Shropshire Neighbourhood

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Transformation work streams

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What this will mean for patients, staff and the system

The STP programme will deliver sustainable benefits by:

1. *Developing leadership with the knowledge, skills and experience to deliver system-wide clinical, operational and financial transformation across all organisations and at all levels*

2. *Increasing (through better demand management and reduced duplication) capacity across the system to deliver safer, more accessible and higher quality planned, preventative and urgent care services*

3. *Making better use of innovative approaches to care records, care navigation, staff roles & responsibilities and service delivery to increase the efficiency and effectiveness of services*

4. *Increasing engagement and meaningful co-design with service users, all partners and our workforce, to enable the creation of processes and systems that deliver benefits for everyone*

5. *Building a system-wide culture, which ensures that the benefit to the system is considered in all organisational level planning and which dissuades any decision-making in organisations that is at the expense of others*

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Our Current Challenges	What We Will Deliver

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The Shropshire Neighbourhood Workstream will deliver:

The following table provides an overview of the Shropshire Outcomes

Outcome Statement	Clinical Outcomes Demonstrated by	Patient Experience Improved by	Safety/Quality Assured by	Resource requirements	Resource sustainability
Reduced levels of avoidable hospitalisation	Reduced levels of avoidable non-elective admissions (current estimate c4,000 admissions per year) Improved access to community based conservative management and reduced levels of surgical interventions (current estimate c£12m per year)	Enabled independence Prompt access to urgent and emergency services Reduced LOS and improved discharge Improved access to community therapy Improved access to surgery Improved patient reported outcome measure Scores (PROMS)	Consistent evidence based service models and specifications: • NEL admission prevention and avoidance • Frailty pathway • Ambulatory care • Community based conservative management • VBC		

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High level actions

Shropshire Out of Hospital (Neighbourhoods and Prevention – Healthy Lives and Family Matters)								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Implement system prevention programme (all partners)								
1.0 MECC plus - a new approach to MECC that supports health and care practitioners to have behaviour change conversations.	People routinely have conversations with health and care practitioners (including the vcs) regarding their health and wellbeing. Health and care practitioners are confident to connect people to support mechanisms they need.	People's lifestyles are improved. People's health behaviours are improved People feel supported	All commissioners and services (including the vcs) adopt MECC plus principles throughout organisations. MECC plus is considered a competency for all grades within services			Pilot?		Ongoing
1.1 Developing locality hubs – Drawing together services to offer support, information and advice in a hub **linked to all out of hospital schemes including the 5 year forward view**	Families and people will access services, advice and information for a range of health and wellbeing issues at a coordinated hub. Some services will be offered at the hub, other services will be available through the hub virtually	People will have a clear understanding of where to access their health and wellbeing services	Develop common view of what a hub will do (it is envisaged that it will include social prescribing, nursing, some council services, children's support services etc) Shared development and timeline Piloting in one local area first Rolling out					Aril 18

1.2 Care navigation– services are joined up as one model supporting the whole population (including families) led through hub models, let's talk local, and the community care coordinator schemes **linked to population health management** – the most vulnerable people as identified through population health management – to include strengthening families	Statutory and commissioned services in Shropshire proactively seek to support people who are vulnerable (or who could use support) due to health and wellbeing issues. Services know how to connect people to assets within their communities through hubs and care navigators (let's talk local & community care coordinators)	People feel supported to improve their health and wellbeing. People's experience of care is improved. People's lifestyles are improved. People's health behaviours are improved	Develop a model of care navigation through existing structures that is jointly funded, • Let's talk local • Community care coordinators • Social prescribing • Dementia Companions • Children's centres • (links to other services like alcohol liaison and Stop before your op)					April 18
1.3 Healthy Conversations – supports development and delivery of MECC plus, Care navigation and Social prescribing	Healthy conversations is a behaviour change tool used to support organisations to adopt a MECC plus approach and which supports care navigation. Healthy conversations is developed with tiers of learning to support colleagues to	Staff (statutory and non-statutory) feel confident to have healthy conversations with the people that they work with and feel confident to refer people to Social Prescribing, care navigators, or to	Led by public health, a comprehensive tiered Healthy conversations approach will be developed and delivered across the county. – Pending funding					Ongoing

