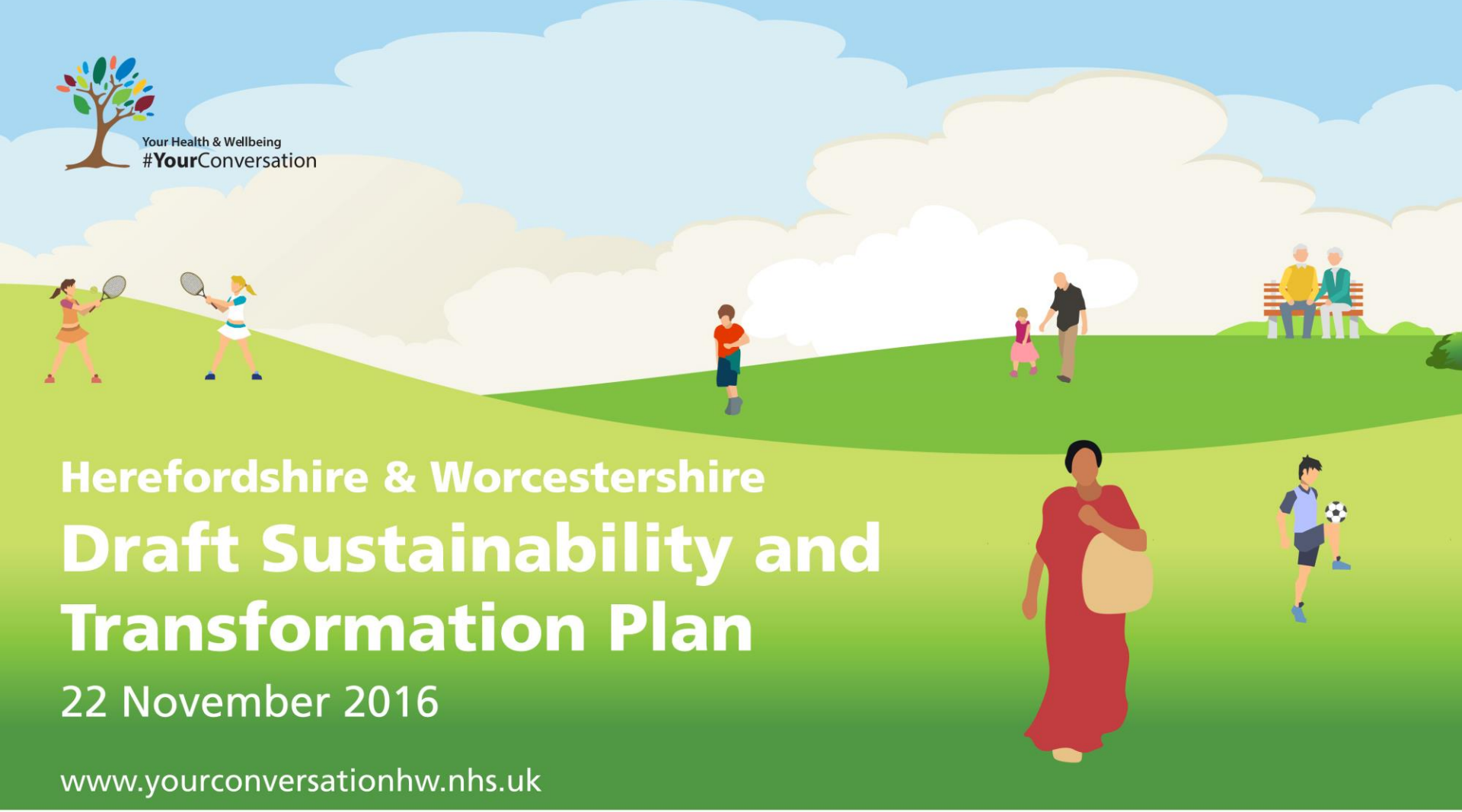
Your Health & Wellbeing
#YourConversation



Herefordshire & Worcestershire

Draft Sustainability and Transformation Plan

22 November 2016

www.yourconversationhw.nhs.uk

Worcestershire Acute Hospitals NHS Trust

Herefordshire Clinical Commissioning Group

Redditch and Bromsgrove Clinical Commissioning Group

South Worcestershire Clinical Commissioning Group

Wyre Forest Clinical Commissioning Group

Wye Valley NHS Trust

Worcestershire Health and Care NHS

2gether NHS Foundation Trust

Taurus Healthcare

worcestershire county council

Herefordshire Council

Name of footprint	Herefordshire and Worcestershire
Region	Midlands and East
Nominated Lead	Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust
Contact Email	whcnhs.yourconversationhw@nhs.uk

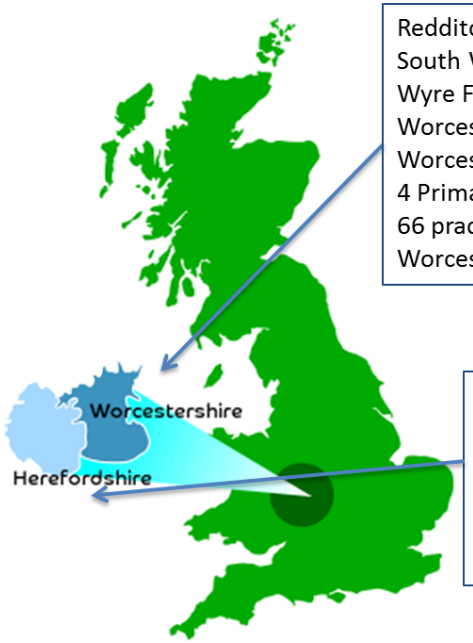
Partners involved	
GP Practices	90
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Health & Well Being Boards	2

Key Statistics	
Population	780,000
Area	1,500sq m
Annual NHS Allocation – 2016/17	£1.168bn
Annual NHS Allocation – 2020/21	£1.327bn
STF allocation in 2020/21	£50m
NHS "Do Nothing" financial gap to 2020/21	£229.6m
NHS Residual Gap after applying national planning assumptions	£61.5m

Herefordshire and Worcestershire

Sustainability and Transformation Plan

(22nd November 2016 Draft)



Redditch and Bromsgrove CCG
South Worcestershire CCG
Wyre Forest CCG
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council

Herefordshire CCG
Wye Valley NHS Trust
2gether NHS Foundation Trust
Taurus GP Federation (representing 24 practices)
Herefordshire Council

#yourconversationHW

Contents and foreword

Foreword by Mark Yates, Independent STP Chair

Our STP footprint has some unusual challenges compared to many of the other footprints. Our footprint is one of the largest in terms of geography – covering 1,500 sq miles, but one of the smallest in terms of population – covering about 780,000 people. By way of example the distance between Hereford County Hospital and Worcestershire Royal Hospital is more than 30 miles and typically takes more than an hour to drive on single carriageway roads.

Our STP footprint is also unusual in that it provides hospital services for 40,000 people from the Welsh health system who are external to the footprint. Powys has no district general hospitals and the people of mid-Powys rely on the County Hospital in Hereford and with Powys being even more sparsely populated than Herefordshire, for some residents, the nearest acute hospital after Hereford is some considerable distance away in Aberystwyth. Service provision in this area is characterised by long travel times for patients and staff and we have the challenge of achieving a balance of what can be provided locally in Wales and centrally in England.

