conversations, develop stronger trust, and work more effectively together
- deploying integrated multidisciplinary teams to support people identified as having complex needs or at risk
- securing necessary inputs from services outside of the cluster as required (acute hospital services; in patient mental health; services scaled up between clusters)

Developing our Neighbourhood Model - Overview

The Neighbourhoods teams exist to support the partner organisations in these tasks.

The scale of the challenge facing the NHS requires that the Neighbourhoods are focussed as much on the prevention of ill health as on the provision of care. The place that the Neighbourhood occupies includes localities; streets; estates; schools; residential and nursing homes; workplaces; shopping facilities; leisure facilities ; hostels; etc. Knowing these places and working with them on primary and secondary prevention as well as service offers will be key to the overall objective.

The Core Neighbourhood offer

Every Neighbourhood will provide a 'Core' service to a consistent set of standards defined by the commissioners in collaboration with delivery partners. This is essential to underpin overall resilience and confidence in the new model of care.

The Core offer requires the following services to be delineated, linked and in some cases provided and integrated at a Neighbourhood level . This may not be on the same basis as now. For example, specialist services might focus more on education, support, and providing input in the most difficult cases. The role and contribution of each should be understood and documented for each cluster in a simple overall partnership agreement, sitting alongside more extensive contractual arrangements). Shared assessment and care planning processes are key; a single assessment that can be done by any member of the team is a Core requirement

- GP primary care
- community mental health
- community nursing and therapy
- community pharmacy
- community dentistry
- community optometry
- social worker and social care
- specialist community services e.g. school nursing; tissue viability; palliative care; rapid response
- voluntary sector in relation to health and care
- outreach specialist services from hospital (to be defined as appropriate)

Developing our Neighbourhood Model - Overview

The Core offer also requires a systematic process to be applied to identify patients and citizens in need of complex care. It also requires identification of those at risk of becoming major consumers of care that could be avoided through early intervention. At minimum, all those on a known register should be in receipt of evidence based good practice care. This will require a combination of the use of registers; information about population cohort characteristics, especially the presence of combinations of LTCs; local clinical judgement; sharing information on risk factors. Risk stratification tools are not considered appropriate for targeting of individual care, but such information will be used by the Neighbourhoods as part of its intelligence

The Core Plus Neighbourhood offer

- Every Neighbourhood will also use its local knowledge, its local partnerships and its expertise to develop innovative service responses, to the particular challenges and opportunities experienced in their 'place'.
- There will be maximum devolved authority to do this and a highly permissive environment. Each Neighbourhood will be expected to be able to describe what they are doing, why and whether it is working. They won't be required to ask permission first as the aim is about innovation and experimentation. It may be about taking risks.
- The only rules are that risks are identified and understood; that significant risks are not taken without the Neighbourhood support; that initiatives have clear objectives that are measurable and measured ; that learning is shared ; that there is a willingness to demonstrate value and that where value isn't achieved the initiative is stopped; that public money is used appropriately.
- Each year, the Neighbourhood will together agree (contractual agreement between commissioners and providers) the ambitions and intentions it has for localised plan.

Neighbourhood Model: Key Metrics

Whilst there will be a host of ways that the Neighbourhood assesses itself, and many metrics that will determine contractual arrangements, there are a few enduring measures that all LCs will guide themselves by. A suite of relevant metrics will be developed to allow the LC an overview. In each case, there won't be artificial targets but instead we will look for:

1. relative improvement over time
2. awareness and a thirst for understanding where the neighbourhood is out of line with other
3. increased equity

For example:-

- increasing preventative power and effect (reducing hospital admissions for conditions amenable to prevention; reducing the prevalence of smoking, alcohol misuse and obesity)
- reducing intensity of utilisation (reducing hospital admissions or other high cost activity where known lower cost and equivalent or higher quality alternatives exist)
- increasing confidence in ability to self-manage amongst patients
- increasing continuity and clarity of care
- increasing the proportion of people able to die at home
- reducing the gap in health and life expectancy between those in contact with mental health services and the rest of the population
- reducing the travelling that patients need to access services
- reducing length of stay in hospital and numbers and length of long stays
- increasingly confident and supported learning workforce

Overview Of The 3 Neighbourhood Plans

The people of Shropshire and Telford & Wrekin are at the heart of our plans and we therefore want our plans to be as locally responsive to local health needs as appropriate possibly resulting in different solutions in each of our three Neighbourhoods.

These neighbourhoods are:

- Telford & Wrekin
- Shropshire
- Powys

We think this is the right approach, working with each community to shape what those solutions are. However, our collective aim is to help them flourish: to support them when they need support; to guide them when they need guidance; and to promote independence throughout. They are individuals and citizens first, patients and service users second. Our whole approach starts with this understanding.

Key enablers are the assets of the Shropshire and Telford &Wrekin People:

- Building on self-care in a more proactive manner by engaging and activating patients not only to contribute to their own health and wellbeing but also to support others to do the same;
- Building strong, resilient communities and connecting people together, reducing social isolation; and
- Maintaining a strong Voluntary Sector.

The following pages set out an illustration of the work taking place in each of the three neighbourhoods.

1. Telford & Wrekin: Neighbourhood Working

The Telford and Wrekin Model of Care aims to promote:

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

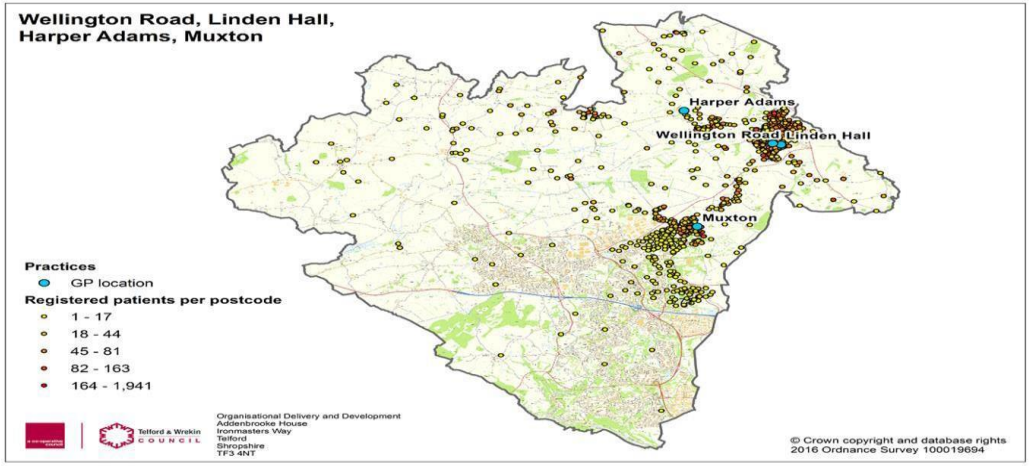
Our approach to developing Neighbourhoods

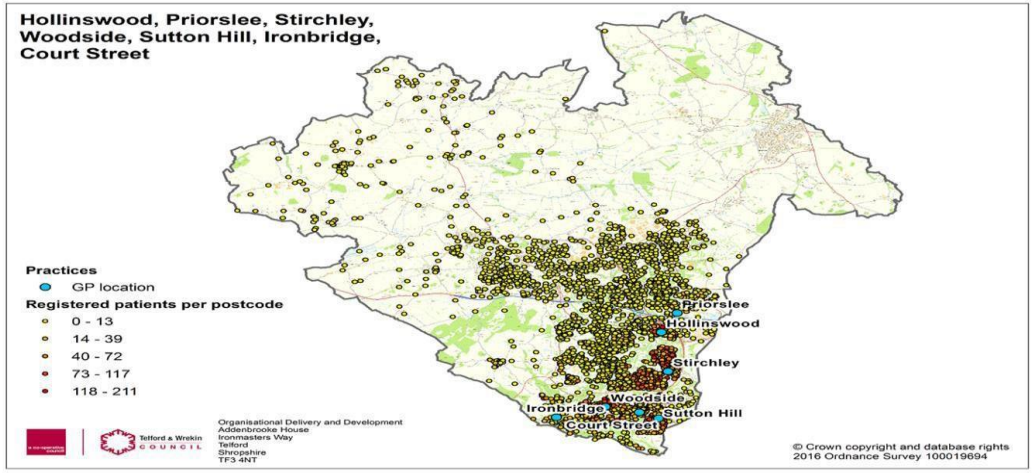
- Building some prototypes around natural neighbourhoods.
- Optimising the total resource in the neighbourhood
- A community centred approach that increases access to community resources to meet health needs and increase social participation
- Supporting the development of strong neighbourhoods that 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

1. Telford & 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'

1. Telford & 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:

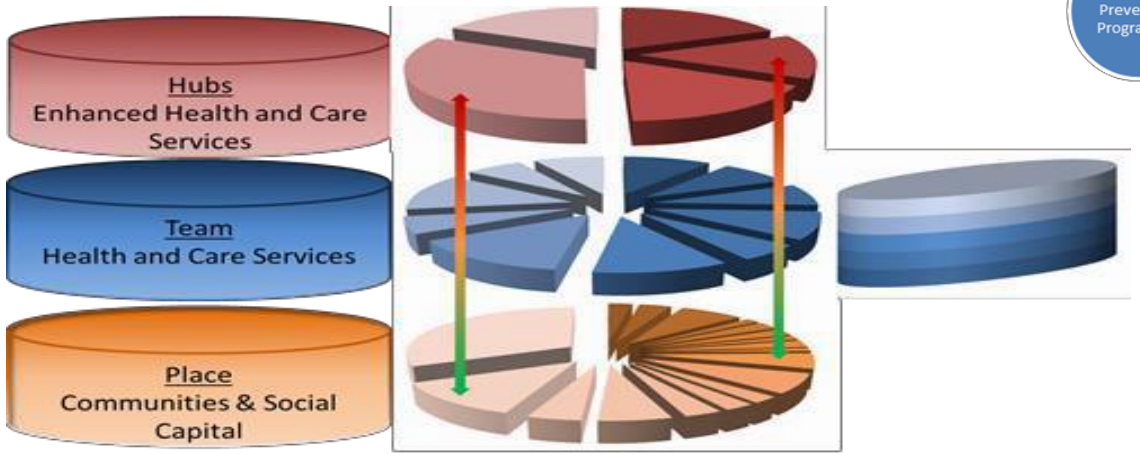
- Integration of health and social care teams
- Greater involvement of drug and alcohol services
- Consideration of those aged 0-5, initially through improved alignment of health visiting
- Implementation of creative support planning and other links with local authority teams

