One Gloucestershire

Transforming Care, Transforming Communities

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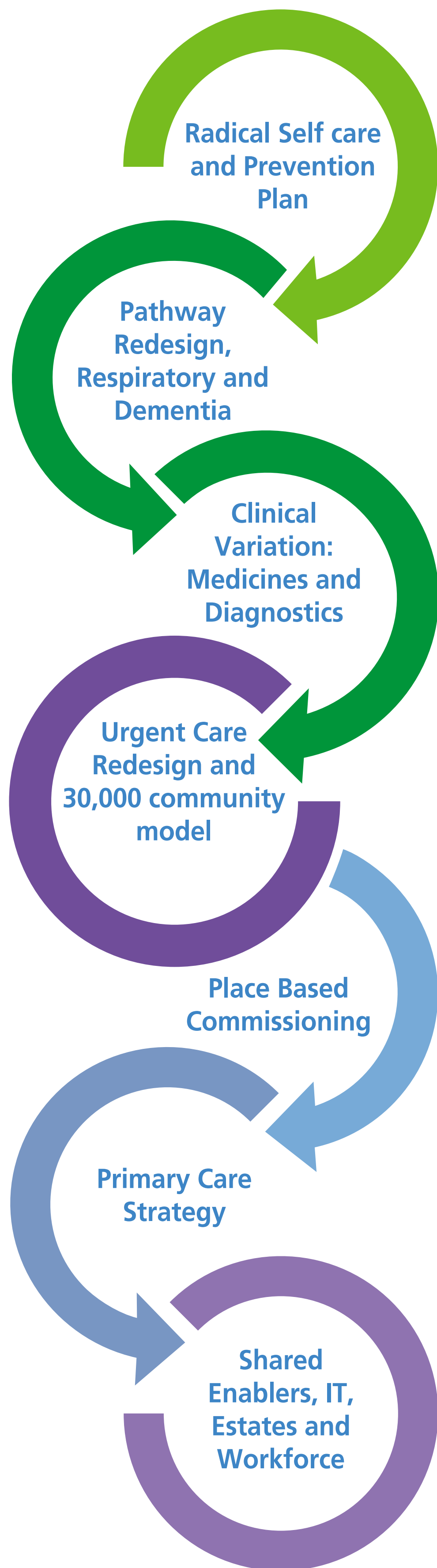
The One Gloucestershire Challenge



"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946

In October 2014, the Chief Executive of the NHS, Simon Stevens published a compelling vision and strategy for the NHS, *the Five Year Forward View.*

The vision described the opportunities and challenges facing the NHS for the future, expressed as three key 'gaps': The Health and Wellbeing Gap, the Care and Quality Gap and the Finance and Efficiency Gap.

This is our local 5 year Sustainability and Transformation Plan (STP) for Gloucestershire. It describes our vision for how publically funded health and social care services can support a healthier Gloucestershire, that is socially and economically strong and vibrant. Through delivery of this plan, we believe we can achieve an improved and more sustainable health and care system.

Our plan will help us meet a number of major challenges:

- A growing population with more complex needs – in Gloucestershire, it is estimated that 47,500 people over the age of 65 are living with a long term condition. This is projected to rise to 77,000 by 2030
- Increasing demand for services and rising public expectations, coupled with low levels of personal responsibility in some areas over personal health and care and a lack of ownership over personal health planning
- Innovation in new medical technology and medicines, which has the potential to improve lives for many people but needs funding for implementation
- Even with a degree of government investment in the NHS, and using the social care levy locally, the pressures far outstrip this funding leaving us with a financial gap of £226m over four years unless we make radical changes to the way we deliver services and provide support for local people
- Strengthening Mental Health Care and Support
- Significant pressures on our NHS and Social Care workforce capacity, with the potential for gaps to arise in key roles unless joint action is taken to develop new roles and ways of working

What do we want to achieve and how can it be done?

Our long-term ambition is to have a Gloucestershire population, which is:

- Healthy and Well – people taking personal responsibility for their health and care, and reaping the personal benefits that this can bring. A consequence will be less dependence on health and social care services for support

- Living in healthy, active communities and benefitting from strong networks of community services and support
- Able when needed, to access consistently high quality, safe care in the right place, at the right time.

We believe that in order to deliver this ambition, we need to stay true to the principles set out in our 'Joining up your Care,' programme which was shaped by local people. However, it is clear that if we are going to meet the growing challenges set out above, more of the same will not do. We are going to have to accelerate the pace of change and be even more ambitious and innovative in how we organise services and use money and other resources available to us.

Moving forward we will need to:

- Place a greater focus on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- Place a greater emphasis on joined up community based care and support, provided in patients' own homes and in the right number of community settings, supported by specialist staff and teams when needed
- Continue to bring together specialist services and resources where possible. We will also reduce the reliance on inpatient care (and consequently the need for bed based services) across our system by redesigning our models of care in order to provide services more efficiently and effectively in future
- Offer much greater potential to support people locally, within and connected to their community by creating 16 health and social care communities based around clusters of existing GPs and the county's market towns; this will require fewer referrals to acute hospitals and specialist services
- Developing new roles and ways of working across our system to make best use of the workforce we have, and bring new people and skills into our delivery system to deliver patient care

Looking ahead, we believe that by all working together in a joined up way as *'One Gloucestershire'*, there is an opportunity to build stronger, healthier and happier communities and transform the quality of care and support we provide to all local people.

However, the size of the challenge is great and we can't do it alone. First and foremost we need people in Gloucestershire to want to do this with us. We will need to work in collaboration with all our community partners, statutory and otherwise to develop our detailed proposals for change. Achieving a state of 'health' for people in Gloucestershire and providing high quality care and safe services when they are needed must remain our priorities throughout.

Signed: Mary Hutton – Accountable Officer, Gloucestershire Clinical Commissioning Group
Dr Andy Seymour – Clinical Chair, Gloucestershire Clinical Commissioning Group
Paul Jennings – Chief Executive, Gloucestershire Care Services NHS Trust
Deborah Lee – Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Peter Bungard – Chief Executive, Gloucestershire County Council
Shaun Clee – Chief Executive, 2gether NHS Foundation Trust
Ken Wenman – Chief Executive, South Western Ambulance Service Foundation Trust

Acknowledgments:

This STP plan has been produced on behalf of the Gloucestershire system and contains the contributions, feedback and inputs of many colleagues from each of the partner organisations. We would like to thank them all for their input and support over many months of the production process.

Lead Author: Ellen Rule, STP Programme Director, Director of Transformation GCCG

Coordinating Editors: Sadie Trout, Head of Planning GCCG & Beth Gibbons, STP Project Officer GCCG

Graphics Support: Fiona Leppard, Graphic Designer GCCG

Our Plan on a Page:

STP Gloucestershire: Joining Up Your Care

System Development Programme

- Countywide OD Strategy Group
- Quality Academy
- STP Programme Development
- Governance Models

Health and Wellbeing Gap

Care and Quality Gap

Finance and Efficiency Gap

Enabling Active Communities

- Prevention and Self Care strategy
- Asset Based Community Models
- Focus on carers and carer support
- Social Prescribing/Cultural Commissioning

One Place, One Budget, One System

- Urgent Care Model and 7 day services
- People and Place – 30,000 community model
- Devolution and integrated commissioning
- Personal Health Budgets / Integrated Personal Commissioning

Clinical Programme Approach

- Transforming Care: Respiratory and Dementia
- Clinical Programme Approach developing pathways and focus on prevention
- Delivering the Mental Health 5 Year Forward View

Reducing Clinical Variation

- Choosing Wisely: Medicines Optimisation
- Reducing clinical variation
- Diagnostics, Pathology and Follow Up Care

System Enablers

- Joint IT Strategy
- Primary Care Strategy
- Joint Estates Strategy
- Joint Workforce Strategy

Chapter 1: The Gloucestershire Context

1.1 Our Vision:

Vision: "To improve health and wellbeing, we believe that by all working better together – in a more joined up way – and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people"

Our shared vision was developed through extensive public engagement and set out in the strategy 'Joining Up Your Care' in 2014. We believe that the NHS and social care in Gloucestershire is in good shape to move forward, but that there remain significant opportunities for a new conversation with people in our county and for organisations to work together to ensure a sustainable future for health and social care in our county.

In October 2014 Simon Stevens published a compelling vision and strategy for the NHS, the Five Year Forward View. This vision describes the opportunities and challenges facing the NHS for the future, expressed as three key 'gaps' – and urges local health and care communities not to rely on "short term expedients to preserve services and standards" at a time which calls for true leadership and transformational change. Health and social care organisations in Gloucestershire have made a commitment to work together to deliver system level change by working together in **four new ways**:

Enabling Active Communities – building a new sense of personal responsibility and promoting independence for health, supporting community capacity, and making it easier for voluntary and community agencies to work in partnership with us. Using this approach we will deliver a **Self Care and Prevention Plan** to close the **Health and Wellbeing gap**.

One Place, One Budget, One System – by taking a place based approach to commissioning and providing we will deliver best value for every Gloucestershire pound. Our first priority will be to **roll out a new Urgent Care provision** and **develop a 30,000 place based care model** through this principle. This will ensure we close the **Finance and Efficiency Gap,** and move us towards delivery of a **new care model** for our county.

Clinical Programme Approach – systematically **redesigning pathways of care**, building on our successes with **Cancer, Eye Health and Musculoskeletal** redesign, challenging each organisation to remove barriers to pathway delivery. Year one will focus on delivery of new pathways for **Respiratory Disorders and Dementia** and progress the Mental health Task Force recommendations to help us close the **Care and Quality Gap**.

Reducing Clinical Variation – elevating key issues of clinical variation to the system level to have a new joined up conversation with the public around some of the harder priority decisions we need to make. Our initial priorities will be to deliver a **'Choosing Wisely for Gloucestershire' Medicines Optimisation** programme and undertake a **Diagnostics Services Review**. This programme will turn the dial for our system to close the **Care and Quality Gap.**

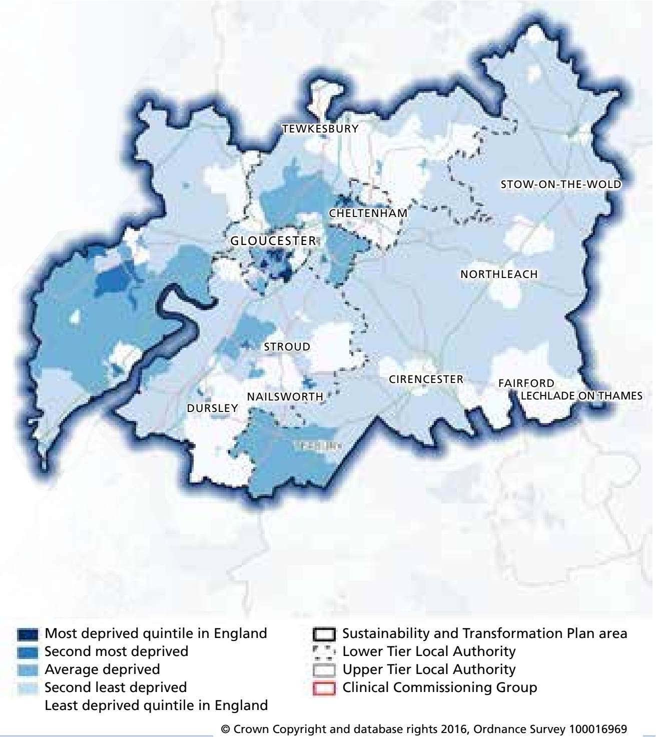
We have also committed to work together on the following system enablers:

- **Primary Care Strategy:** a sustainable future for primary care in Gloucestershire
- **Gloucestershire Local Digital Roadmap:** joint IT Programme setting out digital roadmap delivery
- **One Gloucestershire Workforce, OD Programme** and shared **Quality Academy**
- **One Gloucestershire Estates Strategy:** one approach to the public sector estate

1.2 Gloucestershire Facts and Figures:

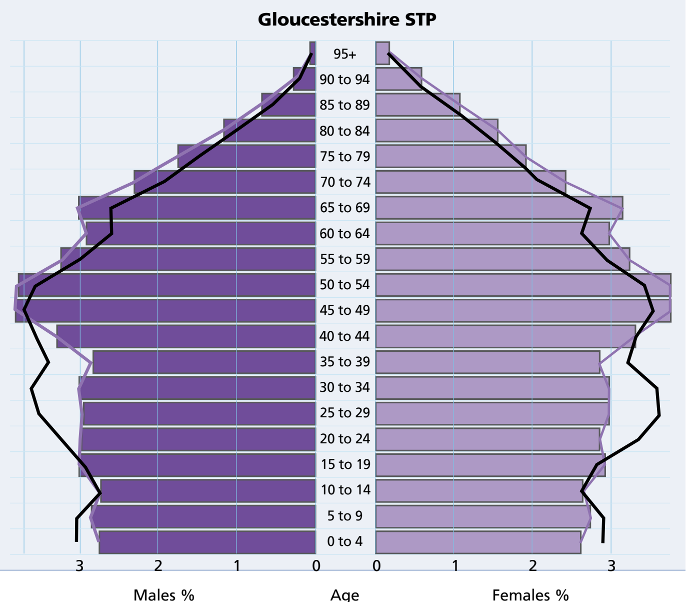
Footprint Facts

- 2,653 km^2
- one upper tier, six lower tier local authorities are projected
- 2016 resident population of 618,200[1]
- registered population of 635,481 across 81 GP Practices and seven GP Localities
- 71% population concentrated in urban areas of mainly Gloucester and Cheltenham
- 29% population in rural areas
- Increasing diversity within the population
- Deprivation lower than average, but spread in pockets across the county
- Age structure older than England 75 to 84 year olds set to increase by almost 20% by the end of 20/21
- 85 and over group set to increase the fastest in the future



Health Outcomes

- Health of people in Gloucestershire is better than the England average
- Life Expectancy at Birth – higher than England average
- Healthy Life Expectancy at Birth for males has been declining since 2010
- Life expectancy at 65 years better than the England average for both genders but not improving in line with the national experience, especially for females.
- The major causes of death are cancer, cardiovascular and respiratory problems
- People with severe Mental Health needs die 15-20 years earlier



Wider Determinants

- 'School Readiness' (a key measure of early years development across a wide range of developmental areas) is an area of poor performance
- Children from poorer backgrounds including children in care are more at risk of poorer development and health outcomes. The evidence shows that differences by social background emerge early in life
- Other areas of focus for us include Fuel Poverty[2] and Social Isolation

Age	2015/16	Five year change (2020/21)
0 to 14	103,887	5.3%
15 to 44	228,279	-0.7%
45 to 64	174,782	1.5%
65 to 74	69,965	4.4%
75 to 84	40,541	19.7%
85 plus	18,027	18.3%

Source: ONS ● England -10 0 10 30 50

1 ONS 2012-based sub-national population projections

2 There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures (Wilkinson et al 2001) and the recent Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes.

Focus for health improvement	• Excess weight in 4 – 5 year olds • Smoking prevalence at age 15 years – occasional smokers • Successful completion of drug treatment for opiate and non-opiate users • Admissions for alcohol-related conditions (persons and females) • Access to diabetic retinopathy screening • Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check
Health Protection, Healthcare and Premature Mortality	• Population vaccination coverage for flu for older people aged 65 years and over, as well as for at risk individuals • Mortality from communicable diseases (persons, males, females) • Suicide rate (persons, males) • Excess winter deaths index - single year, age 85+ (males)
Health Inequalities	• Give every child the best start in life: child poverty levels in the county are much better than England average, thereby increasing healthy life expectancy • Enable all children, young people and adults to maximise their capabilities and have control over their lives: Young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes. The county has historically done well in terms of NEETs (better than England) as well as adults with learning disabilities in employment. The gap in employment rate between those with a learning disability and the overall employment rate has recently increased following a downward trend, especially for females • Create fair employment and good work for all: Overall Gloucestershire does well in terms of employment. • Ensure healthy standard of living for all: Work on wider determinants of health • Create and develop healthy and sustainable places and communities • Strengthen the role and impact of ill-health prevention: Prevention and implementation of Self-Care Plan
Social Care	• Enable people to live independently, in their community, for as long as possible. • Safeguard vulnerable adults. • Reduce the number of people in residential care. • Increase accessibility to home care • Support carers so they can continue in their role. • Improve the quality of information, guidance and advice to enable people to make informed choices

1.3 Gloucestershire's Health and wellbeing Gap

The three leading causes of death for our population are cancer (27.9%), cardiovascular disease (26.8%) and respiratory disease (14.2%). Age is the leading risk. The burden of disease in these categories is associated with four additional key risk factors: **poor diet, physical inactivity, smoking and excess alcohol consumption**. **Poor mental and emotional wellbeing** also have a key part to play. Gloucestershire is broadly in line with national and regional benchmarks for alcohol related admissions to hospital, levels of physical activity and adult excess weight, although some districts have worse rates than the county as a whole, notably in the west of the county in the Forest of Dean, Gloucester and Tewkesbury. Smoking rates in Gloucestershire are steadily declining and are lower than comparators. Work is underway to capture the impact of loneliness and social isolation as both are factors in worse health outcomes through adding a depression / mental health dimension to needs. Whilst healthy life expectancy for women is almost two years better than for their regional counterparts, the average for Gloucestershire men is lower than for the South West as a whole.

Our ageing population, changing patterns of disease (more people living with multiple long-term conditions) and rising public and patient expectations mean that fundamental changes are required to the way in which care is delivered in our county. We will **more fully involve individuals in their own health and care** by making **shared decision-making** a reality by intensively training our clinicians to give people the support and information they need for effective self-management, and involving their families and carers to support them in making the changes needed to keep healthy. Evidence is clear **that most people want to be more involved in their own health**, and that when they are, decisions are better, **health and health outcomes improve**, and resources are allocated more efficiently.