Partners across the footprint recognise that the solution to the sustainability and efficiency challenges facing health and social care cannot be dealt with by partners nor organisations working alone. Individuals, families, local communities, Voluntary and Community Sector Partners all have a core role to play in developing solutions. We need to place equal if not greater focus on helping communities and individuals to live healthily, be resilient and avoid the need to access organised services for things that many people are able to deal with themselves. Carers play a vital role in this vision and are a hugely important asset to the NHS and social care system. We need to do more to help identify, support and recognise their vital roles. We will do this by working towards achieving system wide agreement to implement the "Commitment to Carers – Carers Toolkit". Helping carers to provide better care and to stay well themselves will contribute to better lives for those needing care and more effective use of NHS and social care resources.

These a just a few of the many challenges faced by our STP footprint, but all partners continue to be equally committed to providing the best and most cost effective services to our communities and patients. We've been working very closely together throughout 2016 and this commitment to the STP process will see our collective journey forge well into the future. However, partners also recognise the magnitude of the difficulty of providing health and social care services to a very diverse and widespread population within a very tight cost envelope. We recognise that this submission is not an end point – it is merely a stage in our collective journey towards a better health and social care system for the population of Herefordshire and Worcestershire and we are committed to engaging with our communities to ensure this is the case going forward.

Our vision for 2020/21

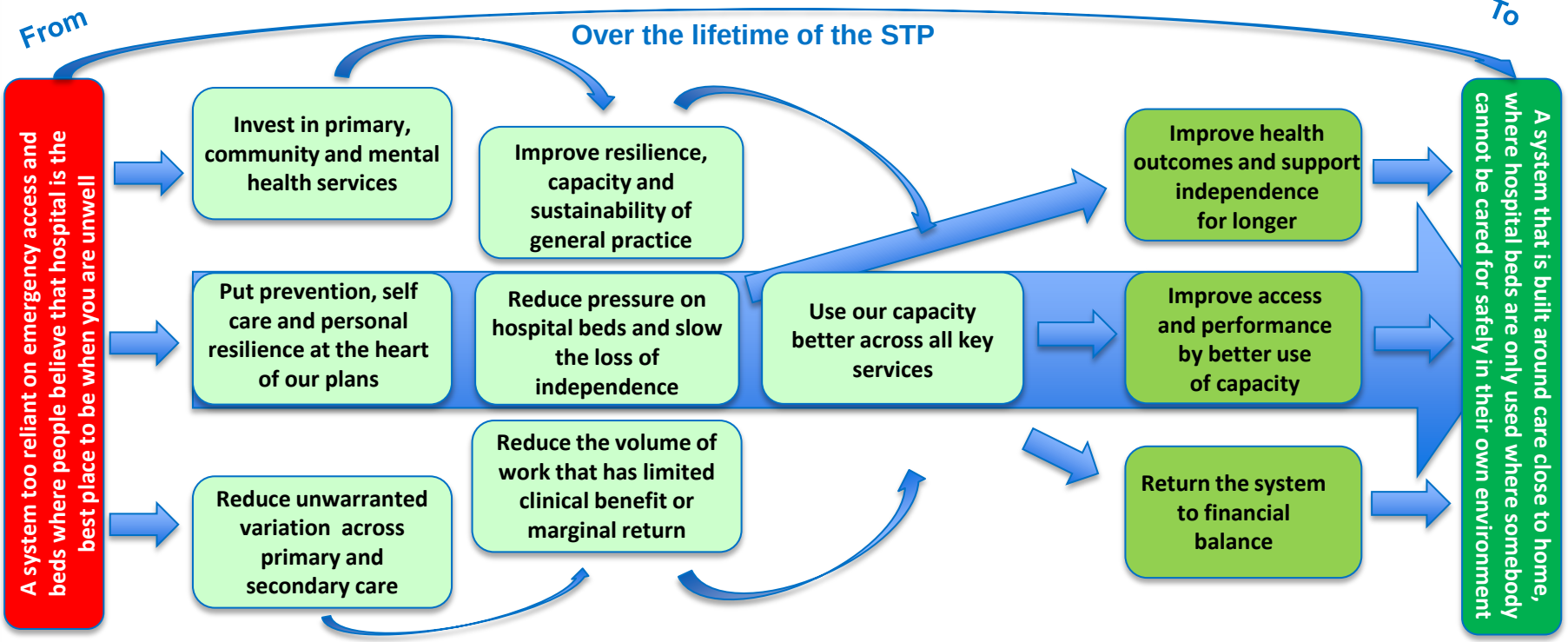
"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people".

What we mean	
Live well in a supportive community…	There is collective agreement across the wider public and voluntary/community sector that one of the most effective ways to improve health is for people to live well within supportive resilient communities taking ownership of their own health and well-being. We will be better at helping residents to draw on the support available from their local communities and voluntary groups, and we will help those communities and groups develop the capacity to meet these needs. We will use social impact bonds and social prescribing to support this. This will apply across all age groups.
…with joined up care…	Where individuals have a health or care need this will be delivered in an integrated way, with a single plan developed with and owned by the individual in true partnership and available wherever people access the system. Local integrated delivery teams will be in place which recognise the central role of the GP and reflect a broad range of skills and expertise from across the organisations. We will make care boundaries invisible to people using our services by removing operational boundaries between organisations and we will ensure that co-production is embedded in everything we do.
…underpinned by specialists…	Specialist care will always be needed, but there are times when care could be safely provided under the remote supervision of a specialist across a digital solution. For example, by developing better digital links between practices and hospitals we believe that more care can be provided locally by GPs and other health or social care staff based in the community. This is particularly important given our rurality challenge. Our workforce, organisational development and recruitment plans will focus on making sure that we make Herefordshire and Worcestershire an attractive place to work so we have a stable and committed workforce, with much less reliance on agency employment.

What we mean	
…delivered in the best place…	We will have completely adopted and embraced the principle of "home first" and will deliver as many services as possible close to home. We will carefully balance the need and benefit of local access against that of service consolidation for quality, safety and cost effectiveness. We will reduce as far as possible the need for people to travel out of their area to access most services. Some services will be brought out into communities and delivered in GP surgeries, community hospitals or other local premises. Equally some services will be consolidated where clinical sustainability or quality of care is significantly improved by doing so. Joined up transport planning will enable us to support people in planning their travel arrangements where this is the case. We will involve the public in any decisions and provide the information needed to understand how and why things need to change.
…by the most appropriate person.	We need to create the capacity and resilience to enable GPs to be clinical navigators and senior clinical decision makers in the out of hospital care setting. This will be with a particular emphasis on people who are frail and those at risk of emergency admission. We will develop extended roles such as physician assistants and advanced practitioners in areas such as physiotherapy, dermatology and pharmacy and review the skill mix to free up the GP time needed to focus on patients with the most complex needs. Equally there are times when the demarcations in roles are too prohibitive and result in the need for additional roles that add more cost than value. This will change with alignment of pathways of care. Over time we have introduced a degree of complexity and cost that is not sustainable. The work we do to implement this plan will mean that people will be seen by the right person in the right place at the right time. This will mean change to the way in which services are delivered.

The essence of our Sustainability and Transformation Plan

Our health and care economy has become too dependent on reactive bed based care that results in reduced wellbeing, a poor patient experience and higher cost of services. There remains a public perception that being in hospital is the best place to be when people are unwell. This is despite there being considerable evidence to the contrary, particularly for people who are frail. The essence of our STP is to change this by keeping people well and enabling them to remain in their own homes. We will achieve this by focusing our efforts more on what happens in our communities, not just in hospitals. We will build our system around resilient and properly resourced general practice, that has community services wrapped around them. This will relieve pressure on our hospitals, which will be freed up to focus on efficiently dealing with complex elective and emergency care. Waiting times and outcomes for patients will be better. For the system it will enable us to live within the financial means available by the end of the 5 year period. To achieve this change we will require all partners to commit to this approach and to deliver this through their operational planning and delivery work. It will also require change from the population. We will need local residents and citizens to take more control of their own health and well being, to take more responsibility for supporting others in their communities. Building strong and resilient communities, through wider work around employment, housing and education, will be an essential foundation for this. As a result, people will no longer need the historic range and level of public services, and will be sensible consumers of the services we do need to provide.