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Outcome 2 –Develop model of social prescribing to be used for scaling up across the county								
2.0 Social Prescribing Model development – based on Oswestry Pilot – **linked to population health management – hubs and care navigation -supporting those who are vulnerable or need support to improve health and wellbeing**	Social prescribing model is available across Shropshire. Social prescribing is aimed at those individuals who are at risk of developing ill health or are beginning to become unwell and who the referrer feels would benefit from structured support to reduce their risk.	People will feel supported to access the help they need Reduced unplanned hospital admissions Reduced GP appointments Reduced reliance on ASC	Pilot operation in Oswestry will provide feedback needed to develop a Shropshire model. Public Health will lead on model development and implementation				X	
2.1 Social Prescribing evaluation	Social Prescribing pilot is evaluated providing commissioners and practitioners a good basis for social prescribing model development/ improvement to support rollout	Evidence base will be developed for improvement and roll out of social prescribing	Contract for delivery already in place – Westminster University				X	
2.2 Resilient Communities roll out - support social prescribing	All (18 place plan areas in Shropshire) will be supported by the Community Enablement team; developing improved communication channels, community connectors, and supporting health and	Communities feel connected and are working together to support each other Unplanned hospital admissions are reduced Reduced GP appointments Reduced reliance on ASC	Delivered by Shropshire Council's community enablement team					Ongoing

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Outcome 3 –diabetes prevention, CVD and respiratory prevention programmes								
Deliver the diabetes prevention programme – focussed on the Shropshire pre-diabetes protocol – **linked to GP 5YFV and social prescribing**	People who are identified as pre-diabetic are offered information sessions, community support through social prescribing and structured education (EXPERT)	Fewer people who have pre-diabetes progress to have type 2 diabetes	Scaling up the two pilots currently running in Oswestry and Shrewsbury Pending funding				X	
Work with GP practices to identify practice population with CVD or CVD risk **– linked to pre-diabetes and social prescribing & GP 5YFV**	People who are at risk of developing CVD or who have CVD are proactively identified through the GP record. Community support and improved information provided regarding lifestyle risk associated with CVD. Those at risk are offered social prescribing.	Improved health outcomes for those with CVD or those at risk of CVD Reduced unplanned hospital admissions due to heart attack and stroke	Programme of work linked to Healthy Lives and Help2Change			X		
Work with all providers to identify those who have respiratory issues and provide community support - **linked to pre-diabetes and social prescribing & GP 5YFV**	People who have respiratory issues are proactively identified by health and care practitioners. Community support, information provision, stop smoking services, and social prescribing offered.	Improved health outcomes for those with respiratory issues Reduced unplanned hospital admissions	Programme of work linked to Healthy Lives and Help2Change			X		

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Outcome 4 - Deliver all age carers strategy								
4.1 Carers, including young carers are included in care planning (for example at hospital discharge).	Carers will be involved in the discharge process, to help ensure they are able to manage to care for the person they look after at home.	Hospital discharge paperwork will ask if patient is being cared for at home, This will trigger support and information for the carer if needed, including medication discussion.	Liaise with hospital partners through Task and Finish Group to implement.				X	
4.2 Review assessment process for all carers and ensure understanding of replacement care needs. *4.2 & 4.4 are linked*	Assessment process will feel simpler and avoid carer having to repeat their story	Reduction in the number of assessments a carer may have from different agencies, thus saving staff and carer time.	Review of Partners current assessment methods for carers, to help meet their needs and avoid having to repeat their story.				X	
4.3 Providers and partners communicate to ensure information is easily accessible and in different formats. This should include health information and interventions for carers to help avoid ill health and injury.	Carers will know where to access good written, online and face-to-face advice and information relating to their caring role.	Up to date timely information will be available on-line, from professionals and in written format.	Consultation has been taking place with carers to establish the best way to communicate sources of help and support.					
4.4 Embed planning for the future as a part of All-Age Carer Health and other assessment discussions. *4.2 & 4.4 are linked*	Assessment process will feel simpler and avoid carer having to repeat their story	Reduction in the number of assessments a carer may have from different agencies, thus saving staff and carer time.	Review of Partners current assessment methods for carers, to help meet their needs and avoid having to repeat their story.				X	
4.5 Actively encourage all local organisations to adopt the Employer and Employee Pledge to recognise and support Carers in their employment.	All major employers, starting with Shropshire Council, will adopt the pledge.	The Employer Pledge for carers will be known by carers, and embedded in their Shropshire employer's policy.	Work with employers in Shropshire to adopt the pledge to recognise and support Carers in their employment.				X	

