APPENDIX

DRAFT SUSTAINABILITY AND TRANSFORMATION PLAN – SHROPSHIRE AND TELFORD & WREKIN

JUNE 2016

CONTENTS

EXECUTIVE SUMMARY

We have a unified vision for our population to be the healthiest on the planet; to achieve this we will need to develop a transformed system of care that is high quality, financially sustainable, and efficient and delivers on national standards all the time. Central to this will be our ability 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.

The overall population within the footprint is approximately 470,000 people, but a number of outlying populations, most notably Powys, access services at providers within Shropshire. The population profile differs across the footprint with Shropshire characterized by a low density, isolated and more elderly population, and Telford and Wrekin more urban and with a lower proportion of households where residents are over 65 years of age.

The Shropshire Telford and Wrekin health and social care economy comprises 2 CCGs, four main NHS providers, 2 Councils and a range of smaller private and third sector providers; one of the providers, Robert Jones and Agnes Hunt NHS FT is a tertiary centre for Orthopaedic services.

Life expectancy rates overall have improved steadily in last decade across the footprint; however, rates in Telford & Wrekin remain significantly worse than average and those in Shropshire. Preventable lifestyle-related diseases associated with smoking, alcohol consumption, excess weight and physical inactivity make a significant contribution to the burden of ill health.

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 captialise on the power of this rich source of social support to build individual and community resilience. We will support people to lead healthier lives and prevent ill health, and empower patients to adopt and promote self-care in order to reduce the demand and dependency on our public services.

The Call to action Consultation process in 2013 set out the clear Case for Change for the reconfiguration of hospital services. The Future Fit clinical model which provided a wider model than just hospital provision then emerged in 2014; as a whole system plan, developed through whole system engagement, the scope of the report is much wider than acute and community hospital reconfiguration. It describes and demonstrates critical interdependencies across the whole economy and points firmly to the need to begin the process of transformational change now. Only by doing this will the reconfiguration of hospital services be successful.

The Future Fit clinical and design principles have been the basis of developing and setting out the three main areas of health care delivery:

- Acute and episodic care;
- Planned care.
- Long term conditions and or frailty

The Strategic Outline Case demonstrates that there are potential solutions which are in line with the Future Fit Clinical Model. This proposed model will need to be supported by integrated health and care services and a networked Rural Urgent Care Service.

Having established the case for whole system transformation, and having agreed that that we need to build social capital around neighbourhoods, we have agreed a number fundamental programmes of work that need to take place during the life of the STP; these are not exclusive as other work will carry on in a business as usual way, but these programmes represent where we intend to put extra-ordinary effort for extra-ordinary gain and are as follows:

- We will progress a radical upgrade in the prevention and self-care agenda, building resilient communities around neighbourhoods and drawing on the social capital that exists in communities. This work will be driven by 3 Neighbourhoods Transformation Groups and will draw on the work already started through the Community Fit Transformation Programme.

- As part of the Neighbourhoods work we will support the development of Community Services and the Primary Care offer for patients, founded on the place based concept of care. This offer will be consistent in terms of outcomes and standards, whilst accepting the place based nature may need different delivery models to suit local need. This work will address the range and location of Community and Primary Care services and offer solutions to organisational form that flow from the new models of care.

- The Strategic Outline Case for Acute Hospital services will now move on to Outline Business Case stage and Senate Stage 2 Review over the 2016 summer; there is a clear critical path set out in this plan and agreed within the health and care community.

- We have agreed to commence a review of the range and location of orthopaedic services commissioned throughout the footprint; currently provided on 3 sites, and at a level beyond comparator peer groups, we need to ensure services provided are appropriate, delivered to consistent outcomes and provide value for money for the taxpayer; this review will also address whether having 2 general acute sites and a specialist orthopaedic site is the right configuration. Draft Terms of Reference for this work have been developed.

- We have an agreed Deficit Reduction Plan which addresses the system wide health deficit of £140.5m by 2020/21; an agreed list of actions to close this gap is included in the plan. All partners agree that we need to work with Social Care colleagues to close the wider Health and Social Care; this work is ongoing and all partners are committed to agreeing a plan by September 2016.

The transformation journey has already started in Shropshire, and Telford and Wrekin through the Future Fit and Community Fit Programmes; we are building on that work with the governance and supporting programme infrastructure we are putting in place. We have a Partnership Board comprising Chief Officers of all the health and social care partners. The Operational Group comprises of Executive leads from all partners, along with patient representation and LMC membership. We have established four main transformation groups, with six supporting enabler groups, each with a Chief Executive Sponsor and Executive lead. We have an agreed supporting programme structure that all partners have agreed to resource and which will be put in place by September 2016.

1. INTRODUCTION

VISION AND OBJECTIVES FOR THE STP

VISION

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

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

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

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

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. 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.

WHAT THE STP IS INTENDED TO DO

1.5 The transformation journey has already started in Shropshire, and Telford and Wrekin. The Future Fit Programme and Community Fit Programme established broad agreement that, in order to create a better future for the NHS, all those with a stake in health and care must make changes to how we live, how we access care, and how care is delivered. For health and social care to meet the needs of future

patients in a sustainable way, we need to close the gaps in health, finance and quality of care between where we are now and where we need to be in 2020/21.

1.6 The opportunity to develop the STP is particularly timely for us because it will enable us to continue the work we have done on the Future Fit Programme without replacing any of the plans already developed. However, the Future Fit Clinical Design Workstream Models of Care report it was stated that:

"The clinicians also strongly emphasise three additional challenges, beyond hospital services, that should be addressed; the need to integrate health and social care and resolve the funding anomalies between them, the absolute requirement to create community capacity to manage the shift in care closer to home and the need for local communities and society as a whole to tackle the prevention and wellbeing agenda."

1.7 These three challenges have become the focus of the STP which starts from the premise that we need to look at the health of our population from a different perspective than the traditional hospital based perspective; this means we need to:

- Help our population to develop healthy lifestyles so they do not need to access services in the first place
- Build community assets and social capital so communities have the resilience to support themselves in a healthier and socially sustainable way
- Develop primary and community services around localities of interest which support the social capital model of care and prevent admission to more acute services
- Develop a model of secondary and specialist care that meets patient needs and only sees those people who really need their services after primary and community interventions have proved insufficient
- Adopt the principle that "home is best" and create a system that supports people through the health and care system, before and after their care, so they can remain in their place of residence as long as possible

Given these challenges work has commenced on the wider Neighbourhoods programme which will develop models of community and primary care services further with clinicians, service users and the public, and provide the balance across the system that clinicians and the public have told us is needed. Achieving this will be dependent on having the right digital infrastructure in place, delivered through our digital roadmap programme.

1.8 It is however important to state that much of the work that is done across the footprint will carry on, and become business as usual; the STP will not negate all the good work that takes place in the many areas of joint planning, and which will continue. For example, there has been a lot of excellent joint working across Shropshire Telford and Wrekin through the Better Care Fund; this will continue and develop further as part of a planned approach to integrated working and financial planning.

1.9 The Better Care Fund will continue to sit within a unique whole system transformation plan in which there will be fundamental redesign of the health and care landscape over the next five years and beyond. The Better Care Fund will reinforce the underlying interdependence of all the local transformation schemes and will form a key work stream within our local Sustainability and Transformation Plan as it develops in the early part of 2016. The two Health and Wellbeing Boards are the vehicles through which the local health and care economy will ensure alignment of these transformation schemes across the local footprint.

SHROPSHIRE TELFORD AND WREKIN POPULATION

1.10 Shropshire Clinical Commissioning Group (CCG) covers a large geography with issues of physical isolation and low population density within a mix of rural and urban aging populations. Shropshire is a large rural county with a population of approximately 308,000 which is set to rise to 320,600 by 2020. The graph at Appendix 1 shows the trend in population growth and change in population profile.

1.11 Telford & Wrekin CCG has a large, younger urban population within areas of rurality. Telford is ranked amongst the 30% of 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%. Telford and Wrekin has a higher proportion of households with dependent children than the national average and a lower proportion of households where all residents are aged over 65. The graph at Appendix 1 shows the trend in population growth and change in population profile.

SHROPSHIRE AND TELFORD AND WREKIN HEALTH AND SOCIAL CARE ECONOMY

1.12 The Shropshire, and Telford and Wrekin health and social care economy comprises of 2 CCGs, 4 main NHS providers, 2 Councils and a range of smaller private and third sector providers; one of the providers, Roberts Jones and Agnes Hunt NHS FT is a national centre for Orthopaedic services. More detail on the footprint organisations can be found at Appendix 2.

1.13 The overall population within the footprint is approximately 470,000 people, but a number of outlying populations, most notably Powys, access services at providers within Shropshire; whilst Powys is not officially part of the STP footprint, we believe it is important to include the Powys population in the STP planning considerations and for the community to be represented on the Partnership Board.

CASE FOR CHANGE

1.14 In November 2013 the system undertook a major consultation 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.

1.15 The Call to Action consultation also highlighted many challenges faced by the service and these are set out below:

CHANGES IN OUR POPULATION PROFILE

1.16 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. The pattern of demand for services has shifted with greater need for services that support frailer people, often with multiple long-term conditions.

CHANGING PATTERNS OF ILLNESS

1.17 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. Our plans for the use of Big Data set out in the Digital Roadmap will help us to achieve this challenge.

HIGHER EXPECTATIONS

1.18 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 MEDICAL TECHNOLOGY

1.19 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.

CLINICAL AND FINANCIAL SUSTAINABILITY

1.20 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.

MEDICAL WORKFORCE CHALLENGES

1.21 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 is now having a detrimental effect on recruitment; this issue is dealt with in more detail in section 3. 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.

GOVERNANCE AND LEADERSHIP OF THE PROGRAMME

1.22 Having already embarked on the Future Fit programme, the Shropshire, and Telford and Wrekin Community has been able to build on existing governance arrangements. Whilst the initial focus of Future Fit was on acute and community hospital services, the STP programme is now addressing the wider issues in the system and the governance arrangements have been adapted accordingly. The detailed Governance arrangements can be found at Appendix 3.

The system recognises the tension between Accountable Officer responsibility to Partner Boards and the need to work collectively through the STP; the Partnership Board will provide the support to Chief Officers to manage this and deliver system leadership for the programme.

1.23 There are four main workstreams which will lead the planning and implementation of the transformation agenda; each has a Chief Executive Sponsor and Executive lead:

1.24 **Acute Services Workstream** – This will take over the responsibilities of the Future Fit programme and continue the development of acute service transformation; this will include the upcoming work on option appraisal, business case development, consultation and implementation of preferred option.

1.25 This group will also undertake the work to establish the correct acute provider landscape moving forward; there are 3 main hospital sites in Shropshire, and Telford and Wrekin and the Partnership Board has approved a proposal that the acute site landscape should be included in the remit of the STP. This work will assess whether having 2 general acute sites and a specialist orthopaedic site is the right configuration; a draft Terms of Reference have been developed which will be reviewed by the Partnership Board in July 2016

1.26 **Neighbourhoods Workstreams x3** – We are clear that, in order to properly develop integrated, place-based services, we need to plan around neighbourhoods and build on the work already in train to develop a neighbourhood approach and develop social capital. These groups will take the work already started under the Community Fit Programme and integrate this into the wider place-based approach for community and primary care service delivery. We have 3 Neighbourhoods Workstreams for Telford and Wrekin, Shropshire, and Powys. Similar to the Acute Services Workstream, the Partnership Board has agreed that the provider landscape for community services will be part of the STP and the organisational form will emerge from the Neighbourhoods models that develop.

1.27 We have also established six Enabler Workstreams, each with a Chief Executive Sponsor and Executive lead.

- **Communications /Citizens Panel** - Membership of the group will comprise specialists as well as Healthwatch and patient representatives. The group will empower all stakeholder leadership as the heart of the Programme, ensuring the creation and delivery of a compelling vision for excellent and sustainable acute, community and primary care services. Shropshire, and Telford and Wrekin has a good record of engagement and this will continue through the reformed arrangements. Attached at Appendices 4 and 5 respectively are the draft Communications and Engagement Partnership Agreement and the Terms of Reference for the Communications and Engagement PMO which will manage the agenda and which are currently going through the approvals process.

- **Estates and Transport** - This workstream will lead the review of estate under the "One Public Estate" principle, building on an already existing group working to this principle. This will include assessing options to realign services and support across Police, Health, Care, Fire and Rescue and the 3rd Sector and look at how we can support the change in public relationship with health and social care by the developing new models of public ownership of assets and adjust the rural offer to communities.