To deliver change we will build on **our existing collaborations** between the NHS, local government, the third sector, employers, Local Enterprise Partnership, Police & Crime Commissioner, Constabulary and others. This is evidenced in our delivery of Social Prescribing as a partnership between all of these partners and our new initiatives to tackle workplace health with our local LEP being developed for delivery in 2016/17. The **following prevention opportunities** have been identified as having the highest potential significant impact in our county:

- Decrease the incidence and prevalence of colorectal cancer
- Reduce diabetes prevalence (17+)
- Providing people with common mental illnesses with better support
- Increase detection of hypertension and Coronary Heart Disease
- Reduce the prevalence of Asthma
- Increase Flu vaccine uptake by children and pregnant women
- Decrease percentage of low birth weight babies
- Decrease the percentage of children aged 4-5 who are overweight or obese
- Increase the percentage of children receiving MMR vaccine by age 5
- Reduce the number of decayed, filled or missing teeth in children aged 5 years
- Increase proactive care for those with complex needs 55+ and for babies, children and their mothers, particularly those with circulatory, cancer and gastrointestinal problems
- Improve targeted support for those whose medications may increase their risk profile

1.4 Gloucestershire's Care and Quality Gap

Our assessment of the Care and Quality Gap considers a wide range of indicators and data sets at a national and local level. This includes Right Care; Commissioning for Value, The Atlas of Variation in Healthcare, measures of our local performance delivery and our learning from the reviews of our services conducted by national bodies including the Care Quality Commission. Our key findings are set out below:

Top range indicators:

- Percentage of deaths which take place in hospital is higher than it should be
- People with a long-term condition need to feel more supported to self-manage their conditions
- More Injuries from falls in people aged 65 and over per 100,000 population
- Poorer Quality of life of carers as measured by the health status score EQ5D

Areas of focus identified by Right Care

Source: PHE, Right Care, NHS England. Commissioning for Value: Where to Look. January 2016. NHS Gloucestershire

The national Right Care Programme identifies the potential savings for each health community if care was delivered in line with the most efficient areas in the country. This table shows the opportunities identified through the Right Care Programme for Gloucestershire:

Savings (£000s)					
	Programme Area	**Elective admissions**	**Non-elective admissions**	**Prescribing**	**Total**
1	Cancer	733	1840	411	2984
2	Neurological	709		654	1363
3	Circulation	-	2078	1077	3155
4	Respiratory	173	1132	686	1991
5	Gastrointestinal	435	415	-	850
6	Musculoskeletal	1424	541	-	1965
7	Trauma and Injuries	1774	918	95	2787

Specific Improvement Opportunities – Cost and Quality

- Cancer and tumours: increasing detection of breast cancer at an early stage, increasing screening uptake, improving mortality, increasing lung cancer detection
- Endocrine, nutritional and metabolic problems: uptake of retinal screening
- Circulation problems: improve proportion of stroke patients spending 90% of their time in hospital on a Stroke Unit, reducing premature mortality from all circulatory disease, increasing proportion of patients returning home after treatment
- Respiratory: reducing premature mortality from bronchitis, emphysema and Chronic Obstructive Pulmonary Disease, Increasing the proportion of asthma patients with annual reviews, reducing asthma emergency admission rates for children, increasing the proportion of COPD patients with a record of their respiratory function
- Gastrointestinal: reducing emergency admissions for alcohol-related liver disease, reducing premature mortality from gastro-intestinal and liver disease
- Musculoskeletal problems: improving Patient Reported Outcome Measure (PROM) – for hip replacement and knee replacement
- Trauma and Injuries: reducing mortality from accidents, increasing proportion of patients with a fractured neck of femur returning home in 28 days, reducing hip fracture emergency readmissions within 28 days, reducing mortality for hip fracture
- Genito-urinary problems: especially renal conditions with high first outpatient attendances and increasing the proportion of patients accessing transplants
- Mental health problems: psychosis pathway, Improving Access to Psychological Therapies (IAPT) Pathway and reducing need for out of area treatments
- Children: reducing the emergency admission rates for children under 1 for gastroenteritis and lower respiratory tract infections for children under 5

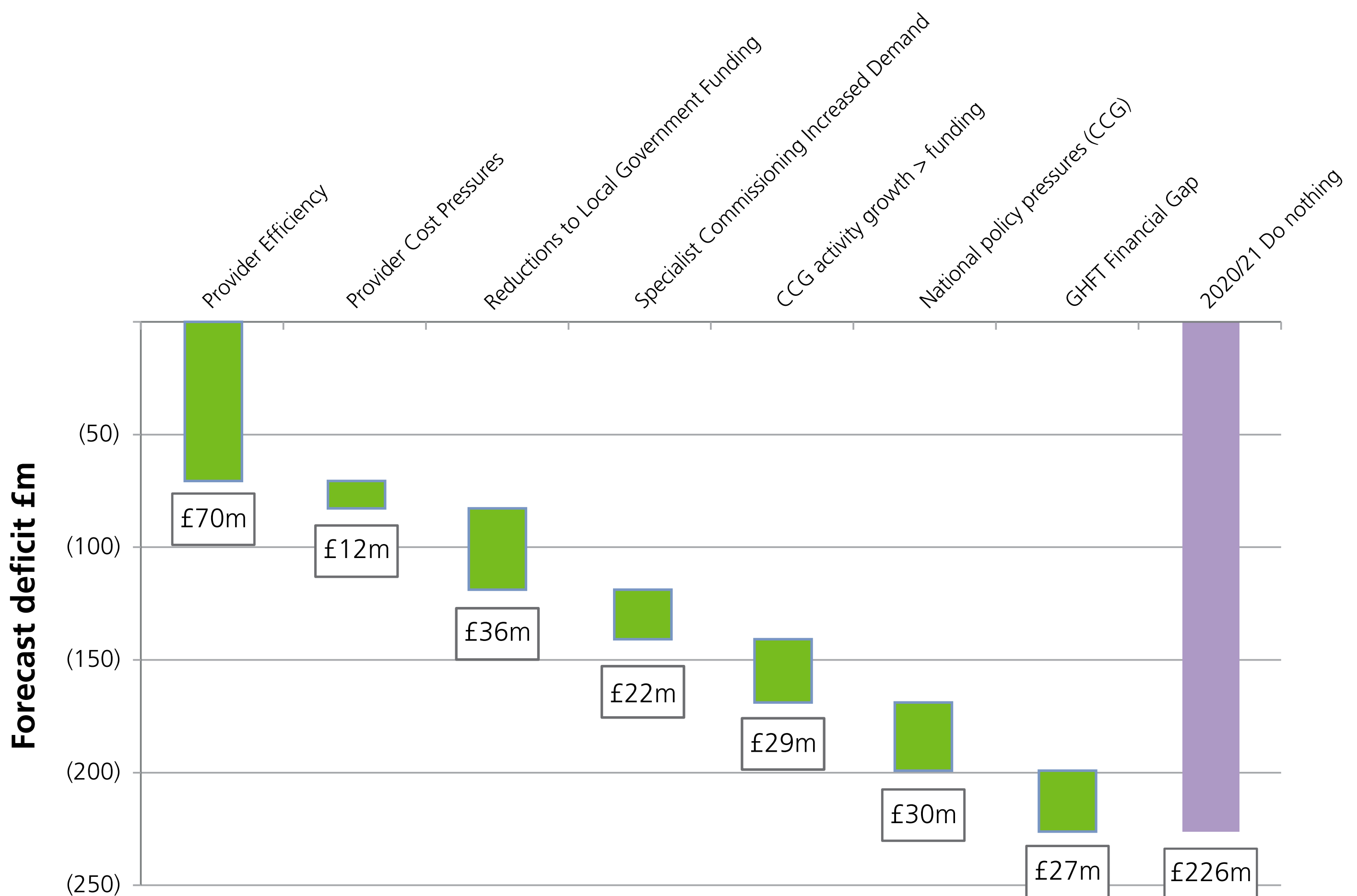
Complex Patients	• The 2% most complex patients in Gloucestershire were responsible for 14.9% (£32,112,000) of the total CCG spend in 2015/16 • 12.4% of patients had more than 5 A&E attendances (less than peer group average) • 68% of people using our outpatients attended more than 5 times, 43% more than 10 times and 28% more than 15 times with all frequencies higher than peer average • The top five conditions for outpatient attendances were cancer, trauma and MSK, circulation, vision and genito-urinary conditions. • Use of NHS Resources increases significantly for patients aged 55 years and over • Resources use is also significant for children aged 10 -14 years and babies and toddlers
Parity of Esteem	• People experiencing mental illness often experience many social determinants e.g. poverty, social isolation, discrimination, abuse, neglect, drug and alcohol dependencies, leading to poor health outcomes • Medications used to treat physical illness can have side-effects that produce psychiatric symptoms, and medications used to treat mental illness needs can affect physical health. • There are higher rates of unhealthy behaviours amongst people with mental health needs i.e. smoking and use of alcohol or other substances • There are barriers to accessing support relating to stigma, prejudice and discrimination
Constitution Delivery	• Local delivery of NHS Constitution measures is significantly challenged in the following key areas: IAPT (Primary Care Psychological Therapy Service) Performance, A&E 4hr wait performance, cancer waiting times
CQC Ratings	• The vast majority of Primary Care assessments completed so far all rated as good or outstanding • 2G: Inspection Oct 2015 overall good. Outstanding for crisis, home treatment and place of safety, adult inpatient wards and Psychiatric Intensive Care Unit. Two areas required improvement 1) wards for people with LD or autism, all domains except caring require work, 2) Community based Mental Health services for older people: effective and well-led require improvement. Long stay /rehab Mental Health wards and community services for working age adults, Mental Health wards for older people require improvement in the safe domain only • GHFT: Inspected in March 2015 with outcome of requires improvement especially in the care of patients in the Emergency Department, where excessive waits were experienced. A review of the emergency pathway was required and staffing levels were highlighted. The Trust received outstanding for the critical care areas and good for well-led. • GCS: Inspected in June 2015 with outcome of requires improvement, issues raised with unregistered practitioners in MIIU undertaking tasks such as triage; long waiting times for therapies and the need to develop an end of life strategy. The Trust were given outstanding for caring in the community hospitals • SWASFT: Inspected in June 2016 overall ‘requires improvement’. Issues raised with aspects of safety with regard to incident reporting and adherence to Trust policies, procedures and protocols, and effective services. Rated ‘outstanding’ for caring and ‘good’ for responsiveness.
Primary Care	• Workforce: 40% of all practices are carrying GP vacancies, 75% are partners. 56% have impending GP retirements,. • Quality, IT and Transformational Change: improving access at evening and weekends, more on-the-day urgent appointments
Patient Safety	• Antimicrobial Resistance: use of anti-microbials in the county are recognised as already being lower than many other areas. The county-wide antimicrobial group continue to target those areas where improvements can be made • Winterbourne View: The resettlement of LD patients continues to be a high priority with a clear action plan being successfully implemented • Francis Report: We are committed to achieving the safe staffing levels and have recruitment initiatives to improve staffing and reduce the use of agency staff • We are committed to ‘Sign up to Safety’ and through a county-wide patient safety forum are working to reduce harm to patients whether in hospital or at home

1.5 Gloucestershire's Finance and Efficiency Gap:

In 2016/17 the Gloucestershire STP footprint has faced some financial challenges, with an emergent deficit at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) impacting on the starting position for our STP plan. The scale of the challenge for our system is derived from analysis comparing future funding growth compared to demographic change, the rising burden of disease, managing local government funding settlements and the ongoing health efficiency requirements. The collective challenge over the life of our STP plan if no mitigating actions or efficiencies are delivered for health and social care is expected to be **£226 million**.

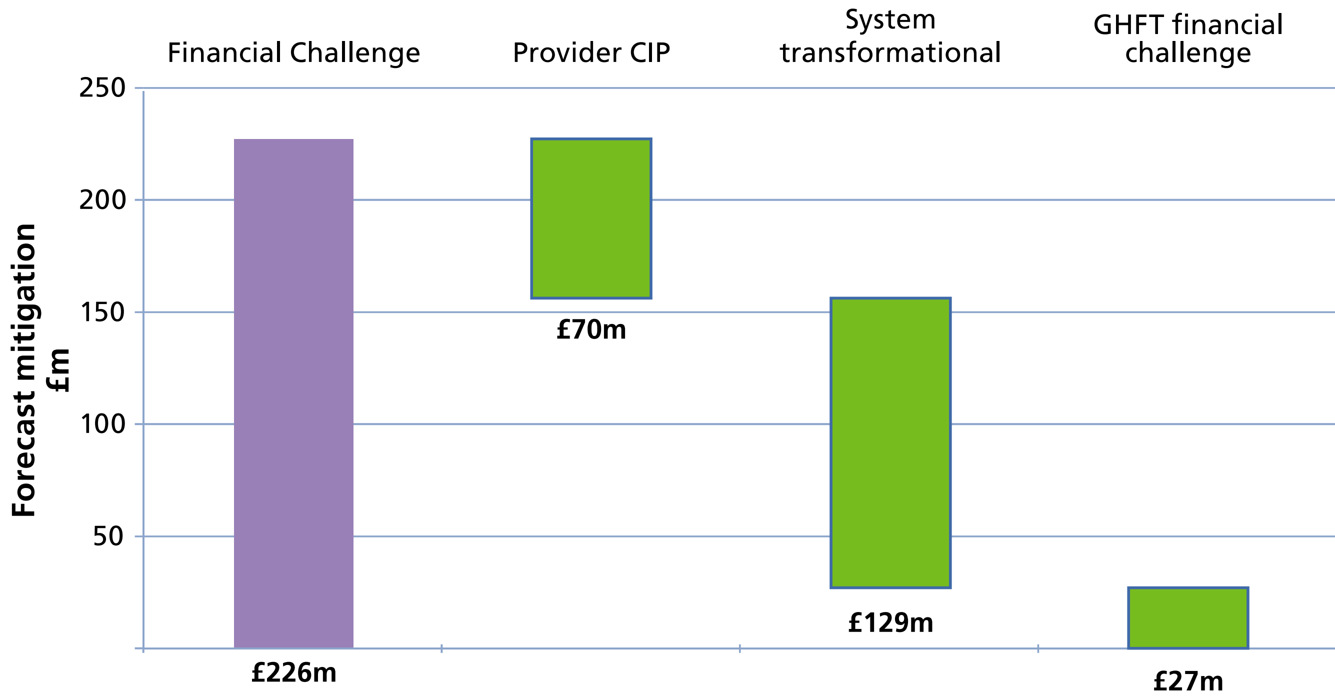
Our approach to modelling the gap has worked forward from the expenditure requirements of our STP partner organisations and the values set out in the national planning assumptions for expected areas of increasing costs. These include pay, pensions, drugs and nationally mandated programmes such as the implementation of 7 day services and new investment for primary care. Opportunities for our community to work together on closing this gap will look to ways to make cashable savings through delivering technical and structural efficiency, alongside increasing allocative efficiency though ensuring the effective use of health care resources to meet available needs. Alongside ensuring efficiency, our system will support people and communities to live healthier lives to ensure we can reduce increasing demand. The system is working together on a shared plan for all the savings expressed in this plan, however, initially in recognition of the existing organisational accountabilities in place these will continue to be expressed through the currencies of provider Cost Improvement Plans (CIP) and system wide transformation plans. A joint approach has been taken to understand the impact of planned local authority savings which are modelled from both a commissioning and provider perspective

Financial Gap without mitigations:



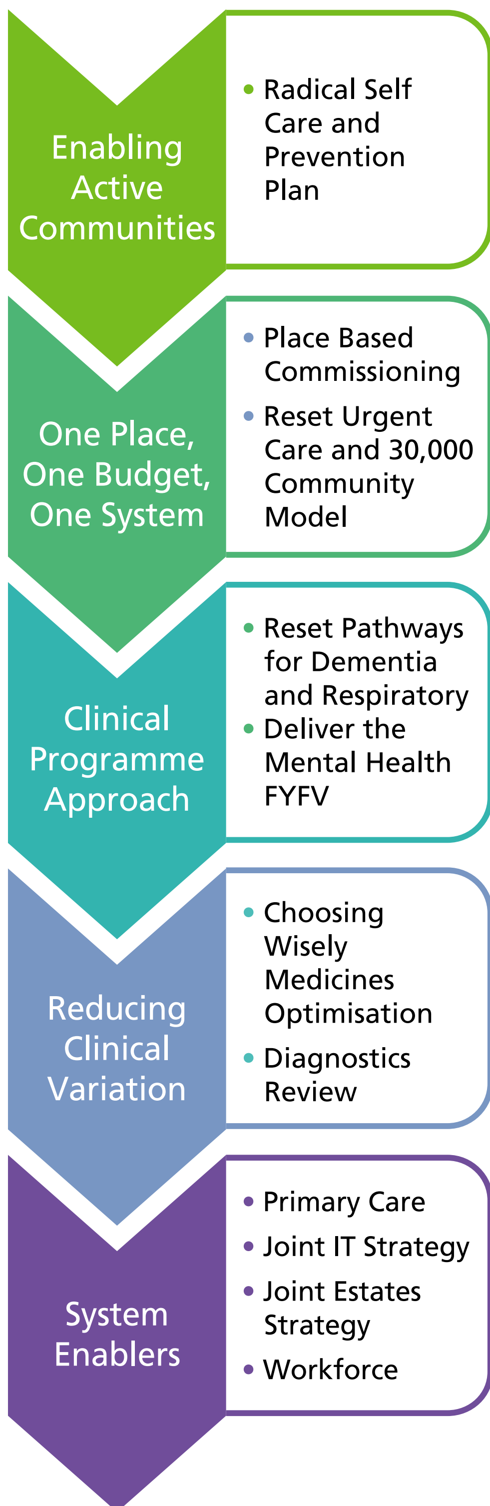
Financial Gap:

Through the STP, the system has come together to agree a clear plan to managing the delivery of our financial plan that will ensure that there are true savings for the community without just moving activity and cost around between STP partners whilst also ensuring the continued availability of safe, sustainable services in the future.