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5. Mental Health								
5.1 Tamhs – continued improvement supporting children's health through schools	Children and young people's emotional resilience is developed through work with schools to: Increase awareness of mental health/mental ill-health; Develop a common language that expresses thoughts and feelings; Promote and develop strategies to support mental health, build confidence self-esteem and resilience; Improve communication and consultation with 0-25 EHWS; Support schools to develop their role as commissioners to achieve positive mental health outcomes	Improved mental health outcomes for young people The stigma surrounding mental ill health is eroded School staff can recognise and respond to emotional needs of young people and what to do and say following identification of need.	Schools and partner agencies participate in multi agency core training on issues such as self harm, suicide prevention, domestic abuse, loss and bereavement.					Ongoing
5.2 Link to MECC plus	People routinely have conversations with health and care practitioners (including the VCS) regarding their mental health and wellbeing. Health and care practitioners are confident to connect people to support mechanisms to fulfil	People's lifestyles are improved People's mental health is improved People feel supported The stigma surrounding mental ill health is eroded	All commissioners and services (Including the VCS) adopt MECC plus principles throughout their organisation					Ongoing

5.3 Embed the Adverse Childhood Experiences (ACE) approach	People routinely have conversations with public sector professionals with whom they have built a rapport. This will allow consideration of the impact that adverse childhood experiences may have on their behaviour or reaction to life experiences. This knowledge will provide a deeper understanding and lead to identifying possible coping mechanisms or support where it is needed.	People feel supported People's mental health is improved	All public sector organisations (including VCS) adopt the principles of the ACE approach and routine enquiry across their organisation	Multi agency conference as first step				
5.4 Develop Suicide prevention strategy	The Suicide Prevention Strategy will provide a common understanding and vision for Telford and Wrekin and Shropshire.	Joint suicide prevention strategy in place Reduction in numbers of those people taking their own life Improved support for those affected by suicide	Community Suicide prevention Action Group's in place, actions identified and undertaken.	Action Groups established and first meetings held.				Ongoing
5.5 Develop alternative to use of Section 136	The Shropshire Sanctuary, will provide one to one support to a person experiencing mental health crisis. The Shropshire Sanctuary will be a safe place as an alternative to section 136 and will	People in mental health crisis feel supported not criminalised Fewer people detained under Section 136 of the Mental Health Act.	Develop a Shropshire Sanctuary alternative to Section 136 – initially this will be used by the police. Once established the alternative will be rolled out to A&E services.	Open to police referral now.				

5.6 Health checks	People living with long term mental health conditions receive regular physical health checks and advice & support to improve their physical health and wellbeing	Improved physical health of those living with long term mental health conditions More people living with long term mental health conditions live longer healthier lives.	Develop a model of physical health checks and guidance linked to prescription of medical interventions for long term mental health conditions. Help2change undertake a pilot with the Clozapine clinic in Telford & Wrekin.			Pilot ?	
5.7 Campaigns – the One You	A holistic approach to improving people's health and wellbeing. It will see adults in Shropshire encouraged to move more, eat well, drink less and be smoke free, as well as understanding how people can reduce their stress levels and sleep better.	Peoples physical and mental health is improved People live longer, healthier, independent lives	Online campaign promoted across all public sector organisations in Shropshire.				

6. MSK (including Falls prevention) – must be linked to Frailty for the full system falls transformation								
6.1 Healthy Ageing Exercise and Activity – **linked to social prescribing and hubs**	People have access to a number of different opportunities for activity and exercise as they age. Activity supports people feeling connected and part of their communities.	reduction in CVD reduction in diabetes reduction in falls related injuries/ conveyances	Work through resilient communities and hub models to support and develop activity for older people Use Everybody Active Everyday framework to improve activity take up across all age groups.					Ongoing
6.2 Falls Service specification improvements (SCHT)	Falls prevention contract with the Community Trust to be a distributed and embedded function widely delivered throughout SCHT, rather than the sole responsibility of one team in the Trust.	Reduction in falls (ambulance data, a&e data, fracture data)	Contract management and service specification development with the falls service	X				
6.2 Community PSI	evidence-based community exercise postural stability classes, enabling older people to be referred from local health services; classes will be available in at least 10 locations across Shropshire	Programme is implemented Reduction in falls (ambulance data, a&e data, fracture data)	Contract community PSI with local provider			X		Ongoing

6.3 Campaign - Let's talk about the F word	Social media campaign to raise awareness of the on -line national and local tools available to help people to understand falls risks and enable older adults to take action to reduce their risk of falls.	Reduction in falls (ambulance data, a&e data, fracture data) Social media tracking	Work as a system to promote the campaign through health and wellbeing partners	X				Ongoing
6.4 Skills development Healthy Conversations- **(behaviour change skills development with public sector partners) – as described in 1.2 above**								