- **Clinical Reference Group** – There is already a Clinical Reference Group (CRG) supporting the Future Fit Programme and this will continue as the STP widens the scope of the Transformation Agenda. The CRG plays a vital role in testing the underlying assumptions, modelling and analysis, and the methodology of service design. It will also take a lead in Quality Impact Assessments of the models of care that evolve through the work of the STP.

- **Finance and Governance** – The Finance and Governance Group will ensure a coordinated approach to the Deficit Reduction Plan across Health and Social Care, and test the costing methodology of any developments emerging from the planning phase. The group will also provide a check on governance processes for the overall programme.

- **Workforce** – We already have a Workforce Group in place which is addressing the issues across the systems. There will need to be significant changes to the health and care workforce if we are to meet the challenges set out in the STP and the Workforce Group will be fundamental in supporting the development of the new roles, integration and retraining of the workforce. The summary of Appendix 6 outlines the approach being taken.

- **IM&T** – We have a countywide IM&T Workstream Chaired by a CCG Clinical Lead; this group has led the work on the Digital Roadmap submission and is using the STP to underpin its work plan moving forward. There are a number of initiatives highlighted in the STP which have been submitted by this workstream and which show the increasing consistency of what the STP and Digital Roadmap seek to deliver.

Each of the 4 main Transformation workstreams and 6 enabler workstreams will establish full programme implementation plans, delivery outcomes and programme milestones by September 2016.

1.28 It has been acknowledged by the system leaders that the transformational journey needed over the next 5 years will require significant leadership, resilience and joint working, more so than in previous years; to that end a system Compact has been developed and is detailed at Appendix 7. It has also been agreed that we need to work to a single Production Methodology to increase convergence of working behaviours and enhance integration; two organisations are already working with the LEAN methodology with the Virginia Mason Institute and this is the proposed model for the STP Programme; sections 2 and 3 give examples of pilot programmes where this methodology will be tested, before full deployment during the implementation phase of the STP after September 2016

1.29 Capacity to support the transformation journey has been agreed and contributions from all the main stakeholders has ensured the infrastructure at Appendix 3 is fully funded and is currently being put in place.

2. IMPROVING THE HEALTH AND WELL-BEING OF THE PEOPLE OF SHROPSHIRE, TELFORD AND WREKIN

CAUSES OF ILL-HEALTH IN SHROPSHIRE AND TELFORD & WREKIN

2.1 We know from our Business Intelligence systems that the main causes of ill-health across the Shropshire, and Telford and Wrekin footprint are similar to many areas; of particular note are:

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

- High blood pressure is a significant risk factor for chronic health conditions and 71,750 people in Shropshire, and Telford and Wrekin are currently diagnosed and recorded in primary care as having hypertension. However, a significant number of people (circa 57,000) have potentially harmful high blood pressure and have not yet been diagnosed.

PREVENTION AND WELLNESS

2.2 Our view is of health as a broad concept - an overall sense of physical, mental and social wellbeing, rather than merely being free from disease, illness or disability. To close the health and wellbeing gap we will focus on actions to improve the health of people in our area across three key priorities identified by our Health & Wellbeing Strategies to improve healthy life expectancy and narrow inequalities.

2.3 To do this we will continue to use and develop advanced data analytics with our public health colleagues to manage current and to identify future demand at patient level where early intervention can result in better health and wellbeing.

2.4 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. We will support people to lead healthier lives, prevent ill health and empower patients enabled by technology to adopt and promote self-care in order to reduce the demand and dependency on our public services.

2.5 As our population ages it is becoming more usual for us to live with more than one health issue or co-morbidity at the same time, but people can live well with chronic conditions and we need to widely promote the view that it is never too late to prevent or delay complications and for those conditions that are preventable we need to focus on activities that prevent our citizens developing them

STRENGTHENING COMMUNITIES AND DEVELOPING SOCIAL CAPITAL

2.6 All organisations agree that community-centred approaches are a vital part of the prevention agenda as well as the transformation of health and social care. Work on the integration agenda across the patch, which further develops learning from the Better Care Fund, clearly acknowledges building community resilience as a golden thread. Residents support this change - the local Be Healthy, Safe and Independent Survey found that “being involved” was important to people having positive lives including volunteering in groups such as church, charities and community projects. The Place Based Health Commission Report, commissioned by the New Local Government Network entitled “Get Well Soon – Reimagining Place Based Health” sets out much about the relationships between institutions that need to be built, and about ways in which services could be knitted together more effectively for people who need them most. It suggests that, if we are to deliver our “radical upgrade” in prevention, we need to share the future of the health and care system beyond the borders of our current service silos. It further stresses that “if we are really serious about reorienting our health and care model around the grain of people’s lives, assets and ambitions, then we need to take it seriously as a starting point for reform”. We will be able to draw on the learning in this report as we develop our place based approach to service planning and delivery.

2.7 To change the dynamic, to strengthen communities and develop social capital we will focus on:

- Strengthening communities by taking action on the causes of poor health

- Supporting volunteer and peer roles
- Enabling collaboration and partnership in planning of services between communities and statutory organisations
- Connecting individuals and families to community resources

To achieve the change we will:

- Identify local leaders who can champion change
- Consider 'social isolation' and how communities can help to address it
- Map all the existing assets to celebrate the diversity and identify gaps
- Fund prototypes to kick start the movement, illustrating what can be achieved
- Develop a workforce to help us get to know our communities
- Invest in digital technologies to connect communities and enable change.

2.8 In Telford and Wrekin, Neighbourhood Care Teams will support people with identified long term health conditions to live their life to their full potential in their community. The virtual teams will be formed from professionals from different organisations such as GP practices, community nursing teams, hospital outreach teams, third sector organisations, carers and local authority teams enabled by our shared care record programme set out in our Digital Roadmap. The Neighbourhood Care Teams will be grouped around natural communities and GP practices and will promote self-care and self-management.

2.9 In Shropshire the Resilient Communities movement encompassing Community Enablement Teams and working with Community and Care Co-ordinators will take a similar approach, wrapping around GP practices and working within communities and third sector partners developing social action, social value and asset based approaches to meeting need.

2.10 Local examples where this approach is already working includes:

- Locality working integration prototype in South Telford, a multi-disciplinary team of professionals around the Stirchley Medical Practice (SMP), is changing the way statutory services interact with vulnerable people, building on individual strengths, assets and community.
- Shropshire's nationally recognised Community & Care Co-ordinators (C&CC) scheme embeds a C&CC within GP practices to speedily identify and support those patients deemed to be at risk of loss of independence and hospital admission. They work collaboratively between the practice, voluntary sector and community groups, the local authority and volunteers. This has resulted in a 48% reduction in GP consultations, a 33% reduction on A&E attendances and a 58% reduction in unscheduled hospital admissions.

IMPROVING HEALTHIER LIFESTYLES AND REDUCING RISK

2.11 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.

2.12 Both health and wellbeing strategies highlight improving health lifestyles and prevention as key priorities. Shropshire Council and Telford & Wrekin Council ensure that high quality, accessible lifestyle and prevention services and programmes are in place as part of their local authority public health duties, through the Telford & Wrekin Council Healthy Lifestyles Offer and Shropshire's Help2Change Programme. The local authorities also ensure the provision of recovery treatment services for substance misuse.

2.13 Local examples where our approaches are already working include:

- Maternal public health partnership in Telford & Wrekin where public health and children's services teams, midwives and health visitors have been working together to improve infant health outcomes
- Shropshire's Diabetes Exemplar project – taking a whole systems approach to reducing the incidence of type 2 diabetes by focusing on reducing the risk of individuals with impaired glucose intolerance becoming diabetic. Supported by the Local Government Association and Design Council this approach uses ethnographic data to plan and develop suitable interventions across the system

WHAT MORE NEEDS TO BE DONE TO TACKLE KEY CAUSES?

2.14 Unhealthy lifestyle behaviours remain a local challenge despite the provision of high quality local health improvement services. Trends indicate that health professionals do not systematically give lifestyle advice or signpost and refer into prevention services in a comprehensive way which exacerbates our local health inequalities. Whole system approaches, which are applied systematically and at scale, are needed to reduce the key risk factors which cause the greatest burden of ill health in our population.

2.15 Primary prevention aims to delay or prevent the onset of clinical conditions. Where conditions do develop, secondary prevention approaches need be adopted to minimise the impact on health and wellbeing and support independence. Such approaches often rely on the early identification of a clinical need followed by timely access to appropriate care. For example we know that circa 80% of NHS diabetes spending on goes on managing complications, most of which could be prevented in the first place.

2.16 As previously mentioned, the prevalence of key risk factors such as diabetes and hypertension is increasing over time, in part due to the growing numbers of people who are overweight and harmful alcohol consumption. Right Care intelligence also indicates that the management of people with diagnosed cardiovascular disease still needs to be systematically improved across all GP practices - of the patients diagnosed with hypertension, circa 16% (11,500 people) do not have their high blood pressure controlled appropriately. With respect to patients with diabetes, circa 42% (10,400 people) do not have their blood pressure, blood sugar and cholesterol level risk factors treated to target. High quality primary care is crucial for improving outcomes in CVD because the majority of prevention and most diagnoses and treatment are delivered in General Practice.

2.17 As part of our commitment to radically upgrade prevention we will:

- Guarantee the systematic delivery of lifestyle advice, signposting and referral into lifestyle services by all healthcare professionals, approach, across primary and secondary care so it happens consistently and appropriately at every patient contact, through the following:
  - Adopting the Making Every Contact Count (MECC) approach comprehensively
  - Expanding the delivery of brief interventions in the NHS

  - Embedding healthy lifestyle advice from Health Trainers into hospital settings
  - Developing Health Champion volunteers from the community
  - Exploiting the use of 'prescribed Apps' to help support track and motivate patients in achieving their health and wellbeing goals.

- Systematically upgrade the role of the NHS in tackling harmful alcohol consumption by healthcare professionals in primary and community care and acute hospital settings to ensure identification and delivery of brief advice and referral into treatment services as appropriate, including through:

  - Routine alcohol consumption screening for all A&E attendees
  - Redefining the role of the Alcohol Liaison Nursing Service
  - Expanding identification and brief advice delivered in primary care

- Tackle the obesity epidemic using a whole-systems approach through the Health & Wellbeing Boards, across various local authority teams, the NHS, partners and wider organisations, including the following:

  - CCG commissioning of tier 3 clinically-led weight management services to complement the transfer of responsibility for tier 4 services for severe and complex obesity surgery
  - Improvement in the systematic identification and appropriate referral of adults and children with excess weight by primary and secondary care into appropriate weight management pathways
  - Capitalising on the opportunity to benefit from the support available from the GP Clinical Physical Activity Champions

- Deliver the expectations of the national Cancer Strategy for England, given Right Care intelligence on local cancer risk factors and outcomes, specifically the following elements:

  - Delivery of comprehensive, whole-system prevention plans to reduce cancer risk factors e.g. action tobacco control, including adopting a completely smoke-free policy at Shrewsbury & Telford Hospital NHS Trust to protect patients, visitors and staff from the impacts of second hand smoke and encourage further smokers to quit
  - Ensuring earlier diagnosis and prompt treatment through symptom awareness raising with the public and in primary care and focussed action to improve the uptake of breast, cervical and bowel cancer screening.

- Systematically improve the prevention, detection, treatment and management of hypertension and diabetes, including primary and secondary prevention elements such as:

  - Delivery of the diabetes prevention programme approach to identify and manage people at high risk of developing diabetes
  - Improving the uptake of vascular risk assessment through NHS Health Check
  - Reducing unwarranted variation across GP practice performance will contribute to reducing health inequalities.
  - Redesigning the diabetes integrated service and treatment pathways
  - Implementation of a detection and management of risk factors for stroke schemes
  - Improving seasonal 'flu immunisation for people in at risk clinical groups, as well as those 75 years of age

IMPROVING MENTAL WELLBEING AND MENTAL HEALTH IN TELFORD & WREKIN

2.18 Common mental health disorders are higher than average in Telford and Wrekin and people with serious mental illness have poorer life expectancies, and tend to have more unhealthy lifestyles.

2.19 Improving emotional health and wellbeing broadly is seen as critical, and our mental health strategies commit to: improve community wellbeing, develop emotional resilience, identify people at risk earlier and improve the quality of life and physical health of those with mental illness. Local insight and intelligence from the public, patients and carers is shaping our approach.

2.20 There is clear recognition that developing supportive communities – " *a place I am proud to call home*" will promote independence and resilience ensuring that people have the capacity to cope with the challenges that life, including mental health, can pose. This vision is that people are supported to live as independently as possible within their families and communities, with minimal intervention.