Chapter 2: Our Delivery Priorities

Our delivery priorities have been shaped in response to our challenges described in Chapter 1. Our four key approaches to turning the dial over the next five years are described below. These are our top priorities designed to deliver services that meet the needs of our population in the face of constrained resources, and maintain our current financially balanced position. Each is explained in more detail in Chapter 2.



In summary, we will address our challenge by:

We have developed an approach '**One System, One Place, One Budget**' to ensure that everyone in our system 'owns' the Gloucestershire pound. This is a new place based commissioning and provider approach based on our people and place model, and we will use this to support our urgent care design and deliver a 30,000 community model, pooling our resources and expertise across the system to redesign our model of care and ensure we can deliver responsive joined up care for our population when they need us. By aligning incentives away from organisations and ensuring every part of our system benefits from doing the right thing this will support transformational change at scale.

We will join together as system partners in a new working arrangement supported by a Memorandum of Understanding to work together on **Clinical Pathway Redesign, Reducing Clinical Variation** and key **System Enablers** together. Not all of this work is new, but the way we will work together to deliver it is.

We will take a new approach to **Enabling Active Communities** to deliver a Self-Care and Prevention Plan at scale, taking the conversation beyond traditional health and social care boundaries and engaging with a whole range of partners in a new way.

NHS England asked us to describe how this plan would address '10 big questions' laid out in their planning guidance. A summary of our response to their challenge is set out at Annex D to this document. In return, we are asking NHS England to support our system to deliver through the following key 'asks' which are expanded on through our programme level descriptions:

- Permission to take a local approach to commissioning our new urgent care offer
- Support at a national level for a new conversation with the public regarding personal responsibility for health and self-care
- A national drive and joined up approach to the Choosing Wisely programme and prioritisation of health interventions
- Support to develop plans for delegated co-commissioning of specialist commissioning

2.1 Enabling Active Communities

Programme Leaders: Margaret Willcox – Director of Commissioning, Adults (GCC), **Linda Uren** – Director of Commissioning Children and Families (GCC), **Mary Hutton**

Enabling Active Communities – building a new sense of personal responsibility and improved independence for health, supporting community capacity and ensuring we make it easier for voluntary and community agencies to work in partnership with us. We will use this approach to deliver a **radical Self Care and Prevention Plan led by Public Health** to close the **Health and Wellbeing Gap** in Gloucestershire. Improving Lives is a core function of the NHS, expressed in the NHS Constitution as the need for the NHS to "help people and their communities take responsibility for living healthier lives".

Our first year will focus on delivering Social Prescribing and the shared Prevention and Self-Care Plan. We recognise that more systematic prevention is critical in order to reduce the overall burden of disease in the population and maintain the financial sustainability of our system. Our Prevention and Self-Care Programme provides a clear framework and plan for whole system change that will enable patients and communities to take a lead in their health and care. Our aim is to create the conditions for community and individuals to thrive, to remove any barriers and for our services to work to meet the needs and harness the assets of our communities in ways that are empowering, engaging and meaningful.

Our approach to prevention will help us to focus on how we remove the barriers to access for people with a range of health inequalities. For example, we will ensure we address how individuals with mental health needs including dementia can be supported in accessing the health prevention screening, planning and interventions, which will be available to the general population. To deliver this, mental health services and patients will help co-design/produce a programme of interventions, and ensure those practitioners and others working in mental health, community/ primary care and voluntary services can facilitate access for those that need focused individual motivation, help and support.

Similar plans are being developed in relation to social inclusion and social reablement programmes, so that individuals with mental health needs are supported into employment opportunities and have access to appropriate accommodation to minimise the impact these factors contribute to their ill health. Progressing these programmes in this way, will contribute to improving the "Parity of Esteem" for people with mental health needs, enabling them to access services that the majority of the public are able to do/enjoy freely.

"What is the matter with you?' and 'what matter's to you?' are two phrases that are increasingly going hand in hand with each other. As how we deliver healthcare is changing, we are becoming less the experts to our patients and more the facilitators and teachers of our patients. A recent example of taking a motivational interviewing approach and asking what mattered to a patient I look after with diabetes resulted in him taking a slimming world referral, losing 2 stone and stopping his two types of insulin and blood pressure tablets. He and his family are very proud of his achievement."

Dr Hein Le Roux, Minchinhampton Surgery

Through our STP we will work together to:

- Promote healthy lifestyles and self-care: a new conversation with the public through a 'social movement' approach focussed on personal responsibility for health and wellbeing
- Promote healthy workplace environments through the Workplace Wellbeing Charter
- Targeted approaches for vulnerable population groups
- Tackle health inequalities through asset-based approaches
- Take a whole system approach to obesity working with Leeds Beckett University and Public Health England
- Ensure appropriate coverage of key secondary prevention interventions that systematically detect the early stages of disease i.e. Diabetes Prevention Programme
- Ensure a strategic approach to the commissioning of self-management support
- Develop our system to support person-led care and personalised care planning i.e. Integrated Personal Commissioning (IPC)
- Utilise the capacity and strengths within our communities through closer working with the Voluntary, Community and Social Enterprise (VCSE) Sector i.e. Social Prescribing
- Ensure substantial involvement of communities and individuals to co-produce local solutions and services i.e. Cultural Commissioning Programme
- Ensure a range of carer services are delivered in line with the Care Act
- Implement innovative technologies i.e. Diabetes NHSE Digital Test Bed
- Increase visibility, awareness and acceptance of Mental Health

By 2017 we will have:

- Accredited 40 organisations through the National Workplace Wellbeing Charter
- Rolled out Atrial Fibrillation diagnosis treatment programme with Academic Health Science Network to 60 practices
- Trained 80% of our primary schools to support the implementation of the 'daily mile'
- Trained 21 leaders within our Integrated Community Teams to roll out health coaching
- Worked to develop a new integrated healthy lifestyle service to target the top four modifiable lifestyle causes of chronic disease and support self-care
- Built on our investment of £600,000 in Social Prescribing to support over 2500 individuals through our Social Prescribing programme.
- Developed Social Prescribing schemes together with mental health including investment in a Crisis Café
- Developed plans to invest £1.7 million to support implementation of the Prevention and Self-Care Plan
- Worked with Active Gloucestershire to develop ways to increase activity
- Implemented new services for personality disorder, perinatal mental health conditions and developed mental health services for young people under Future in Mind
- Piloted with AHSN the NHSE Digital Test bed on diabetes management

By 2021 we will have:

- Stabilised the prevalence of Type 2 Diabetes through the implementation of the National Diabetes Prevention Programme and our whole system approach to obesity
- Adopted the learning from our NHSE Digital Test Bed and developed innovative approaches to support individuals with long-term conditions to self-manage
- Reduced the number of 'inactive individuals' by 90,000 through investment in a broad range of physical activity initiatives
- Stronger, more resilient and well-connected communities that lead to better health and wellbeing and a reduction in inequalities
- We will have a personalised care plan for a targeted proportion of patients with one or more long-term conditions having a personalised care plan

2.2 One Place, One Budget, One System

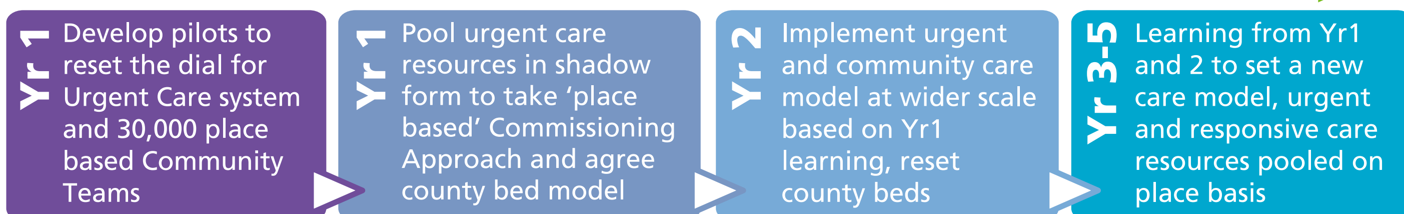
Programme Leaders: Paul Jennings, Mary Hutton

One Place, One Budget, One System – we will take a place based approach to our resources and deliver best value for every Gloucestershire pound. Our first priority will be to redesign our **Urgent Care system** and deliver **our 30,000 community model.** We will take a place based commissioning approach to reset urgent and community care to deliver efficiently and effectively. This will ensure we close the **Finance and Efficiency Gap**, and move us towards delivery of a new care model for Gloucestershire**. Our new care model** will be informed by the learning from year one and two of our STP delivery.

Urgent and Emergency Care:

When you need to access health care urgently, it's essential that you get the right response for your needs. Our vision is that this is provided in a range of facilities and locations, but that each of these will have the best expertise and facilities to give you the best chances of a good recovery.

New model of care delivered through One Place, One Budget, One System approach



Sometimes the first step can be self-care and prevention which our ASAP website and App and the NHS 111 phone number can help provide; directing patients to the right service for their needs. Services such as pharmacists may be able to help, or give self-care advice for patients to prevent an illness from getting worse.

Often, the next step would be primary care or a GP. At the moment a patient might call them directly to get an urgent appointment, but in the evening and at weekends their call would link them to a GP out of hours service. We plan to develop an urgent primary care service in key locations throughout the county so that patients access these services 24/7 in a location that's convenient to where they live.

These Urgent Care Centres in key locations will be the hubs that can link patients to other services. As well as a GP service, they will have other highly trained staff who can further assess what care patients need, order tests and treat a wide range of conditions. Our vision is the majority of patients can access this care within a maximum of 30 minutes driving time.

Of course, some very urgent health problems are life-threatening emergencies, like a heart attack or serious head injury. These will need very specialist care in hospital and would usually be accessed by calling the 999 emergency number for an ambulance.

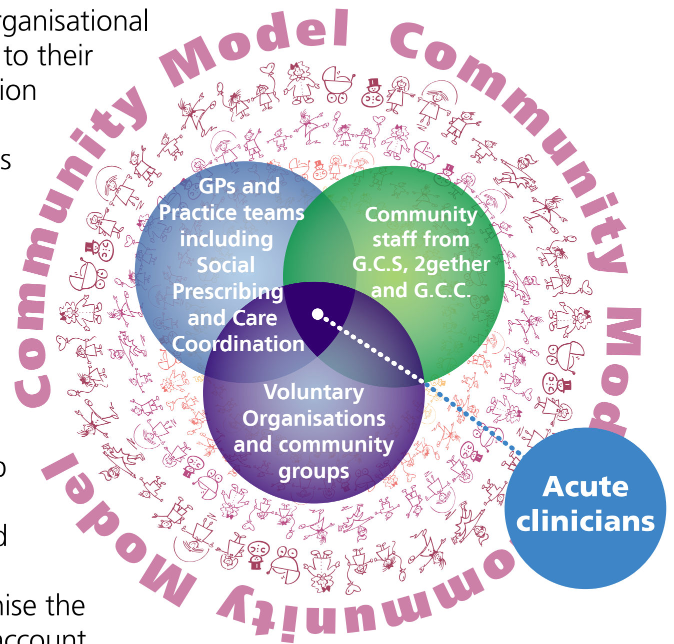
Our vision for Urgent Care will deliver the right care for patients, when they need it. We plan that it will deliver 7 day services across the county by 2021.

In order to make this vision a reality and provide safe and sustainable services in to the future, we need to consider how to make best use our resources, facilities and beds in hospitals and in the community. We want to improve arrangements for patients to access timely and senior clinical decision making about their treatment and ensure specialist support is accessed as soon as possible.

New Models of Care:

Our community care redesign will ensure responsive community based care is delivered through a transformative system approach to health and social care. The intention is to enable people in Gloucestershire to be more self-supporting and less dependent on health and social care services (see self-care and prevention plan), living in healthy communities, benefitting from strong networks of community support and being able to access high quality care when needed in the right place, at the right time. New locality led 'Models of Care' Pilots will be carried out during 2016/17 to 'test and learn' from their implementation and outcomes to help inform and develop the future model of care for Gloucestershire.

These pilots are already testing one system working across organisational boundaries, with staff accountability to each other as well as to their own organisations, giving an opportunity for greater integration of health and social care services to support delivery of co-ordinated care. The pilots provide an opportunity for clinicians to design and implement models of care based upon the needs of the local population to provide the best outcomes for local people. We are open to the possibility that this could lead to the potential for organisational change in our system, but strongly believe the model of care must lead any such change and demonstrate that patient care would benefit as an outcome.



Primary care is a central component in our plans for joined up care and care co-ordination. We are actively developing the primary care aspect of our new models of care, based around a minimum of 30,000 populations. We are working with our localities to lead the delivery of place based plans that recognise the needs of our populations across our varied footprint, taking account of the different delivery models needed in urban vs. rural areas of our county. Work to date has developed our thinking about the future organisation of primary care, with GP surgeries in Gloucestershire proposing to form 16 GP 'clusters' from 2017/18. These clusters will enable practices to work together to share skills providing a stronger and more robust primary care service for Gloucestershire.

Design of the pilots will be devolved to locality levels, developing a network of learning about how best to provide community based services and support. Through this work our primary care clinicians across the system can directly contribute towards a sustainable future for primary care. We will bring together the learning from these pilots through the New Models of Care Programme Board.

Pilots:

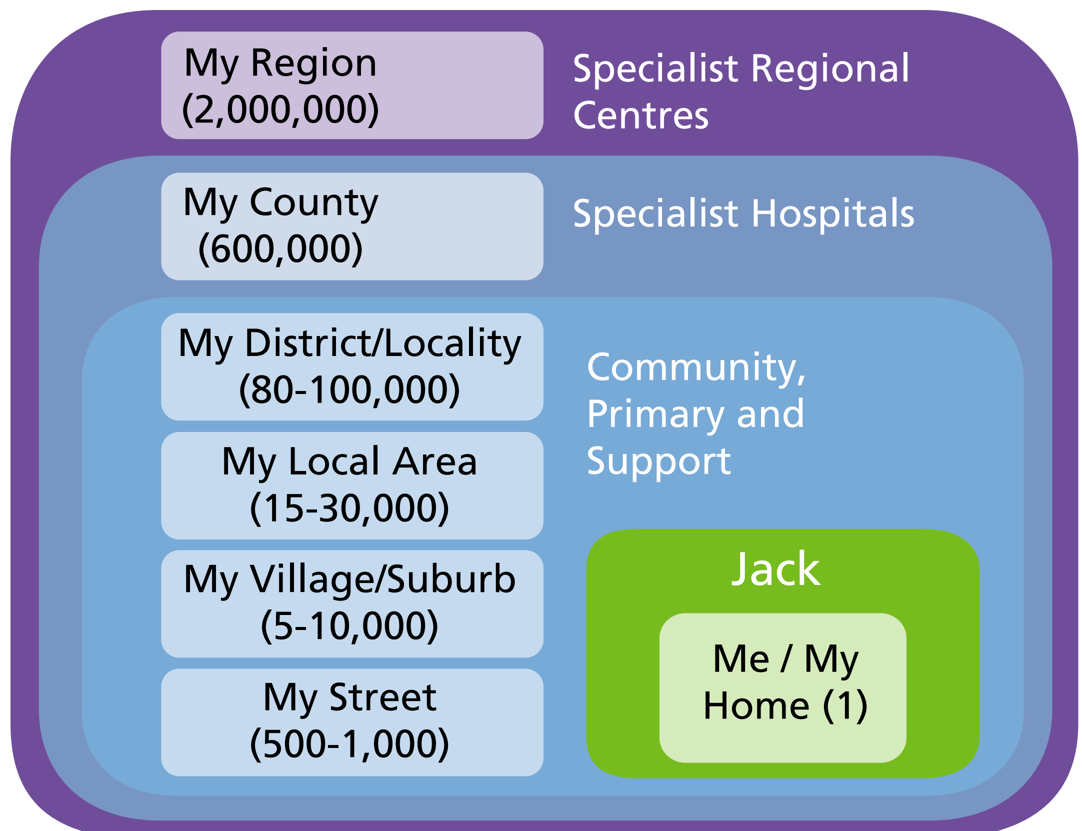
Integrated Primary & Community based Urgent Care

Stroud & Berkeley Vale
One Place, One Budget, One System

South Cotswolds –
Frailty Primary Care at Scale GP Forward View (countywide)

Our One Place, One Budget, One System approach to provision and delivery of services will be enabled by the concurrent development of a place based commissioning approach for responsive and urgent care, described by our People and Place Model. In 2016/17 we will set indicative budgets and share transparently through the STP how resources are used across urgent and community care services to pave the way for a new commissioning approach to enable early implementation in 2017/18.

Fig 1: People and Place model.