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Shropshire Out of Hospital (Population Health Management)								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Develop a population health management tool and approach to under pin priorities for the STP								
1.0 Identification and analysis of a wide range of data from different sources to support formulating priorities	Should produce a report / report that can be available with high level priorities							Ie.Dec/19
1.1 Drill down to understand relationship between different data relating to the priorities and how it relates to the population or how the population impacts on priorities. Also how this fits with current service provision	Will include further in depth analysis based around the identified priorities, patterns of health care use / activity, population trends, variation and identifying inequalities – conclusions can then be made about how priorities can be met							
1.2 Review evidence of what works to prevent / manage issues raised in the priorities. What does this tell us about future service provision and where we need to be	Look at this in relation to overarching priorities and also they can be implemented based on findings from more in depth work.							
Outcome 2 – Establish population level identification of at risk groups using data from GP practice								
2.0 Build consensus to support the use of using practice data to identify								

2.1 Develop pathways / signposting for patients not deemed very high risk, but who could still benefit from a more upstream intervention								
2.2 Put this into practice starting by looking at conditions that have been identified through the population health management approach								

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1. Early Discharge Planning								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 - Early discharge planning – non elective admissions								
1.1.1 Identify level of problem via **joint (Shropshire and T&W) audit**	The system and those working within will understand processes for planned care	An audit will be produced	Commissioners will conduct an audit of current practices		X			
1.1.2 Develop systems for early discharge planning that connect to current hospital and community solutions	Discharge planning will happen at an early stage and all services involved in care will know and understand the discharge plan	People's experience of care is improved Delayed transfers are reduced Systems and transformation schemes will link up (eg Red – Green & Social Prescribing)	Commissioners, providers, GPs and service users/ patients will agree early planning process Process will be connect to safer bundle, red to green and ibcf improvements			X		
Outcome 2 – Emergency admissions to hospital								
1.2.1 Develop system for discharge planning for emergency admissions will begin as early as possible (in A&E) and will understood by all those involved in the health and care of the patient	Active discharge planning will happen routinely at A&E, even prior to moving to a ward. The discharge plan will be available for regular review and discussion with the patient and carers. Health and care committed to meeting discharge plan.	Patients and their carers are actively involved in their discharge planning Patients experience of care is improved Delayed transfers of care are reduced	Develop new discharge planning at time of entry to hospital Connect current transformation programmes (including safer bundle and red to green), with Social care ibcf improvements		X	X		

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2.Systems to monitor patient flow								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – SaTH Internal Demand and Capacity development								
2.1.1 Needs analysis re internal capacity	Better understanding of internal flow	Needs analysis completed	Needs analysis delivered by Kate Shaw	X				
2.1.2 Reducing length of stay in the acute and community hospitals	Clinical decision making and patient flow are connected. Clinicians feel confident in system to provide right care at the right place	Hospital transformation plans are linked Future Fit and to community transformation plans Delayed transfers are reduced Length of stay is reduced	Include clinical decision making in workforce planning Link discharge planning to community services review and available resources in the community				X	
Outcome 2: External demand flow								
2.2.1 Clarity required over time line for FF reconfiguration and link to community services, and other transformation programmes	Better joined up transformation planning Patient and carers are at the centre of planning	A system plan is developed for Admissions avoidance and transfer of care that is recognised by the system	Supported by the STP PMO, the Optimity work, system planning is clear and agreed. Work programmes progress toward clear plans Wayne Greenwoods work, Tony Menzies work and the IBCF are joined up			X		

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Outcome 3 – Draw together independent pieces of work on patient flow to provide needs analysis								
2.3.1 needs analysis to include - safer bundle and red to green work taking this forward – **capacity and demand modelling**	Flow in and out of hospital is mapped and understood and improvement plans are joined up – **linked to outcome 1**	Improved patient flow Reduced delayed transfers Reduced length of stay	Specific piece of work with SaTH and the Community Trust		X			
Outcome 4 - IBCF								
2.4.1 IBCF will introduce let's talk local sessions and social workers on wards to aid with discharge, assessment and reablement planning	Social care and clinicians working together to support the patient, to identify needs and to ensure as many as possible needs can be addressed in the community	People's experience of care is improved Length of stay is reduced Delayed transfers reduced	Implement let's talk local sessions in the acute hospital		X			