2.21 Local insight indicates that early intervention – "*I know where to go for advice*" will support people who are in need at the earliest opportunity to prevent further escalation.

2.22 For mental health services, people with mental health problems have told us - *"I need to understand my condition and to have help to live my life to the best of my ability without my condition taking over my life".*

IMPROVING MENTAL WELLBEING AND MENTAL HEALTH IN SHROPSHIRE

2.23 Shropshire has engaged in a system wide mental health needs assessment to inform a new 5 year Mental Health Strategy and action plan. The needs assessment is taking a partnership approach to building a detailed profile of current need in the county and will be completed in the coming months. The outcome of the needs assessment will inform the priorities of the strategy and action plan and inform how we build on current services or re-align provision.

2.24 Local examples from Shropshire, and Telford and Wrekin where a focus on prevention is already working includes:

- Development of the 5 ways to wellbeing Telford public mental health movement to help people feel good, function well and have a positive experience of life by through key partners, blogging and social media networks
- Shropshire's Dementia Early diagnosis programme
- Collaborative local commissioning between both councils and both CCGs for a holistic emotional health and wellbeing service for children and young people aged 0-25 years

2.25 We will improve mental health and wellbeing across the footprint in these priority areas specifically by:

- Promoting good emotional health and wellbeing by supporting the development of universal services
- Supporting people to live as independently as possible, with minimal intervention
- Promoting independence and resilience to ensure people have the capacity to cope with the challenges that life, including mental health, can pose
- Ensuring information will be readily available at places, and in formats that are accessible when

people need it most

- Taking a whole system approach to commissioning mental health services where recovery is the expected outcome and service users are empowered to contribute to their community

- Ensuring people better understand how to work with people with mental health issues in ways that promote their independence, ensure their safety and support their recovery.

- Focussing of mental health support on need rather than age or diagnosis, especially dual diagnosis and personality disorder

3. DEVELOPING SERVICES AROUND NEIGHBOURHOODS

3.1 We have agreed that we need to develop services around neighbourhoods and we have structured the governance of the STP to support this; this work is well advanced in some areas but needs a more systematic approach. Because of the previous Transformation work in progress through Community Fit, we are in a process of transition which will move this pre-existing programme into the three coordinated Neighbourhoods approach; this transition we will bring together the work described in Section 2 on prevention, self-care and social capital into a single Neighbourhood approach and create an integrated workstream for each of the three main Neighbourhood groups. The following sections describe the work on the Community Fit Programme to date, which will transition into the Neighbourhoods workstreams as outlined above.

BACKGROUND TO COMMUNITY FIT

3.2 The Community Fit Programme was borne out of the need to describe in detail how the Future Fit model (reconfiguration of acute and community bed based services) would function and enable the intended transfer of inpatient activity to be delivered within the community.

3.3 The aim of the Community Fit programme is to deliver a sustainable, community based, health and social care system focussed on prevention and continuity of care, delivered by integrated teams of clinicians, through bespoke local solutions utilising the unique locality asset base.

3.4 It is clear that in order to enable safe transition from the current care model, which is heavily inpatient based, all aspects of care will need to be covered to ensure that the reliance on inpatient beds is adequately met by community alternatives before the Future Fit model is fully implemented.

OUTPUTS FROM PHASE ONE OF COMMUNITY FIT

3.5 Phase one of Community Fit has just concluded in April 2016 and has successfully delivered the key enabling project as intended. We have modelled and described the types of service which will be required in the community to absorb the activity coming out of the acute trust and the other changes which will impact on the use of primary and community healthcare services such as demography, ageing population and increased demands on the primary care and community services.

3.6 Insights from phase one of Community Fit are now available and are providing a strong foundation for our ongoing planning as we describe the community response to both the demographic challenge and the shift of activity out of hospital as a consequence of Future Fit.

3.7 The list below summarises the outputs from phase one:

- An agreed way of modelling activity in of social care, primary care, community healthcare, and mental health
- An agreed taxonomy (classification) of care packages delivered by each of these sectors
- An agreed estimate of the impact of demographic change on activity levels within these sectors
- A linked health and social care dataset, identifying patients receiving care from two or more sectors and describing the care they receive
- A description of the activity that the NHS Future Fit Programme models anticipate will move out of the acute setting and therefore may have an impact on primary care, community services, mental health and social care services.
- An assessment of the potential voluntary and third sector services contribution to the broader programme and suggestions of mechanisms and approaches that might be employed to maximise this contribution.

COMMUNITY FIT ANALYSIS

3.8 The total cost of the analysed health and social care (H&SC) services incurred in 2014/15 was £408,147,156 which covered 210,859 service users. The highest costing 2% of service users cost £132,910,335 compared to the least costing 80% of service users who cost less than this at £77,218,916. This shows a large proportion of costs were incurred by a relatively small proportion of service users.

3.9 A large proportion of spend on Social Care Packages, Mental Health Contacts and Mental Health Inpatients were on Very High cost service users. There may be scope for efficiencies to be gained and for the quality of services to be improved by removing duplication between these two types of services.

3.10 A larger proportion of females receive Health and Social Care services, especially in the older age groups, this may be due to the female population having a longer life expectancy than males and as a result living as a single occupier. Living arrangement is not included in the dataset so this as a cause cannot be proved based on the analysis shown. Improving the life expectancy of males may delay the need for H&SC services in the female population.

3.11 Dementia, Atrial Fibrillation, Coronary Heart Disease, Chronic Kidney Disease, Diabetes and Stroke are more prevalent amongst the Very High Cost group. Co-morbidities are also more common amongst this group. This might suggest the basis for at least a component of a frailty register at practice level and in turn a focus for joint Health and Social Care case review.

3.12 Social Care service users are more likely to interact with Mental Health and Community services compared to other services. There may be scope to integrate services within these and to also identify potential future Social Care service users from within these services.

3.13 All health and social care providers have told us that their data quality has increased significantly since 14/15, the year on which the Community Fit phase one analysis has focussed. Added to this, we now

have the confidence of the GP Federation and they are willing to recommend to their members that they sign up to include data extracted from GP practices to give the fullest possible picture of community activity. We would therefore propose to re-run the data analysis piece including primary care and also CHC (Continuing Health Care) which, was previously omitted for expedience only, simultaneously with implementing the other activities planned under Community Fit phase 2.

3.14 Having gathered and linked data about patients' service usage, the Community Fit project explored the extent to which patients could be usefully classified in terms of service usage patterns into a relatively small number of groups. If possible, this might support the health and social care system to identify those areas where service integration or improved care coordination might be of particular benefit and support thinking about the nature of out-of-hospital package that might substitute for care packages currently supplied in acute hospital settings.

3.15 In summary, 16 distinct clusters were found with the following characteristics:

Cluster	Cluster Name	Cluster size (n)	Cluster size (%)	Average cost £)	Average Age	Average acute cost (£)	Average community cost (£)	Average mental health cost (£)	Average social care cost (£)
Multi-sector patients									
11	Complex frail elderly	2,516	1.2%	18,913	76	5,071	2,186	1,873	9,315
6	Complex needs – mainly managed in community	273	0.1%	32,606	73	5,217	19,185	444	7,430
3	Long stay acute care	3,514	1.7%	13,360	70	11,860	1,027	85	288
4	Younger adults with complex disabilities	234	0.1%	94,599	44	995	1,307	2,469	89,689
2	Intensive / institutional mental healthcare	180	0.1%	51,672	57	2,728	741	42,714	5,230
7	Young adults with simpler mental health needs	5,121	2.4%	3,420	50	1,028	53	1,787	431
5	Well-maintained social care users	1,486	0.7%	13,040	61	548	305	148	11,863
1	Discrete planned care with community follow-up	12,571	6.0%	2,815	62	2,588	191	2	14
8	Community support-occasional acute input	7,940	3.8%	2,751	71	1,574	949	30	186
9	Community & social care – occasional acute input	6,075	2.9%	5,728	74	2,288	965	468	1,713
10	Simple investigations – physical health	20,041	9.5%	642	61	431	172	4	16
12	Simple investigations – physical/mental health	3,775	1.8%	824	55	233	128	423	1
Single-sector patients									
13	Acute contact only	113,689	54.0%	931	50	931	-	-	-
14	Community contact only	30,557	14.5%	267	60	-	267	-	-
15	Mental Health contact only	270	0.1%	2,520	50	-	-	2,520	-
16	Social Care contact only	2,237	1.1%	5,880	52	-	-	-	5,880

3.16 As part of the analysis we looked at Primary Care usage, using a proxy of 3 practice data sets; whilst this is a small sample, the benefits have become apparent and we are now working with colleagues in Primary Care to extend the number of practices in the data set to produce a richer picture. We developed the modelling to project into the future, using Disability Free Life Expectancy (DFLE), which estimates lifetime free from a limiting persistent illness or disability. This is based upon a self-rated assessment of how health limits an individual's ability to carry out day-to-day activities. We used this measure to assess population health status over time and the effect this would have on the use of Primary Care and Community services under an optimistic, moderate and pessimistic scenario.

3.17 Our modelling suggests that if we successfully implement our plans for locality based programmes which prevented people from becoming ill and manage those with healthcare problems differently,

characterised as 'dynamic equilibrium', a moderately optimistic scenario , there is potential over the next 5 years to achieve improved outcomes for our population and a balanced financial position. The charts below show the analysis data for the 3 GP practices and from Shropshire Community Trust data.

Impact of Demographic Change on Primary Care

	Practice A			Practice B			Practice C		
	Pessimistic	Moderate	Optimistic	Pessimistic	Moderate	Optimistic	Pessimistic	Moderate	Optimistic
Consultations	6.0%	-0.6%	-0.9%	8.4%	-0.9%	-1.2%	3.2%	-0.6%	-0.8%
by type									
GP Surgery	6.1%	-0.3%	-0.6%	8.2%	-0.2%	-0.4%	3.2%	-0.4%	-0.6%
Telephone & 3rd Party	5.4%	-4.7%	-7.1%	8.2%	-4.2%	-6.6%	2.8%	-3.9%	-5.8%
Home Visits	10.3%	0.0%	-0.2%	13.5%	-0.5%	-0.9%	8.8%	-0.5%	-0.7%
by staff type									
GP	5.7%	-0.2%	-0.4%	Data not available			3.1%	-0.5%	-0.7%
Nurse	5.9%	-0.2%	-0.4%				3.6%	-0.7%	-1.0%
Other	6.3%	-0.5%	-0.8%				3.1%	-0.4%	-0.6%

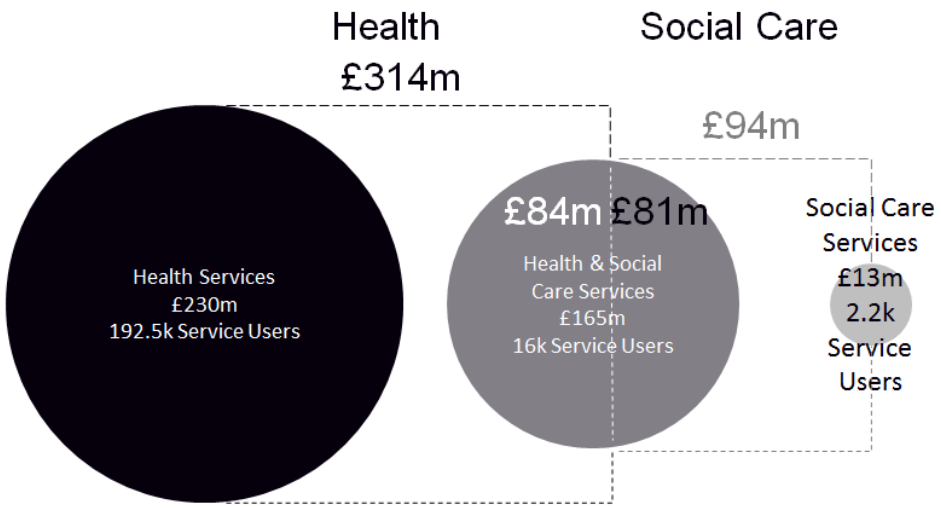
Impact of Demographic Change on Community Healthcare

		Health Ageing Scenarios 2019/20					
	Activity Baseline	Pessimistic		Moderate		Optimistic	
Community Nursing Contacts	265,354	294,166	*28,812*	251,684	*-13,670*	246,799	*-18,555*
Community Specialist Nursing Contacts	56,172	60,110	*3,938*	55,247	*-925*	54,914	*-1,258*
A&E and Outpatients Contacts	69,875	74,328	*4,453*	68,929	*-946*	68,593	*-1,282*
Therapy Contacts	38,694	40,850	*2,156*	38,516	*-178*	38,452	*-242*
Podiatry Contacts	46,293	50,623	*4,330*	45,107	*-1,186*	44,684	*-1,609*
Contacts Total	**476,388**	**520,076**	***43,688***	**459,483**	***-16,905***	**453,442**	***-22,946***
Intermediate Care Bed Days	42,752	47,772	*5,020*	40,210	*-2,542*	39,303	*-3,449*

3.18 With regards to the table above, after accounting for the impacts of population growth and changing age structure, there could be between 44k more or 23k less contacts for the population, depending on

confidence in one of the 3 scenarios. In the same way the number of intermediate care bed days may rise by 5,000 or fall by 3,500.
This analysis requires further work and will form part of the neighbourhoods Workstreams going forward.