A single page summary of the big priorities for this STP

Sustainable General Practice

- Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health and care services.
- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.
- Share information across practices and other providers to enable seamless care.
- Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.

Primary & Community Services

- During 2018/19, organise and provide services from locality based Multi-Speciality Community Providers (Worcestershire) and similarly formed alliance model (Herefordshire).
- Through the One Herefordshire Alliance and the Worcestershire Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.
- Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness.
- Develop plans which integrate specialist support, reducing the time taken to access specialist input and reducing the steps in the pathway. Initially focussed on supporting people living with frailty and end of life care, but adopting principles and learning quickly to a range of other priority pathways.

Prevention & self care

- Embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change.
- Put long term life outcomes for children, young people and their families' needs at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future.
- Support people to manage their own health, linking them with social support systems in their communities and identify when a non-clinical intervention will produce the best experience and outcomes for patients.

MH & LD

- Deliver the requirements of the national taskforce.
- Work with NHS specialised services to increase local child mental health services to reduce demand for complex out of county services and enable repatriation of complex cases back to the local footprint.
- With local authorities, develop joint outcomes and shared care for people with learning disabilities.

Urgent Care

- Reduce the number of individual physical access points to urgent care services across the STP footprint by 2020/21.
- Retain 3 units with an A&E function across the footprint. Explore the need for the number of MIUs and the Walk in Centre as we move to 7 day primary care services, and the opportunity for standardised opening hours for MIUs in Worcestershire.
- Shift to home based care – explore whether we should reduce the number of community based beds across the system and shift resources to primary and community services.

Maternity

- Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.
- Develop a jointly commissioned, jointly provided maternity service across the whole footprint delivering the Better Births strategy.
- Establish a single service with specialist teams working under a common management structure, delivered locally within both counties.

Elective Care

- Develop 4 key prevention programmes to reduce demand for surgery delivered at scale and improve the likelihood of positive clinical outcomes following surgery.
- Undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes.
- Develop strategic partnerships with external partners to secure organised access to elective surge capacity in a planned and managed way.
- Expand pan STP working on cancer services and deliver the requirements of the national taskforce.

Infrastructure

- Explore the benefits from integration in pathology, radiology and pharmacy services across the footprint.
- Develop robotic pharmacy functions and maximise the use of technology.
- Develop a single strategy and implementation plan for a joined up place based back office across all local government and NHS partners.
- Develop a place based estates strategy and a place based transport strategy.

Our STP development journey – past, present and future

Between February and April 2016 we…

- Developed our leadership team.
- Established a Programme Board, Planning Group and PMO.
- Completed our local triple aim gap.
- Agreed clinical pathway priorities based on care and quality gaps.
- Identified enabler workstreams that will be critical in delivering transformation.

Between April and October 2016 we…….

- Established our communications and engagement workstream and started briefing staff and key stakeholders.
- Developed our first draft Plan with 5 priorities for transformation, agreed by system leaders.
- Received feedback and direction from NHS England and NHS Improvement.
- Used an allocative budget analysis to agree a strategic approach to investing and disinvesting in service areas.
- Developed a full set of concept papers presenting transformational solutions to address our triple aim gap.
- Initiated work on clinical, staff and local engagement.
- Confirmed that we would need to allocate at least half of the STF funding to support sustainability during the five year period, with a plan to retain the rest for transformation (noting the associated risk to delivery).
- Submitted a balanced financial plan for 2020/21 agreed by system leaders, subject to some caveats and assumptions that needed further work and a recognition of the challenge presented by the revised control totals in 2017/18 and 2018/19.

From October 2016 to April 2017 we will…

- Conduct further and more detailed analysis of strategic demand and patient flow to enable us to more accurately project need for services over the full planning period.
- Translate our strategic intentions from the STP into aligned commissioner and provider operational plans.
- Undertake detailed analytical work to develop clearer proposals for alternative pathways.
- Establish a clear plan for stakeholder engagement and consultation on any changes that need to be considered immediately.
- Extend community engagement to ensure that communities have the opportunity to shape and develop our plans.
- Extend clinical engagement to ensure that front line staff help to shape the development of ideas and implementation plans to deliver the transformation required.
- Use the STP priorities as the basis for contracting to ensure that services developments and plans are affordable within the financial resources available to partners.
- Roll out our communications and engagement plan, including written briefs, drop-in sessions and road shows in all partner organisations as well as interactive #yourconversation webinars, blogs, etc.
- Agree and implement a delivery structure that will enable the development and testing of the required modelling, assessment of the impact our STP plans on quality.
- Progress work to join up commissioning strategies and joint working across commissioner and provider organisations across the footprint.
- Explore opportunities to align primary care, community services and secondary care more closely.
- Agree how we phase our available funding across the period so that we can pump prime our key transformation proposals.

Our biggest challenges – health and well being

Overall, health outcomes in Herefordshire and Worcestershire are good but we face significant challenges now and into the future. We recognise that radically scaling up prevention activities across all our health and care interactions with the population will be a vital element of securing improvements.

- **The gap between life expectancy (LE) and healthy life expectancy (HLE)** There are large numbers of people living in poor health in our older population and this is one of the most significant gaps to reduce. In Herefordshire the gap at 65 years of age is 7.8 years for men and 9.4 years for women. In Worcestershire 7.1 and 9.1 years respectively. Closing these gaps is essential to improving the quality of life for the population.

- **Premature mortality rates vary significantly between the two Counties** Worcestershire mortality rates are most concerning – the county ranks 55th out of 150 Authorities nationally (where 1st is best) for premature mortality rate per 100,000 population. Herefordshire ranks 21st out of 150. In comparison with its statistical neighbours, Worcs ranks 12th out of 15, with a premature death rate of 320 per 100,000, compared with 256 for the 1st ranked. This is equivalent to around 370 additional premature deaths a year. Herefordshire ranks best for its comparative group, with a premature death rate of only 287 per 100,000.

- **There are some condition specific premature mortality concerns -** In Herefordshire, colorectal cancer, heart disease and stroke are slightly higher than expected (but not significantly), whereas in Worcestershire, premature mortality in some of these areas is amongst the worst or actually is the worst for its comparator group (for example colo-rectal cancers and heart disease) .

Gap between life expectancy & healthy life expectancy

	Men	Women
Herefordshire	7.8 yrs	9.4 yrs
Worcestershire	7.1 yrs	9.1 yrs

Premature mortality rates compared to other areas (1 is best performing)

	England	Family
Herefordshire	21st of 150	1st of 15
Worcestershire	55th of 150	12th of 15

Our biggest challenges – health and well being

There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire - The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcs and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access.

Some outcomes for children and young people which are lower than expected:

- **School readiness** - In Herefordshire only 40% of Children receiving free school meals reach a good level of development at the end of the reception school year. In Worcestershire the figure is 46%. Both are worse than the England average of 51%.
- **Neonatal mortality and stillbirth rates** – These are amongst the worst in the comparative groups for both counties. In Herefordshire it is 9.7 per 1,000 live births and Worcestershire 7.5 per 1,000.
- **Obesity** – In Herefordshire 22% and in Worcestershire 23% of reception class children are obese or overweight.
- **Alcohol admissions under 18s –** In Herefordshire the figure of 56 per 100,000 population and in Worcestershire 46.5 per 100,000 are both significantly higher than the England average of 40. This equates to an additional 30 admissions in Herefordshire and 37 in Worcestershire per annum.
- **Breast-feeding initiation rates** are both below the national average (68% in Herefordshire and 70% in Worcs with a national figure of 74%).
- **Occurrence of low birth weight** in both counties is amongst the worst of their comparator groups.
- **Teenage conceptions** - 24 per 1,000 in Herefordshire and 25 per 1,000 in Worcestershire are the highest rates amongst their comparator groups.