By 2017 we will have:

Urgent Care:

- Completed an evidence-based proposal to reshape Urgent Care Pathways within Gloucestershire across hospital and community based services for engagement with our local community. This will start to inform our thinking on a whole county bed model to make best use of resources available across our county and support delivery of 7 day services
- Continued to promote ASAP online to help people identify their symptoms, obtain self care advice, find the nearest relevant services, information on when to use them and to check opening hours. This will be supported by the development of an urgent care digital platform that will ensure 24/7 access to a reliable and robust directory of service for both public and health and social care staff
- Ensured that advice and treatment is available from a network of community pharmacies across our county
- Ensured we have delivered a responsive Mental Health Crisis Service for young people and adults and developed a programme for communities to have local Accredited Mental Health First Aiders and Champions delivering increased visibility, awareness and acceptability
- Provided a consistent approach to the use of National Early Warning Score across our Urgent Care System
- Established a clear Memorandum of Understanding to enable shadow pooling of budgets in a one system approach for urgent and responsive care

New Models of Care:

- Delivered our 30,000 model and community pilots through which we will pilot a number of local clinics to reduce admissions including providing an expanded Community Intravenous Therapy Service
- Commenced implementation of our End of Life Strategy
- Further developed our Social Prescribing offer and integrate Cultural Commissioning Pilots
- Link paramedic practitioners and additional mental health staff to practices and make sure pharmaceutical advisors cover a single cluster
- Agreed our emerging model of 16 GP cluster groups, supporting these to integrate and develop new ways of working, such as developing shared clinical and pharmaceutical policies and back office functions such as shared telephony
- Appointed a Joint Director of Integration to work between health and social care

By 2021 we will have:

Urgent Care:

- Developed new 'Urgent Care Centres' across localities in a way which allows the majority of patients to access them within a maximum of 30 minutes driving time. These centres will have access to a range of diagnostic services and clinical expertise
- Delivered easier and more convenient access to GP practice services including additional slots for urgent appointments. Primary care in normal working hours will work closely with primary care 'out of hours' where patients may receive telephone advice, be seen in their own home or at a local primary care centre and local GPs will play a unique role as 'conductors' of urgent care within their locality
- Ensured our urgent care offer is fully integrated, with NHS 111 continuing to be the main route into urgent care services for many patients – with the option to speak to a clinician if needed, and, with your consent, your health records being available to clinicians treating you wherever you are
- Ensured that those people with more serious or life-threatening emergencies are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery
- Ensured that the range of options open to senior decision makers will include services which do not require admission to hospital. These include enhanced ambulatory care (medical care provided on an outpatient basis, including diagnosis, observation, treatment and rehabilitation services) and quick access to 'hot clinics' (appointment slots with senior clinicians with priority for urgent cases)
- Ensured when an admission to hospital is needed, that we will start planning discharge home as soon as possible so people do not stay in hospital any longer than absolutely necessary, and so health and social care work together effectively to support safe discharges
- Ensured that our main hospitals provide a range of services 7 days a week in order to meet the agreed national clinical standards
- Commissioned for urgent and responsive care on a new placed based basis, utilising a multiyear whole population budget and contract with effective gain/risk share approach
- Delivered a new countywide bed model making best use of sites and resources, which will include a new approach to rehabilitation across our county

New Models of Care:

- All practices will be working through new networks, sharing ways of working such as shared clinical and pharmaceutical policies and shared/ integrated telephony and IT systems
- 'Locality Urgent Care Hubs' established in each area, meeting the particular needs of these local communities – these will provide a focus for urgent care within geographical localities and will include GP, community hospital and other community services working together. As part of this development GP practices will also work together in collaboration to share resources (e.g. to prioritise calls received via NHS 111 or to better co-ordinate home visits)

"At last a sensible strategy to put patients at the centre of care planning. The new STP aims to provide a new localised primary care where social support and medical needs are planned and delivered in a co-ordinated package"

Dr Victoria Blackburn, Stroud GP

2.3 Clinical Programme Approach

Clinical Programme Approach – We will work together across our system to **redesign pathways of care**, building on our successful delivery to date with Cancer, Eye Health and Musculoskeletal redesign, challenging each organisation to remove barriers to pathway delivery. Our first year will focus on delivery of new pathways for **Respiratory and Dementia** to help us close the **Care and Quality Gap**.

Programme Leader: Deborah Lee

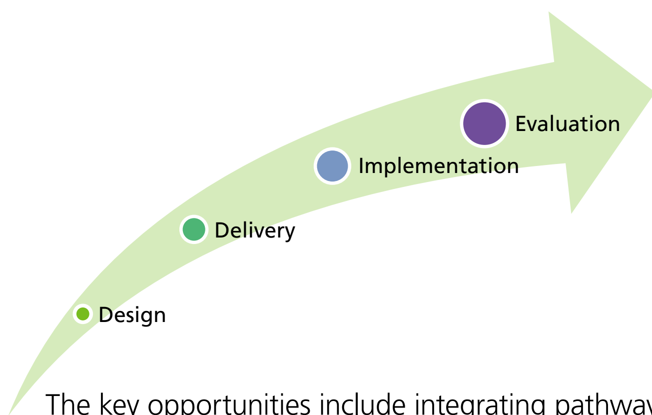
We will systematically redesign the way care is delivered in our system by reorganising care pathways and delivery systems to deliver right care, in the right place, at the right time. We will build on the strong foundations of the Clinical Programme Approach, strengthening it with a new systems leadership model enabled by our STP to deliver truly integrated pathways. The approach will utilise improvement science, learning from programmes already reaching implementation (Cancer, Eye Health and MSK) and embedding a pro-active approach to preventing disease, diagnosing earlier and treating and managing the condition from its early stages. We will apply this thinking across all our programme areas, for example the Children's Clinical Programme Group are focussed on a shift to prevention over a range of areas including promoting resilience and good emotional wellbeing through an earlier identification and support of mental health needs. In the first year of our STP, pathway work in respiratory and dementia will provide a test bed for delivery of truly integrated pathways across our system supported through these principles:

- Resources, including staff, will be aligned to optimum pathways of care reducing duplication and inefficiency. Through this approach the system will work towards upper decile efficiency as benchmarked through the Right Care approach
- Pathways of care will be designed to maximise delivery locally, (utilising the full range of assets in a community, including technology) reducing the dependency on hospital based care, and reducing costs in the system overall
- Clinical teams will feel empowered to change services to make the best use of available resources, working with an agreed integrated clinical governance model
- Patients, carers and the public meaningfully involved using co-production methodology where appropriate in the whole pathway design
- Delivering Parity of Esteem through delivering the Mental Health 5 Year Forward View

We will test out an additional focus on 'Designing for Delivery', designing and agreeing the supportive governance and funding arrangements between organisations that will support rather than frustrate the delivery of an integrated pathway model.

The learning and evaluation from Respiratory and Dementia within our STP framework will be rapidly evaluated and scaled up to other pathways across our priority programme areas of circulatory disease, conditions impacting on Mental Health, End of Life and Diabetes.

> "We are looking forward to working more closely with our partners in the county to provide more person centred care for people with dementia. Dementia is more common in older people, who often have co-morbid physical health conditions. Their dementia can make their physical health conditions worse, and vice versa. It's important that we provide a holistic approach to mind and body and that our services wrap around the person, rather than them moving between services themselves. Dementia is everyone's business and we are keen to ensure that all of our services are working together to provide the best service for people with dementia and their families"
>
> *Dr Martin Ansell, Consultant Psychiatrist for Older People and Clinical Director for Older People's Services at ²gether NHS Foundation Trust*



Where pathways interface with other commissioners including specialist commissioning, we will work with them to ensure an integrated approach that works across commissioning boundaries with the patient at the centre. Our early engagement with the Specialised Commissioning team clearly identifies important opportunities for improvement in a number of pathways but in particular Children and Adolescent Mental Health Service, Forensic and Secure, Trauma, Cancer and Chemotherapy, Neurosurgery/Rehabilitation, and Cardiovascular.

The key opportunities include integrating pathways, developing local service alternatives and helping to crystallise opportunities for consolidation as part of reconfiguration plans. As outlined in the first part of Chapter 2, our system would like support from NHS England to progress the collaborative commissioning process and set out plans for a delegated commissioning approach to develop through 2017/18 and 2018/19. The working assumption is that any released efficiencies arising from pathway redesign of specialist pathways would be reinvested in the local system for the benefit of patients in Gloucestershire. We have agreed as local STP partners to focus on the cancer programme and during 2017 will scope how a co-commissioning approach can deliver greater service improvement.

Where clinical programme design infers that local services would be better supported as part of wider clinical networks we will engage with these networks through the clinical programme group. This is the model we have used through existing programmes, for example the Cancer Clinical Programme Group which provides our connection to the specialist cancer clinical network groups and is now an active member of our local Cancer Network, delivering the national strategy Achieving World Class Cancer Outcomes.

Development of Children and Maternity Services

Giving birth is a special time for all women and their families and although there are 6000 births per year each one is uniquely important. In recent years significant progress has been made to improve the quality and safety of services, as well improving choice for women and their overall experience.

During 2016/17 the Gloucestershire Health Community has focussed on delivering the commitments set out in Gloucestershire's 'Future in Mind' Strategy, progressing the response to gaps identified in perinatal mental health care and improvements in paediatric continence and autism pathways. Work is ongoing to review the support available to children who are frequently admitted to hospital and the steps to tackle reducing emergency admission rates for common conditions such as gastroenteritis in children under 1 and lower respiratory tract infections for children under 5.

Improving the experience of our maternity services and the findings of the National Maternity Services Review: Better Births (2016) continue to be key drivers in our approach to improving maternity services in Gloucestershire. Our resulting action plan has seen the revised pathway for unscheduled care for maternity services and highlighted postnatal care as a key area of focus for improvement locally.

By 2017 we will have:

- Implemented a new MSK model for Gloucestershire with clear pathways across our system across primary and secondary care
- Delivered a step change in cancer pathways with a new community based survivorship model in place and a rigorous and innovative approach to cancer case audit reviews in partnership with the Royal College of General Practitioners
- Completed the implementation for our Eye Health Clinical Programme including delivery of new community Eye Health Services
- Through our new STP ways of working we will develop and implement new pathways for Respiratory and Dementia across our system
- Continue to implement the action plan associated with the Better Births Report (2016) to include:
    - Work with women, families and stakeholders to improve postnatal care
    - Develop community hubs and integrating better together services that support women and families in the early years including health visiting and children's services.

- Implement the action plan relating to Saving Babies Lives, aiming to reduce stillbirths via smoking cessation and monitoring movements and growth of babies.
- Continue to develop and implement different ways of engaging women and families in diverse communities in conjunction with Health watch and GHNHSFT through social media and other means.
- Work with public health and the new Healthy Lifestyles service to embed pathways of support for women to improve their health and wellbeing.

- Develop an integrated specialist perinatal health service comprising of specialist maternity, infant and adult mental health knowledge and support to ensure that women and families with complex mental health needs consistently receive robust specialist assessment, multiagency planning and support. This will include a skilled workforce that is trained to be able to support women, an increased range of community support options and the development of an anti-stigma campaign.
- Fully implement the paediatric continence action plan to ensure that children's continence issues are detected as early as possible, with children being supported in the community where possible to ensure the best experience and outcomes.
- Continue to improve transition for young people with long term conditions to ensure that the Ready, Steady, Go Programme is fully embedded.

By 2021 we will have:

- Systematically reviewed key programmes of care across our system, implementing new pathways based on best practice evidence ensuring right care, right place, right time and that patients are offered choice of provider where appropriate
- Improved our elective and urgent care Standardised Admission Ratios (SARs) to ensure we are at or below benchmarks

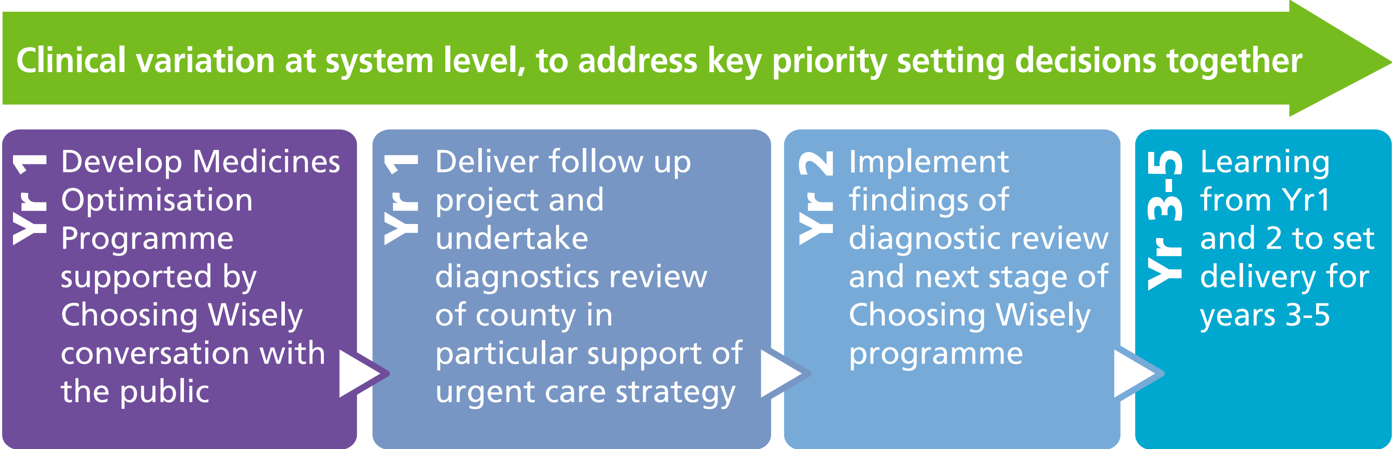
"There have been huge changes over the past few years within the Gloucestershire Health Community. There has been a growing demand on health care resources due to the increased prevalence of chronic diseases and a resulting unsustainable pressure upon emergency care in our hospitals. These pressures have resulted in various initiatives by the different health care providers to deliver more sustainable alternatives to the traditional health care model. Whilst these services have often been of high quality they have resulted in a degree of duplication and fragmentation of care. We now need to blur the organisational divides and refocus on patients in order to utilise all of these resources more efficiently and effectively. Patients require that our services work as seamlessly as possible and that care along the clinical pathway is integrated. Our ambition is to develop integrated specialist teams that provide multidisciplinary specialist skills to patients from the home to the hospital and to support pathways from prevention, early diagnosis and through to emergency and palliative care."

Dr Andrew White, Consultant in Thoracic Medicine at Gloucestershire Hospitals NHS Foundation Trust

2.4 Reducing Clinical Variation

Programme Leader: Paul Jennings

Reducing Clinical Variation – We will elevate key issues of clinical variation to the system level and have a new joined up conversation with the public around some of the harder priority decisions we will need to make. We will continue to build on our variation approach with primary care, deliver a step change in variation in **outpatient follow up care** and promote a **'Choosing Wisely for Gloucestershire' and Medicines Optimisation** approach, and undertake a **Diagnostics Review**. This programme will set the dial for our system to close the **Care and Quality Gap.**



Clinical variation is an issue that spans all aspects of care. In year one, we will continue to work on variation in primary care, learning from delivery to date, and will focus as a system on a shared Medicines Optimisation programme, reducing variation in outpatient follow up care and commissioning a review of our diagnostics utilisation to inform a programme of work to start in 2017/18. Our Outpatient Follow Up Project is already underway and set to deliver significant movement back towards upper quartile benchmark position in 2017.

In 2016/17 we will commission a review to understand the use of diagnostics across our system. We believe there is currently significant variation in the use of diagnostics and that a more innovative approach to diagnostics provision can provide essential support to our urgent care service redesign.

In terms of Medicines Optimisation we know that medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and technological challenge it is crucial that patients get the best quality outcomes from medicines. However, there is a growing body of evidence that shows there is an urgent need to get the fundamentals of medicines use right and that medicines use today is too often sub-optimal. Medicines Optimisation represents a patient-focused approach to getting the best from investment in and use of medicines that requires a holistic approach, an enhanced level of patient centred professionalism, and partnership between clinical professionals and patients. Medicines Optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety.[3]

3 Royal Pharmaceutical Society, Medicines Optimisation: Helping Patients make the most of their Medicines

We will take a joined up approach in our county to Medicines Optimisation and will support it with a programme embracing the principles described in the Choosing Wisely approach. Choosing Wisely aims to promote conversations between clinicians and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm and truly necessary. We will have a new conversation with the public to help patients engage their clinicians in these conversations and empower them to ask questions about what tests and procedures are right for them.

We will also work with our population to minimise waste of medicines and other medical supplies, and prioritise treatments that provide the most potential benefit per pound. We know that this will mean we need to make some difficult choices. One of our first changes has been to re-appraise the approach that we are taking to prescriptions for food items, and we intend to set a new approach for the commissioning of Gluten Free food and sip feeds this autumn. We will also need to look carefully at a number of other areas that are being considered across the NHS in England, including prescriptions for basic over the counter medicines and approach to issuing repeat prescriptions, where we could prioritise this funding to other treatments where there is a higher level of need.

One of our first year priorities will be to develop a new and innovative medicines optimisation approach for patients living with pain, considering the role of pharmaceutical interventions, the pathway of care and new ways to provide alternative and holistic support to this often complex group of people. This approach will be informed by a pilot we have delivered as part of our Cultural Commissioning Programme in 2015/16 for men living with chronic pain.

Our system is currently in the process of strengthening the number of Clinical Pharmacists working with our local GP practices. The CCG successfully applied to NHSE three year Clinical Pharmacist Pilot and has Clinical Pharmacists working in five practices. A number of other GP practices have employed Clinical Pharmacists to widen the degree of skill mix within their general practice we are supporting the continued development of Clinical Pharmacists by supporting structured independent prescribing training to appropriate Pharmacists.