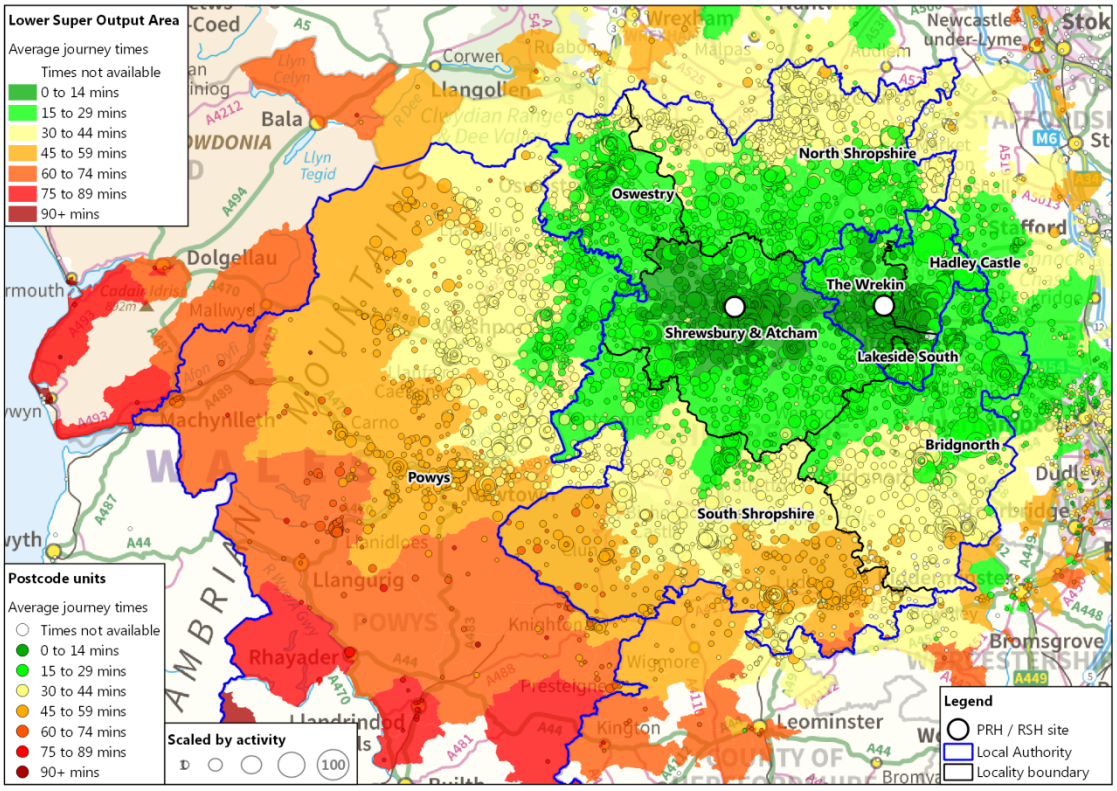
3.19 The diagram below shows that 91% of the matched population received Health services only and accounted for 56% of the costs compared to Health & Social Care Users who accounted for 8% of the matched population and 40% of the costs. The average cost of the Health and Social Care group was more than 5 times the average cost.



RURAL URGENT CARE

3.20 A network of rural urgent care centres were proposed as part of the Future Fit solution designed to offer a more accessible urgent care service across some of the more rural areas (see map below). Census data shows that there are significant minorities of people who do not own a car in the county. The Future Fit Rural Urgent Care Sub Group report (May 2016) suggested that alongside existing initiatives to improve urgent care pathways, there are opportunities to enhance the urgent care offer in rural communities in a way that has the potential to meet the requirements of the Future Fit clinical model and to be both clinically and financially viable. Consistent with the locality, place based approach, we are beginning work with health and care staff currently operating in a more rural areas to understand how they could work in a more integrated way, harnessing community capacity and mobilising local communities, to improve access to care in rural areas and begin to tackle prevention and wellbeing.

3.21 The map below shows current travel times for localities served by SaTH hospitals.



PRIMARY CARE- IMPLEMENTING THE GP FORWARD VIEW

3.22 Our system has historically benefitted from strong primary care which has enabled us to adapt to change, but some of our practices are beginning to feel the pressure; our approach will include investment to ensure primary care remains sustainable and at the heart of delivery. Our out of hospital care models will be based around the GP lists for local populations and this will support a shift of resource to enable out of hospital care to be a reality. We will also implement the menu of ten high impact actions for practices, to release capacity in GP practices and undertake demand and capacity work across our footprint to help develop resilient primary care. We will work with localities, the GP Federation and practices to identify the functions needed to provide holistic care across the spectrum.

We have started to identify the range of service providers, the wider support (Private, Independent and Voluntary sectors, carers, families) and IT solutions that will be needed to deliver these functions, and to enable the focusing of unique GP resource on patients with complex care needs. Our strategy to develop primary and community care at scale will support the development of a sustainable workforce that has the capacity, capability and culture to deliver out of hospital care. We are already working with some localities that are keen to explore new care models that suit their situation. The coproduction approach outlined below is beginning to see the emergence of distinct approaches and practice groupings that are keen to shape the delivery of health and care for their populations.

LOCALITY COPRODUCTION APPROACH

3.23 In order to develop the thinking, a coproduction approach has been adopted working with a full range of stakeholders including NHS Providers, Commissioners, Local Government officers and Politicians, Private Providers, Public, General Practice, Healthwatch. A Clinical Reference Group was held on 19 April which had 140 representatives from the clinical community and others; the workshop assessed the outputs from the Phase 1 analysis, agreed that there was a compelling data set which highlighted where we should focus our attention and agreed to a further workshop to develop the approach going forward.

3.24 At a June workshop of over 90 health and social care professionals from across Shrewsbury, Telford & Wrekin, there was an overwhelming endorsement for the proposed place based approach to be the main vehicle further developing the community response to our current challenges. The group fully accepted the community case for change and welcomed input from two Vanguard sites (Erewash and West Wakefield), who presented their learning and progress to the workshop.

3.25 The proposal that a locality co-production approach should be adopted was welcomed, as this would free up local health, voluntary sector and care leaders to work with their populations, capitalising on existing local assets. Following the commitment from senior health and care leaders to provide project and management resource to support the proposed locality based projects, we are now actively working up the detailed design with up to 4 localities; these include practices covering rural areas and larger urban groupings. Localities have registered interest in a range of potential delivery models which include close working with the acute trust, independent practice groupings and a potential social enterprise type model. Leaders are committed to support rapid development of these models so that a range of approaches can be tested to support wider roll-out, depending on locality support.

WORK TO DESCRIBE HIGH VOLUME CARE PATHWAYS

3.26 In parallel, work is well progressed on setting up pathway groups across the health and care economy to review and redesign a number of high volume care pathways from prevention through to end of life care. Led by a GP commissioner and supported by experts from the acute trust, social care, community trust and other expert input relevant to the pathway, these groups have been tasked with describing the full pathway and facilitating implementation across the county. There is a process in place to oversee both the pathway work and locality based service redesign to ensure consistency with the overall Neighbourhoods approach.

WHAT WE DO NEXT

3.27 The analysis in paragraphs 3.5 – 3.17 is a very high level summary of a much deeper analytical piece which provides an incredibly rich picture about patients and service users, and their use of health and social care services. Having agreement to use this analysis, and having agreement from the 2 workshops to move forward on a place based approach we will bring together the different strands from the previous Transformation work around Community Fit with all the other work around the Better Care Fund, prevention, self-care and social capital into unifying workstreams around Neighbourhoods.

4. DRIVING TRANSFORMATION FOR ACUTE SERVICES

THE FUTURE FIT VISION

4.1 The Call to action Consultation process in 2013 set out the clear Case for Change for the reconfiguration of hospital services. The Future Fit clinical model which provided a wider model than just hospital provision then emerged in 2014. Three hundred clinicians and patients involved in the Clinical Design work stream agreed that high quality, safe, efficient and sustainable hospital services can only be delivered if the whole health and social care economy is functioning to the same high standards. There were also some specific challenges faced by Shrewsbury and Telford Hospitals NHS Trust in relation to workforce and the need to support rotas over 2 main acute site; solving these challenges is fundamental to securing the high quality, safe services that we need to deliver for our population and more detail is given in sections 3.10-3.15.

4.2 The Future Fit Clinical Model serves as an agreed common destination for all stakeholders. As a whole system plan, the scope of the report is much wider than acute and community hospital reconfiguration. It describes and demonstrates critical interdependencies across the whole economy and points firmly to the need to begin the process of transformational change now. Only by doing this will the reconfiguration of hospital services be successful.

4.3 The principles and changes in working practices proposed in the model reflect the requirement for a sustainable health and social care system, but balance that requirement with the need to empower patients, clinicians and communities. System wide design principles were agreed:

- Targeted prevention and Wellbeing as the biggest single success factors
- Home is normal with less bed based focus
- Needs led, matching the correct level of care
- Empowered patients, clinicians and communities
- Sustainability: clinically, for our workforce and financially
- Integrated Care with smooth transitions
- Partnership Care with shared decision making redefine specialist and generalist roles
- IT enabled

4.4 These clinical and design principles have been the basis of developing and setting out the three main areas of health care delivery:

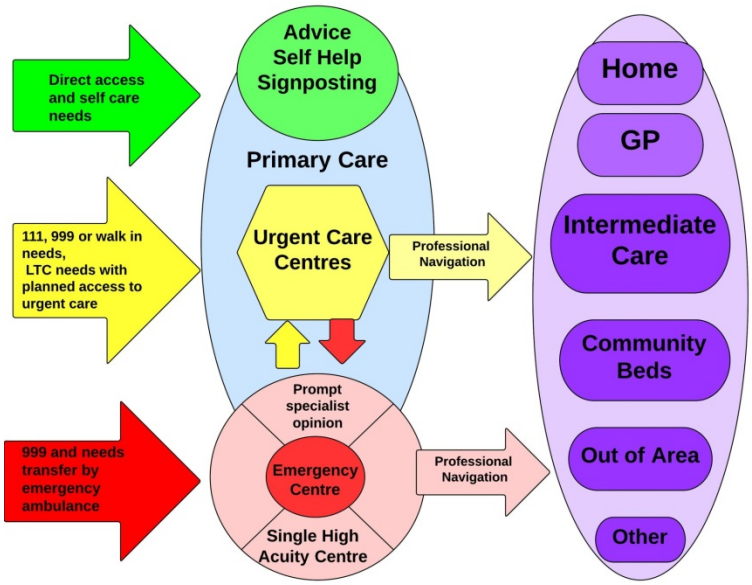
- Acute and episodic care;
- Planned care.
- Long term conditions and frailty

4.5 It also set out the importance of co-location of services across providers and particularly those of the acute sites and the community services in Shropshire. From an estates and cost efficiency perspective, transforming community services through the co-location of a community hub, ambulatory services, inpatient beds and urgent care centre is logical. From a patient perspective, care will be delivered in a way that makes the services feel coordinated and part of a community when visiting the community hub.

EMERGENCY AND URGENT CARE

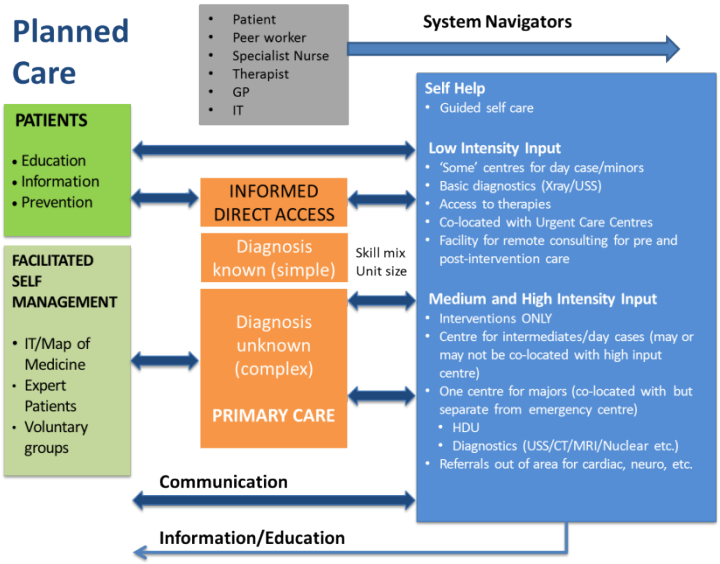
4.6 The clinical model for acute and episodic care describes an urgent care network, within which one central emergency centre works closely with peripheral urgent care centres; two urban urgent care centres and a number of rural locations where urgent care is provided on a locality basis, the number and location to be defined. The recent Shropshire Rural Urgent Care Review, which includes prototyping a Rural Urgent Care Centre at one of the existing Community Hubs in Bridgnorth, is described elsewhere in this plan.