Mortality variation between different social groups

Difference between less deprived and more deprived areas

Herefordshire	4.9 yrs
Worcestershire	7.8 yrs

Areas of concern regarding poor outcomes for children and young people across both counties

Older ---------- Younger

- **Neonatal mortality and still births**
- **Low birth weight**
- **Breastfeeding rates**
- **School readiness**
- **School age obesity**
- **Under 18 alcohol admissions**
- **Teenage conception rate**

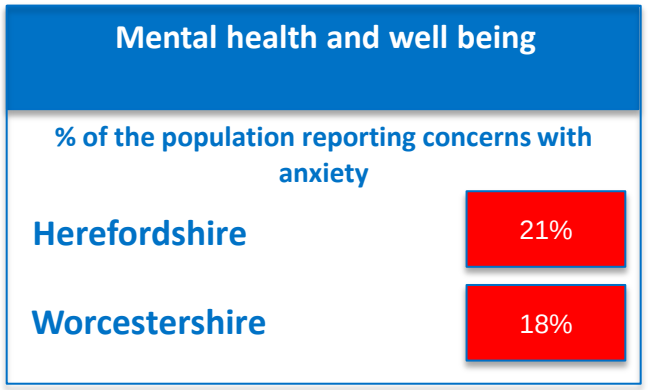
Our biggest challenges – health and well being

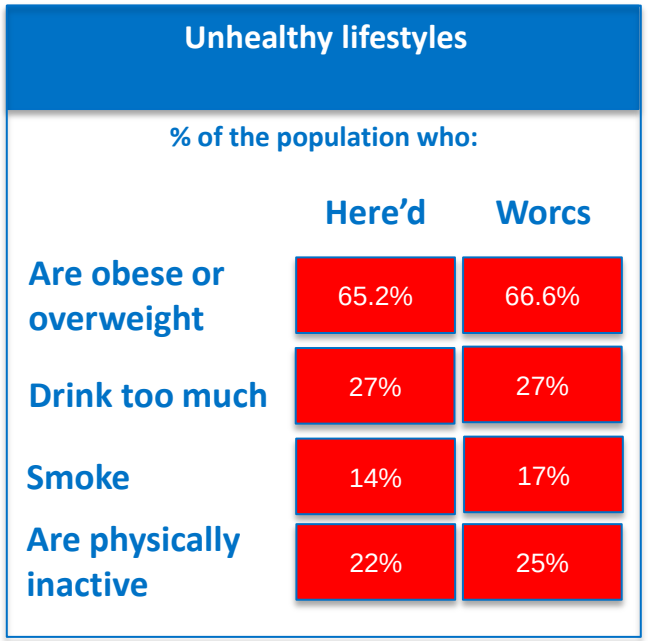
Mental health and well-being - This is a theme that cuts across and impacts on all the outcomes**.** On the Integrated Household Survey 21% of residents in Herefordshire and 18% in Worcestershire reported an anxiety score of over 5/10. In addition, we know that people suffering from mental health conditions suffer higher levels health inequality and outcomes across an array of measures. We will focus on improving mental health and well-being which will in turn impact on capacity for individual behaviour change.

To narrow the gaps identified above, we will focus on changing the lifestyle behaviours that increase risks of poor health outcomes**.** We want to reduce:

- **The numbers of people eating too many high fat, salt and sugar foods** - In Herefordshire 65.2% of adults are overweight or obese and in Worcestershire 66.6%.
- **Alcohol consumption** - in both counties about 27% of the drinking population drink at increasing or higher risk levels
- **Smoking** - 14% of adults in Herefordshire and 17% in Worcestershire still smoke
- **Physical inactivity** - 22% of adults in Herefordshire and 25% in Worcestershire are inactive

Although we are generally at national average in terms of these behaviours, the national figures themselves give rise for concern and average performance should not be allowed to provide false comfort. If unchecked, these issues will mean that the rising burden of avoidable disease will continue. Furthermore, there are marked differences between deprived and non-deprived areas which will require careful referral and targeting (for example smoking prevalence among routine and manual workers is 25% in Herefordshire and 32% in Worcestershire). The biggest single staff group across the footprint is employed by the NHS and local government. We will focus on implementing local strategies to support our own workforces to lead the way in changing behaviour for others.





Our biggest challenges – care and quality

In addition to our health and well being challenges, we also have a number of areas where our performance on care and quality can be significantly improved. We know there are significant workforce challenges in a number of areas leaving services too reliant and locums and agency staff to meet demand.

Our biggest challenges include:

- Lack of capacity and resilience in primary care and general practice.
- Social care provider capacity & quality (domiciliary and residential care capacity is stretched).
- One Trust in the CQC special measures regime and one that has recently emerged from it, having been re-categorised as "requires improvement".
- Poor Urgent Care performance on a number of measures including ambulance measures, 4 hour waits in A&E, long trolley waits and challenges around including stroke performance.
- Poor performance against elective care referral to treatment times (18 week waits) and access to mental health services such as psychological therapies.
- Poor performance of cancer waiting times.
- Low dementia diagnosis rates.
- Poor performance in parts of the STP area on a number of maternity indicators such as uptake of flu vaccinations, smoking at the time of delivery, low birth weight and breastfeeding initiation.

Sept 2016 Highest risk areas for key NHS Constitutional standards

Urgent Care	• 4 hour A&E standards across all sites • Poor patient flow resulting in 12 Hour Trolley breaches (WAHT) • Stroke TIA (WVT) • Ambulance Handovers
Planned Care	• Referral to treatment 18 week (WVT & WAHT) • Cancer 62 day wait • Cancer all 2 week wait referrals • Cancer 2 week wait – Breast Symptomatic • Cancelled operations (WAHT)
Mental Health	• Dementia Diagnosis • IAPT Access (Improved access to psychological therapies) • IAPT Recovery

Our biggest challenges – finance and efficiency

The STP has developed a financial model that sets out a 'do nothing' scenario for the health and care economy. The model has been calculated showing the impact of increases in demography, inflation and other factors. The model also includes those investments required to deliver the priority areas set out in the Five Year Forward View. The Programme Board has reiterated the importance of the investment in delivering the programmes set out in the General Practice Forward View. The 'Do Nothing' base case for Herefordshire and Worcestershire split by sector is:

Area	Herefordshire	Worcestershire	Do nothing gap
NHS Commissioners	£33.2m	£53.4m	£252.6m*
NHS Providers	£53.3m	£112.7m	

**includes £23.0m investment requirement to deliver the NHS Five Year Forward View.*

In addition to this, the financial modelling shows that the two local authorities combined have a "do nothing" gap of circa £84m that are being addressed through local efficiency savings alongside the STP– taking the system gap to £336.6m.

We recognise the importance of addressing this position as quickly and effectively as possible. Whilst spending allocations will increase from £1.168bn to £1.327bn, if the population continues to access services in the same way as now, and we continue to provided them in the same way, then our spending will be likely to increase by an additional £175m over and above this increase. When added to our opening gap and the social care gap, this results in the total financial challenge for the system by the end of 2020/21 of £336m.