By 2017 we will have:

- Evaluated the learning from our approach to managing variation in primary care
- Designed and started to implement a joint Medicines Optimisation Programme
- Started our new conversation about Choosing Wisely with the public in Gloucestershire
- Commissioned an independent review of diagnostics provision
- Developed and delivered an innovative pain pathway across our system

By 2021 we will have:

- Developed a new culture and approach to Medicines Optimisation in Gloucestershire, delivering significantly improved patient outcomes and ensuring an efficient use of resources (measured by benchmarked position as per right care)
- Implemented a new diagnostics model for Gloucestershire based on the findings from our review
- Implemented a step change in rates of follow up care
- Considered a review of other areas of clinical variation, such as Pathology

“Maximising the effectiveness and getting best value for each ‘Gloucestershire Pound’ is essential for all our services which spend public money. Making our money go as far as possible is something we all take for granted in our everyday lives. This ‘Choosing Wisely’ approach must of course be fair, transparent and have a wide level of agreement that this is the right thing to do. We must all try to ‘Choose Wisely’ in our personal decision making and in shared informed decisions with health and care providers and in a spirit of common purpose and shared values make sure that we are all contributing to squeezing the best value out of our inevitably limited resources. This will not always be easy to accept and not always getting all we want, in order that others with more opportunity to benefit can have, will be inevitable and sometimes hard to take but if we can achieve the right trust, transparency and fair processes we can stretch every pound much further and together achieve the best affordable results and outcomes for all the people of Gloucestershire’.”

Dr Charles Buckley, Frampton Surgery

Chapter 3: Our System Development Programme

As a group of health and social care partners we have worked together to develop a shared **System Development Programme** to ensure our system is in good shape to deliver against the challenging agenda set out in this plan.

3.1 Organisational Development

Programme Leader: Shaun Clee

In order to successfully deliver our Sustainability and Transformation Plan we need to develop the right culture within and across our organisations and invest in skills and leadership to support people to work in new ways across the system. We want people who work for us to adopt the values and behaviours agreed by the system and we are committed to developing our senior leaders to model and cascade these and are working together as a community to take this forward. We have established an Organisational Development (OD) and Workforce Strategy Group as part of our STP governance which is made up of representatives of our STP partners. This group has developed a work programme with a focus on Culture, Capability and Capacity. This work programme is an annex to this STP. Please see Annex C.

By 2017 we will have:

- Confirmed the values we want to work to as a system and align our organisational strategies to the vision and these values
- Agreed a model for distributed leadership which supports people to lead our 12 STP priorities across the system
- Developed a leadership network across our footprint and train 100 leaders in the values to be role models within their organisations
- Trained 300 staff in service improvement and change management skills

By 2021 we will have:

- Introduced 500 shared and rotating clinical roles to support our new models of care
- Agreed and embedded the One Gloucestershire culture as evidenced in staff survey results
- Made key decisions about the shape our system needs to take to support our new models of care and made the transition from organisation to system development

3.2 Quality Academy

Programme Leaders: Deborah Lee, Shaun Clee

We are working to develop **a system wide approach to quality and service improvement** through the development of a countywide quality academy. Gloucestershire STP partners already have a good foundation of capability and capacity for service redesign, quality improvement and innovation to build upon. We are engaging with the West of England Academic Health Science Network and the national NHS Quality Service Improvement & Redesign (QSIR) College to ensure application of the latest thinking, application in practices and education materials. We plan to commence system wide learning programmes from Autumn 2016. We plan that participants of our Quality Academy will be able to access a range of support including coaching, access to on-line resources (e.g. local case studies) and action learning sets. We believe that investment in creating a system wide approach will support us to deliver our transformational goals. We will develop and include a new approach to building improvement capability in primary care to ensure we support primary care to make the transition needed to work as a central part of our New Models of Care.

By 2017 we will have:

- Developed and launched a collaborative system wide academy with a curriculum designed to meet the needs of system-wide transformation and quality improvement
- Scheduled programmes to meet the needs of teams responsible for the delivery of STP strategic priorities
- Trained approximately 200 key service improvers, with a further 200 trained each year
- Built on our case reviews to inform improvements in pathways and discharge

By 2021 we will have:

- Embedded our approach systematically across the Gloucestershire System to enable exceptional joined up working across partner organisations and effective delivery of transformation goals

3.3 STP Programme Development and Governance Models

Programme Leaders: Mary Hutton, Paul Jennings

Whilst our STP in Gloucestershire has evolved from our work together as a system, we have laid out a significant challenge in this STP. The priorities have been developed through sustained work with system partners, clinicians and through stakeholder engagement events to inform our plan development and we have a programme of work to support the development of the STP programme architecture. This includes the development of a shared Communications and Engagement plan, Finance and Resources Plan and Performance reporting across all of our delivery programmes.

To support plan delivery, we are developing a Memorandum of Understanding (MOU) to cover the STP, with detailed schedules to support the four main programmes of Enabling Active Communities, Clinical Programme Approach, Reducing Clinical Variation and One Place, One Budget, One System. The MOU will incorporate the Kings Fund 10 overarching principles for integration. It will set out the way we have agreed to work together across our system, confirming our approach to sharing of risk, information sharing and governance and clinical governance in support of integrated working.

By 2017 we will have:

- A system wide Sustainability and Transformation Plan developed with delivery co-ordinated through agreed governance structures
- Agreed a Memorandum of Understanding (MOU) that supports the new STP collaboration approach and through this ensure a joined up approach to managing resources, risks and engagement across our STP priorities

By 2021 we will have:

- A 'One Gloucestershire' approval through our commitment to reducing the 3 gaps collectively and delivery of this plan
- Supported our system to work together to ensure success of our programmes

Chapter 4: Our System Enablers:

4.1 Joint IT Strategy

Programme Leader: Shaun Clee

We have a shared approach to developing a Digital Road Map and have developed a **Local Digital Roadmap Footprint** (Gloucestershire) aligned to our STP boundary. We will digitally enable people to support their care, support staff in the adoption of new technologies, utilise data to support commissioning and work towards becoming a paper free NHS by 2020. As a system we have a shared records implementation plan**: Joining up Your Information** (JUYI). This will enable those involved in the delivery of urgent care services to be able to see all records held about a patient in the County in 2017/18. The ability to share information across professionals and organisations is fundamental to supporting the effective delivery of our new models of care. It will improve the quality of clinical decision making and support the development of electronic care plans. We are committed to using technology to support more efficient working e.g. through roll out of Electronic Prescribing and E-rostering. We also see the use of technology as pivotal to supporting our self-care agenda and we are working with the ASHN test bed to evaluate the use of apps in our clinical pathways. We have established a Joint IT Strategy Group to take this work forward and the LDR roadmap/strategy is available on request as Annex F.

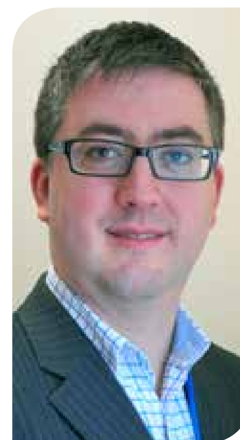
By 2017 we will have:

- Introduced a public facing directory of services to support people to understand local pathways and support opportunities in their communities
- Delivered Joining Up Your Information (JUYI)
- Created a pool of decision support tools for use at the point of delivery/care

By 2021 we will have:

- Become a paper free NHS
- Enabled clinicians across the county to see relevant information about patients at any point of contact

> “Over the last decade new Technologies have changed the care we can offer. Now it is time to bring the Information about you together from our separate systems to provide the right care at the right time.”
>
> *Dr Paul Atkinson, Chief Clinical Information Officer, CCG*



4.2 Primary Care Strategy

Programme Leader: Dr Andy Seymour

Developing a resilient primary care sector that supports our goal of delivering joined up care closer to home will be key to our success in Gloucestershire. Our Primary Care Strategy (available on request as Annex H) sets out how we will support the primary care workforce and infrastructure, offer patients increased access, and how primary care will develop to work more collaboratively at scale. Primary care is a central component in our plans for joined up care and care co-ordination as set out in section 2.2 of this plan.

By 2017 we will have:

- Offered 5,000 additional appointments per month across primary care through our Choice Plus scheme and our new integrated urgent care model
- Ensured 10% of patients are actively accessing primary care services online or through apps
- Invested £1.2 million in General Practice sustainability and transformation plans
- Practices starting to collaborate to deliver primary care at scale

By 2021 we will have:

- Delivered 35 additional pharmacists qualified as prescribers working in practices, 65 additional GPs and 45 whole time equivalent advanced/specialist nurses, supported by our retention and return to practice programme
- Ensured a minimum of 95% patients are able to access digital primary care services, online or through apps

- Ensured 100% population has access to weekend/evening routine GP appointments
- Achieved Good or Outstanding ratings from CQC for all 81 of our practices
- Delivered, as a minimum, the eleven key strategic primary care practice developments as prioritised by our six facet survey
- Practices collaborating in 30,000+ patient population units, delivering place-based, integrated, provision for the population they serve

> "We are serious about change, not for the sake of change, but in order to deliver a sustainable, high quality primary care service in to the future. It's what we as clinicians want to see and what our patients need. Whether it's tackling the workforce challenge, reducing bureaucracy or supporting new ways of working in, and across practices, we are determined to do what we can locally."
>
> *Dr Andy Seymour, Heathville Medical Practice*

4.3 Joint Estates Strategy

Programme Leader: Peter Bungard

Partners within Gloucestershire, including the County and District Councils, Police, Fire Service, Ambulance Service, Gloucestershire NHS Foundation Trust, Gloucestershire Care Services and the ²Gether Trust have set up a 'One Gloucestershire Estates' initiative. This group has mapped information on all assets held by all organisations as well as collecting and sharing capacity and usage data. Many opportunities have already been taken to rationalise land and buildings as well as implementing some colocation models/public sector hubs. It continues to identify further opportunities to better utilise public sector assets across the wider estate within the county. More specifically, the CCG has approved a Primary Care Infrastructure Plan (Available on request as Annex G) for the period 2016/ 2021 setting out key priorities for investment in GP surgeries to deliver new models of care. The STP now provides the catalyst, in conjunction with the wider strategic plan, for taking this strategy forward to meet the following ambitions:

- Enhance the patients' experience;
- Provide staff excellent facilities to work in;
- Use the existing estate more effectively;
- Reduce running and holding costs;
- Reconfigure the estate to better meet population needs;
- Share property (particularly with social care and the wider public sector);
- Dispose of surplus estate to generate capital receipts for reinvestment;
- Ensure effective future investment.

By 2017 we will have:

- Identified and implemented quick wins within the existing estate
- A strategy in place for optimum configuration of wider Gloucestershire estate
- New development with identified benefits and return on investment providing value for money
- Clear service delivery strategies linked to estate provision

By 2021 we will have:

- Implemented joint strategic estates strategy
- Disposed of all surplus assets
- Place based service delivery achieved with strategic partners
- Clear flexible working arrangements in place supported by optimised space and IT provision

4.4 Joint Workforce Strategy

Programme Leader: Shaun Clee

As part of our Joint OD and Workforce Programme we are working with partners across our footprint to understand our current workforce, address key gaps and support the development of the workforce we need to deliver 7 day working commitments and our new models of care. Our 3 priorities are:

- Developing a sustainable primary care workforce
- Developing a sustainable nursing and Allied Health Professions (AHP) workforce
- Ensuring that our workforce has the skills to work effectively within new models of care and to work collaboratively to meet the three Five Year Forward View gaps

We are actively supporting the development of new roles to help us to bridge our workforce gaps, to widen access to the healthcare professions and respond to national directions. Our expectation is that whilst workforce numbers will broadly stay level, the skill mix within our staff profile will change to match new healthcare models and current availability gaps in key professions. We are pursuing innovative developments including proposals to explore the concept of having a University Technical College, wider provision for registered nurse education in the county and working with our Local Economic Partnership to develop a collective approach with local schools and colleges. We are committed to developing a single Gloucestershire branding for health and care recruitment so that we can attract people to live and work within our diverse county. We are working to understand opportunities for greater productivity and efficiency within our workforce by reducing agency spend and introducing supportive technology. Our key challenge is to further develop our future workforce projections and to anticipate the roles and skill mix we need in the future and to support our financial gap. We are working closely with the new care models programme and the pilots within our STP to understand how we need to adapt our current projections to meet these needs. The OD and Workforce action plan is included at Annex C.

By 2017 we will have:

- Developed a single Gloucestershire branding to support our health and care recruitment in the county
- Refined and developed our workforce projections for 2020
- Supported the development of nurse associates as part of the Rapid Follower Wave
- Supported 400 staff with CPD masterclasses that support our STP goals

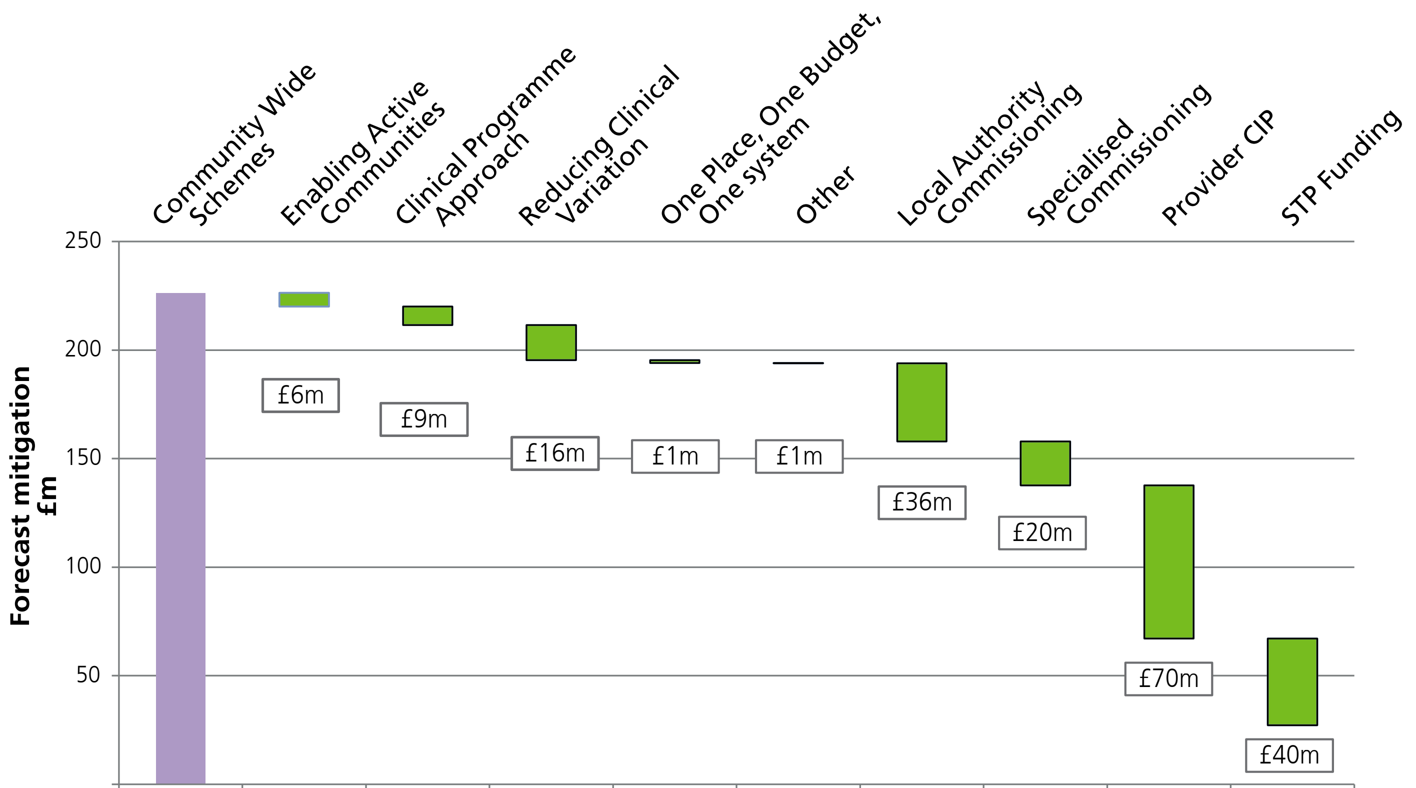
By 2021:

- Introduced a range of new and different approaches to education and learning that is unique to Gloucestershire and supports the increased number of healthcare staff becoming registered progression i.e. nursing.
- Trained 2,000 staff in health coaching, supportive technology and healthy lifestyles
- Delivered the 7 day working standards
- Achieved further integration of 'back office' functions across our system
- Achieved a reduction in agency and temporary staff costs and a joined up approach to workforce capacity management across all partners.

Chapter 5: Impact of Change

5.1 Financial impact

In 2016/17 the Gloucestershire STP footprint has faced some financial challenges, with an emergent deficit at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) impacting on the starting position for our STP plan. . The scale of the challenge for our system is significant as outlined in the previous section. System benchmarking has indicated the headline savings opportunities for each of our programmes; these are set out below for information:



Gloucestershire STP: Opportunities to address 2020/21 residual gap:

The system is committed to owning and working together to deliver these savings. There will inevitably be **additional costs inherent in delivering change**, not just in terms of costs to support new ways of working as they develop but also in terms of the capacity needed to design and deliver at scale and pace.