4.7 In addition there will be a single point of access acting as a portal to a wide range of onward services for health and care needs, as shown below:



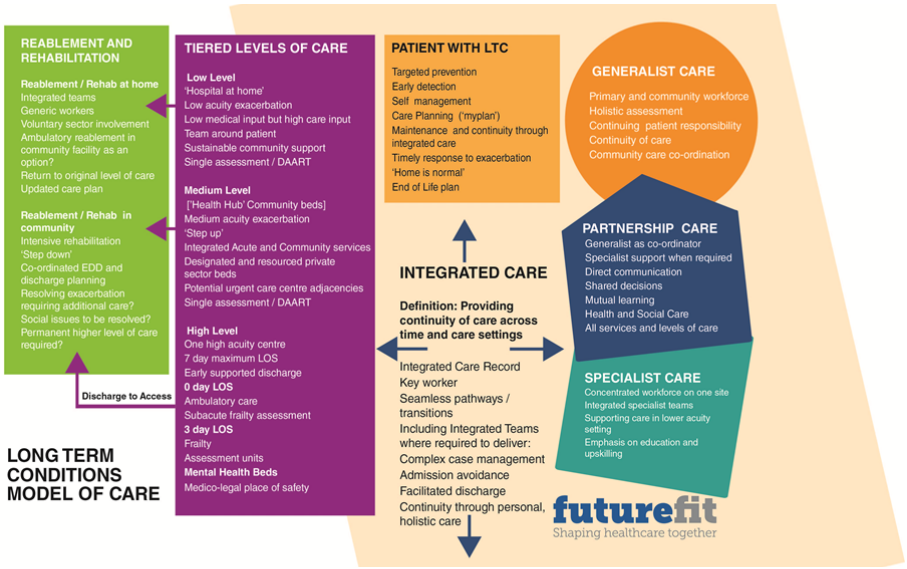
PLANNED CARE

4.8 For planned care, one central diagnostics and treatment centre will provide around 80% of planned surgery whilst the majority of assessment, diagnosis and follow up will be performed closer to peoples' homes. How this will work is shown in the diagram below:



LONG TERM CONDITIONS MANAGEMENT

4.9 The care of people with long term conditions will be seamless, responsive and lifelong and is detailed in the following flow diagram:



Our model for the management of patients with Long Term Conditions is one which relies heavily on the use of technology.

We will:

- Use and develop our Business Intelligence capability to identify patients at risk or with an early diagnosis of a LTC
- Use our Integrated Care Record to ensure that there is a Care Co-ordination plan is place, accessible by all of those professionals will be involved in supporting the patient.
- Maximise the use of telehealth to enable remote monitoring of patients where appropriate and intervene when necessary.
- Maximise the use of telecare to support patients living more independently.
- Use technology to support Health Coaching and enabling patient to live as much a normal life as possible with their condition.
- Introduce the use of telecare/telemedicine where this is appropriate to do so to maximise clinical capacity.
- Provide through the development of Self-Management portals access to information, services and tools to support patients with the management of their condition.

4.10 Like all hospitals, the greatest asset of Shrewsbury and Telford NHS Trust (SaTH) is its workforce. However, the Trust does not have all the staff it needs in the right locations. The organisation is faced with difficulties in recruiting to essential medical and nursing clinical roles; within the Emergency Departments, Critical Care services and other areas across the Trust. This means a heavy reliance on temporary staff and increased pressure on teams. Continued and innovative solutions to address this recruitment challenge have been explored but all have failed to provide a sustainable solution and a long term solution is urgently needed.

4.11 The Trust does not currently meet staffing levels recommended by the College of Emergency Medicine across all medical roles including Consultant, Middle and Training grades. Research demonstrates a greater consultant presence in A&E reduces admissions, reduces inappropriate discharges, improves clinical outcomes and reduces risk to patients.

4.12 Critical Care is covered with a mix of general anaesthetists and the small number of intensivists available, but consultant presence is still well below recommended levels. The Trust is one of very few nationally that have not been able to split its Anaesthetics and Critical Care rotas. The Trust has continuously attempted to recruit additional Intensivists; however potential candidates consider the absence of formal split rotas and very onerous on-call arrangements deeply unattractive.

All West Midlands Emergency Departments	ED Consultant Hours per week (max 24x7 = 168)	
Hospital Site	Number	%
Queen Elizabeth Hospital, Birmingham	119.0	70.8%
University Hospital, Coventry	119.0	70.8%
County Hospital, Stafford	117.3	69.8%
City General Hospital, Stoke	112.0	66.7%
New Cross Hospital, Wolverhampton	97.0	57.7%
Birmingham Children's Hospital	92.9	55.3%
Manor Hospital, Walsall	88.0	52.4%
Good Hope Hospital	86.0	51.2%
Heartlands Hospital, Birmingham	86.0	51.2%
City Hospital, Birmingham	82.0	48.8%
Sandwell General Hospital	82.0	48.8%
Queen's Hospital, Burton	81.0	48.2%
Worcestershire Royal Hospital	79.0	47.0%
Russells Hall Hospital, Dudley	77.0	45.8%
George Eliot Hospital, Nuneaton	70.0	41.7%
Warwick Hospital	68.0	40.5%
The County Hospital, Hereford	65.0	38.7%
Alexandra Hospital, Redditch	60.0	35.7%
Royal Shrewsbury Hospital	**58.0**	**34.5%**
Princess Royal Hospital, Telford	**49.0**	**29.2%**
Solihull Hospital	40.0	23.8%
AVERAGE	82.3	49.0%

4.13 In 2004, the Royal College of Physicians recommended that there should be a minimum of 3 acute physicians per hospital by 2008 with a minimum consultant staffing level for weekend rotas to deliver sustainability. The Trust does not meet the recommended staffing levels; this again limits the ability to provide the levels of senior review needed to ensure timely patient assessment and treatment, and move towards more 7 day working.

4.14 Duplication of services on both sites reduces the ability to support favourable on call rotas and it is difficult to support the development of advancing and extending practice for non-medical staff with the limited capacity of medical colleagues to mentor and support appropriately.

4.15 This need for a long lasting, sustainable solution has been addressed through the development of a Strategic Outline Case by the Acute Trust, in line with the aspirations of the Future Fit

STRATEGIC OUTLINE CASE

4.16 The Strategic Outline Case demonstrates that there are potential solutions which, in line with the Future Fit Clinical Model and the Options developed in partnership with clinicians, patients and the public, could address the Trust's workforce challenges in A&E, Critical Care and Acute Medicine by developing a single Emergency Centre, a single Critical Care Unit, a Diagnosis and Treatment Centre with local Urgent Care Centres and planned care services provided at both PRH and RSH. These solutions could also address the substantial 'backlog maintenance' of key elements of the estate at both PRH and RSH. This proposed model will need to be supported by integrated community services and a network of rural urgent care; this latter element is being developed under the Neighbourhoods Programme outlined in section 3.

4.17 The proposed solutions included within the SOC, identified from a range of potential delivery solutions, describe evenly balanced distribution of services across the RSH and PRH sites which would deliver recognisable, vibrant hospital sites 24/7 within the communities served; the options are:

Option A: Provider and Commissioner Strategies implemented but no major service change

Option B: Emergency Centre at PRH Telford including colocation of Women and Children's

Option C1: Emergency Centre at RSH Shrewsbury including colocation of Women and Children's

Option C2: Emergency centre at Shrewsbury; Women and Children's Centre retained at PRH Telford

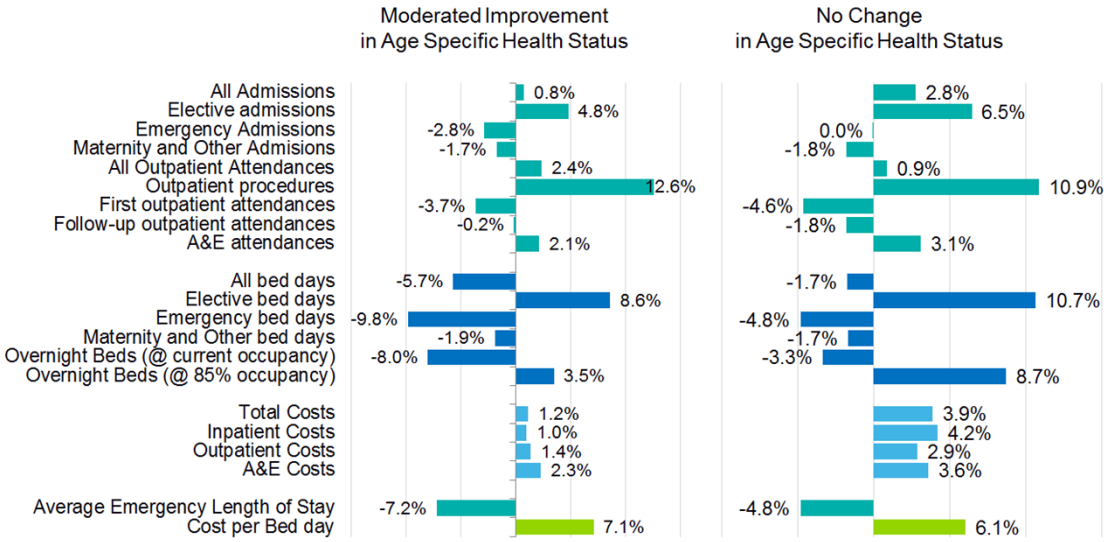
ACTIVITY AND CAPACITY IMPLICATIONS

4.18 Phase 1 modelling estimated the levels of activity that the Trust and Shropshire Community Trust might be expected to manage in 2018/19 taking into account demographic change, a range of commissioner activity avoidance schemes and provider efficiency schemes. Aspects of demographic change were also considered and modelled.

4.19 A range of commissioner activity avoidance strategies was then analysed and considered based on the subsets of acute activity that commonly form the basis of commissioner Quality, Innovation, Productivity and Prevention (QIPP) plans. These included areas such as: Conditions amenable to ambulatory care; fall related admissions; Patients who left A&E without being treated; Obesity related admissions etc.

4.20 The provider efficiency strategies considered during the modelling utilised the Trust's and other acute providers Cost Improvement Plans (CIPs) in both elective care and urgent care. The aim being to reduce the bed usage for admitted patients or the resource impact of outpatient and A&E activity. This included areas such as: enhanced recovery; frail elderly step-down care; A&E number of investigations etc.

4.21 Figure 2 shows the headline changes in acute activity, resource use and costs between the baseline year 2012/13 and 2018/19, under the two demographic scenarios.



4.22 A further modelling phase built on the initial models to estimate the consequences of more radical redesign proposals generated by the three clinical redesign workstreams. The headline outputs are:

- 69% of front door urgent care activity incorporating activity currently in a number of different services could be managed at an Urgent Care Centre, with the remaining 31% (circa 68,000 attendances) requiring care in the Emergency Department (ED)

- 75% of the activity being managed by the Urgent Care Centres will take the form of minor injuries or ailments, 12% as Ambulatory Emergency Care, 8% as frailty management and 5% as others

- Approximately 35,000 follow-up outpatient attendances managed by the local planned care centres could take place virtually by maximising the benefits of digital capability.

- Of the 10,000 emergency admissions associated with either frailty or long term conditions in 2012/13, the phase 1 models suggested these admissions could fall by 8% by 2018/19 (largely as a consequence of improvements in primary care management and through better use of community services)

- The Phase 2 model suggests that a further 24% could be avoided by reducing the prevalence of the key risk factors that give rise to Long Term Conditions (e.g. smoking, high cholesterol, high blood pressure) and through greater integration of community and primary care. Adopting technologies described in the digital roadmap we can target patient groups and provide the necessary health and well-being support/coaching.