NHS £226.9m gap by area	2020/21 'Do Nothing'	Population	Per head
Herefordshire *Including net import from Wales*	*-£86.6m*	*225,000*	*£384*
	-£86.6m	185,000	£468
Worcestershire	-£166.0m	595,000	£279

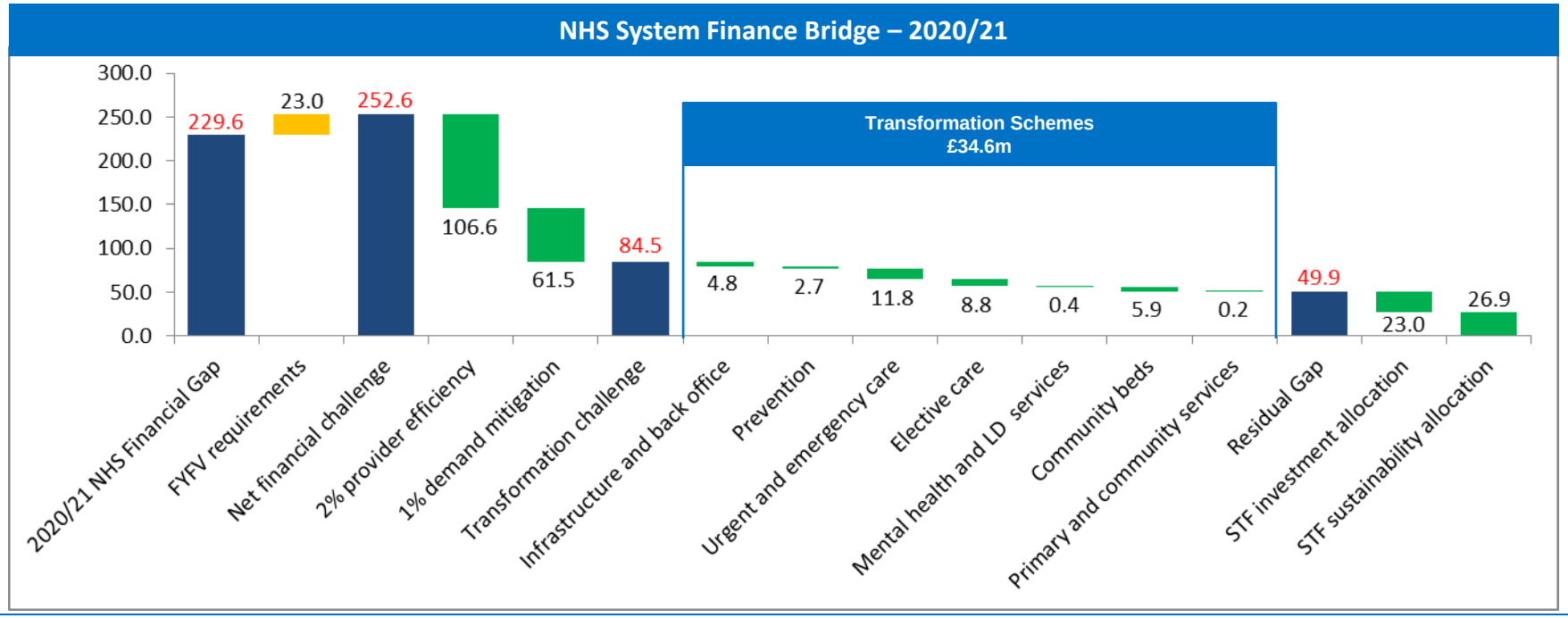
We are very conscious of the challenge between the need to live within individual control totals in the short term and the delivery of a balanced and sustainable system in the long term. In seeking to meet both challenges, we recognise the need to take radical steps, but equally will be careful not to compromise long term sustainability with rash steps towards short-term financial savings.

There is a significant disparity in the scale of the financial challenge across the footprint. The additional challenge in Herefordshire, in part, stems from the inherent additional costs resulting from serving a very dispersed rural population where there is limited access to the internet. These challenges are not fully reflected in the national funding formula.

Our biggest challenges – finance and efficiency

Closing the NHS Gap by 2020/21

If we achieve the national planning assumptions of 1% demand mitigation and deliver 2% provider efficiency gains and additional QIPP savings, then our local modelling suggests that we will reduce the NHS deficit by £168m but will still be left with a financial gap in the NHS at the end of the period of £61.5m (£84.5m-£23.0m investment requirement). We have currently identified transformational schemes totalling £34.6m that could begin to bridge the gap, leaving £26.9m to be covered by the STF money after covering the investment requirement from our STF allocation. Delivering this scale of transformation will be challenging without access to sufficient transformation resource to support change (see page 17 for plans). This is one of the key risks that the system will need to address as part of the next phase of development. In implementing any changes to services, all partners have agreed to the principle that we must not take decisions in one part of the system that have an adverse effect or shunt costs into another part of the system, without this being part of an agreed and organised approach. We are very conscious that there may be a tension between the need to live within the control totals of individual organisations in the short term and the delivery of a balanced and sustainable system in 2021. In seeking to meet both challenges, we are ready to take radical steps, but we will not be foolhardy, in taking rash steps towards short-term financial savings that undermine outcomes in the longer term.'



Opportunities identified using Right Care to support demand mitigation

In order to deliver our commissioner QIPP and provider CIP challenge we intend to apply the NHS Right Care approach and the wider efficiency work recommended by national reviews such as *Carter* . The CCG Right Care Commissioning for Value packs show that there are significant opportunities for demand mitigation compared to other areas in both elective and non-elective care. Other sources of analysis show opportunities in Continuing Healthcare and variation in GP prescribing.

Elective Admissions

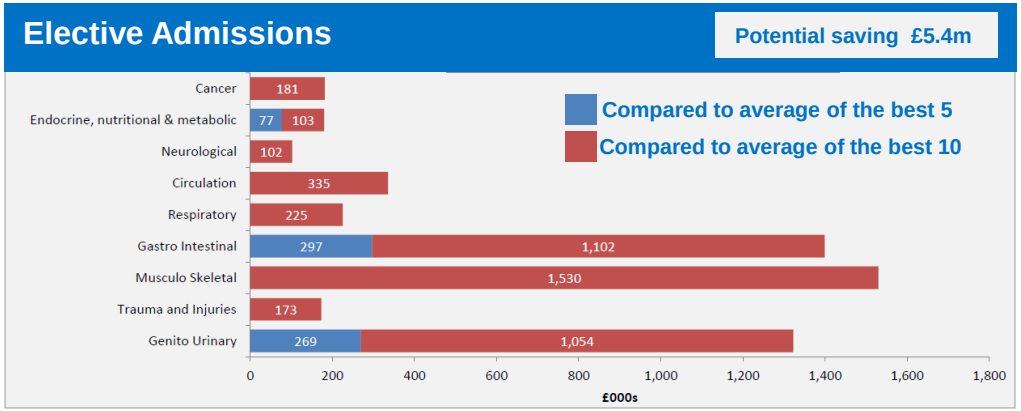
- There are significant opportunities to deliver efficiencies in this area, most notably in Gastro-Intestinal and Musco-skeletal
- Total saving opportunity =
  - £643k against the top 10 comparators
  - £5.4m against the top 5 comparators