Allocative	*Allocative efficiency:* is about whether to do something, or how much of it to do, rather than how to do it. Allocative efficiency in health care is achieved when it is not possible to increase the overall benefits produced by the health system by reallocating resources between programmes of care
Technical	*Technical efficiency:* is about maximising the output that the system gets from given quantities of inputs and is linked to the concept of cost effectiveness. The combination of technically efficient inputs that minimises the cost of achieving a given level of service is that which is cost effective
Structural	*Structural efficiency:* is a component of technical efficiency and is concerned with ensuring the most efficient use of our fixed assets and overheads

Further Detail of Programme Level Savings:

Type of Scheme	Area	Summary of Opportunity	£m in bridge
Allocative	Enabling Active Communities	Opportunities to reduce overall demand through investing in a range of interventions identified as best practice in health prevention and self-care. These areas should lead to a lower incidence of long term conditions. Demand reduction is lower in the first five years and increases over the longer term. The opportunities have been developed using evidence from a number of sources including NICE and Public Health England.	20
Allocative	Clinical Programme Approach (CPA)	Analysis of Benchmarking data for Gloucestershire system shows opportunities of £30m if we get to Upper Quartile performance and a further £10m if we can get to 'Upper Decile' efficiency compared to similar counties.	20
Technical	Reducing Clinical Variation	Medicines Optimisation and management benchmarking has shown that moving to Peer Upper Quartile performance will save the system £20m. Opportunities have also been identified in diagnostics, pathology, variation in care setting and in primary care practice, these are estimated to be able to deliver c£8m.	21.7
Structural	One Place, One Budget, One System	Analysis of the urgent care standardised admissions ratio shows that getting to Upper Quartile performance compared to peer group would save £10m. (n.b. some of these opportunities may need to be delivered through the Reducing Clinical Variation or Clinical Programme Approach strands once further analysis identifies the changes required).	9.5
Structural	Joint IM&T Strategy	Service changes associated with a number of IM&T developments including enabling care professionals to see a patient's record, thus reducing duplication, saving time, use of apps by patients and care professionals, digital appointments etc.	5
Structural	Primary Care Strategy	Reduction in secondary care demand through better ways of working within primary care itself enabled by changes to premises and supporting infrastructure.	1
Structural	Estates Strategy	Countywide estates usage is being reviewed to look at consolidating into fewer locations, centralising any non-frontline services and reviewing numbers of locations that services are provided from.	3
Technical	Joint Workforce Strategy	Opportunity for a reduction in agency and temporary staff costs, different ways of working, development of different types of role. Facilitated by a joint leadership and cultural change programme and a joint approach to recruitment and induction.	5
Technical and Structural	Other	Review of corporate and other functions across the county, opportunity for more integration of "back office" functions across the system.	6
Allocative	Local Authority Schemes	GCC – Social Care Plan – the Local Authority is operating and further developing plans for preventative interventions and system changes that should reduce demand for adult social care. It also has plans in place to manage the public health spend in line with funding.	36
Allocative	Specialist Commissioning	Range of schemes identified by specialist commissioning (to be assigned to key programmes once further detail known).	20

Technical	Other	The Carter Review has identified £21.2m of opportunity across the next 5 years for Gloucestershire Hospital NHS Foundation Trust which is built into the Trust's cost improvement plans (CIP). Opportunities will be explored by the other provider Trusts to see what can be carried across to their individual Cost Improvement Programmes (CIP). Opportunities have also been identified through the reconfiguration of services within the acute hospital, however, delivery of these is dependent on capital availability to enable these changes. The Community and Mental Health Providers are both active in reference cost and other bench marking analysis with both of them benchmarking favourably in the 2014/15 comparisons. Nonetheless, they are both targeting areas where they are high in benchmarking and also identifying opportunities where there is variation in cost / contact in different localities within the Trust to ensure the provision of cost effective services.	52

Proposed Investments in Transformational Change:

Our current assumptions set out in the financial templates supplied to NHS England currently assume that headroom is delivered at footprint level each year. If agreement is reached to deploy commissioner headroom as set out below, then as a system, we will be able to invest this non-recurrently in our transformational programmes; which will offer the opportunity to move faster towards delivering system sustainability.

Source Of Funds	Detail	%age
Headroom 2017/18 and 2018/19	50% will be planned to be spent non recurrently funding to pump prime transformation. 50% will be uncommitted at the start of the financial year and will be utilised according to national business rules.	1% CCG allocation

Capital

Source Of Funds	Detail	£m
National capital	GHNHSFT – Estimated capital investment in new models of care for Gloucestershire Hospitals Trust (will be revised following outputs of public engagement and subsequent consultation)	c. £70m
National capital, ETTF bids, 3rd party developer capital	Primary care estate – In line with primary care estates strategy, development of a fit for purpose primary care estate to enable delivery primary care of primary care in accordance with the primary care forward view	£33m
National capital, ETTF bids	Local Digital Roadmap – Funding to resource investment required to deliver the IM&T capabilities required within Gloucestershire to support the STP	£13.3m
National capital, other Trust capital	Development of Community Infrastructure – estimate will be revised following output of public engagement and consultation	c.£14.5m

We will create a cross organisational project team to support delivery of our financial savings programme across the lifespan of the STP.

5.2 Delivery Impact

The table below provides an overview of high level outcome metrics by programme and initiatives identified to demonstrate the impact of delivering our STP. This list is not exhaustive and each programme will have a further set of measures it is accountable for developing and monitoring. These are available within the specific programme plans which will demonstrate impact on a range of health and care metrics relating back to the areas we wish to improve as indicated in our '3 gaps' analysis. Our assessment of the impact of each programme on the Finance and Efficiency Gap is referenced in section 5.1. Our enablers are not included in this table as more detailed plans regarding enabling programmes is available in the attached annexes.

Programmes	Health and Wellbeing Gap Indicators linked to programmes	Care and Quality Gap Indicators linked to programmes
Enabling Active Communities - Self Care and Prevention Plan	• Move to 'top decile' for percentage of over 16 year olds classified as physically inactive • Move from 'about average' detection rates for asthma, hypertension and CHD to 'top decile' • Increasing participation by men in weight management programmes so that they are equivalent to women	• Maintain 'top performing status' for how well supported people with a long-term condition report feeling to self- manage their conditions • Maintain 'top performing' quality of life of carers as measured by the health status score (EQ5D) • Maintain 'top performing' status for number of smokers who have still quit after 4 weeks • Maintain 'top performing' status for number of pregnant women smoking at time of delivery
One Place, One Budget, One System	• Standardised Admission Ratio at or below 90 • Move from 'above average' to 'top decile' for unplanned hospitalisation for chronic ambulatory care sensitive conditions • Move from 'below average' to 'top decile' for asthma emergency admission rates • Move from 'above average' to 'top decile' for emergency admissions for acute conditions that would not normally require hospitalisation	• Achievement of the 4 hours A & E waiting time target • Achievement of 8 and 19 minute ambulance waiting time targets

Clinical Programme Approach	• Maintain 'top performing' status for number of deaths in hospital (less is better) • Achieve top decile performance for diabetes prevalence in over 17s • Achieve SSNAP targets for stroke patients to access to a stroke unit in 4 hours and thrombolysis • Achieve top decile performance for premature mortality from respiratory conditions • Move from 'above average' to 'top quartile' performance for diabetes patients that have achieved all NICE recommended treatment targets • Significantly improve one-year survival to achieve 75% by 2020 for all cancers combined	• NHS Constitution compliant delivery across all pathways • Achievement of Improving Access to Psychological Therapies access targets • Achievement of dementia diagnosis targets • Move from 'below average' to 'top quartile' for proportion of asthma patients with annual reviews • Move to top quartile performance for Patient Reported Outcome Measures (PROM) for hip and knee replacement • Maintain and improve upon 'above average' performance to top quartile for people with diabetes diagnosed less than a year who attend a structured education course • To increase the proportion of cancers diagnosed at Stage 1 or 2 by 2020 to 62%
Reducing Clinical Variation	• Top decile performance of GCCG against metrics on the Medicines Optimisation Dashboard (NHS England) • Continue to add new pathways to G-Care website and monitor usage focusing in the first instance on pathways for gastroenterology, gynaecology, neurology, urology, ENT and dermatology.	• Adherence to NICE 'Do Not Do' recommendations • Implement findings of local review of Practice Variation in Gloucestershire • Impement recommendations of Academy of Medical Royal Colleges Choosing Wisely report

Chapter 6: Implementation

6.1 Communication and Engagement Strategy and Plan

In developing our two phase communications and engagement approach we have drawn upon published national guidance[4], as well as our local experience of what works well in Gloucestershire.

Phase One will support countywide engagement regarding our plans for new ways of working and new models of care. This will build upon our earlier *Joining Up Your Care engagement*[5], when over 2000 local people were involved in shaping our current thinking. Phase One will run through autumn 2016 to early spring 2017.

Phase Two, will support our legal duty[6] to consult with the public regarding more detailed proposals for service change. Phase Two will commence during summer 2017.

For Phase One, we have identified key stakeholders and plan to target our communications and engagement activities in ways to maximise their interest and involvement. We have prepared key messages that are easy to understand for both individuals, staff and partners who are frequently engaged with health and care services, as well as for the wider general population, for whom health and care is not something they think about very often. Our engagement approach in Phase One will include both qualitative and quantitative methods such as facilitated deliberative events, public drop-ins and staff feedback events, Information Bus visits, and online surveys.

Our aim is to ensure we achieve comprehensive engagement, co-production, consultation and communication with local people throughout the life time of the STP. We want everyone who has a view to be able to have their say and know that their voice will be heard and feel confident that the impact of their contribution will be recognised and acknowledged.

Our Sustainability and Transformation Plan (STP) Communication and Engagement Strategy and Plan states that during Phase 1 'Engagement' we will:

- **Establish a calendar of existing events**
- **Establish a calendar of additional events/engagement sessions**
  On publication of the STP in November we will contact 1200+ contacts on our Stakeholder database. This communication will include details of the STP document and STP Short Guide (including questionnaire). The communication will invite stakeholders to let us know if they would like us to meet them to discuss our STP.
- **Capture public interest**
  We will use the STP engagement period to obtain expressions of interest to be involved.

4 https://www.england.nhs.uk/wp-content/uploads/2016/09/engag-local-people-stps.pdf
5 http://www.gloucestershireccg.nhs.uk/wp-content/uploads/2012/03/JUYC-Outcome-of-Engagement-Report-Final-v2.pdf
6 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Calendar of Events (planned to date)

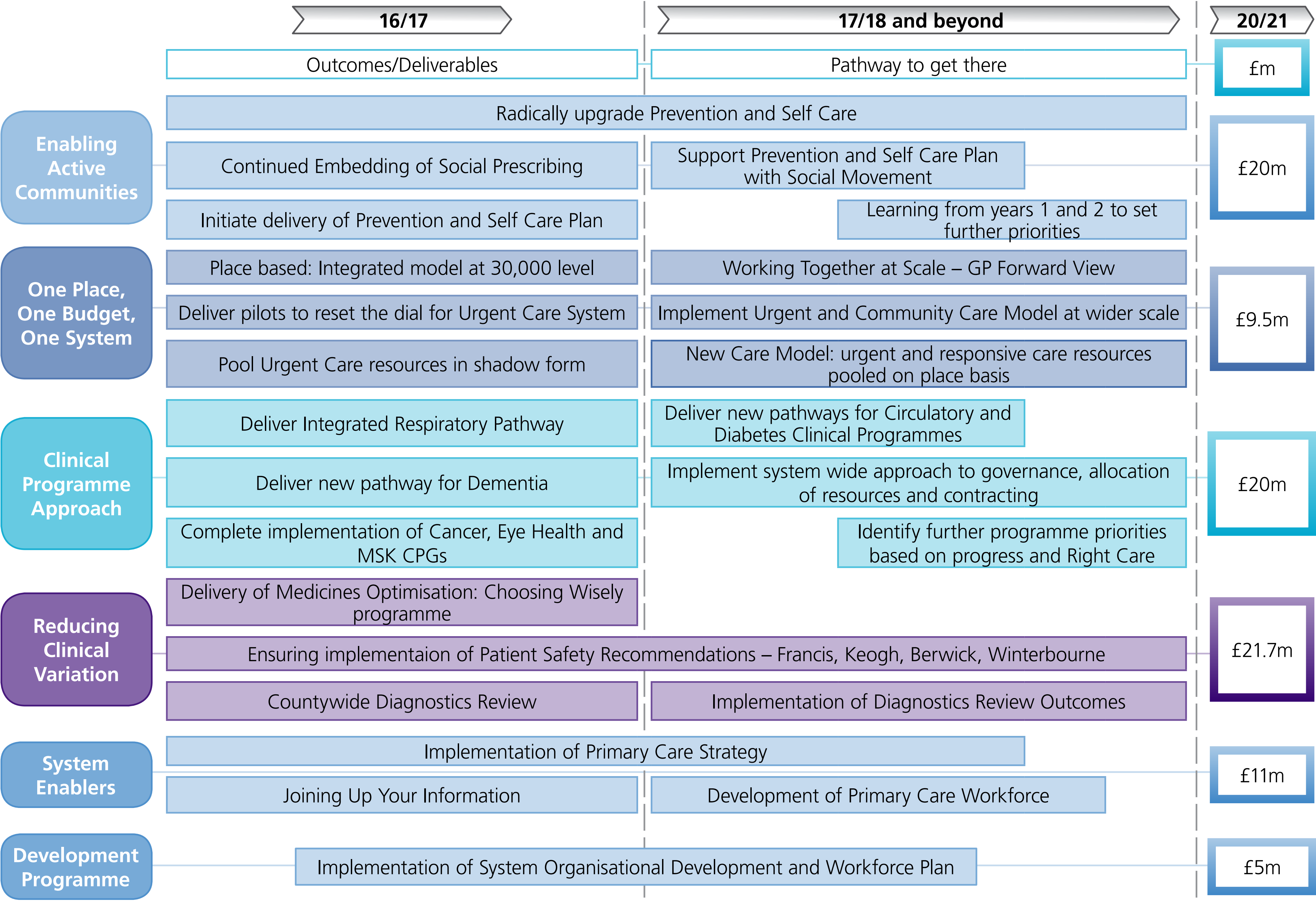
[Further events, including Foundation Trust Member events and Patient Participation Group (PPG) Network are planned for January – February 2017.]

Date (2016)	Event	Activity
27 October	Healthwatch Board Meeting	STP Presentation and testing of STP Short Guide and questionnaire.
3 November	Your Care, your Opinion – Gloucestershire Care Services NHS Trust	Community Partner Event, STP overview presentation, workshops focussing on STP One Place, One Budget, One System
November / December / January / February (venues to be confirmed – across all Localities)	Information Bus	STP Drop Ins /Awareness Raising
15 November	Health & Care Overview and Scrutiny (HCOSC)	STP Presentation
15 November (Cancer) 17 November (Respiratory)	Clinical Programme Groups	STP Clinical programme approach – clinical and lay engagement, awareness raising, discussion
24 November	Voluntary Sector Locality Event	Community Partner Event, STP overview presentation
30 November	B&ME Community Health Event, Friendship Café	Community Partner Event, STP overview presentation
1 December (Diabetes)	Clinical Programme Groups	STP Clinical programme approach – clinical and lay engagement, awareness raising, discussion
6 December	Health and Wellbeing – Voluntary and Community Sector Provider Forum	Community Partner Event, STP overview presentation
6 December (Eye Health)	Clinical Programme Groups	STP Clinical programme approach – clinical and lay engagement, awareness raising, discussion
13 December (Muskulo-Skeletal)	Clinical Programme Groups	STP Clinical programme approach – clinical and lay engagement, awareness raising, discussion
14 December	Community Hospitals League of Friends meeting	Community Partner Event, STP overview presentation
14 December	Stakeholder event	Community Partner event, STP overview presentation, workshops focussing on Urgent Care
15 December	Health & Care Overview and Scrutiny (HCOSC)	STP One Place, One Budget, One System – focus on Urgent Care. Engagement begins on Urgent Care model of care
December / January	Focus groups for: – Place-Based Care – Rehab model – Urgent Care Model of Care	Community Partner Event, STP overview presentation, focus group
June (2017)	HCOSC	Consultation on Urgent Care system model

Survey

We want everyone to be able to have their say and know that their voice will be heard. As well as public Drop Ins a survey, print and online, has been created to collect feedback on our STP: **www.gloucestershireSTP.net**

6.2 Delivery Plan & High Level Timeline



6.3 Delivery Risks

Risk	Risk to System	L x C (inc. RAG)	Comments/Mitigating actions
Capacity and Capability to Deliver	There are considerable resource requirements associated with delivering such large Transformational change. Organisational capacity across the county will have a key impact on the likelihood of success. Clinical leadership and change capabilities will determine likelihood of improvements being sustainable in the long term.	3x3	Complete review of capacity aligned to key programmes and ensure this is reviewed at delivery board, discussion on commitment of resources with CEOs
Reaching a common goal	It has been identified that language, in particular definitions, can be inconsistent across organisations. This may affect the changes of successful collaboration. A common understanding and shared vision is needed going forward.	3x3	Common vision established in core STP plan and supported by programme level plans. All programme documents shared through briefings and sharepoint
Changes in national priorities	Whilst it is unlikely national priorities will move away from the principles outlined in the FYFV, organisations may have to be flexible in their application should the local environment change.	3x3	Programme office to keep watching brief on national policy and advise Delivery Board if change is required
Lack of external stakeholder support for change	Closing the gaps may require redesign of services. Patients and public will be encouraged to participate in all stages of the design to ensure wide and meaningful engagement in line with health and social care act responsibilities.	3x3	Programme Development group to manage duties under health and social care act to ensure smooth passage
Managing short term delivery to ensure longer term success	Identified quick wins and pilot schemes will need to be adopted in the first instance with a clear longer term road map in place to deliver wider scale changes.	3x3	Short term operational delivery must remain a key focus of our system whilst looking to longer term development
Workforce capacity	The system has identified some key workforce gaps that will impact on workforce supply in key roles across our system. Through the STP we will have a new opportunity to pool our knowledge and take a one system approach to developing new roles to fill gaps in essential services.	3x4	Ensure a system-wide understanding of workforce issues to agree shared priorities for action. Workforce plan attached sets out more detailed actions to work together to develop new roles