4.23 Initial financial analysis indicates the proposed solutions would be affordable, and approval to a Strategic Outline Case is awaited from NHSI, DH and HM Treasury. The table below outlines the financial summary of the options under consideration and demonstrates the affordability of the potential solution at both PRH and RSH to the Trust. Savings achieved as a direct result of implementing the potential solution is £15.585m in Option B at PRH and £10.190m in Option C at RSH.

	Option A Do Minimum	Option B PRH Emergency	Option C RSH Emergency
	£000	*£000*	*£000*
Capital Expenditure (Current Prices)		102,028	195,325
Remaining Backlog	103,400	90,100	87,000
Income and Expenditure			
Baseline Recurrent Position	(17,271)	(17,271)	(17,271)
Revenue Impact (reduction)/Increase			
Sustainability Fund	0	10,500	10,500
Demographic Growth	11,300	11,300	11,300
Activity Reductions	(9,600)	(9,600)	(9,600)
Repatriation	12,000	8,640	12,000
General Efficiencies	32,786	32,786	32,786
Inflation	(49,800)	(49,800)	(49,800)
Sustainable Services Case Revenue Savings and Costs			
Workforce Savings	(4,600)	21,389	21,302
Cost of Capital	0	(5,805)	(11,112)
Total Savings from Sustainable Services Case	**(4,600)**	**15,585**	**10,190**
Total Revenue Impact	**(7,914)**	**19,411**	**17,376**
Recurrent Income and Expenditure Position	**(25,185)**	**2,140**	**105**

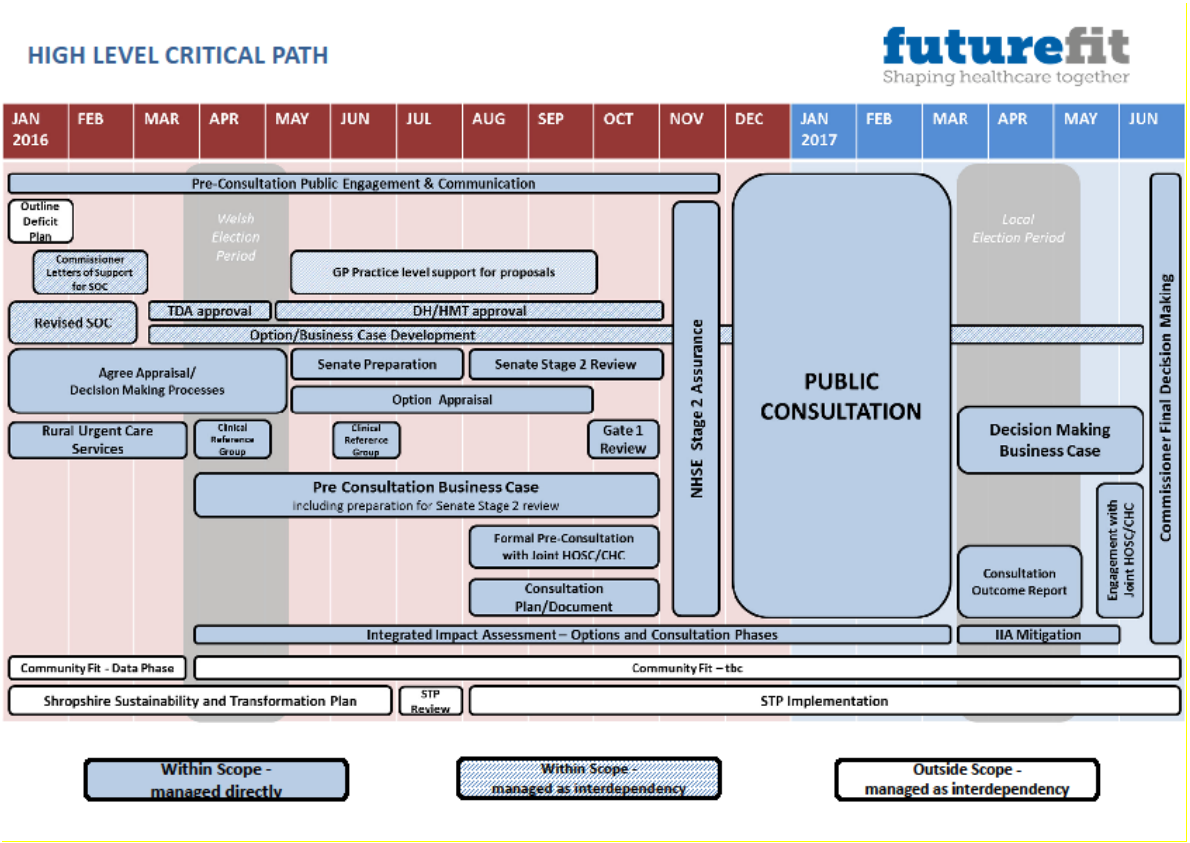
TIMESCALES AND CRITICAL PATH

4.24 The high level critical path is set out below; the work to enable a public consultation in December 2016 is currently on track. Whilst challenging to deliver in this timescale, the programme has set out the work necessary to develop the vision and how the assumptions within the SOC for the shift to community services will be delivered.

4.25 The more comprehensive design of community solutions is underway with a clear Case for Change and a programme of work set out under the STP Neighbourhood work streams and is outlined in section 3.

4.26 The delivery solutions for the shortlisted options are due to be appraised in September 2016, leading to Stage 2 assurance processes and Public Consultation from December 2016. It is vital to remain true to this timescale because any delay would prevent consultation from commencing until after local elections in May 2017. The solutions would support the maintenance of two vibrant hospitals in a hot-warm model.

HIGH LEVEL CRITICAL PATH



5. HOW WE WILL CLOSE THE FINANCE AND EFFICIENCY GAP

BACKGROUND

5.1 The Shropshire Health Economy is currently under significant financial pressure. PWC were commissioned in January 2016 to support a Health Economy wide review of the financial position and the financial plans of the key health care organisations in the Health Economy. The scope of this work included a review of the system wide cost base and revenue assumptions over the next five years (up to 2020/21) to develop a system wide Profit & Loss (P&L) and network of spend, which will support the STP development. It was acknowledged that this review would seek to indicate the outline magnitude and scale of the financial challenge and, whilst this was not a precise reconciliation, it would be the base from which to onward plan and model the recovery actions being worked up through the STP programme.

5.2 The review has been based on the two commissioners' five year plans submitted to NHS England in March 2016 and provider 2016/17 financial plans plus on-going income and expenditure assumptions. The report covers the following NHS organisations:

- Shropshire CCG
- Telford and Wrekin CCG
- Shrewsbury and Telford Hospitals NHS Trust
- Robert Jones and Agnes Hunt NHS FT
- Shropshire Community Health NHS Trust
- NHSE Local Area Team

5.3 In addition the report also incorporates a financial view relating to:

- Shropshire Council
- Telford Council

5.4 To date the deficit reduction work has focused on rectifying the gap across the health sector; however, the STP Partnership Board has agreed that it is essential for the future sustainability of the health and care system to adopt a collective solution to the social care deficit as well. Paragraph 5.5 onwards, sets out the proposals to close the financial gap in the health sector. Work will continue over the coming months to find a solution the wider health and social care financial deficit.

RESULTANT ACTION PLAN AND PROGRESS TO DATE - METHODOLOGY

5.5 In establishing a financial plan for the Shropshire Health Economy, the community has committed to ensuring that each of the predominant health bodies operating within the system are, through the actions taken, able to record by the year 2020/21 a balanced financial position. In making this commitment the system also recognises the need to respond appropriately to the challenges also being experienced by local authority colleagues and will do so in ultimately finalising its plans for the years 2016/17 – 2020/21.

5.6 The scale of financial challenge is significant. Collectively the two clinical commissioning groups responsible for commissioning healthcare for the populations of Telford and Wrekin and Shropshire enter the 2016/17 financial year with a sizeable financial deficit amounting to circa £36.5 million. Provider organisations within the community similarly take into the planning period a structural

financial position that will require important decisions to be made to ensure that the provision of services can be sustainable into the future. The size of structural deficit within providers is calculated as amounting to £21.5 million.

5.7 Over the period 2016/17 to 2020/21 the collective level of resource available to commission healthcare is planned to increase by £119 million, such that by the year 2020/21 the level of resource available amounts to £884 million. Contained within this, exists a dedicated sum amounting to £33 million available to support the health economy in delivering its transformation plans. Despite receiving this level of increase the combination of demographic growth and inflationary pressures across commissioning spending results in a shortfall that will need to be recovered through new, more efficient ways of working. The level of shortfall is estimated to amount to £16.7 million.

5.8 Collectively the three provider organisations identified within the Shropshire system and transformation footprint, The Shrewsbury and Telford Hospital NHS Trust, Robert Jones and Agnes Hunt Foundation Trust and Shropshire Community Trust estimate increased pay and non-pay costs will introduce a further £65.8 million cost pressure over the years 2016/17 to 2020/21

5.9 Accordingly the need to address the opening structural financial problems and spending growth in response to inflation and demography, sets a recurrent financial challenge for the health system amounting to £140.5 million.

	Commissioners	Providers	Total
	£millions	£millions	£millions
Structural deficit	36.5	21.5	58.0
Inflation / Demographic cost pressures	16.7	65.8	82.5
	53.2	87.3	140.5

5.10 In responding to this scale of financial challenge provider organisations have committed to delivering internal efficiencies within their respective organisations equivalent to 2% per annum. Delivering this level of savings generates cost reduction amounting to £53.7 million. In addition to these internal efficiencies, the Carter Review highlights further cost reductions, particularly in respect of Agency premiums of medical and nursing staff, improved workforce management and benefits from greater consolidation of back office functions. These are estimated to introduce additional cost savings amounting to £8.8 million.

5.11 Beyond activities associated with internal efficiencies, the local health system has identified a series of important transformational activities that if delivered to the scale identified in the table below, are expected to restore the financial balance of the health economy. These transformational activities are summarised in the table below

	£millions
Repatriation of Income	12.0
Rebasing of Orthopaedic spending – as per Right Care benchmarking	4.5
Community service reconfiguration	6.0
Reconfiguration of hospital services	22.0
Rationalisation of Acute services	3.0
Consolidation of provider organisations	1.0
Utilisation of Transformation funds	10.5
Other – transferred to Health bodies outside of STP	9.0
Total Transformation savings	68.0

- **Repatriation of Income** – The two local commissioners are presently commissioning activity from NHS provider bodies operating outside of the local health economy. A detailed review is being undertaken to determine the opportunity to re-establish such spending locally. It is estimated that doing so would generate a financial benefit to the health system of £12.0 million.
- **Rebasing orthopaedic spending** – The Right Care benchmarking programme has identified that Shropshire County CCG is an outlier in respect of spending in relation to orthopaedic services. Commissioning at levels consistent with benchmarked CCG's reduces spending by £4.5 million.
- **Community service reconfiguration** – providers and commissioners within the health and social care system are presently working to develop new integrated pathways of care structured around definable neighbourhoods. It is expected that these new models of care will lead to cost reduction of circa £6 million per annum.
- **Rationalisation of Acute services** – Secondary and Tertiary care services are presently provided within the health system through three hospital facilities located in Shrewsbury, Telford and Oswestry. A programme of work has commenced to determine the level of savings possible though a rationalisation of the services provided on these three sites. It is estimated that this can be expected to generate savings amounting to £3 – 5 million per year.
- **Consolidation of provider organisations** – Three provider organisations and two clinical commissioning groups presently exist within the Shrewsbury and Telford heath system. In taking forward the transformation programme it is intended to review opportunity to consolidate these various organisations.
- **Reconfiguration of hospital services** – In response to significant operational service challenges, The Shrewsbury and Telford Hospital NHS Trust has developed a case for reconfiguring the delivery of its hospital services between the existing Shrewsbury and Telford hospital sites. The intention being to establish a Hot and Warm secondary care clinical model. In order to take forward this reconfiguration, the change requires the availability of £300 million capital resource. Consolidation of clinical services is expected to generate cost savings amounting to £22 million as a consequence of reduced levels of service duplication, revised working practices and improved efficiency in the utilisation of the facilities.
- **Utilisation of Transformation Funds** – The financial plan for the health system has been set to enable the provider organisations and commissioners to deliver a financial surplus consistent with Business Rules. The level of Transformation Funds required amounts to £6.5 million.