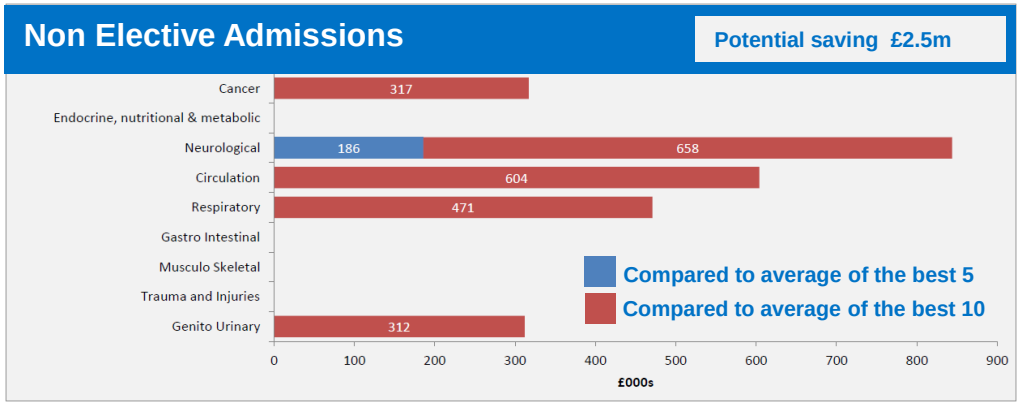
Non Elective Admissions

- There are also significant opportunities to be pursued in the non-elective admissions, but in a smaller number of areas. The most significant being Neurological.
- Total saving opportunity =
  - £186k against the top 10 comparators
  - £2.5m against the top 5 comparators

Other areas (not shown in charts)

- In addition to these areas CCGs have also identified CHC and GP Prescribing as areas to target for demand mitigation strategies with savings of £2.1m and £3.7m targeted.





In addition to existing schemes, jointly developed QIPP/CIP schemes will be developed through the operational planning process to support delivery of these savings, alongside the additional requirements to support control total compliant spend in 2017/18 and 2018/19.

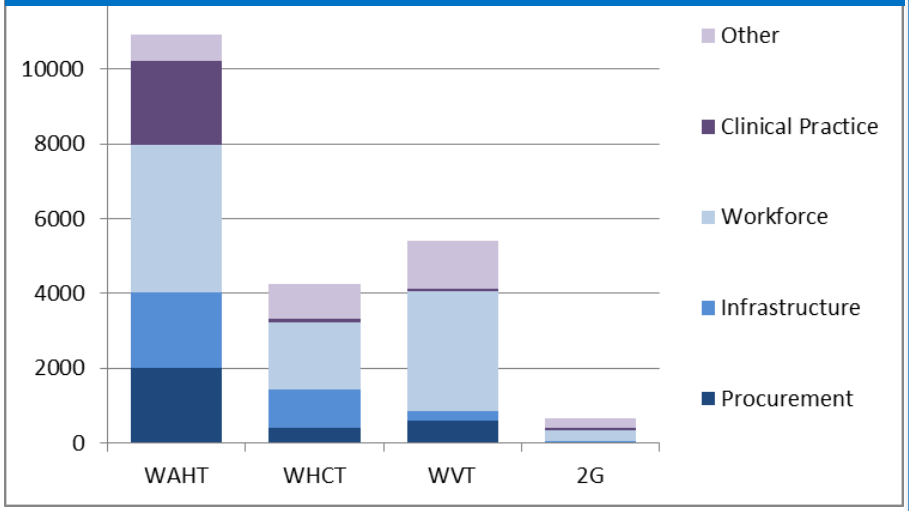
Identification of provider cost improvement plans – 2017/18 and 2018/19

Providers are developing plans to deliver the 2% cost improvement requirements outlined on slide 12. These plans are consistent with the areas set out in the Carter review and include the following elements:

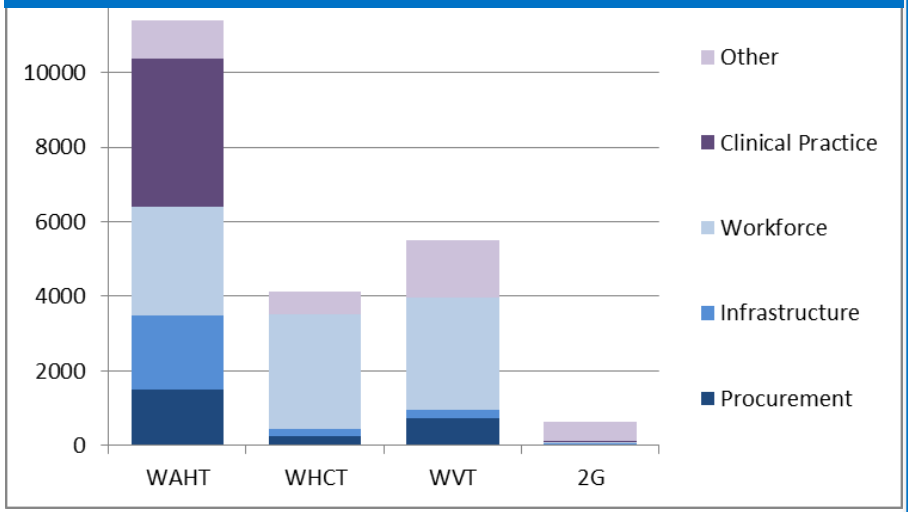
- **Procurement** – a total of £3.0m savings across the 4 providers in 2017/18 and a further £2.5m in 2018/19
- **Infrastructure** - £4.4m in 2017/18 and a further £2.5m in 2018/19. These savings are based on spend to save schemes, likely impairments and increased commercial income as part of an efficiency review linked to the Carter recommendations and other benchmarked opportunities such as estate management and PFI efficiencies.
- **Workforce** – this is the biggest area of focus in provider plans and is centred heavily on reducing spend on temporary staffing. Plans currently aim for £9.2m in 2017/18 and a further £9.0m in 2018/19.
- **Clinical Practice** – a reduction of £2.5m in 2017/18 and £4.0m in 2018/19. These savings include productivity and efficiency improvements in areas such as length of stay, day case rates, outpatient follow up rates, reducing non attenders and readmissions as well as more efficient prescribing practise and improved theatre utilisation.
- **Other** - £3.1m in 2017/18 and a further £3.7m in 2018/19. These savings include improved income recovery through better productivity, improved CQUIN performance and better contract management.

Note that, combined, these savings equate to £21.2m and £21.7m respectively for the next two years. However, in order to achieve control total compliant expenditure, additional savings across the providers or almost £27m will need to be identified in 2017/18.

2017/18



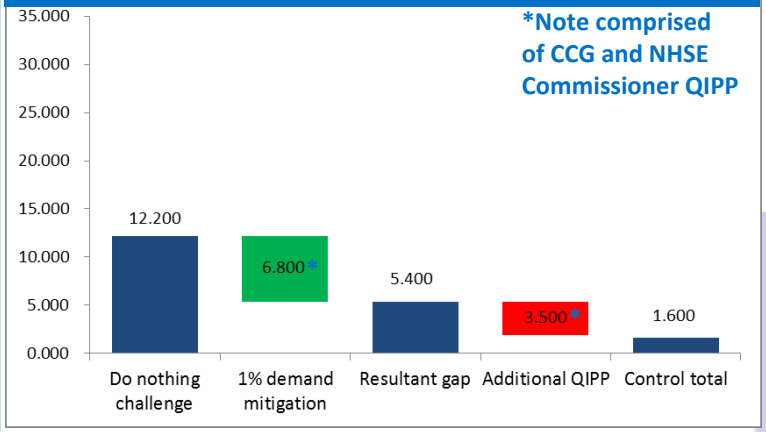
2018/19



Our biggest challenges – finance and efficiency

Our financial modelling shows that we can bring the system into financial balance by 2020/21 by using £26.9m of our STF allocation to support sustainability. However, we have a significant challenge in achieving the system control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals the Herefordshire system would need to achieve combined savings of £28.3m in year. For Worcestershire this figure is £54.4m. In reality because a significant proportion of the commissioner challenge would be in spend areas with the provider, the provider challenge would be further magnified. Significantly for the two acute providers these programmes equate to circa 15.0% and 9.3% of income respectively.