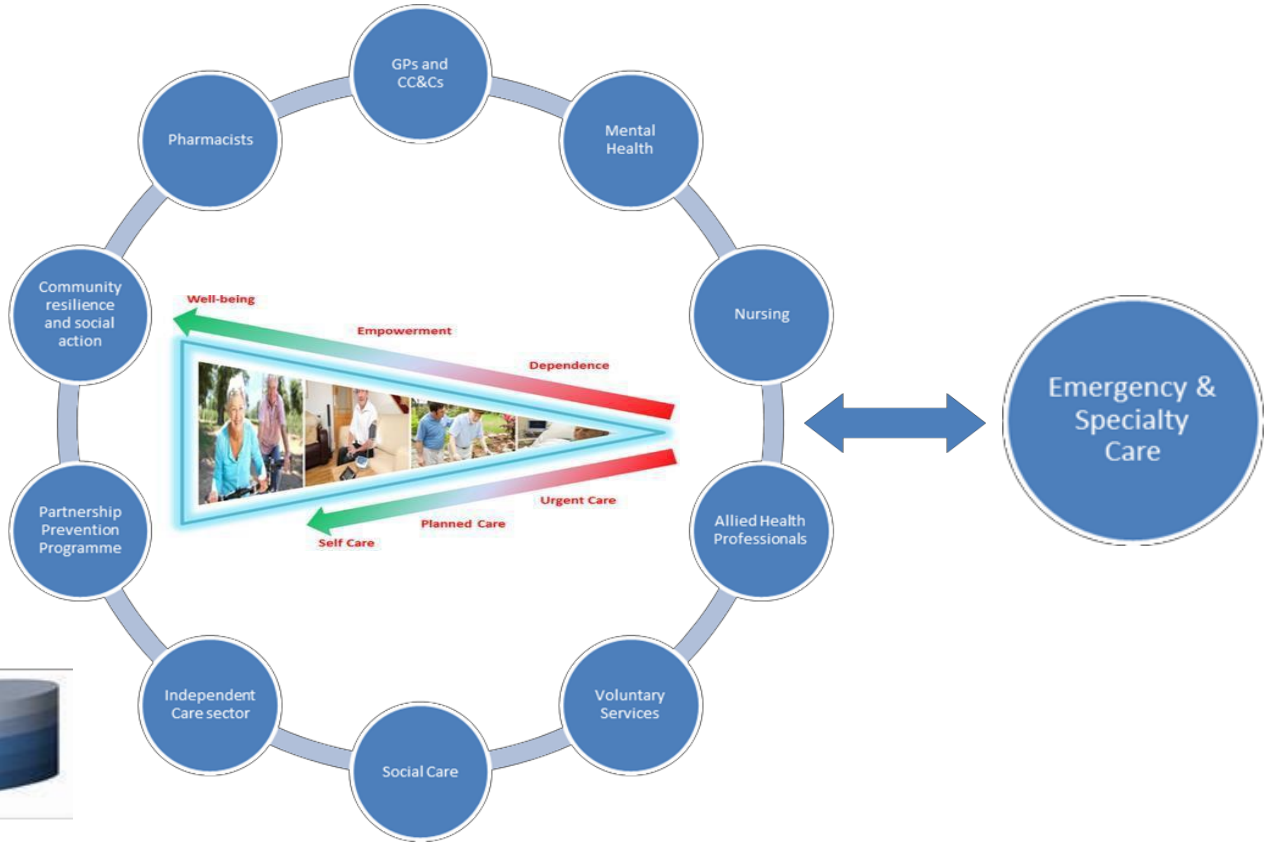
Neighbourhoods	
TELDOC	49,615
South Telford	45,427
Newport	27,412
Group 4	59,155

2. Shropshire: Neighbourhood Working

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





2. Shropshire: Community Resilience & Prevention

1. 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

3. 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)

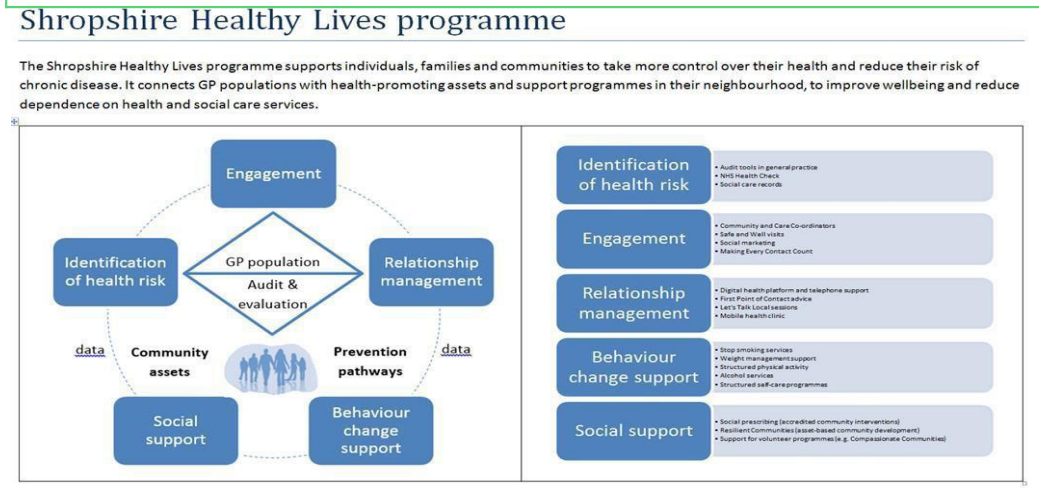
2. Partnership Prevention Programme: Healthy Lives

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

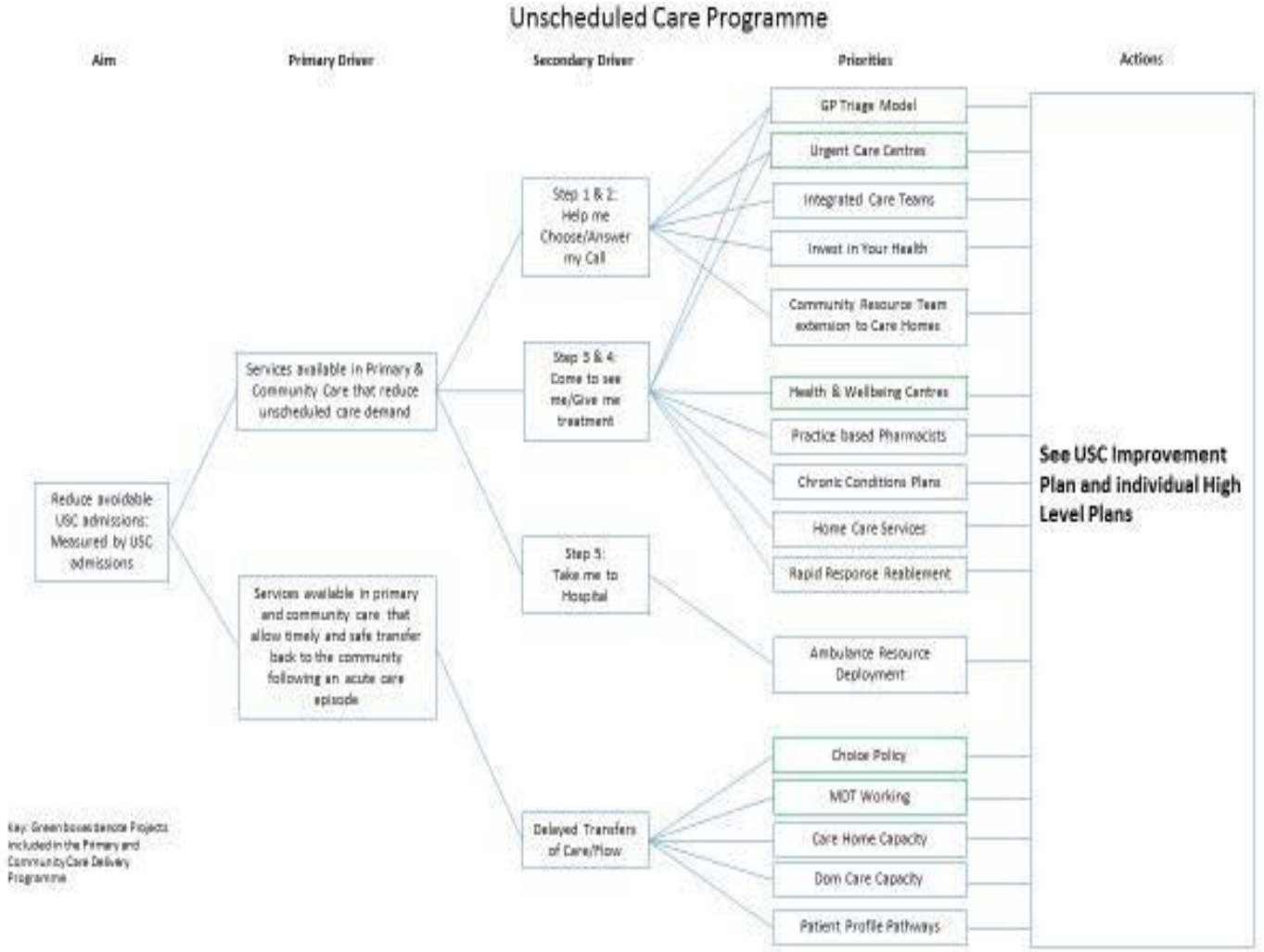


3. Powys: Neighbourhood Working

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 12 months



1. Neighbourhoods Programme

Project Lead – Richard Partington & Clive Wright

Project Ambitions

- To address the changing needs of our populations with integrated care solutions that maximise the potential of individual patients, teams that support them and the wider health and care system.
- To commission 3 place based neighbourhood models which supports population health improvement and reduce demand on acute services with key interdependencies with GPFV .
- To commission a review of Shropshire's model for community and primary care services to enable the commissioning of an appropriate and sustainable model of care
- To implement neighbourhood plans that deliver the above ambitions
- To adopt a evaluation framework that will enable accelerated implementation from a robust evidence base, capable of replication across the neighbourhoods.