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3. Multi-disciplinary admission avoidance /multi – agency discharge teams								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Integrated Discharge hub								
3.1.1 Clarify the scope and function of an integrated hub and clarify how it can link into or reconfigure what we already have – ICS (Shropshire) ICT (Telford),	Assessments are as streamlined as possible and where possible one assessment needed for all health and care providers Teams work together and care feels seamless	People's experience of care is improved People are better informed about options Delayed transfers are reduced	work needs to take place for acute, community hospital and care homes		X			
3.2.1 link multidisciplinary teams to community services transformation and admission avoidance and readmission avoidance	Teams work together to keep people out of hospital and receiving appropriate levels of care in the community	Reduced unplanned admissions More people receiving care at home	Develop the community services offer Develop crisis response multidisciplinary team			X		
Outcome 2 - VCS - T&W needs to further develop VCS role in discharge teams								
3.2.1 T&W Develop improved contracting and working relationships with the VCS	VCS are fully involved as part of the discharge team	T&W reporting improved connection with the VCS as part of the multidisciplinary team	T&W commissioners to ensure VCS connected to commissioning plans and intentions			X		
Outcome 3 – Develop understanding of long delays in relation to CHC decision making -								
3.3.1 Audit - mwhy do some take as long as they do? Is it possible to shorten the time it takes for a decision? – could	It is fully understood why CHC decision making can take a long time	Reduced delayed transfers of care	Short piece of work jointly commissioned by Shropshire and T&W			X		
3.3.2 reduce CHC decision making time for complex cases	CHC decisions are as efficient as possible	Reduced length of stay Reduced delayed transfers of care	Follow on work from the CHC audit					2018/19

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Outcome 4 – Admission Avoidance and Discharge teams are linked with care navigators/ community care coordinators								
3.4.1 Develop system Community care coordination/ care navigators that provide links to social prescribing, voluntary and community sector, social care	Community 'care navigators' are a key part of supporting people to remain independent at home. They are available to support people with information, signposting and referral to Social prescribing	People's experience of care is improved. Reduced hospital admissions Reduced GP appointments	Link to Neighbourhoods Workstream – develop model that integrates health and social care -				X	

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4. Home first/discharge to access								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – 48 hour target								
4.1.1improve performance against 48 hours discharge following FFA – enhance and develop the trusted assessor – connect up with demand and capacity modelling from WG	Patients are able to return home within 48 hours of being declared Fit for assessment where their health and care needs going forward will be assessed	Delayed transfers of care will reduce More people will remain independent at home for longer	**Complete the capacity and demand modelling as per section 2 – systems to monitor patient flow**			X		
4.1.2								
Outcome 2 - Trusted Assessor work with SPIC								
4.2.1 Develop trusted assessor role for all care homes	One trusted assessor/ assessment will be used for all care homes reducing the need for multiple assessments and time delays in accessing assessments	Reduced delayed transfers of care Reduced length of stay	Working with SPIC to gain system agreement for a trusted assessor model Shropshire Council to contract for the trusted assessor		X			

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4. Seven-day service								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Workforce and service design – link to **ADMISSIONS AVOIDANCE 90 day plan – see this plan for timescales**								
5.1.1 long term service redesign to deliver improvements – for 7 day working – for admissions avoidance and discharge – whole system response needed – links to work in SATH – safer bundle/ red to green	Service design and workforce embrace 7 day working across health and care. Admission avoidance and discharge teams work 7 days a week. Care (including hospital discharge) and transfers of care happen 7 days a week.	Reduced bottlenecks Reduced delayed transfers of care Improved patient experience	Include in service transformation planning Operationalise Supported by IBCF additional funding					
5.1.2 ICS – service specification and contract – currently being reviewed to ensure 7 day working for Admissions avoidance and discharge – link to SaTH internal workforce plan moving to 7 day working – workforce issues remain barrier iBCF have identified monies to support 7 day working	Developing ICS and ICT to ensure 7 day working to support patient flow out of hospital and to stop people from going to hospital in the first place.	New ICS and ICT integrated teams working at full capacity Reduced non elective admissions Reduced length of stay Reduced delayed transfers	Include in ICS and ICT service specification as part of the Admissions Avoidance work					

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Outcome 2 - Contracting								
5.2.1 **Contracting** - all contracts will be reviewed for assessment and starting care at the weekend– IBCF initiatives	Contracts will include 7 day working when needed	More services will be offered 7 days per week	More patients will be discharged 7 days a week Delayed transfers will reduce		X			