Herefordshire Commissioner Bridge 2017/18

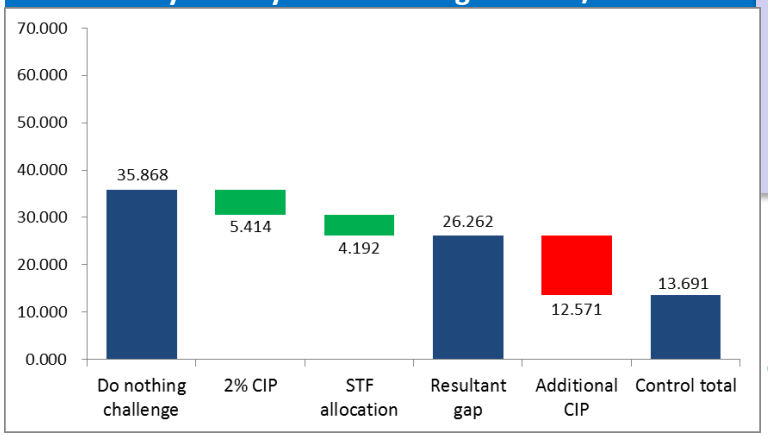


Herefordshire Challenge

£6.8m
£3.5m
£10.3m

£28.3m

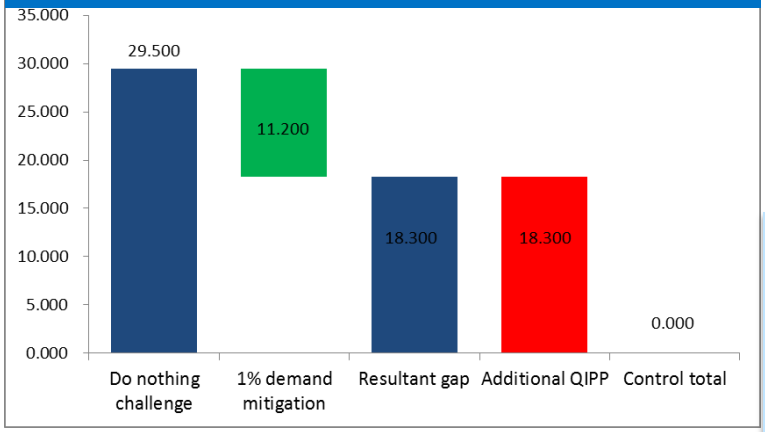
Wye Valley Finance Bridge – 2017/18



£5.4m
£12.6m
£18.0m

circa **15.0%** CIP (inc impact of commissioner QIPP)

Worcestershire Commissioner Bridge 2017/18

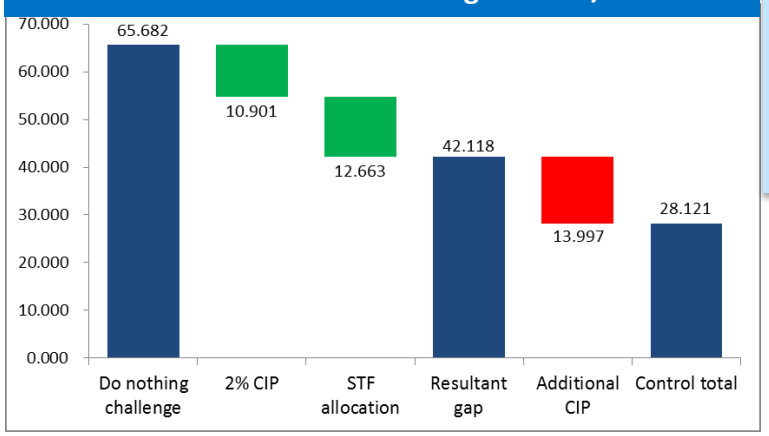


Worcestershire Challenge

£11.2m
£18.3m
£29.5m

£54.4m

Worcs Acute Finance Bridge – 2017/18



£10.9m
£14.0m
£24.9m

circa **9.3%** CIP (inc impact of commissioner QIPP)

Investing in change and transformation

An Allocative Approach to Budget Prioritisation

Partners on the programme board agreed to take a strategic approach to making investment and disinvestment decisions across the system budgets. A budget allocation exercise was facilitated by The Strategy Unit of the Midlands and Lancashire Commissioning Support Unit.

This process included partners reviewing national "asks", local performance and outcome information from the gap analysis and agreeing a strategic direction of travel for how we believed we could most efficiently optimise the use of resources to achieve the best outcomes for the population.

The core purpose was to enable rational allocation of any growth money that CCGs will receive in their allocations over the STP period and agree where the most significant efficiencies and service changes would need to be targeted in order to achieve this strategic intent. The intention is to use this process to support the strategic shift in resources over the lifetime of the STP.

However, it will be a significant challenge for the system to achieve this quickly using traditional methods of contracting. Any additional investment highlighted in the table is naturally reliant on the system's ability to disinvest equivalent amounts in the other areas. It is therefore a priority of the STP to move towards population based capitated allocations using more flexible contracts to enable commissioners and providers to ensure that resource is targeted to the right areas.

Through the joint operational planning process, CCGs and Providers are working together to develop joint schemes to support each other to deliver their respective financial positions. By the end of December 2016 these arrangements will be clarified and included in published operational plans.

Funding area	Indicative funding share	Real terms change*	Actual funding increase
Running costs	Reduce	-26%	-15%
Back office and infrastructure		-7%	
Urgent care and emergency admissions	Reduce	-6%	+7%
Maternity care	Increase	+1%	+15%
Mental health and learning disability services	Increase	+8%	+23%
Elective treatment – life threatening conditions (cancer, cardiac etc)	Increase	+7%	+22%
Elective treatment – non life threatening conditions	Reduce	-20%	-8%
Diagnostics and clinical support services	Reduce	-11%	+2%
Medicines optimisation	Reduce	-8%	+5%
Core primary care (GMS)	Apply national formula and GPFV requirements		
Extended primary and community services to support proactive out of hospital care	Increase	+17%	+33%
Total		**0.0%**	**+13.0%**