Key actions		Milestones
1	Commission review of Shropshire's model for community and primary care to enable the design of an appropriate and sustainable model of care for the neighbourhood. Map current intentions and models in the other two neighbourhoods.	• End March 17
2	Agree outline business case for each neighbourhood and define associated workstreams.	• End May 17
3	Agree Implementation plan and programme delivery with associated resources in place	• End May 17
4	System wide bed impact (acute & community) confirmed and phased	• October 17
5	Orthopaedic pathway reviewed and aligned	• End April 17

Outcomes Impact

Category	Type/scale	• Timing
Better care	Improved health & care outcomes for local people Standardised access to services through the new neighbourhood models Access to early advice and support and care closer to peoples homes Better co-ordination of care for frail elderly and those with complex health and social care needs	
Sustainability	We anticipate that the outcome of this work will enable us to design a more appropriate response to the future sustainability of our local system by supporting a reduction in demand for secondary care services	

Key Risks & Mitigations

Engagement & leadership
Risk to sponsor engagement due to potential changes to system incentives.
Mitigation- Plans are placed based and therefore have a level of accountability & autonomy for implementation.

Contractual
Contractual and procurement risks due to commissioning of new models of care
Mitigate- Adoption of learning from vanguard sites and other new models of care

Workforce
Securing a workforce with the required skills s ch as GPWSI, ANPs.
Engage with Health Education England WM and Universities, Deanaries

Resources required

Resource plan to be developed post review phase

Primary Care: Integration with STP

Vision

Primary Care is the first point of entry for most patients in diagnosing and treating health problems. GPs and other staff play a crucial role in treating minor medical conditions, managing patients' long term conditions in the community and referring them for hospital treatment, social care etc as appropriate.

There is widespread consensus that our health and social care services need to change if they are to be sustainable for the future. Demand for all Health and Social care services continues to grow and this pressure is evident in primary care. The Vision for Primary Care therefore is to support Practices to become more resilient and sustainable by breaking down the boundaries of traditional services and becoming more effective organisations. Working "at Scale" General Practice will lead innovation and reform the provision and continuity of high quality holistic person-centred care in line with the General Practice Forward View (published by NHS England April 2016).

Discussions on New models of care, including Multispecialty Community Providers have commenced and Neighbourhood working will bring together community based health and care professionals to support the population is in development. Primary Care will sit at the centre of the system and Neighbourhood working will be fully integrated wrapping around groups of practices. The combined outcome of neighbourhood working and the delivery of the GP Forward View will ensure sustainable community resilience. In Telford and Wrekin neighbourhoods have been defined, which have consistent boundaries with the Practices working "At scale".

The overall quality improvements which will be seen by implementing the GP Forward View include:

- Improved access during core and extended hours addressing identified and evidenced patient need
- Seamless patient care delivered by highly skilled and integrated professional workforce
- Learning and adhering to best practice e.g. national programmes, vanguards, CQC excellent practice ratings, GP patient surveys and patient feedback
- The monitoring of improvements reported by Primary Care Quality Dashboards
- Continued engagement with Practice patient participation Groups

Primary Care: Integration with STP

GP Practices

Telford and Wrekin CCG has 17 GP Practices serving a population of circa 180,000 . The average practice list size is currently around 10,000 in population and with 3 practices due to merge in April, this will be further increased. 16 practices currently hold a GMS contract and 1 an APMS contract. Currently practices are working in four localities to deliver the GP Forward View plans.

Shropshire has 43 GP practices aligned to three locality areas; North, Shrewsbury & Atcham and South. Each locality is served by a Locality committee as sub-committees of the CCG Board. Currently Shropshire Practices are establishing opportunities for working at scale. This will vary across the county based on a number of factors including rurality, proximity to other practices, practice size and current facilities. Although the majority of practices (32) hold GMS contracts, a number (9) hold PMS contracts and 2 practices hold an APMS contract. A further 8 practices will be returning to GMS contracts in the coming months. As a result of its rurality, Shropshire has a high number of dispensing practices (18 of 43) which dispense medicines to eligible patients.

GP Forward View

The GP Forward View was published in April 2016 and sets out a plan backed by a national multi-billion pound investment, to stabilise and transform general practice. The plan contains specific, practical and funded steps to grow and develop workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology, and support local practices to redesign the way modern primary care is offered to patients.

CCGs are aware of the funding allocations as part of the NHS Operational Planning and Contracting Guidance process for 2017-2019 and will take opportunities to access additional national support available for Practices to deliver the GP Forward View from the national development team.

Both CCGs have submitted their GP Forward View Plans to NHS England and are awaiting a formal response. The main areas of the GP Forward view where the CCGs will be focusing their plans are around improving access and workflows in General Practice by using the 10 high impact changes:-

Active Signposting	Personal productivity
New consultation types	Partnership working
Reduction in DNAs	Social Prescribing
Development of teams	Support Self Care
Productive Workflows	Develop Quality Improvement expertise

Primary Care: Next Steps

Progress & next steps

- Active signposting and care navigation for practice administration staff within practices is being devedloped – redirecting patients to the most appropriate service to support their care (in line with the neighbourhood model of care). This will be supported by a local comprehensive directory of services accessible by Primary Care staff, appropriate training and agreed algorithms.
- Promotion of new consultation types supported by developments in technology e.g. online and telephone and raising awareness of how patients access care.
- Reduction of DNAs by supporting practices to identity patients who consistently DNA and implementation of improved ways to book appointments and cancel unwanted appointments by improved technology and use of SMS Text alerts to remind patients of pre booked appointments
- Work with the national Primary Care Development Team to improve Primary Care resilience and sustainability
- Expansion of referral management service to include urgent care referrals as well as planned care referrals to ensure patients have access to the most appropriate care at the first time of referral
- Introduction of Prescription Ordering Direct to improve ordering process and maximise prescribing efficiencies
- Introduction of social prescribing to enable non-medical support within the communities to improve health and well-being
- Ensuring patients are supports to have confidence and information to enable them to manage their own care, promoting disease prevention and living healthy lives-
- Improved use of Advice and Guidance both within and between practices , and with community and acute clinical experts
- Working with Patient Participation Groups to raise awareness of GP Services and to identify further improvements

Priority three:

To create a co-ordinated system of Acute Care to improve Quality and Sustainability of services

Lead Sponsor – Dave Evans & Simon Freeman

Acute Reconfiguration Of Hospital Services: Section Summary

This section describes how this programme will transform acute services in Shropshire and Telford & Wrekin so that they meet the complex and specialist needs of our local population.

- Reconfiguration of Acute Services
- The Benefits for patients
- Acute Reconfiguration Timetable
- Modelling the changes
- Clinical Pathways Development
- Understanding our expenditure
- Next steps

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
- 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.
- The CCG Joint Committee in December had a split vote on the Programme Boards recommendations for consultation on a preferred option, resulting in no decision. Independent review of appraisal process and supplementary IIA work for Women and Children's services impact has been agreed.

Key Milestones

- Clinical Senate Review October 2016
- Draft pre-consultation Business Case to CCG – October 2016
- Gateway Review – November 2016
- Draft OBC December 2016
- CCG Joint Committee December 2016
- Independent review of Appraisal process March 2017
- IIA supplementary work on W&C March 2017
- Public consultation – May 2017
- Decision on OBC – Sept 2017

Acute Reconfiguration: Benefits for patients

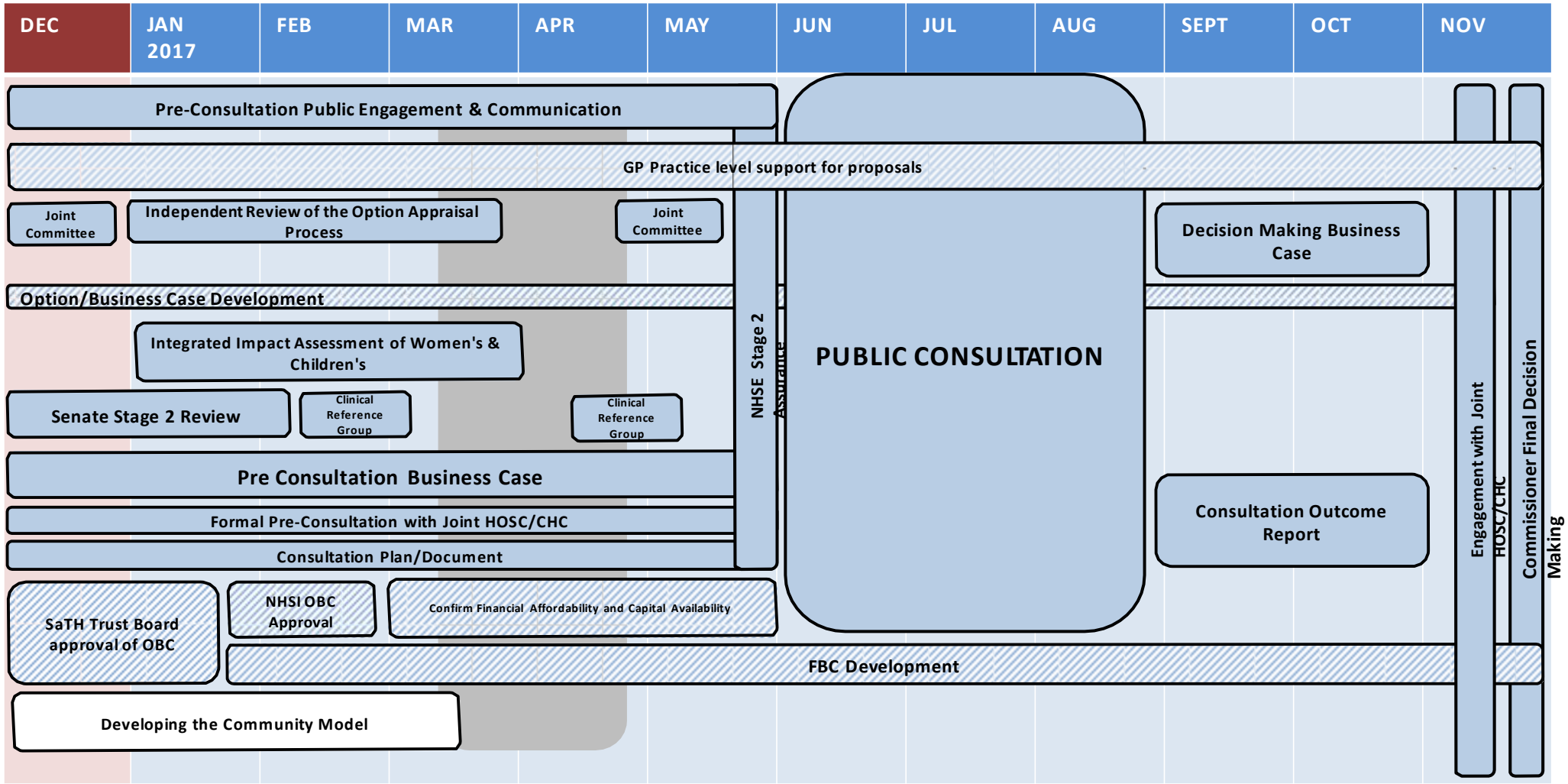
A single purpose built Emergency Centre:

- 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

Acute Reconfiguration: Decision Timeline



Acute Reconfiguration: 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

Acute Reconfiguration: 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.
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.
6. Working with CSU to determine consistent approach to activity modelling for community offer

Key Milestones

Pathway design guiding principles agreed.

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

Frailty stakeholder workshop held.

7. Workforce requirements to deliver the pathways defined including the skills and competencies to deliver

Target timescale for final draft – end of October 2016

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

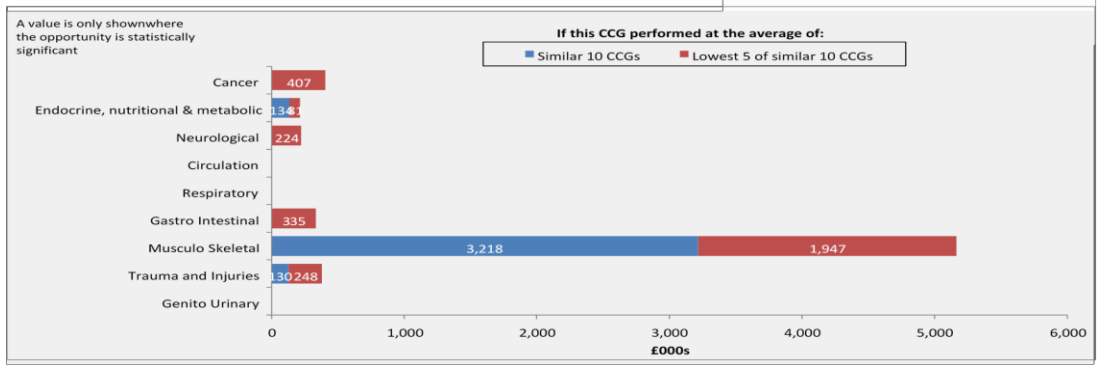
Outcomes

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
2. support of the Futurefit acute reconfiguration Pathways are deliverable and sustainable in terms of workforce and finance

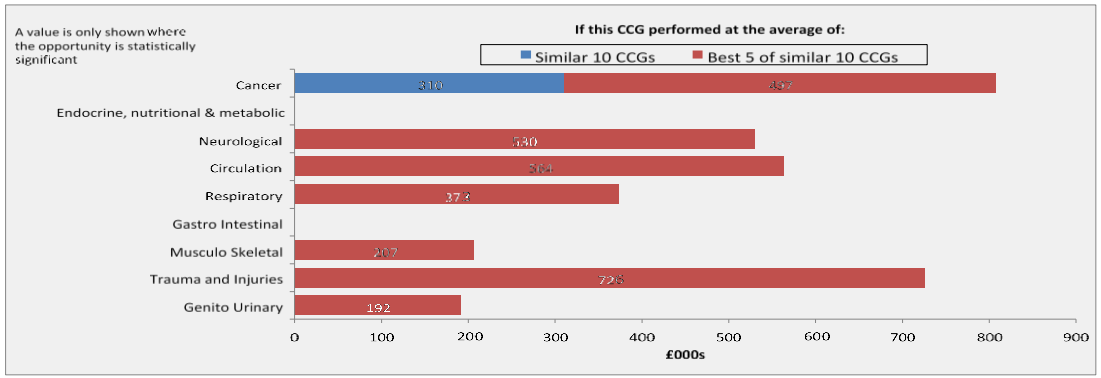
Acute Reconfiguration: Understanding Our Expenditure

Shropshire

How different are we on spend on elective admissions?

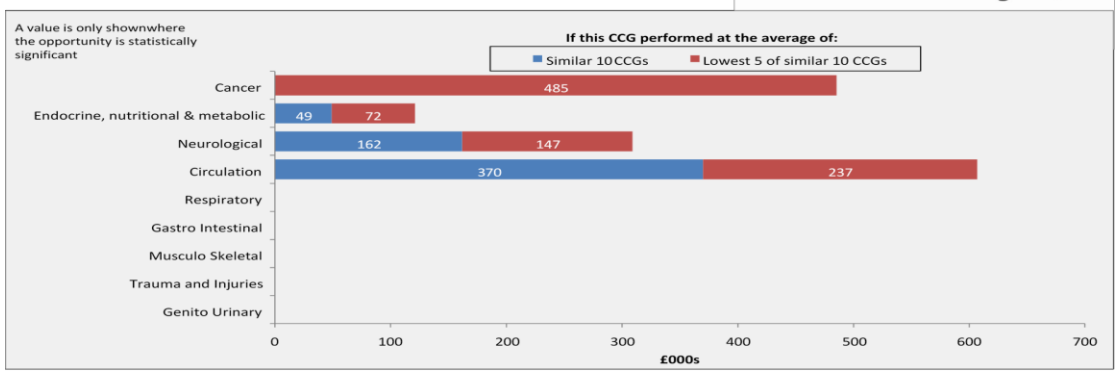


How different are we on spend on non -elective admissions?

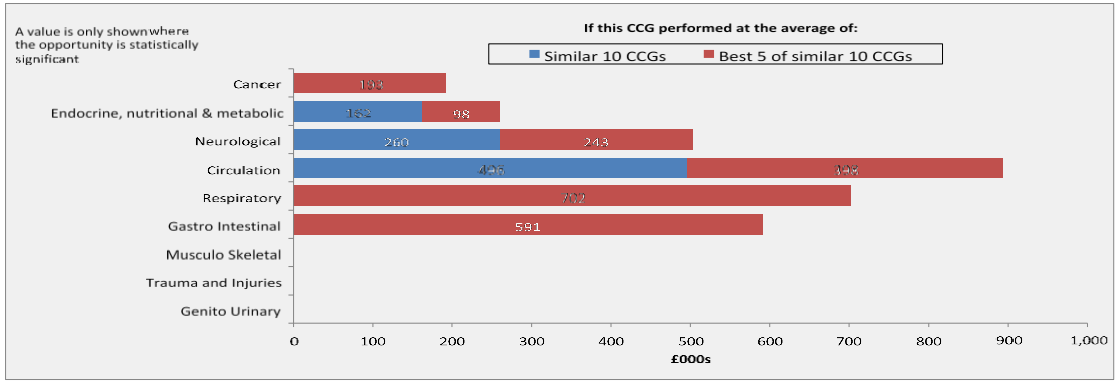


Telford & Wrekin

How different are we on spend on elective admissions?



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



Orthopaedics is 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

- Phase One report to be completed by end of March

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

Acute Reconfiguration: Next Steps

The commencement formal consultation has been delayed as a result of the Joint Committee of the CCG Boards in December 2016 being unable to support the recommendations of the Future Fit Programme Board and therefore referring back for further work which includes an Independent Review of the Options Appraisal process and additional impact assessment for women and children's services. It is anticipated that this work will be completed by the end of March 2017.

Preparations for consultation continue with the development of the consultation materials including the consultation document, survey questionnaire and a refresh of the programme website. Given the above timeline, however, the Programme and the CCGs will need to take advice and consider its options on when it would be recommending proceeding to public consultation given the start of purdah for local elections in Shropshire at the end of March 2017.

NHSE is supporting the CCGs to determine the future decision making arrangements through a Joint Committee which ensures that neither CCG has the power to veto decisions of the Committee.

Work is underway to develop clear and unambiguous messages for the public and local stakeholders in relation to the proposed delivery solutions, particularly in respect of the role and function of the Urgent Care Centres and any differences in the centres between the emergency and planned care site. Both primary and secondary care clinicians are involved in this work. The messaging will be an Important component of the public consultation materials.

Action plans in response to the Clinical Senate and NHSE Gateway Review recommendations have been developed. Key areas of focus are modelling ambulance and workforce development plan, greater level of detail describing the corresponding community model of care particularly in Shropshire, greater detail of the plan to ensure the required IT infrastructure will be in place to enable a system networked approach and greater detail of the desired patient outcomes and how these will be measured.

Demonstrating affordability will be a key element of evidence to enable CCG approval of the Pre-Consultation Business Case and SaTH are working with NHSI to clarify what levels of capital are or are not likely to be available before public consultation including potential alternative sources of capital than through the Treasury.

Priority four:

To build on existing collaborations of care such as the Transforming Care Partnership for Mental Health & Learning Disability Services.