5.12 The financial position for the health economy can then be summarised as follows:

	Commissioners	Providers	Total
	£millions	£millions	£millions
Structural deficit	36.5	21.5	58.0
Inflation / Demography cost pressures	16.7	65.8	82.5
Local Health system deficit	**53.2**	**87.3**	**140.5**
Specialised Services Efficiency Programme	(17.0)		(17.0)
Provider Trust efficiency programme		(53.7)	(53.7)
Carter Review savings		(8.8)	(8.8)
Transformation savings required	**36.2**	**24.8**	**61.0**
Transformation savings	(40.9)	(27.1)	(68.0)
Health economy surplus	**4.7**	**2.3**	**7.0**

RISK PROFILE OF THE DEFICIT REDUCTION PLAN

5.13 In order for the Local Health system to deliver the financial recovery plan by 2020/21 collective recurrent savings/ funds amounting to £147.5 million need to be realised. To test the strength of the recovery plan a risk profile has been undertaken. The risk profile categories savings/ funding into three groupings:

- Red – programme area – under developed
- Amber – programme area – requires further development – confidence in delivery strong
- Green – programme area – well developed – confidence in delivery high

The risk profile is summarised in the table below:

	Red £million's	Amber £million's	Green £million's	Total £million's
Specialised services savings programme	17.0			17.0
Provider Trust efficiency savings	20.7	8.0	25.0	53.7
Carter Review savings		1.0	7.8	8.8
Repatriation of Activity	4.0	4.0	4.0	12.0
Rebasing of orthopaedic services		4.5		4.5
Community services Integration	4.0	2.0		6.0
Reconfiguration of hospital services		2.0	20.0	22.0
Rationalisation of Acute services		3.0		3.0
Consolidation of provider / Commissioner organisations			1.0	1.0
Utilisation of Transformation funds			10.5	10.5
Other – transferred to Health bodies outside of STP			9.0	9.0
Total	45.7	33.5	77.3	147.5
	31%	27%	52%	

5.14 The risk profile illustrates that whilst the Local Health system programme has made considerable progress in developing its financial recovery plan, further more detailed work still needs to be completed, particularly in respect of the :

- Specialised services programme
- Provider Trust efficiency savings – especially over the period 2018/19 – 2020/21
- Repatriation of activity opportunities; and
- Savings capable of being realised through Integration of Community services.

USE OF TRANSFORMATION FUNDS

5.15 By 2020/21 the Local health Economy will receive recurrent Transformation Funds amounting to £33 million. Over the years 2016/17 – 2020/21 these Transformation Funds will be released progressively and the Local Health System Plan intends to use these funds on a non-recurrent basis to underpin the transformation changes.

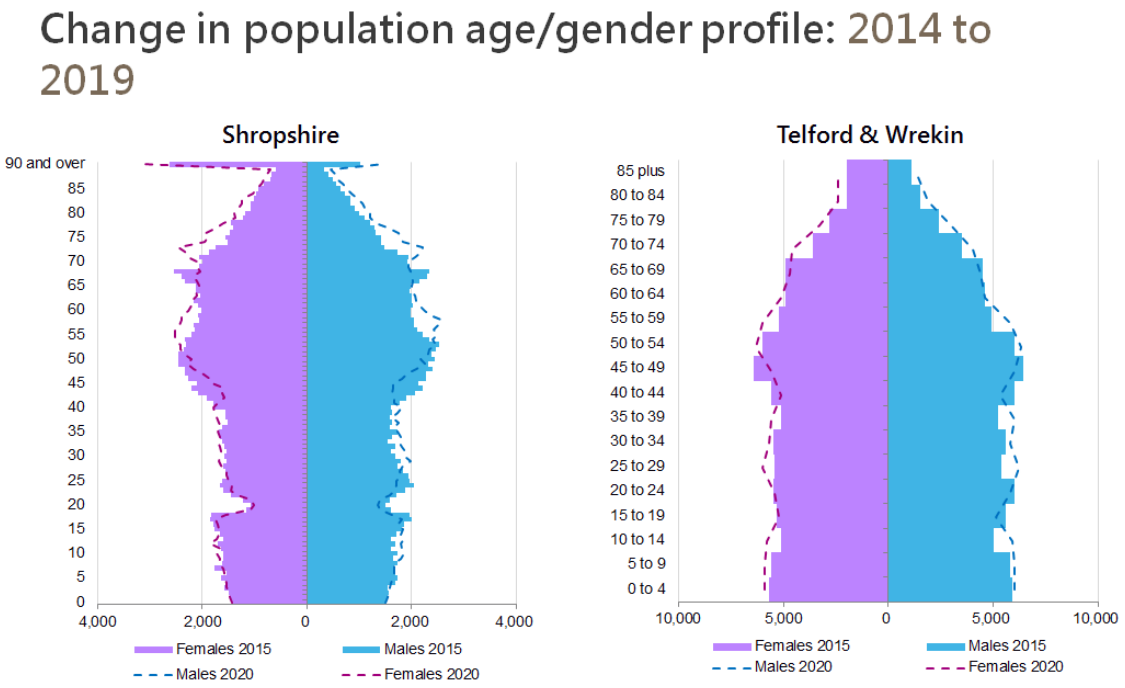
5.16 The recurrent use of the funds however is still to be determined. This financial plan presently assumes that £6.5 million of this sum is used to enable the Local Health Economy to achieve a surplus position. The residual £26.5 million is then intended to be used to take forward:

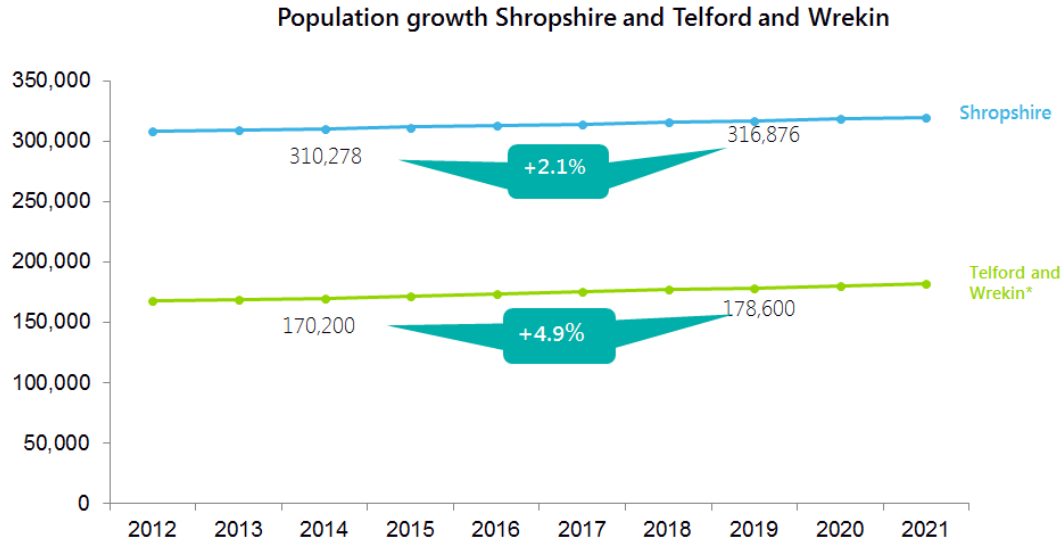
- Extended GP access
- Recommendations contained within the Mental Health Taskforce, Cancer Taskforce strategy, National Maternity Review
- Increasing Child and Adolescent Mental Health service capacity,
- Delivery of seven day urgent and emergency care in hospitals,
- Investment in Prevention programmes, particularly childhood obesity and diabetes care,
- Implementing paperless technology.
- Supporting Local Authority Adult and Children service cost pressures.

APPENDICES

APPENDIX 1

POPULATION GROWTH AND PROFILE CHANGES SHROPSHIRE, TELFORD & WREKIN





* Telford & Wrekin population projections have been adjusted locally to account for major residential build plans. Shropshire projections are taken directly from ONS published figures

APPENDIX 2

SHROPSHIRE AND TELFORD AND WREKIN HEALTH AND SOCIAL CARE ECONOMY

South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide adult and older people's mental health services in the county. Multidisciplinary and multi-agency teams work in partnership with local councils and closely with the voluntary sector, and independent and private organisations to promote the independence, rehabilitation, social inclusion and recovery of people with a mental illness. Facilities include the Redwoods Centre in Shrewsbury which opened in 2012 and provides 80 adult mental health beds for Shropshire, Telford and Wrekin and Powys and 23 low secure beds for the West Midlands and the provision of a memory clinic in support of Dementia services.

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of district general hospital services for half a million people living in Shropshire, Telford and Wrekin and mid Wales. Services are delivered from two main acute sites: Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. Total bed capacity across the two hospitals is 700.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a leading orthopaedic centre of excellence. The Trust provides a comprehensive range of musculoskeletal surgical, medical and rehabilitation services; locally, regionally and nationally from a single site hospital based in Oswestry, Shropshire and close to the border with Wales. As such, the Trust serves the people of England and Wales, as well as acting as a national healthcare provider. It also hosts some local services which support the communities in and around Oswestry.

Shropshire Community Health NHS Trust provides community health services to people across Shropshire in their own homes, local clinics, health centres and GP surgeries. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, and support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, it provides a range of children's services, including specialist child and adolescent mental health services. Shropshire's four community hospitals have a total of 97 beds with an additional 27 independent sector step down beds.

There are 44 GP practices in Shropshire and 18 in Telford and Wrekin, and local practices have recently formed a GP Federation. There are Walk in Centres co-located with the Royal Shrewsbury Hospital site and the Princess Royal Hospital site in order to manage emergency demand and flow into the hospital.

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays. It provides out of hour's primary care services to 600,000 patients in Shropshire, Telford and Wrekin and Powys. Shropdoc also provides home visits and the flagging of high risk end of life and COPD patients.

West Midlands Ambulance Service (Foundation Trust) serves a population of 5.36 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and Black Country conurbation.

The Shropshire Local Pharmaceutical Committee is the representative statutory body for all Community Pharmacy contractors in the county of Shropshire.

People 2 People (P2P) is a not-for-profit independent social work practice working with Shropshire Council to provide adult social care support to older people and those with disabilities. P2P is a community interest company with an independent board of directors, which includes individuals who use the service. The aim of P2P is to offer a different way of supporting individuals to keep their independence for as long as possible. This means helping people to plan how their independence can be improved.

Shropshire Partners in Care (SPIC) is a not-for-profit company registered as a company limited by guarantee representing independent providers of care to the adults of Shropshire and Telford & Wrekin. Shropshire Partners in Care's purpose is to support the development of a high quality social care sector in the areas of Shropshire and Telford & Wrekin. SPIC works in partnership with local authorities, health and the voluntary sector to support continuous improvement and development of adult social care focusing on local need. They provide information, support training and signposting to relevant services to everyone that contacts the office.

The Voluntary and Community Sector Assembly (VCSA) works to facilitate partnership between the VCSE sector and public sector. Representation work ensures that the VCS are represented on the groups led by the CCG, Shropshire Council and other partners. For example the VCS are represented on the Assistive Technology Steering Group, the Prevention Group, and Community Development Group. Members of the Voluntary and Community Sector Assembly include many of the large VCS organisations in Shropshire including Age UK, Shropshire RCC, and the Alzheimer's Society who deliver health and social care services in Shropshire.

Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group have co-terminus boundaries with Shropshire Council and Telford and Wrekin Borough Council respectively. The CCGs are responsible for commissioning the following services:

- Community health services.
- GP out of hour's services.
- Ambulance services.
- Mental health services.
- Specialist health services for people with learning disabilities.
- Acute hospital services

Powys Health Board is responsible for healthcare commissioning and delivery for the Powys population; significant numbers of patients access care in Shropshire which means for planning purposes the Powys requirements need to be factored into the STP.