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4. Trusted assessors								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 –Implement competency based Trusted Assessor approach								
6.1.1 Trusted assessor approach for pathways 1, 2 and 3 embedded in practice including integrated MDT working (Integrated Discharge Team)	Health and care rely on a trusted assessor to determine correct pathway for patient	Integrated teams working well together	Developing a clear assessment process for all health and care Engaging partners to understand and work together					
Outcome 2 - **Brokerage**								
6.2.1- Care providers and Brokerage function to operate 7 days a week to increase weekend assessments NS discharges	Brokerage will be available 7 days per week	?	?					
- Outcome 3 - **Trusted assessor model** for care homes to be developed								
See 4.2.1 above								

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4. Focused on choice								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 - Workforce								
7.1.1 Workforce development – we have the tools but how do we deliver it to patients? Proactive discharge – red to green and trusted assessor will help – **communication** – developing the workforce – ward rounds, **Let's Talk local** – in hospital	Patients and service users will understand the options available to them and are able to make informed decisions when appropriate	Patients / service users experience of care	Working through the workforce development of all partner organisations. Linking to the care navigator role, connecting Let's Talk Local into SaTH, ongoing development of the Neighbourhoods/ out of hospital work stream and Healthy Conversations/ MECC plus approaches					ongoing
Outcome 2 - Communication								
7.2.1 Developing good communication practices between organisation and with patients/ service users – **connected to neighbourhoods and care navigator role**	People will understand what services are available, how to access them and how to support themselves in their communities	Reduced unplanned admissions Reduced GP appointments	Support and develop integrated working Develop neighbourhood/ out of hospital workstream					ongoing
Outcome 3 – Develop Protocol								
7.3.1 Community Trust Protocol development needed – next level of proactive response needed- as per above - promoting choice policy								

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Enhancing health in care homes								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Developing consistent and coordinated primary and community care								
8.1.1 Audit -– enhanced clinical input established but there is variation – audit of care home initiatives needed	All care homes will work with primary and community care	Audit will be complete	Commissioned piece of work		X			
8.1.2 Shropshire – commissioner led plan	All care homes will work with primary and community care	Improved consistency with joint working and service delivery within care homes Reduced hospital admissions from care homes						ongoing
Outcome 2 – Care home planning as part of wider system plan								
8.2.1 Systematically linking care homes into wider system planning	Working with care homes is fully included	Reduced hospital admissions from care homes	Out of hospital plan including frailty pathway, integrated discharge processes and assessments include care home					Ongoing
Outcome 3 – Trusted assessor model for care homes – see 4.2.1 above								
See 4.2.1 above								

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Shropshire MSK Review								
Key actions	What will it look and feel like	How will we know when we have achieved the outcome	How will we do it	Delivery Timescale				
				30 days	60 days	90 days	QTR 4	Future Date
Outcome 1 – Ensure that patients have access to the appropriate evidence based MSK pathway								
1.0 A new model of provision for MSK	A community based specialist MSK service serving the whole geographic area of Shropshire	All elective MSK / orthopaedic referrals will be channelled through a single community based service, and onward referrals coordinated by that provider The expectation is that the prime provider will develop into an ACO across the whole pathway	Establish a prime provider / ACO for MSK Improved access to local based therapy services Establishment of "hub" and "spoke" service units			CCG GB to approve way forward Plans for improved therapy access.		2018/19 2018/19
1.1 A new model of care for MSK	Evidence based MSK assessment and interventions A culture of continuous improvement and innovation across the whole pathway and sectors including prevention	Consistent evidence based conservative management of MSK conditions will be the norm and be governed by single service specifications All orthopaedic referrals assessed by a non-surgically led MSK triage service.	Completion of MSK pathway specifications Introduction of physiotherapy model and specification for all providers New service specification for SOOS			Specs completed Spec in place	Model agreed	2018/19 Expansion complete 2018/19

Outcome 2 -								
2.0 Reduction in orthopaedic intervention rates to expected levels	Prompt access for orthopaedic surgery for those patients who require it. Improved patient recorded outcome measure Scores (PROMS) Improved VFM from sustainable levels of investment in orthopaedics.	Prompt local access to conservative MSK management Improved waiting times for orthopaedic surgery Surgical intervention will have fallen to benchmarked norms	Implementation of the community based MSK service Full implementation of the approved VBC policy	In place for Shropshire Further work with out of area providers			SOOS improvements	New service 2018/19