Lead Sponsor – to be confirmed

Improving & Integrating Other Key Services: Section Summary

This section sets out how we build on the work to date to better integrate services and reduce unwarranted variations in the quality of care to create an environment in which our providers can maximise resources and workforce through better skills utilisation.

This will build on our 'Transforming Care Together' partnership to create synergies and improve the experience of residents across Shropshire and Telford & Wrekin affected by Mental Health and Learning Disabilities. By sharing best practice and aligning to the work of other agencies we will reduce variation; improve access, choice, quality and efficiency; and collaborate to develop new highly specialised services in Shropshire e.g. Children's Tier 4 services and secure services.

- Services for people with Mental Health
- Services for people with Learning Disabilities
- Services for Children and Young People
- Cancer services
- Specialised services -
- National top ten Priorities

Integrating Other Services: Mental 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

Milestone

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

Integrating Other Services: Learning Disabilities

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

Integrating Other Services: Children & 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.

Integrating Other Services: Cancer

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

Integrating Other Services: Specialised Commissioning

Context

We recognise that a unified commissioning approach to services with Specialised Commissioning is critical to a sustainable plan over the next five years.

Early engagement with the Specialised Commissioning team clearly identifies important opportunities in a number of areas. This has been further refined as part of the STP triangulation process with Specialist Commissioners.

Plans

Early discuss indicate that the priority areas for Shropshire and Telford will likely be defined as Cancer Services and Specialist Mental Health Services

Progress since June Submission

- Work on CAMHS and Cancer Services has commenced.
- Early discussions have commenced regarding specialist orthopaedic pathways
- The opportunities include integrating pathways, developing local service alternatives and helping to crystallise opportunities for consolidation as part of reconfiguration plans.

Ne**xt Steps**

In the next planning phase, Shropshire leaders wish to gain agreement through the collaborative commissioning process to set out plans for a delegated commissioning approach to develop through 2017/18 - 2018/19.

We are also seeking discussions to develop plans that would reinvest efficiencies where plans control demand and produce service alternatives that prevent specialised interventions when they are not necessary.

With regards to Mental Health we are working with our Mental Health Care Trust to eliminate all clinically inappropriate out of area placements and to pilot a commissioning model for specialised Secure Care – identifying opportunities to shift resource from hospital care to community pathways. Our aim is to explore the continuation of provision regarding low secure and Tier 4 CAMHS beds to serve the STP footprint.

Delivering 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

Priority five:

To make best use of our scarce resources

Lead Sponsor – Mark Brandreth

Resources: Section Summary

Delivering improvements to our health and care system at a time of increased demand but with a lower growth in resources demands a sustainable approach to funding. This underpins all of our programmes of work. This section sets out an overview of the current financial challenge facing the system and how our STP will address these across our system.

- Bridge diagram & supporting narrative
- The scale of change required to deliver sustainability
- Assumptions
- Investments
- Phasing
- Key issues
- The impact on the system and providers of the proposed changes
- Key enabler – capital investment
- Capital requirements
- Options to access capital
- Risk and mitigation

Resources: Section Currently being updated

System Finances

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

				Shropshire	Telford & Wrekin	Shropshire
		SATH	RJAH	Community	CCG	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.

Resources: 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. NB As stated earlier in this document ,the commencement of formal consultation on the Acute Reconfiguration programme has been delayed as a result of the Joint Committee of the CCG Boards in December 2016 being unable to support the recommendations of the Future Fit Programme Board and therefore referring back for further work which includes an Independent Review of the Options Appraisal process and additional impact assessment for women and children's services. It is anticipated that this work will be completed by the end of March 2017. As such this section of the plan may be subject to further change.

The capital costs associated with the reconfiguration of hospital sites as currently proposed has been established at £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.

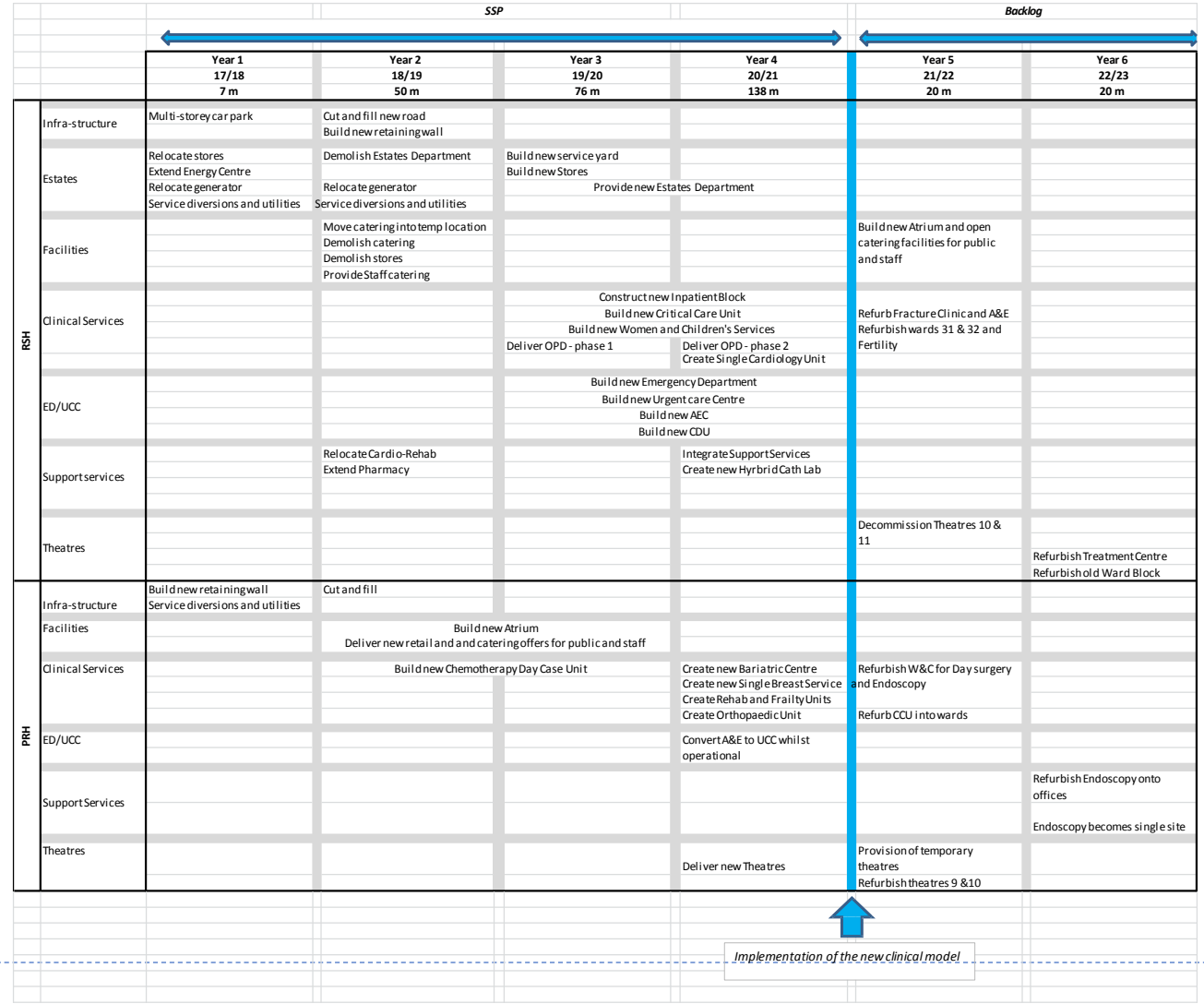
The capital cost is profiled as follows:

	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.

The schedule presented on the next page illustrates the activities to be performed and attributable deadlines.

Resources: Capital Requirements



		SSP				Backlog	
		Year 1 17/18 7 m	Year 2 18/19 50 m	Year 3 19/20 76 m	Year 4 20/21 138 m	Year 5 21/22 20 m	Year 6 22/23 20 m
RSH	Infra-structure	Multi-storey car park	Cut and fill new road Build new retaining wall				
	Estates	Relocate stores Extend Energy Centre Relocate generator Service diversions and utilities	Demolish Estates Department Relocate generator Service diversions and utilities	Build new service yard Build new Stores Provide new Estates Department			
	Facilities		Move catering into temp location Demolish catering Demolish stores Provide Staff catering			Build new Atrium and open catering facilities for public and staff	
	Clinical Services			Construct new Inpatient Block Build new Critical Care Unit Build new Women and Children's Services Deliver OPD - phase 1	Deliver OPD - phase 2 Create Single Cardiology Unit	Refurb Fracture Clinic and A&E Refurbish wards 31 & 32 and Fertility	
	ED/UCC			Build new Emergency Department Build new Urgent care Centre Build new AEC Build new CDU			
	Support services		Relocate Cardio-Rehab Extend Pharmacy		Integrate Support Services Create new Hyrbrid Cath Lab		
	Theatres					Decommission Theatres 10 & 11	Refurbish Treatment Centre Refurbish old Ward Block
PRH	Infra-structure	Build new retaining wall Service diversions and utilities	Cut and fill				
	Facilities		Build new Atrium Deliver new retail and and catering offers for public and staff				
	Clinical Services		Build new Chemotherapy Day Case Unit		Create new Bariatric Centre Create new Single Breast Service Create Rehab and Frailty Units Create Orthopaedic Unit	Refurbish W&C for Day surgery and Endoscopy Refurb CCU into wards	
	ED/UCC				Convert A&E to UCC whilst operational		
	Support Services						Refurbish Endoscopy onto offices Endoscopy becomes single site
	Theatres				Deliver new Theatres	Provision of temporary theatres Refurbish theatres 9 &10	

Implementation of the new clinical model

Resources: Capital Requirements

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.

Resources: 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

Resources: Next Steps

We are in the process of revising our financial plan to address the financial deficit position of Shropshire CCG to ensure that it is fully incorporated within the STP.

Each organisation's financial plan reflecting the changes due to contractual discussion and other key adjustments have been modelled and updated. The aggregate position is in the process of being validated to ensure that assumptions remain consistent and a final review is taking place.