The two Councils are responsible for several key public service areas including:

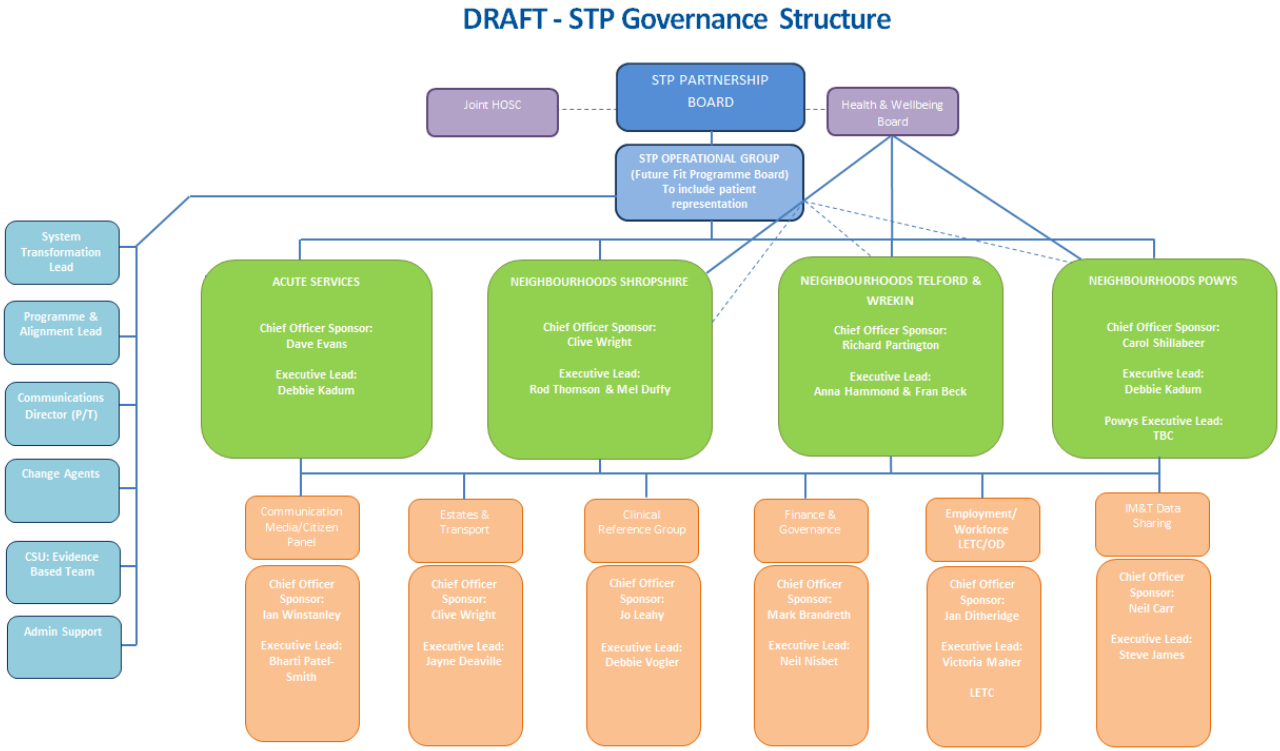
- Community and living,
- Education and learning,
- Environment and planning,
- Housing,
- Leisure and culture
- Health and social care.
- Public Health
- Children's Services

APPENDIX 3

SHROPSHIRE TELFORD AND WREKIN STP GOVERNANCE ARRANGEMENTS

The leadership body created to oversee the STP is the Partnership Board comprising Chief Officers of all partners; this is chaired by the named STP Chief Officer Simon Wright, Chief Executive of SaTH. This group is supported by the Operational Group chaired by the STP Programme Director and comprising Executives from all partner organisations as well as the two HealthWatch Chief Officers, clinical representation from the LMC, HWBB representation from the Directors of Public Health, and the STP Workstream leads. Both the Partnership Board and Operational Group meet fortnightly.

A diagram outlining the governance arrangements is shown below:



APPENDIX 4

DRAFT

HEALTH AND SOCIAL CARE COMMUNICATIONS AND ENGAGEMENT IN SHROPSHIRE AND TELFORD & WREKIN

THE PARTNERSHIP AGREEMENT

A positive and collaborative approach to promoting positive communications about the local NHS and its partners, delivering practical solutions to support joint key health and social care priorities across the county and managing health and social care reputational issues.

BACKGROUND

It's a busy and diverse county with an even busier and diverse health agenda! The local population is the recipient of a vast amount of information about current health and social care services as well as proposals/consultation about potential changes to the local system. Amongst all this noise key messages to help patients navigate the NHS and enable them to take better care of themselves and their loved ones are being lost.

We have a fantastic opportunity through the existing network links of programmes to come together and communicate key health and social care messages and information. Our aim is that through our integrated approach and proactive campaigns our communities will gain guidance on how to better navigate the NHS, receive advice on self-help and learn more about all the amazing things the local health can social care are currently doing to help patients.

We also recognise that our communities want to know accurate and timely information about key developments and learn about how they can get involved or have their views heard.

This approach is in line with the Shropshire and Telford & Wrekin health and social care leadership partnership which has been created to help implement the county wide Sustainability and Transformation Plan. Following the example of our organisations' leaders we are bringing together the senior communications leads from all local health and social care organisations with a commitment to working collaboratively for the benefit of our local communities.

PURPOSE

Working to agreed high-level principles as set out in the county's Sustainability and Transformation Plan, the group will work collaboratively to promote positive and proactive communications about the local NHS, manage health and social care reputational issues and deliver practical communications solutions to support joint key health and social care priorities.

PRINCIPLES

- All the communications leads work together to deliver aligned communications' approaches and responses to build public confidence in health and social care services - integrated communications promoting 'the overall system' outdoes any one single organisation.

- Communications leads come together and plan a county-wide approach to information activity to ensure that positive news regarding health and social care services across Shropshire and Telford & Wrekin is effectively present in what people read, hear and watch.

- Communications leads build relationships to generate mutual trust, enable effective joint working and provide appropriate support at times of significant reputational issues.

- Communication leads provide mutual support and pool resources as appropriate to ensure key reputational issues are managed as well as providing clear, accurate and consistent information for patients and our communities.

FUNCTION

The group will:

- develop an overarching health and social care communications strategy from the creation of the Shropshire and Telford & Wrekin STP, and take responsibility for delivery and evaluation. This will be signed off by every each organisation's Board or equivalent

- commit to participate in a weekly meeting (either conference call or a face to face) to drive forward joint communications plans and share information

- contribute to a monthly planner

- lead on specific areas of work on behalf of the group.

MEMBERSHIP

Membership will be the most senior communications lead for each organisation.

Core members	
NHS Commissioners	Shropshire CCG
	Telford and Wrekin CCG
NHS Providers	The Shrewsbury and Telford Hospital Trust
	Shropshire Community Health NHS Trust
	West Midlands Ambulance Trust
	Shropdoc
	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
	GP Federation
Local Authority	Telford & Wrekin Council
	Shropshire Council
NHS England	NHS England – Local Area Team
Non-core members	
	Directors of the two Healthwatch
	Chairs of the Health and Wellbeing Boards
	Representatives from the Powys Community Health Council will be invited to the meetings on an ad-hoc basis to provide expert patient representation when required.
Communications colleagues from the Powys Health Board, local Police, Fire and Rescue will be invited to attend as appropriate.	

FREQUENCY OF MEETINGS

Meetings will be a weekly conference call and a monthly face to face meeting.

CHAIR AND CO-ORDINATION ARRANGEMENTS

The group will have a rotating Chairperson who will take responsibility for co-ordinating and servicing meetings. The Chair will rotate on a six monthly basis.

RELATIONSHIPS AND REPORTING

A quarterly highlight report will be produced for the executive teams for each organisation represented.

REVIEW

Following approval, the Terms of Reference shall be reviewed on an annual basis.

Due for review: July 2017.

APPENDIX 5

DRAFT

PROCESS IN DELIVERING THE PMO FUNCTION FOR THE COMMUNICATIONS AND ENGAGEMENT PARTNERSHIP AGREEMENT

JUNE 2016

PMO FUNCTION

Underpinning reactive and proactive Engagement and Communications delivery will be the formation of Shropshire and Telford & Wrekin Communications and Engagement agreement hub that will provide PMO support to system partners:

- Organising and servicing meetings
- Maintain an action log
- Coordinating, and where, appropriate responding to system-wide issues
- Support collaboration and joint delivery of communications ensuring continued 'one voice' coherence and confidence-building.

ENGAGEMENT AND COMMUNICATIONS PMO PROTOCOL

INTRODUCTION

The Communications and Engagement hub exists to support all communications and engagement partners in organisations involved with the transformation work in Shropshire and Telford & Wrekin to share information and communicate with the broadest set of stakeholders in the county. The PMO will provide the following core functions across the system.

EFFECTIVE COLLABORATION

- A regular conference call of system communications and engagement leads will be serviced.
- Communications tools and contacts will be collated centrally and shared with the group, providing an overall picture of communications work and stakeholder contacts.
- A regular media summary will be produced and shared.
- A monthly forward planner will be produced and updates shared when needed.
- A single point of access will be provided for sharing information with the PMO and fellow colleagues.

MANAGING RISK AND SEIZING OPPORTUNITIES

- Partners' communications activities will be diarised and support will be provided to plan these in order to ensure continuity of message and collaboration of activities.
- Planned and reactive communications will be supported with message crafting so that the overall narrative can be promoted and strengthened.
- The PMO will make recommendations to changing project milestones where they might damage the integrity of our communications, or affect their preferred sequence.

PROCESSES

PLANNING AND REVIEWING COMMUNICATIONS ACTIVITIES

REPORTING

The PMO will produce regular summary update on:

- A summary of media coverage.
- All key activities taking place for the week ahead – including any stakeholder activities we know of.
- A sense of stakeholder disposition – anyone key we need to worry about or satisfy.

APPENDIX 6

DRAFT

SHROPSHIRE AND TELFORD & WREKIN STP

WORKFORCE

To support the vision and objectives of the Sustainability and Transformation Plan (STP) workforce is a critical element of the plan as it will drive delivery and successful outcomes for our communities.

The workforce agenda is diverse and will encompass a wide range of actions to ensure structurally and culturally the vision is achieved.

Workforce in terms of demand, supply and skills is a collective challenge amongst providers the themes is very similar, in particular the demographic of the workforce that illustrates a large number of potential retirements over the next 5-10 years. This profile picture illustrates the need for workforce innovation and bravery.

The system vision 'healthiest half million people on the planet' is an ambitious one it will require a different workforce profile both in terms of roles but also working practices and behaviours.

The workforce plan will answer the question how we will be delivering care in ten years' time.

SYSTEM WORKFORCE PLANNING AND TRANSFORMATION

The models of care describe three key components

- Reconfigured hospital care
- Care closer to home through neighbourhood models
- Health prevention

To deliver a new model of care the current shape of the workforce will need to change. Further development of advanced and assistant roles will ensure sustainability across the system and support independent practice in rural areas. Roles will span staff groups including nursing, scientific, pharmacy, therapies, social work and radiology.

To provide care closer to our communities through the neighbourhood model, a more diverse role is required to support a range of interventions from one practitioner.

The skills required for these new roles will be based on the health needs of our population; meaning roles will be developed based on the skills and competences needed to deliver care not based on existing roles.

To support the prevention agenda it is envisaged that a more generic worker would be developed to support the scale of change required. This will be on scale and spread, workers will be able to provide advice and signpost into relative services that will support members of our communities to make informed decisions regarding their health and wellbeing.

The system has already begun to plan as one, using the frail and elder pathway supported by Skills for Health. This development of scenario workforce planning enables innovation and supports a strong patient focus.

CULTURAL DEVELOPMENT

Investment in culture is essential to achieve new ways of working, often forgotten cultural development will be a key focus of the workforce programme. Working to '*one system, one vision*' a development plan will be

created to recognise the different organisational and staff group cultures to support agreed behaviours that will drive a unified culture through behaviours and expectations.

LEADERSHIP DEVELOPMENT

Working closely with the Leadership Academy a range of developments will be in place to support leaders to undertake crucial leadership roles across the system. This will include leading agendas outside of their employing organisation, involving wider partners in internal developments to ensure alignment and role modelling the leadership qualities needed to be a leader within the Shropshire and Telford & Wrekin STP. Development proposed to date includes coaching, place based leadership and system leadership.

Through the development of the system compact the commitments of senior leaders have been agreed this will now support all leaders to understand the psychological contract that we will all be entering.

EDUCATION

Through the Local Workforce Action Boards (LWABs) the system will create its educational plan; this plan will focus on enabling workforce transformation but also creating the right supply for the system labour market. Changes in bursaries provide a changing landscape that we require the system to influence and work with Higher Education Institutes (HEIs) to offer innovative health and social care courses to attract talent to the system.

Courses will be jointly developed to meet the system needs.

TALENT MANAGEMENT

The system will aim to develop a talent pool, learning and development offers will be from the system and for the system. For example advanced practice education will offer system placements and employment will be agreed on health and care priorities of the population.

System leaders are committed to working collaboratively to ensure our system is a great place to work and develops, attracts and retains talent.

APPENDIX 7

DRAFT STP LEADERS COMPACT

The overarching purpose of STP is to create a patient centered, sustainable system of health and social care. By implementing the STP we learn how to collaborate to deliver care to an ageing population with less overall resource.

We recognize the work that lies ahead will take discipline and a long-term commitment. In the end ***Shropshire, Telford and Wrekin will be the healthiest population on the planet.***

We recognize achieving this vision will require unprecedented levels of trust, cooperation, collaboration, and working across traditional boundaries.

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

GIVES -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 behaviour so that all organisations have a 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