Supporting Documents and Useful Links

The following appendices to the plan are attached or available separately:

Annex No:	Description:
A	Governance Arrangements
B	Engagement Process
C	Enablers (Local digital roadmap, Estates, Workforce)
D	NHS England Ten Big Questions
E	Plan on a Page summary for each of our programme areas

The following appendices to the plan are available separately:

Annex No:	Description:
F	Local Digital Roadmap
G	Estates plan – Primay care estates plan only as wider plan is still under development
H	Primary Care Strategy
I	Self-Care and Prevention Plan

Annex A: Building and Governing the Plan

A.1 Principles of the Plan

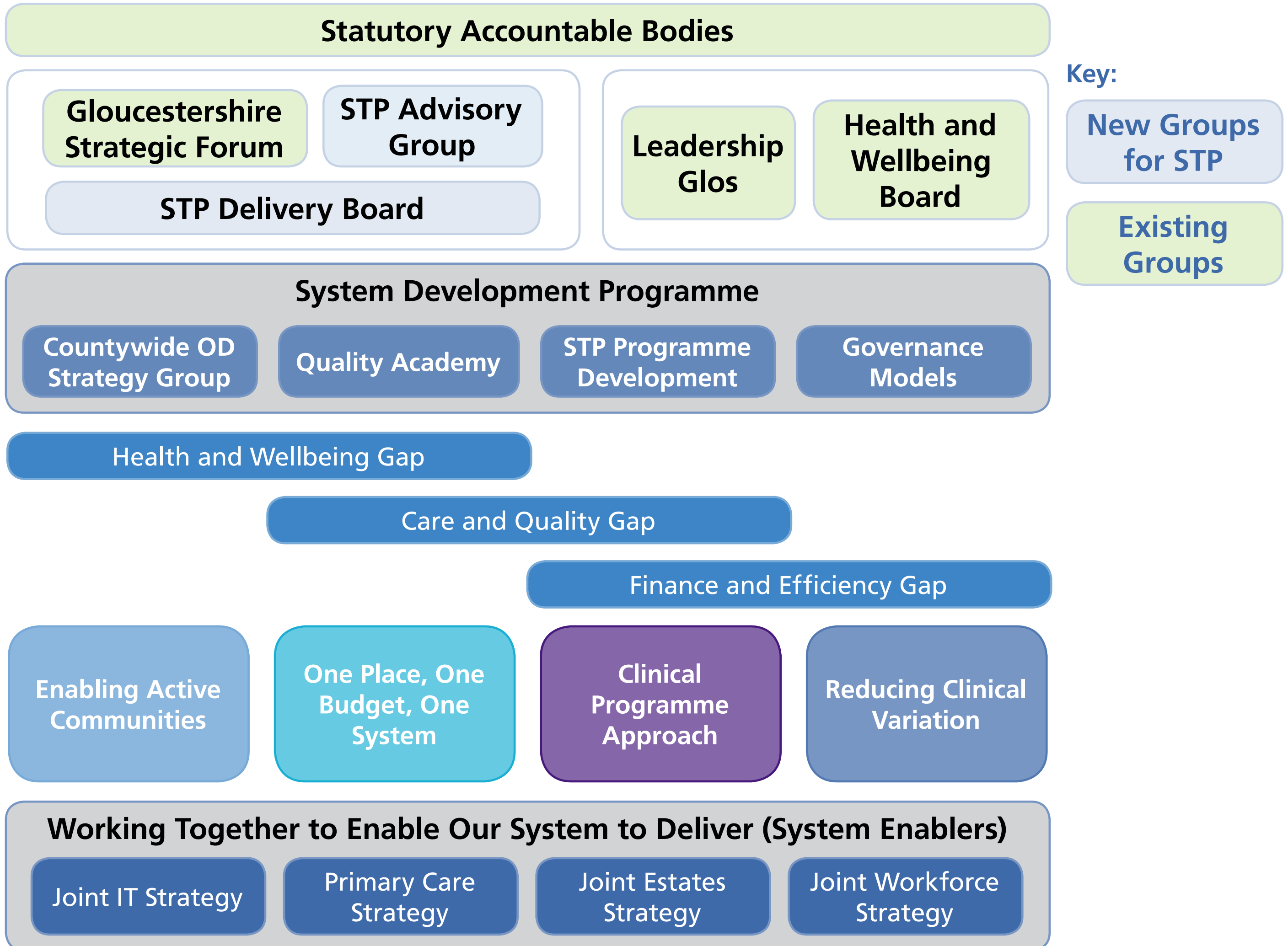
Within the Gloucestershire STP all organisations have agreed to work together on the development of more integrated care for service users, which is underpinned by an Memorandum of Understanding to provide clarity regarding the basis on which the organisations will collaborate with each other.

The principles of collaboration are laid out as:

- Collaborate and co-operate. Organisations will establish and adhere to the governance structure, ensuring that activities are delivered and actions taken as required;
- Be accountable. Organisations will take on, manage and account to each other for performance of their respective roles and responsibilities within the STP;
- Be open. Organisations will communicate openly about major concerns, issues or opportunities relating to the Gloucestershire STP;
- Adhere to statutory requirements and best practice. We will comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation
- Act in a timely manner, recognising the time-critical nature of the Gloucestershire STP and respond accordingly;
- Engage with stakeholders effectively;
- Deploy appropriate resources, ensuring sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities as agreed;
- Act in good faith to support achievement of the Key Objectives and compliance with these Principles.

In addition the MOU details the principles we will work to in addressing the finance and efficiency challenge across the system, as detailed in section 1.5. This framework ensures we have a robust agreement on how Gloucestershire as a system can deliver its STP, within the governance framework detailed overleaf.

A.2 Working Together for Gloucestershire



Annex B: Engaging with our Communities

We are fortunate in Gloucestershire to have been working in our STP footprint (area) for some time and the STP builds on the foundations of our system wide 'Joining up your Care' programme, which was subject to significant patient and public engagement. We expect to develop detailed proposals based on STP priorities for discussion with the public over the course of the year and we will be working on a public guide to the STP this Summer to start to aid conversations.

We consider it to be of the upmost importance that patients and the public are given opportunities to have their say on any future options or proposals for change. Should a future proposal/s be deemed to constitute significant service variation, then the health and social care community is committed to fulfilling its statutory duties with regard to public consultation.

As our STP describes, the future looks particularly challenging and we will need to be innovative and ambitious in how we develop services and use the resources available to us. Prevention of illness, high quality patient care and safety will remain our priorities throughout.

We have developed a Sustainability and Transformation Plan (STP) Communication and Engagement Strategy and Plan. This Communication and Engagement Strategy and Plan has been produced to support the STP development and implementation process and ensure comprehensive and planned engagement and communication with interested parties throughout the life time of the project.

This is a live document – the action plan will be updated to reflect the project plan and the recommendations of the STP Advisory Group and Delivery Board. The purpose of the Strategy and Plan is to:

- Ensure the Communication and Engagement work programme is integrated into the Governance and overall STP programme structure (shared milestones/timelines)
- Ensure robust and sustainable communication arrangements are in place so that all identified audiences are kept up to date with progress (development of the plan and implementation)
- Ensure the approach to Communication and Engagement is system wide – emphasising system wide ownership – both constituent organisations and C&E leads
- Ensure that stakeholder groups are communicated with in the right way and in a timely manner e.g. staff and community partners are aware of developments before other external audiences
- Ensure communication and engagement activity, materials and messages are relevant to each target audience
- Ensure that the STP programme engages with all interested stakeholders – including the seldom heard
- Ensure that key stakeholders know how they can have their say and influence the work of the programme
- Demonstrate and inform stakeholders of the impact that their feedback has made.

Annex C: Enablers

C.1 Workforce Strategy

Gloucestershire Organisational Development and Workforce Delivery Plan

Work streams	Change Activity Required	How?	Outcomes	Delivery Date
1 Embed improvement capability	Shared approach to improvement capability and training delivered to staff across system to support transformational change	Develop joint commissioning skills & resources building on existing arrangements and experience where joint commissioning roles already exist across health and social care Joint transformation/service redesign resources Ensuring embedded improvement capability e.g. through new Continuing Professional Development arrangements – transformation master classes	People have the skills we need to deliver the goals of the STP and feel confident in their ability	October 2016
2 Model for distributed leadership	Develop and describe a shared model for distributed leadership across health and care system, roll out to embed key capabilities	Building on previous work of leadership network will pool thinking between organisations on leadership models, including drawing on work with 'top leaders' programmes. Develop model, agree and then roll out across system	Leaders will feel supported to lead for and across the system. Organisations will collaborate with and support leaders who are assuming these roles	October 2016
3 Build co-production capability with clinicians and carers	Developing shared approach to building co-production capability	Embedding a culture of co-production Health e.g. through coaching to mobilise healthy behaviours and person led care Supporting self-care and prevention agenda – Making Every Contact Count, common e-learning module across Gloucestershire for healthy lifestyles	Patients are motivated to self-care and feel supported to make healthy choices. Improved patient experience and satisfaction. Increased patient activation Staff provide brief interventions to patients and individuals that lead to healthy living	January 2017
4 Enable the workforce in key skills (IM&T)	Define training needs analysis and address gaps taking account of new models of care	IT enabled workforce –use of technology to support remote monitoring across health and care (telehealth and telecare training in domcare/ care homes/ practices/ community nursing). Personal Digital Assistant devices to enable carers and other workers to maximise time spent with patients.	Patients feel confident in using technology to help manage their conditions Staff feel equipped to use technology and integrate this into their working practice	December 2018
	Provide Mutual support and learning opportunities using opportunities in our system	Offering training support within the health and social care community. Develop a training passport for the county	We adopt best practice within the economy and reduce the cost of outsourcing training	September 2017

	Creating one system	DBS clearance to follow individual Assess other elements of HR/recruitment practice that can be shared. Develop integrated health and social care pathways – including leadership pathways	Staff are able to rotate and take up new roles across our organisations without delay	January 2018
5 **Model Current system workforce profile**	Workforce Profiling	Sharing information on workforce, developing a common language, adopting workforce profiling tools, understanding common issues, improving data capture, looking at how we compare to elsewhere, using this to inform our actions, look at how this supports our system plans, keep information under review	We have a system-wide understanding of our workforce issues, we agree priorities for action based on what is best for the system	June 2016 with 6monthly refresh
6 **Develop future workforce profile (skill mix)** • Supporting New Models of Care	Develop 5 year strategic workforce plan	Future – What does future workforce profile need to be to support new models of care (review skill mix and integration opportunities) Now – What are the opportunities for new roles including Apprenticeships – health and social care roles – how can we further harness the capacity and capability of the private, voluntary and independent sector to support health and social care professionals – Can we build career pathways across all health and care economy workforce groups?	We have a robust plan for our future workforce and we are developing the workforce in a timely fashion to underpin the roll out of our models of care	April 2017
	Learn from best practice	Participate in wider networks – e.g. HESW and bring back learning Learn from Vanguards and other national initiatives that have had workforce development at their core. Ensure that we are linked into national workforce development work in Local Government Association, Association of Directors for Adult Social Services, Public Service People Managers Association.	We adopt an evidence based approach to our work and we avoid re-inventing the wheel	Ongoing and as identified
	Supporting access to care	Identify how 7 day working will impact on future workforce profiles	We have an agreed resource plan to support 7 day working	March 2017

7 Sustainable workforce • Recruitment - Encouraging People to Join the Workforce • Retention - Encouraging people to stay in the Workforce	Recruitment – Career Pathways – Schools	Promoting health and care careers as a package to schools, careers advisors, Skillsfest, work experience, business breakfasts	Pupils and career advisors have a better understanding of the range of career opportunities in health and care. Young people are encouraged to think about health and care careers from an earlier age and we see an increase in uptake of these career pathways.	April 2017
	Recruitment – Careers Pathways – 16+	Exploring local pathways into nursing linked to local education providers and development of a University Technical College	Young people are supported to take up routes into health and care professions	September 2017
	Recruitment – Career Pathways – those not in employment	Work with Local Enterprise Partnerships on application advice Support Building Better Opportunities initiative and LEP driven DWP programme to support employability	The statutory sector plays its part in improving employability in Gloucestershire and contributes to a reduction in people not in employment.	Ongoing
	Recruitment - Marketing Gloucestershire	Use community wide branding on advertisements and promote the county – build on work within primary care workforce strategy. Learn from Health and Social Care recruitment event at end June and plan and deliver additional event in September 2016 and onwards	People are attracted to come to work in Gloucestershire. They can see that are a cohesive system offering a wealth of opportunities.	October 2017
	Retention – Career pathways – those currently working in the NHS	Apprenticeships, nurse practitioner role, other social care roles Support the development of a Community Education Provider Network for Gloucestershire	People stay in Gloucestershire and take up training opportunities to pursue new roles	January 2017
	Retention – Health and Wellbeing of staff	Adopt and sponsor Workplace Wellbeing Charter within STP partners and in the local economy	Our organisations promote the wellbeing of staff which keeps them motivated to work here. We increase productivity and reduce staff absenteeism.	June 2017
8 Develop and embed vision, values and behaviours to support the STP agenda	Develop and embed vision and values and align organisational strategies where appropriate	Alignment of organisational OD and workforce strategies to support STP goals	People working in Gloucestershire recognise the culture, values and behaviours agreed by the system and adopt these as their ways of working and this is evidenced through staff surveys	December 2016
9 Actively promote working across boundaries to create enabling culture	Learn from each other	Support network and culture of learning from each other – sharing of strategies, approaches to common problems Explore development of a staff ideas network – so that we can have a rapid assessment of improvements so we can get them implemented quickly Develop mechanisms to improve people's understanding of what different partners across our STP do		Ongoing

Annex D: Local assessment against NHS England Ten Big Questions

Big Questions	Gloucestershire STP Response
How are you going to prevent ill health and moderate demand for healthcare? **Including:** • **A reduction in childhood obesity** • **Enrolling people at risk in the Diabetes Prevention Programme** • **Do more to tackle smoking, alcohol and physical inactivity** • **A reduction in avoidable admissions**	• Upgrade self-care and prevention, to fully involve individuals in their own health, including delivery of Self-Care and Prevention Plan. • Delivery of Enabling Active Communities Programme • Build on existing collaborations between health and social care, local government and the third sector to deliver local solutions. • Continued development and embedding of shared decision making. • Continued provision of Social Prescribing • Social Inclusion and Social Reablement Programmes • Mental Health Programme of Interventions • Adopt a range of innovative technologies i.e. NHSE Digital Test Bed • Whole system approach to obesity, working with Leeds Beckett University and Public Health England
How are you engaging patients, communities and NHS staff? **Including:** • **A step-change in patient activation and self-care** • **Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care** • **Improve the health of NHS employees and reduce sickness rates**	• Development and Implementation of Workplace Wellbeing Charter • Continued development of Cultural Commissioning Programme • Adopting a range of innovative technologies • Train staff in health coaching, supportive technology and healthy lifestyles
How will you support, invest in and improve general practice? **Including:** • **Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff** • **Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package** • **Support primary care redesign, workload management, improved access, more shared working across practices**	• Implementation of Primary Care Strategy • Investment of £1.2 million in General Practice Sustainability and Transformation Plans • Exploration and development of New Models of Care to ensure practice collaboration and care co-ordination including 30,000 models. • Embedding of Choice Plus Service, development of Integrated Urgent Care Model delivering increased appointments and improving access for patients. • Additional Practice support i.e. Prescribing Pharmacists, Advanced/Specialist Nurses

How will you implement new care models that address local challenges? Including: • **Integrated 111/out-of-hours services available everywhere with a single point of contact** • **A simplified UEC system with fewer, less confusing points of entry** • **New whole population models of care** • **Hospitals networks, groups or franchises to share expertise and reduce avoidable variations in cost and quality of care** • **health and social care integration with a reduction in delayed transfers of care** • **A reduction in emergency admission and inpatient bed-day rates**	• Implementation of Primary Care Strategy – Primary Care at Scale. • Network of Urgent Care Centres across Gloucestershire • Evidence based service redesign of Urgent Care Pathways, focusing on local out of hospital care. • Embedding of centralised, integrated Urgent Care Clinical Hub, providing a single point of access for health and social care. • Development of Urgent Care Digital Access Offer. • Development and implementation of system wide plan for 7 Day Services. • Testing of New Models of Care – i.e. locality led models for Frailty, 30,000 population models. • Responsive community based care enabling our population to be less dependent on health and social services, by living in healthy communities, supported by strong networks and timely access.
How will you achieve and maintain performance against core standards? Including: • **A&E and ambulance waits; referral-to-treatment times**	• Continuation of cross-organisation System Resilience Group including delivery of Elective Improvement Plan and Recovery Plan for A&E performance. • Continued development of supporting contractual arrangements to ensure robust mechanisms across the system. • Maintained Referral to Treatment Time with continued focus on management of the market for elective care. • Activity Plans with key providers to account for activity levels and predicted levels of demand.
How will you achieve our 2020 ambitions on key clinical priorities? **Including:** • **Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks** • **Implement two new mental heath waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity** • **Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries** • **Maintain a minimum of two-thirds diagnosis rate for people with dementia**	• Development of acute and early diagnosis cancer pathways including GP masterclasses. • Delivery of Living with and Beyond Cancer Programme • Expansion of Mental Health Crisis Team • Support for families experiencing Mental Health, drug, alcohol and domestic violence issues. • Implementation of Saving Babies Lives Initiative • Midwifery Partnership Teams operating in the most deprived areas of the county. • Delivery of our Dementia Strategy (2015-2018). • Independent Review of Primary Care Pathway to ensure equitable review, support carers and improve effectiveness. • Dementia Training and Education Strategy • Implementation of BME Community Hub.