As a result this section requires amendments to reflect these changes and will be completed and resubmitted imminently once a final validation and review is complete.

Enablers

Enablers: Section Summary

This sections sets out how our working differently, maximising our estate and digitally-enabled programmes act as fundamental enablers to realising our ambitions to radically transform health and care system across Shropshire and Telford & Wrekin.

- Workforce
- Workforce changes
- Estates
- Digital Footprint

Enablers: 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.

Enablers: Workforce Changes

Changes in the acute workforce

Workforce Summary	Establishment	Option B Scale			Option C1 Scale		
Staff Group	at 31/03/2016 WTE	of Change WTE	Option B WTE	Option B Saving £000s	of Change WTE	Option C1 WTE	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.

Enablers: 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.

Enablers: Digital Engagement Plan

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

Progress to date

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

Key Milestones

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.

Communicating the Plan

Sponsor: Julia Clarke & Harpreet Jutla

Communications & Engagement: Section Summary

This section sets out how we will communicate and engage effectively with our patients and publics, partners, workforce and other stakeholders across Shropshire and Telford &Wrekin. We recognise what people want from their local health and care services and are in the process of reorienting and reshaping services to support them . This shift away from managerially and clinically led processes towards a co produced solutions with the public is at the heart of our plans around communications and engagement.

- Communication and Engagement Overview
- Communicating our STP
- Stakeholder Management
- Next steps

Communications & 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

Communications & Engagement: Key activities

Communications & Engagement: Stakeholder 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

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

meanwhile MPs for decision making

Communications & Engagement: Progress To Date

As part of a 90 day plan; we are creating an engagement and communications strategy. Due to the extensive work already done on the acute element of the STP we will focus our attention on the non – acute. Tactics being discussed include pulling together stronger community and primary care narrative, stakeholder analysis and mapping, creating an infrastructure to provide integrated communications and engagement, creating positive proactive media stories based on work stream developments. A key milestone in this programme of work was a Neighbourhood inspired Clinical Reference Group (CRG) in September 2016. The feedback was crucial on gaining support for the concept, priorities and next steps. The next CRG takes place on 1 February and is another key opportunity in engaging with the clinical leadership – for this session there will be an emphasis on the end to end pathways. In addition, we will work in co-production with service users and carers.

In Telford & Wrekin we have initiated a regular steering group which includes local NHS organisations, representatives from third sector organisations, healthwatch and local authority staff.

We have provided presentations and workshops to the local authority (including their policy committee), a briefing with elected members, developmental session for the health and wellbeing board, a presentation/discussion with the joint HOSC, presentation at the CCG public board and engagement at multiple internal CCG committees/groups

In the December 2017 Telford neighbourhood workstream meeting there was a specific focus on communications and engagement. Telford & Wrekin Council Communications lead (supporting this workstream) led the session with a view to creating a communities and engagement strategy.

Specific planned activities to 1 April 2017 include:

- We are clear that the engagement needs to be driven by and within communities. As such, the Newport practices are working with the CCG engagement leads to explore the notion of supportive communities with their registered population. This will link directly into a social prescribing pilot which is being implemented there.
- The Telford and Wrekin Council community participation lead has begun to work with communities around the neighbourhood agenda, with a focus on asset development. As there is a new team as part of the management restructure at the council this work will progress further.

Communications & Engagement: Progress To Date

In Shropshire we have shared progress and received feedback and number of presentations have been undertaken including regular neighbourhood presentations to Shropshire Locality Board (specifically to encourage GP participation in the work), a regular neighbourhood agenda item at Shropshire Health Forum meetings, a presentation and Q&A session with the Shropshire Council elected members, presentations and Q&A sessions with Patient Group representatives.

In addition we have held a number of workshops to engage with communities, this includes a public workshop in Ludlow in December, a session with the Community Trust workforce as well as establishing and holding a regular Shropshire Neighbourhood Reference Group whose membership includes a wide range of stakeholders

Specific planned activities to 1 April 2017 include:

- Presentations to a number of Local Joint Parish Councils (grassroots engagement especially for rural Shropshire)
- We are also planning to repeat the locality public workshops with a restructured agenda based on feedback from the previous meetings.
- We continue to engage through other established work programmes that align to the neighbourhood work (e.g. Better Care Fund Programme, Healthy Lives Programme, etc).

Communications & Engagement: Non Acute Clinicians/ Primary Care

There are a number of engagement mediums for non-acute clinicians. Some of which have been highlighted above in the neighbourhoods section. In addition:

We have an established clinical leadership and think tank group where all local clinicians meet quarterly to work together on key themes or challenges regardless of organisations, type and geographical boundary. This forum is called the Clinical Reference Group (CRG). In the past they have provided through debate, sharing of knowledge and expertise, innovation and problem solving solutions to some of our most challenging clinical issues in the county. Working with and through this group will be a key tactic in engaging non acute clinicians especially in the development of the neighbourhoods activity. The next CRG is taking place on Wednesday 1 February and community / neighbourhoods will be a key agenda item.

In addition, we are creating a programme of briefings via the GP locality board meetings across the county. These meetings are chaired by CCG board members, so utilising their leadership we have an excellent avenue to engage on a local level. We have already begun to do this by attending locality board meetings and providing updates and discussion points, in the next two months we will formalise this attendance and work closer with the locality chairs.

Working with the CCGs and Community Trust we are strengthening the communication being sent to non-acute clinicians. There are already a plethora of established communication avenues such as newsletters and forums. We have already started to ensure information is being distributed by these mediums but in the coming months we will look to ensure that there is a standing item on key information sources so information and work stream updates as well as opportunities for further engagement is shared.

Communications & Engagement: MP's

There are already quarterly briefings in place with MPs from Telford, Shropshire and Powys supported by the acute workstream SROs and the STP SRO. To develop this engagement activity further we intend to:

Circulate a briefing note on a monthly basis with an update on the programme and provide an opportunity for MPs to raise queries directly on the back of information given

Form closer relationships with MP offices including face to face meetings with MP officer managers/ aides to ensure information sharing is prevalent

Engage with MPs to ascertain whether more frequent face to face briefings are preferable, aiming towards alternate months. The briefings would include senior managers and clinicians as well as the SROs.

The next MP briefing is Friday 27 January and we will use this opportunity to engage with our MPs on the above and explore any alternatives or additions they may find helpful.

In addition to MP engagement we have initiated a more rigorous engagement programme with the two Local Authorities, some of which has been mentioned previously but includes;

- Briefing with elected members
- Presentation and briefings with Joint HOSC
- Communications sent to Health and Wellbeing boards with further plans to facilitate a workshop.

Communications & Engagement: Next steps

Looking forward we are planning on engaging with our STP partners within a leadership Organisational Development programme. Our intention is to gain greater understanding of the political interface within the local STP and support all partners to fully play their part in helping us to realise our full potential for the benefit of our local communities.

Key leads for the STP work stream

NHSE have offered to undertake an initial scoping of the STP communication structure and engagement resource in early February with a view to producing an analysis of the most effective way to ensure clear messaging across the Partnership Board with active stakeholder relationships as a key component. This will be in conjunction with national NHSE Comms (STPs) undertaking a high-level and rapid constructive review to understand the most effective model, supplementing existing expertise and resource, to ensure clear communication and engagement,. This will include working closely with partnership organisations to maximise the effective use of current resources and to identify any key gaps in order to emphasise the importance of the wider transformation agenda and local realities.

This high-level review will also focus on how to proactively secure genuine staff involvement in the planning and delivery of change. The alignment of communications and engagement between all STP members is essential to delivering coherent plans that both the public and staff understand. This review could also support a consistent approach across other STP footprints which would drive an ambitious agenda to raise public awareness and staff engagement.

This review should be completed by March 2017 and implementation of an agreed way forward should be completed by April 2017

During the interim months **Harpreet Jutlla, Service Partner Communications and Engagement MLCSU** will continue to lead the communications and engagement activity for the STP.

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Governance and System Leadership

Sponsor: Julia Clarke

Governance & Leadership: Section Summary

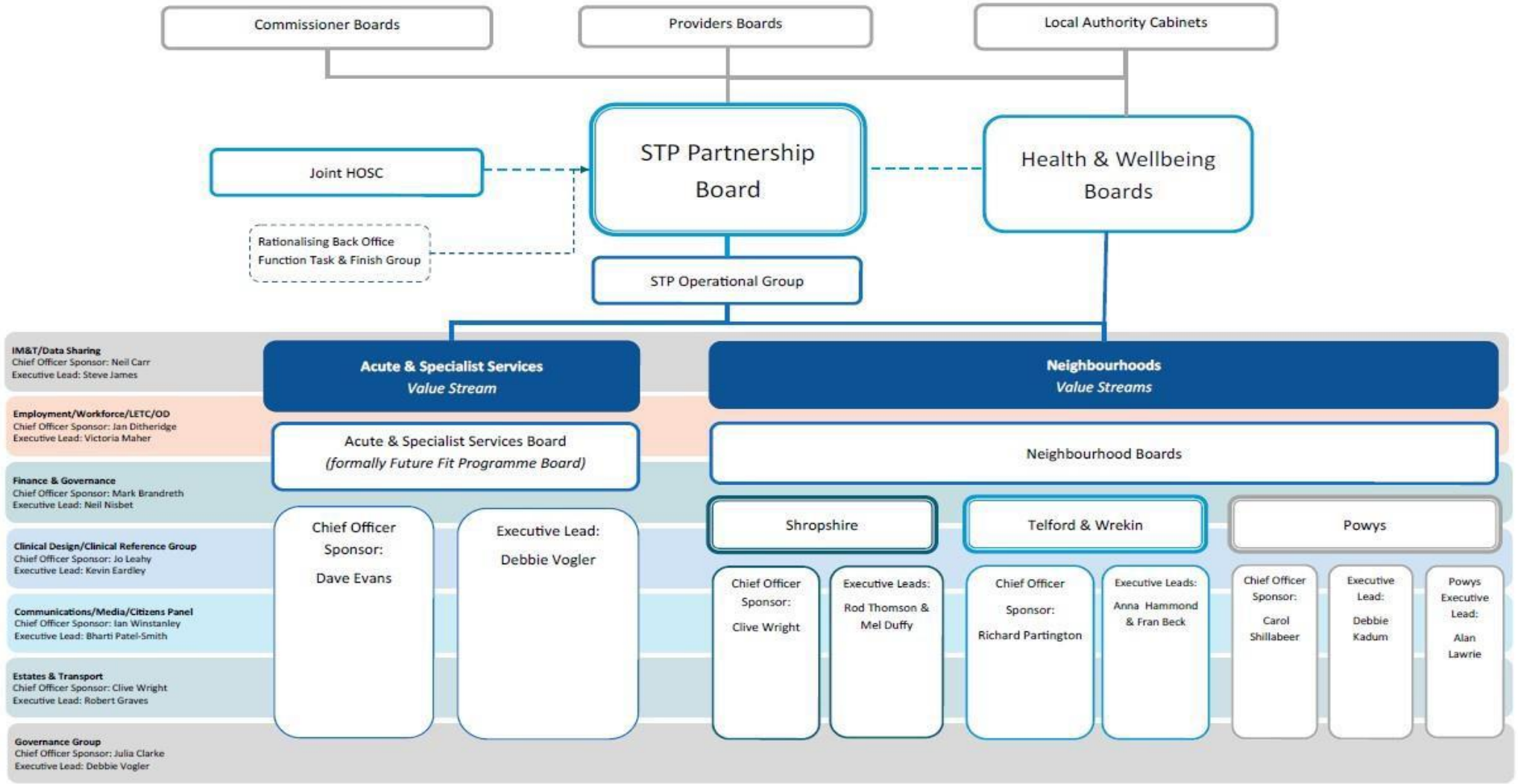
This sections sets out our governance and leadership arrangements. Our STP plan is ‘a work in progress’ on which partners have worked collaboratively. It sets out aspirations and plans for sustainability. The next stage is to formally engage and consult with stakeholders on the plan so that it can be further developed before formal approvals can be considered.

Subject to approval of the plan by national sponsoring bodies we will move to implementation, this will require a review of our governance and leadership of our STP. Our intention is to place our clinicians at the head of our governance so our STP is clinically led and managerially supported endeavour. It is essential that we build upon the advice and guidance provided by key Clinical Reference Groups and effectively engage with the clinical and non clinical workforce. Our Clinical Leaders will enhance the credibility of our plans when we formally engage and consult with our public ands stakeholders as opur plans mature and implementation gathers momentum over the coming months.

The implementation of our STP rest firmly upon each of the neighbourhoods and their constituent partners including patients, commissioners and providers. Our approach recognises the principals of subsidiarity, co production, clinical leadership and system working which has been central to the development of our STP.

- Governance
- System Leadership
- Key risks to the Programme

Governance & Leadership: Overall Structure



Governance & Leadership: 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.
- We recognize achieving this vision will require unprecedented levels of trust, cooperation, collaboration, and working across traditional boundaries. As part of our partnership work we are in the process of reviewing our compact. Following this work during february we will revise our compact where we believe this will enhance our partnership working

The purpose of our compact is to support this partnership way of working. The main 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

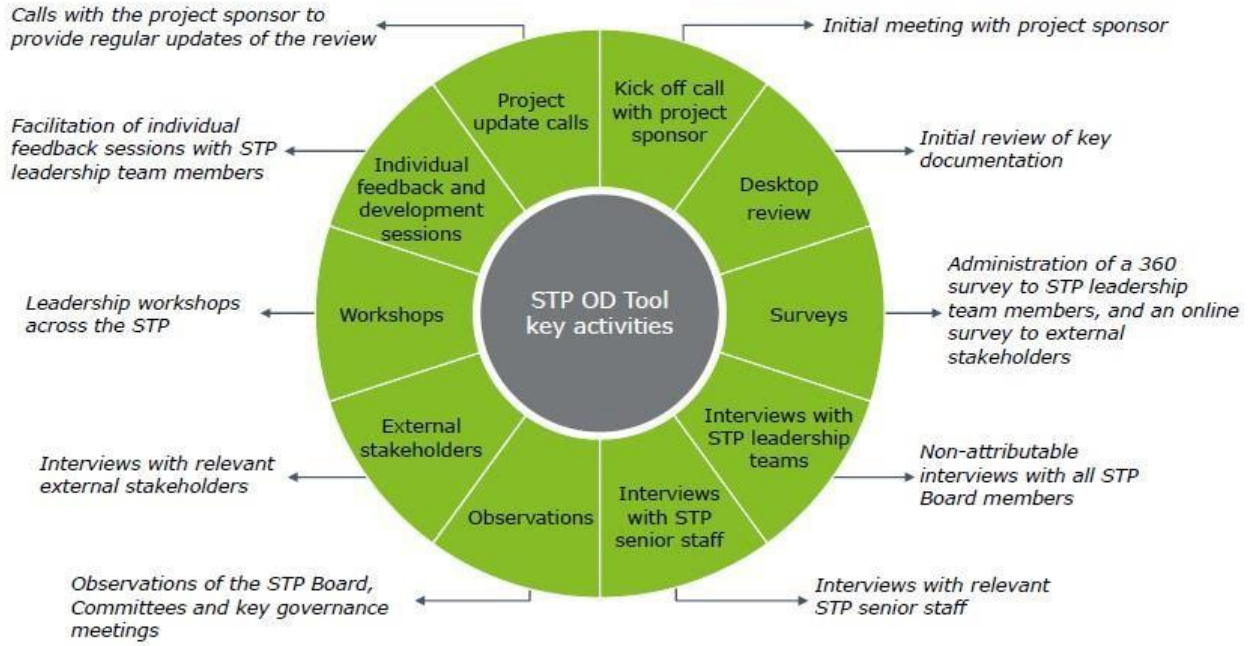
These outcomes should be indicators that our agreements are being lived and we are willing to modify our "gives" as necessary to make progress relative to these outcomes

Governance & Leadership: Development

As system leaders we recognise the scale of the challenge ahead of us and listening carefully and reflecting on the feedback we have received from a range of stakeholders including NHS England and NHSI as well as sections of our publics, we have acknowledged that the success of our STP relies upon our relationships with a wide range of stakeholders as well as each other as strategic partners. Accordingly we have secured the support of external partners, Health Education England to help us to design a comprehensive programme of organisational development for our STP.

System Leadership through Organisational Development

We anticipate our needs to be dynamic and as such changing with the STP as we move through our journey and are therefore seeking to work with our external partner to access a range of support. We have agreed to put aside protected time to meet together to strengthen our partnership work going forward. Our assessment of our requirements include the following:



Governance & Leadership: Development

Key components of diagnostic programme

Engage	Conversations with Chair and SRO for Leadership and OD to flexibly plan how to apply elements of the STP diagnostic tool.
Data gather	Diagnostic tools including; confidential 360 degree survey to stakeholders against a good system-working framework, short interviews with key people, STP Board observation exercises and table top review of relevant contextual documents.
Analyse	All data is reviewed and analysed to build a rounded picture of the STPs strengths and potential development areas, ready to present back to the Board.
Feedback to Board	Analysis of this data will then be presented back to the STP Board in a workshop which will allow the Board to develop/enhance their STP OD plan.
Evaluate & Sustain	A review of effectiveness of the tool and outcomes, including consideration towards future sustainability and further application of the OD tool.

Next steps

Looking forward we are planning on engaging with our STP partners within a leadership Organisational Development programme. Our intention is to gain greater understanding of the political interface within the local STP and support all partners to fully play their part in helping us to realise our full potential for the benefit of our local communities. Specific actions we are taking include the following:

- Work with Health Education England (HEE) to design a bespoke programme of OD for our STP
- Attend HEE STP Leadership and OD SRO/Leads Network Meetings to share best practice and learn from other STP
- Access Executive Coaching for our STP Board member for focused confidential 121 development.
- Access Mentoring opportunities with private sector partners to 'buddy' and mentor health and social staff working in STPs across the West Midlands to participate in cross fertilisation of ideas and processes.
- In the moment coaching: In the moment coaching is designed to provide an on-demand service to STP leads should they require immediate professional coaching support on a current issue.

Implementation

Implementation: Section Summary

This section sets out how we will move beyond planning to ensuring we have the necessary capabilities, capacity and programme management arrangements to mobilise delivery. We recently strengthened our infrastructure for the STP to put in place a dedicated Programme Director office along with a Programme Management Office (PMO). The PMO is in the process of reviewing our current arrangements and subject to the sign off and approval of the plan by national sponsoring bodies we will move rapidly to accelerate our implementation plans.

- Our approach
- Planning and delivery roadmap
- Progress and next steps

Implementation: Approach

We recognise that delivering our STP will require a complex set of changes to be worked up, tested and rolled out at pace.

Therefore we have chosen to adopt a consistent programme methodology which will help provide a framework for all the activities that need to be managed, whilst recognising the need for learning and experience to guide and steer development of the overall transformation.

Our approach will be shaped and informed by the following ingredients -

- Programme management disciplines
- Proven design and development processes from other sectors
- Prototyping and rapid cycle learning

For example, we expect to employ the generic steps in design to implementation illustrated below and adapt these accordingly.