How will you improve quality and safety? **Including:** • **Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions** • **Achieving a significant reduction in avoidable deaths** • **Ensuring most providers are rated outstanding or good– and none are in special measures** • **Improved antimicrobial prescribing and resistance rates**	• Development of Quality Academy • Engagement with South West Academic Health Science Network and QSIR College. • Research and Development Consortium • Supporting development of clinical skills and knowledge through programme of education and workforce development. • All providers including GPs will 'Sign Up To Safety' and work collaboratively through local patient safety forum to reduce avoidable deaths. • All providers have had a CQC inspection and have implemented action plans to address concerns raised and will continue to monitor. • Antimicrobial Rates are already good in Gloucestershire but we will continue to strive to improve on this position.
How will you deploy technology to accelerate change? **Including:** • **Full interoperability by 2020 and paper-free at the point of use** • **Every patient has access to digital health records that they can share with their families, carers and clinical teams** • **Offering all GP patients e-consultations and other digital services**	• Delivery of Joining Up Your Information Programme • Digital Transformation GP IT Programme – includes Patient Online, Electronic Prescription Service, GP to GP record sharing, Infrastructure Upgrades. • Development of our Local Digital Road Map • Digitally enabling patients to support care through use of apps, online programmes etc. • Provider Electronic Patient Record Programmes
How will you develop the workforce you need to deliver? **Including:** • **Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values** • **Integrated multidisciplinary teams to underpin new care models** • **New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice**	• Implement Workforce and OD Plan developed by Strategy Group. • Use coaching to mobilise healthy behaviours • Develop model for distributed leadership across our footprint • Build co-production capability with clinicians and carers e.g. through training in health coaching • Under take modelling of the current workforce profile to understand capacity and develop a future profile. • Develop shared values and behaviours and align these across our organisations. • Create an enabling workforce which supports working across organisational boundaries. • Development of University Technical College and work with Local Economic Partnership. • Develop single Gloucestershire brand for recruitment. • Introduce apprenticeships to develop nurse associates. • Deliver Continuing Professional Development masterclasses.
How will you achieve and maintain financial balance? **Including:** • **A local financial sustainability plan** • **Credible plans for moderating activity growth by c.1% pa** • **Improved provider efficiency of at least 2% p.a. including through delivery of Carter Review recommendations**	• A risk share approach aligned to our priorities. • We will work together to identify opportunities for increased cost effectiveness, minimising the number of steps and driving greater efficiency

Enabling Active Communities

VISION:

"Our programme vision is for Individuals to have the knowledge, skills and confidence to self-care and live in well-connected, resilient and empowered communities."

PROGRAMME AIM:

Enabling Active Communities aim is to build a new sense of personal responsibility and improved independence for health, supporting community capacity and ensuring we make it easier for voluntary and community agencies to work in partnership with us. We will use this approach to deliver a Self Care and Prevention Plan led by Public Health to close the Health and Wellbeing Gap in Gloucestershire. Improving Lives is a core function of the NHS, expressed in the NHS Constitution as the need for the NHS to be "helping people and their communities take responsibility for living healthier lives".

OBJECTIVES:

- Promote healthy lifestyles and self-care as part of our care pathways
- Promote healthy workplace environments i.e. Workplace Wellbeing Charter
- Tackling health inequalities through asset-based approaches
- Develop a whole system approach to obesity working alongside Leeds Beckett University and PHE
- Ensure appropriate coverage of key secondary prevention interventions that systematically detect the early stages of disease i.e. Diabetes Prevention Programme
- Ensure a strategic approach to the commissioning of self-management support.
- Work towards a system that supports person-led care and personalised care planning i.e. Integrated Personal Commissioning
- Utilising the capacity and strengths within our communities through closer working with the Voluntary, Community & Social Enterprise Sector i.e. Social Prescribing
- Substantial involvement of communities and individuals to co-produce local solutions and services i.e. Cultural Commissioning Programme
- Ensure a range of carer services are commissioners across the county in line with the Care Act
- Adopt a range of innovative technologies to enable individuals and communities to self-care i.e. NHSE Digital Test Bed

PROGRAMME DELIVERY:

	YEAR 1	YEAR 2	YEAR 3-5
KEY DELIVERABLES	• Re-procure Social Prescribing service • Develop and initiate the delivery of Prevention and Self Care Plan • CPG obesity workshops • Rollout of workplace health initiative • Implement National Diabetes Programme	• Develop Social Prescribing Plus Model • Begin implementation of system-wide approach to tackling obesity • Full implementation of patient-facing website to support self-care	• Complete system-wide approach to tackling obesity • Full implementation of Prevention and Self-Care Plan

HOW WILL THIS CLOSE.....

	FINANCE & EFFICIENCY GAP	HEALTH & WELLBEING GAP	CARE & QUALITY GAP
BENEFITS	• A greater focus on prevention will result in improved morbidity, reducing the need for acute care. If we are successful in our programme objectives our expectation is that there will be approximately 2500 fewer emergency admissions, 1000 fewer outpatient appointments and 1000 fewer A & E attendances over five years.	• Increased health-related quality of life for individuals with long term conditions • Increased life expectancy and disability free life expectancy • Reduction in avoidable and ambulatory care sensitive conditions • Reduced inequality in avoidable emergency admissions	• Improved health related quality of life for carers • Improved patient experience as a result of access to the Social Prescribing service • Enabling patients to self-care through assessment , advice and support
INDICATORS	• £20m savings	• Move to 'top decile' for percentage of over 16 year olds classified as physically inactive • Move from 'about average' detection rates for asthma, hypertension and CHD to 'top decile' • Increasing participation by men in weight management programmes so that they are equivalent to women.	• Maintain 'top performing status' for how well supported people with a long-term condition report feeling to self- manage their conditions • Maintain 'top performing' quality of life of carers as measured by the health status score (EQ5D) • Maintain 'top performing' status for number of smokers who have still quit after 4 weeks • Maintain 'top performing' status for number of pregnant women smoking at time of delivery

One Place, One Budget, One System

VISION:

"One Place, One Budget, One System aims to deliver the best value for every Gloucestershire Pound, taking a whole system approach to beds, money and workforce that will reset urgent and community care to deliver effective and efficient services."

PROGRAMME AIM:

The One Place, One Budget, One System Programme is focussed on taking a place based approach to resources, to deliver the best outcomes for every Gloucestershire pound. This programme will focus on two key areas that both involve working beyond traditional organisational boundaries , firstly a redesign of our Urgent Care system and secondly to deliver New Models of Care for community and primary care. The New Models of Care work will focus on developing integrated community and primary care at the 30,000 population scale, moving our GP practices towards new ways of working across 15 GP clusters for our county.

OBJECTIVES:

- To ensure that our population is supported when needed by integrated health and social care services delivering joined up care
- To support healthier communities to ensure people benefit from networks of community support and are able to access high quality responsive care when needed in the right place, at the right time.
- To deliver an evidence based review of Urgent Care across Gloucestershire with a focus upon local out of hospital care and a new model of care.
- To positively impact upon health and wellbeing leading to a reduction in utilisation of urgent care services by promoting ill health/accident prevention and supporting self-management
- Develop and implement a system wide plan for 7 day services
- To set the forward programme and design for adoption of a 'new model of care' for Gloucestershire that will enable primary and community care services to work together effectively at the 30,000 scale and be sustainable for the long term future

PROGRAMME DELIVERY:

	YEAR 1	YEAR 2	YEAR 3-5
KEY DELIVERABLES	• Develop pilots to reset the dial for Urgent Care system and 30,000 place based Community Teams • Pool urgent care resources in shadow form to take 'place based' Commissioning Approach	• Implement urgent and community care model at wider scale based on learning in Year 1 • Design and engage / consult on a new approach to the model of care in our hospitals, that will make best use of available resources across our system	• Learning from Yr1 and 2 to set a new care model for Integrated Community Primary Care. • Urgent care resources pooled on place basis to support countywide urgent care model.

HOW WILL THIS CLOSE.....

	FINANCE & EFFICIENCY GAP	HEALTH & WELLBEING GAP	CARE & QUALITY GAP
BENEFITS	• A redesigned Urgent Care system will result in more care being provided outside of hospital based on the needs of local populations and new ways of working between different health sectors • If we are successful in supporting people to better manage their care at home, and deliver top decile performance compared to our national peer group we can expect there to be approximately 5,000 fewer emergency admissions and 6,700 fewer A & E attendances by 2021	• Improved morbidity for a range of conditions due to focus on supporting self-care • Place based approach will ensure services address local health needs	• More care provided closer to home through development of integrated urgent care services • Improved system resilience through a more integrated approach, leading to improved quality of care and support for staff • Improved access will support earlier intervention and better health outcomes
INDICATORS	• Delivering top decile performance would equate to a £9.5m savings so resource utilisation will be a key indicator for this programme	• Standardised Admission Ratio at or below 90 • Move from 'above average' to 'top decile' for unplanned hospitalisation for chronic ambulatory care sensitive conditions • Move from 'below average' to 'top decile' for asthma emergency admission rates • Move from 'above average' to 'top decile' for emergency admissions for acute conditions that would not normally require hospitalisation	• Achievement of the 4 hours A & E waiting time target • Achievement of 8 and 19 minute ambulance waiting time targets • Year on year reduction in numbers of patients on medically stable list • Year on year increase in utilisation of Ambulatory Emergency Care pathways • Increased uptake of Rapid Response service • Named later life professional linked to each cluster • Focussed coordinated care especially for those with dementia, complex psychological conditions and frailty

Reducing Clinical Variation

VISION:

"Our programme vision is to provide consistent, evidence based clinical services for the people of Gloucestershire, that are supported by research and innovation."

PROGRAMME AIM:

Reducing Clinical Variation will continue to build on our variation approach with primary care, deliver a step change in variation in Outpatient follow up care and promote a 'Choosing Wisely for Gloucestershire' and Medicines Optimisation approach, and undertake a Diagnostics Review. This programme will set the dial for our system to close the Care and Quality Gap.

OBJECTIVES:

- Evaluate the learning from our approach to managing variation in Primary Care and continued support by G-care
- Design and implement a joint Medicines Optimisation Programme across system
- Have a new conversation about Choosing Wisely with the public in Gloucestershire
- Commission an independent review of diagnostics provision and implement a new diagnostics model for Gloucestershire based on the findings from our review
- Develop and deliver an innovative pain approach across our system
- Deliver a step change in rates of follow up care
- Review other areas of clinical variation, such as Pathology

PROGRAMME DELIVERY:

	YEAR 1	YEAR 2	YEAR 3-5
KEY DELIVERABLES	• Develop Medicines Optimisation Programme supported by Choosing Wisely conversation with the public • Initial delivery of Follow ups Programme • Undertake Diagnostics Review of county in support of urgent care strategy • Initiate Pain Pathways Programme	• Progress Medicines Optimisation and Follow-ups Programmes • Developed and deliver an innovative Pain Pathway Programme across Gloucestershire • Begin implementation of findings of Diagnostic Review	• Developed a new culture and approach to medicines optimisation • Complete implementation of findings from Diagnostics Review • Implemented step-change in rates of follow-up care up to top decile performance

Reducing Clinical Variation

HOW WILL THIS CLOSE.....

	FINANCE & EFFICIENCY GAP	HEALTH & WELLBEING GAP	CARE & QUALITY GAP
BENEFITS	• The overall impact of the Reducing Clinical Variation Programme through reduced variation in primary care, medicines optimisation, achieving top decile performance in follow-ups and better use of diagnostics at upper decile benchmarks would be approximately 10,000 fewer elective admissions, 850 fewer emergency admissions and 1,500 fewer A & E attendances.	• Improved medicines provision to all patients but particularly those with complex needs • More effective and timely diagnosis of a range of conditions • Better pain management through use of most effective medicines	• Greater consistency will reduce unnecessary and ineffective care provided to patients • Improved patient experience of care through improved diagnosis and more effective prescribing and treatment • More appropriate referrals from primary care and greater provision of care closer to home
INDICATORS	• Delivering upper decile performance would equate to a saving of £21.7m, so a key indicator will be resource utilisation in these areas	• Top decile performance of GCCG against metrics on the Medicines Optimisation Dashboard (NHS England) • Continue to add new pathways to G-Care website and monitor usage focusing in the first instance on pathways for gastroenterology, gynaecology, neurology, urology, ENT and dermatology.	• Adherence to NICE 'Do Not Do' recommendations • Implement findings of local review of Practice Variation in Gloucestershire

Clinical Programme Approach

VISION:

"Our programme vision is to work collaboratively to drive the development of wholly integrated clinical services (commencing with respiratory and dementia) and delivery of care that is safe, joined up, accessible, evidence based and both clinically and cost effective. We need to change our approach to disease from one that is reactive and waits until people develop severe symptoms (which cost more for the NHS and results in poorer outcomes for individuals) to one which is proactive, preventing disease, diagnosing earlier and treating and managing the condition from its early stages."

PROGRAMME AIM:

The aim of the CPA is to deliver whole pathway transformation across key clinical programme areas, utilising a structured 'Clinical Programmes Approach' based on the principles of improvement science.
A fundamental priority will be to deliver the best possible care outcomes within resources available, looking at resource utilisation in our system compared to top decile benchmarks and aiming to deliver the right care, in the right place at the right time for the people that need it. The programmes will take a pro-active approach to preventing disease, diagnosing earlier and treating and managing the condition from its early stages.

OBJECTIVES:

- Improve the health and wellbeing of our population and minimise inequalities
- To ensure the best care is delivered within available resources, with an aim to move towards 'upper decile' resource utilisation across all programmes as described in national benchmarks
- Following an entire pathway approach we will work to the principle of moving care 'upstream', with a greater focus on prevention, self-care and effective long term condition management
- To ensure effective diagnosis and management of long term conditions and their secondary complications to reduce pressure on acute urgent services and health inequalities across our communities, with a focus on reducing those who die prematurely
- To enhance quality of life for people across all social groups, supporting a positive, enabling, experience of care and support, right through to the end of life
- Through a care pathway approach we will engage with professionals, patients and carers from across our system to develop and transform our integrated pathway approach

PROGRAMME DELIVERY:

	YEAR 1	YEAR 2	YEAR 3-5
KEY DELIVERABLES	• Complete implementation of Eye Health and MSK Clinical Programmes • Deliver new pathways for Respiratory and Dementia Clinical Programmes and deliver new community based Cancer survivorship model • Implement integrated service models	• Deliver new pathways for Circulatory and Diabetes Clinical Programmes • Implementation of patient facing website • Develop approach to addressing health inequalities across multiple CPGs	• Further programme priorities will be progressed based on progress made and opportunities identified through national benchmarking and right care programme • Embed education strategy across the system for multiple CPGs

Clinical Programme Approach

HOW WILL THIS CLOSE.....

	FINANCE & EFFICIENCY GAP	HEALTH & WELLBEING GAP	CARE & QUALITY GAP
BENEFITS	• Following the Clinical Programme Approach will see a transformation in the way that services are delivered. Our system has set a target to achieve 'upper decile' performance compared to similar systems across a range of performance indicators. • Delivering upper decile efficiencies and outcomes would be equivalent to an approximate reduction of 3,900 emergency admissions, 3,900 elective admissions, 125,000 fewer outpatient appointments and 6,700 fewer A & E attendances by 2021.	• Improved mortality and morbidity rates through development of evidence based care pathways • Reduced incidence and prevalence of preventable conditions due to investment in prevention • Improved support for patients with long term conditions resulting in reduced access to acute care services	• Better outcomes due to care being provided in a timely way (in accordance with NHS Constitution standards) • Reduced readmissions through provision of high quality care • Parity of esteem for mental health patients and services • Greater support for patients and carers in providing self-care • More care provided in community settings where currently provided in acute care
INDICATORS	• Achievement of upper decile productivity would be equivalent to a £20m saving against current patterns of care delivery over the 4 years of our STP. Resource utilisation by programme will therefore be a key indicator	• Maintain 'top performing' status for number of deaths in hospital (less is better) • Achieve top decile performance for diabetes prevalence in over 17s • Achieve SSNAP targets for stroke patients to access to a stroke unit in 4 hours and thrombolysis • Achieve top decile performance for premature mortality from respiratory conditions • Move from 'above average' to 'top quartile' performance for diabetes patients that have achieved all NICE recommended treatment targets • Significantly improve one-year survival to achieve 75% by 2020 for all cancers combined	• NHS Constitution compliant delivery across all pathways • Achievement of IAPT access targets • Achievement of dementia diagnosis targets • Move from 'below average' to 'top quartile' for proportion of asthma patients with annual reviews • Move to top quartile performance for Patient Reported Outcome Measures (PROM) for hip and knee replacement • Maintain and improve upon 'above average' performance to top quartile for people with diabetes diagnosed less than a year who attend a structured education course • To increase the proportion of cancers diagnosed at Stage 1 or 2 by 2020 to 62%

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