Phase	1. Planning/ scoping	2. Service Design	3. Process Design	4. Validation	5. Ramp up	6. Launch
Key Tasks	• Initial study of options • Agree goals • Research • Fund development cycles	• Initial specification • Modelling of service • Define initial resources • Identify key interfaces	• Operational/ system design • Process development • 'Simulation' • Flow • Identify enablers	• Design of Experiment • Develop approval criteria • Metric development • Feedback loops • 'Sign off'	• Planning for scale • Recruitment • Finalise supply chain • 'Snagging'	• Monitoring • Continuous improvement • Learning review
Outcomes	**Vision/ plan signed off**	**Model agreed**	**Process agreed**	**Design and process proven**	**Resources contracted and deployed**	**Activity/ quality and cost targets achieved**

Implementation: Approach

To deliver change at the scale of the STP will require a number of key programme components to be developed in parallel as illustrated below –

System leadership development
- Undertake diagnostic of current partnership working
- Protected away day Feb 6th
- Bespoke OD programme with HEE

Governance & control
- Set up structures & processes
- Define work-streams
- Embed programme measures & KPI's

Delivery methodology

Design new models of care
- Apply the best evidence
- Co-production
- Learning from Vanguard sites
- Define evaluation criteria

Prototype & test
- Neighbourhood operational model
- Partnership working
- Communications

Implement & roll out at scale
- Ramp up capacity to deliver
- Mobilise workforce changes
- Continuous monitoring

Finance & benefits realisation
- Plan for financial sustainability
- Manage investments and tracking of benefits
- Workforce transition

Communications & engagement
- Consistent vision for public and staff
- Consultation on key issues

Planning & Delivery Roadmap (First 90 days to 12 months)

	Within 90 days	Within 6 months	Within 12 months
Systemleadership Management	▸ Refreshed STP submitted to national sponsoring bodies ▸ Enhanced programme governance agreed, OD plan commissioned, arrangements to strengthen system leadership in place ▸ STP Programme Director /PMO in place ▸ Programme work streams defined ▸ 90 days -12months implementation plan developed	▸ New programme governance in place ▸ OD plan in place with core and bespoke components modified ▸ Steering and delivery groups in place ▸ Delivery teams established ▸ System KPI's defined and measures in place	▸ Fully functional PMO in place Phase one of OD plan evaluated and next steps agreed ▸ Routine review of KPI's established ▸ In depth review of priorities and development Yr 2 plans
Neighbourhood& Acute development & implementation	▸ High level neighbourhood model articulated and key interdependencies with GPFV established in some of the neighbourhoods. ▸ Clinical pathway task & finish groups mobilised ▸ Outline goals & objectives for each workstream agreed ▸ Investment & benefits for each workstream quantified ▸ Mental Health/ LD, Children's & Cancer integration programmes defined	▸ Clinical & operational model defined for community services for Shropshire Neighbourhood including detail on GPFV. ▸ Outline business case for each workstream defined & agreed ▸ Implementation plan agreed and programme delivery resources in place ▸ System wide bed impact (acute & community) confirmed and phased ▸ Orthopaedic pathway reviewed and aligned	▸ All clinical models agreed and signed off ▸ Review of Neighbourhood models undertaken to identify best practice and areas of replication to accelerate implementation ▸ Adoption of a developmental evaluation framework will enable implementation from robust evidence base ▸ Accelerate learning from vanguard sites as appropriate
Enabling Programmes	▸ Financial implications defined including confirmation of plan's ability to close system gap ▸ Alternative capital scenarios and solutions defined ▸ Overall workforce change deliverability assessed ▸ Digital Roadmap published	▸ Complete deficit reduction plan ▸ Evaluate QIPP proposals against STP aims and priorities ▸ Contracts signed that deliver STP requirements ▸ Quantify investments need to deliver Yr 1 of STP priorities	▸ Feasibility & timing for digital transformation confirmed ▸ All enabler programmes evaluated and plans further refined for Yr 2
Comms & Engagement	▸ Dedicated Communication and Engagement Lead for STP in place ▸ Stakeholder mapping complete ▸ Comm's & Engagement strategy defined & agreed ▸ Timetable for consultation prepared in readiness for preferred configuration option	▸ Decision reached on preferred option for Acute Reconfiguration ▸ Consultation process on key changes prepared and timescale agreed ▸ Proceed to public consultation	Feedback collated and reflected in comm's plan as appropriate Engagement and communication embedded Plans for stakeholder management evaluated and refined

Implementation: Progress & Next Steps

What we have progressed to date

- Reviewed current STP in light of feedback from key stakeholders including ALB and agreed priority areas for action
- Submitted a refreshed STP plan
- Reviewed progress against key work stream and prioritised next step
- Reviewed the STP 'Out of Hospital' plans to ensure they are fit for purpose in reducing demand for secondary care (Future Fit Programme). Agreed next steps in developing neighbourhood models.
- Commenced review of Shropshire CCG neighbourhood model to design an integrated primary care and community services model designed to deliver demand reduction as part to CCG deficit reduction plan, and to reflect the needs of our rural and urban populations, including developing an integrated and flexible approach to 'Team around the Practice'
- STP infrastructure Recruitment in place for STP Programme Director, interim PD in place and appointed to programme admin lead
- STP Mobilised Programme Management Office which is now implementing programme disciple ie structure, process etc
- Coms Dedicated Communication and engagement lead in place for STP
- Comms In process to secure long term expertise in Communication & Engagement incorporating public relations
- Governance Leadership and partnerships Commissioned programme of leadership development in partnership with Health Education England, commencing with away during feb followed by a Diagnostic phase to identify strengths and weaknesses of current partnership arrangements

Implementation: Progress & Next Steps

Next steps

Please see our 90 day implementation plan for details

- We have reviewed our 'Out of Hospital' Programme to ensure it is of sufficient breadth and depth to support population health improvement whilst also reducing demand for secondary care services. Our current assessment is that each of the three Neighbourhoods plans are at different stages of development, with the Shropshire (CCG catchment area) requiring the greatest level of development. With this in mind we have commissioned a short piece of work from external partners which will help us to address these issues and marry up the Shropshire CCG strategic commissioning position in respect of community services. We anticipate that the outcome of this work will enable us to design a more appropriate response to the future sustainability of our local system.
- We are in the process of revising our financial plan to address the financial deficit position of Shropshire CCG to ensure it is fully incorporated in the STP.
- With regards to our Acute Reconfiguration programme we are working with NHSE to determine the process by which we will approve a preferred option for public consultation.
- The timescale to complete these critical pieces of work is set out in our implementation plan.
- We have commissioned a programme of Organisational Development for our STP to further strengthen collective leadership for this endeavour. We have identified Health Education as our external partner to support us in this work and have set aside some protected time to further build upon existing relationships.
- We have enhanced our Programme Management capacity and capability with a Programme Director, and a PMO function is now in place. We are also in the process of securing additional analytical capacity to support our clinical modelling requirements alongside a dedicated Communication and Engagement resource with capability to support public relations and stakeholder management.
- Strengthen our arrangements for identifying and managing risk. This will include the adoption of a more detailed form for our risk register.
- Secure specialist strategic support for; modelling, informatics and large scale change. Our STP is currently working with MLCSU to reshape our support requirements to achieve value for money and we are also exploring the repurposing of strategic support from the Strategy Unit and its partners.

STP Risk Register

Risk	Description	Mitigation
Delivery	Insufficient ownership of STP plan by system partners Scale and complexity of service transformation	Working with external partner (HEE) to design and implement OD programme to build system leadership • Strengthen system capacity and capability to manage complex large scale change programme. Appointment to STP programme Director and PMO function. Secure specialist strategic support for; modelling, informatics and large scale change. Our STP is currently working with MLCSU to reshape our support requirements to achieve value for money and we are also exploring the repurposing of strategic support from the Strategy Unit and its partners.
	Implementation plans are not yet fully developed Lack of dedicated PMO function at system level Timely progress not being made against priority work streams	Review and revision of priority work streams currently being undertaken PMO arrangements currently being strengthened Refocus the Terms of reference for STP Partnership Board Review and refocus STP Operational room to create an 'engine room' for STP Programme

STP Risk Register

Risk	Description	Mitigation
Financial	Anticipated savings may not materialise	Revised Financial recovery plan for STP
	Unable to obtain capital funding for changes	Secure alternative sources for capital under discussion and consider alternative scenario planning
	Unavailability of Local Authority funding to continue Neighbourhood working	Local Authorities have committed to continue support for the medium term
Workforce	Difficulty with recruitment to key roles e.g. emergency care teams Difficulty in sustaining a primary care workforce	Reshape our workforce strategy to engage our staff and other colleagues as key asset in STP plan by improving engagement with them to build & explain the key changes that will be needed and how they will be supported to make these. Ensure plans for sustaining 'Primary Care at Scale' are rapidly developed
Engagement	Insufficient engagement with key stakeholders in the STP aims and case for change including current and new models of care: • Lack of political support for proposed changes. • Lack of patient and public support for proposed changes • Lack of Clinical support for proposed changes	Enhanced Communication & Engagement strategy to key stakeholders including our patients, carers, publics and workforce. Include discussion on risks associated with no change as well as proposed changes Development of Neighbourhoods setting out alternative approaches & provide opportunity for positive messaging Ongoing clinical engagement including with primary care
Regulatory	Regulatory bodies enforce individual organization based actions which may undermine STP wide plans	Single control total for the system under consideration

Support we need

The Support We Need To Deliver The Plan

We have set out our vision and plan to close gaps in health and well-being, care and quality, and finance and efficiency gaps; and some immediate priorities that we are all focused on delivering. We are all committed to working together and at pace to implement our plans over the next five years.

Our system already has some important foundations in place. Crucially, there are some positive relationships between the organisations across our health and care system and we have plans to enhance these by working together to devise and deliver services. We have recently strengthened leadership and governance arrangements which we believe will help us to accelerate the delivery of our plans. Our out of hospital Programme (neighbourhoods)and our Acute Services reconfiguration 'Future Fit' programme mean we are not at a standing start: much of the analysis and modelling work (Future Fit) is complete and we are in process of agreeing our the decision making process to move this to the next stages of development..

We are moving into a strong position, but national support and investment would enable us to move faster to deliver the changes we are aiming for. The following areas are those where we are seeking support from sponsoring bodies to accelerate our plans.

- Advice and support on potential consultation resulting significant service changes, particularly around managing to tight timeline and preparation required to facilitate smooth transition through NHSE gateway process
- Support to engage with politicians at a senior level to facilitate the delivery of significant change
- Communication advice and support – including national messaging change to services available from the health and care community
- National messaging to the public around increased self-care and the need to change how we use health and care services
- Support aggregating the local and regional work including more engagement with nationally commissioned services