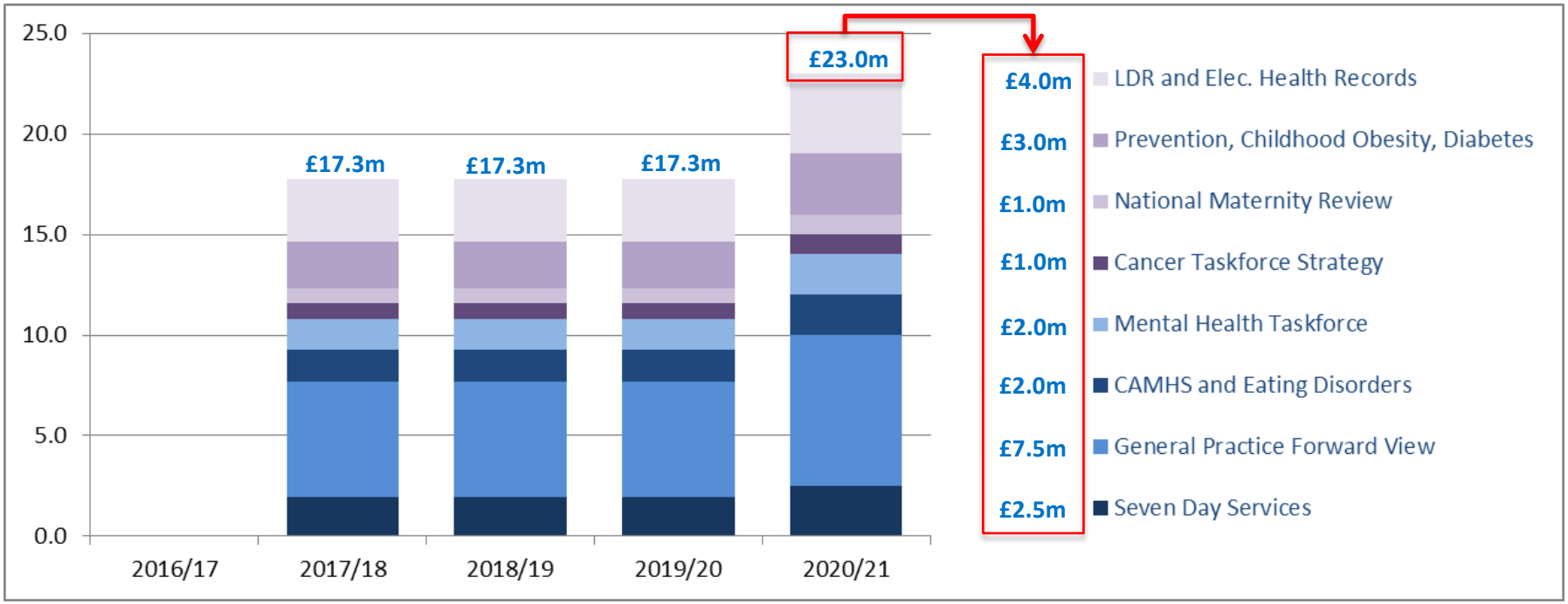
**Ambition for funding growth above inflationary increase*

Investing in change and transformation

Allocating the STF Money

The allocation exercise was also used to inform discussions and prioritisation for use of the transformation element of the STF. These investments will need to be made early in the planning cycle if they are to begin delivering the scale of transformation required to improve services and achieve financial balance. Any risk to our ability to make this investment will severely compromise our ability to deliver a balanced plan by the end of the period.

The chart below shows the initial proposed allocation of the STF transformation element. It shows a build up from £17.3m from 2017 through to the end of 2020, before growing to £23.0m in 2020/21. It is important to note that this is the initial proposed allocation and may be subject to change as further work is conducted to develop the project delivery plans in each area.



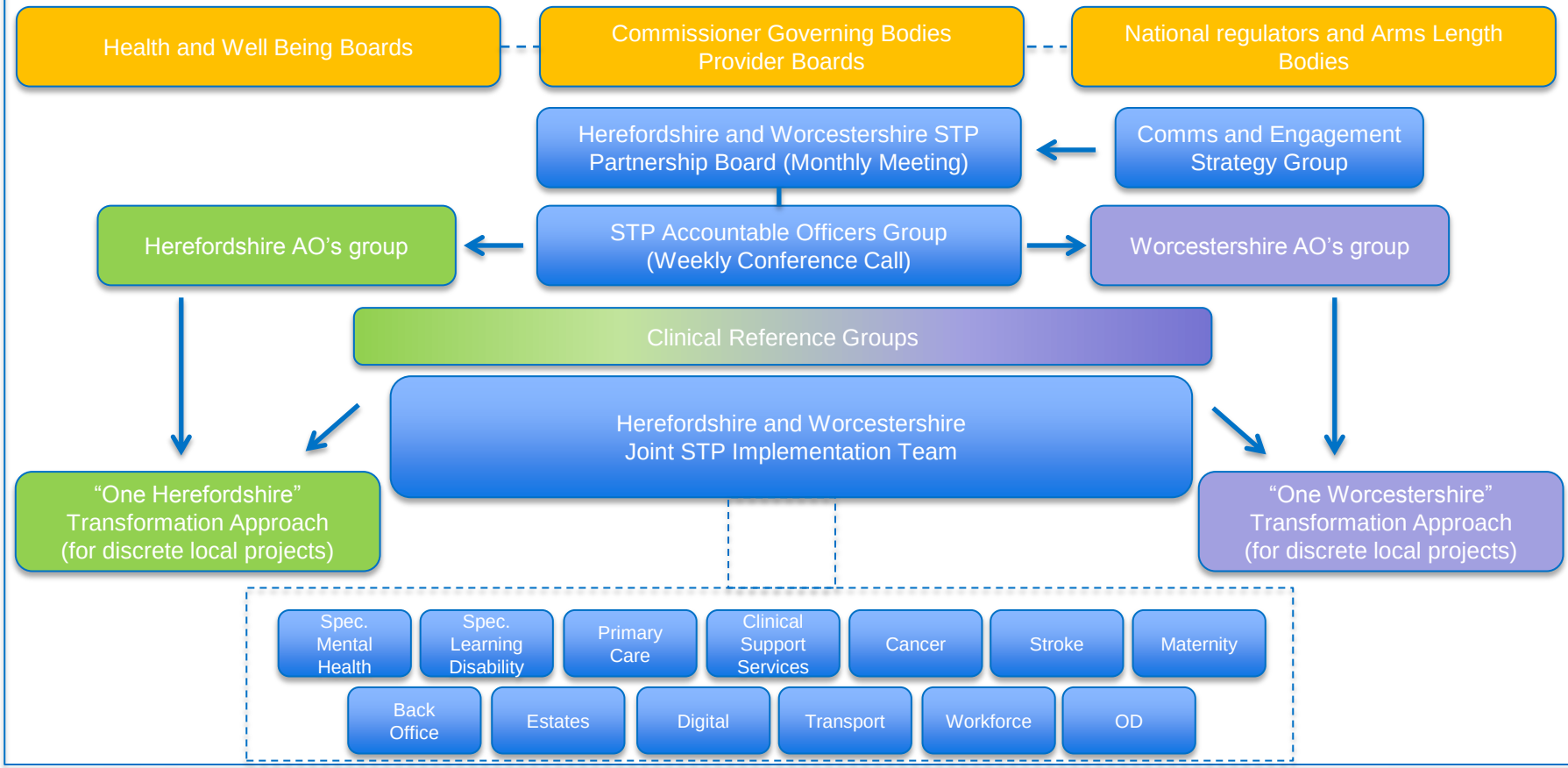
Within the use of this transformation resource there are specific primary care data sharing and governance issues that will need to be resolved.

Our priorities for transformation

Transformation Priorities	Delivery Programmes	Enablers
1 Maximise **efficiency and effectiveness** across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes.	• Maximising efficiency in infrastructure and back office services (annex 1a) • Transforming diagnostics and clinical support services (annex 1b) • Medicines optimisation and eradicating waste (annex 1c)	Develop **the right workforce and Organisational Development** within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face. Invest in **digital and new technologies** to support self care and independence and to enable our workforce to provide, and patients to access, care in the most efficient and effective way, delivering the best outcomes. Engage with the **voluntary and community sector** to build vibrant and sustainable partnerships that harness innovation, further strengthen community resilience and place based solutions. Develop a **clear communications and engagement plan** to set out our strong commitment to involving key stakeholders in the shaping of our plan and describe the process and potential timelines associated with this.
2 Reshape our **approach to prevention**, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.	• Embedding prevention in everything we do and investing in 4 key at scale prevention programmes (annex 2a) • Supporting resilient communities and promoting self care and patient activation (annex 2b)	
3 Develop an improved **out of hospital care** model, by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising "own bed instead".	• Investing in primary care to develop the infrastructure, IG requirements and a new workforce model that has capacity and capability as well as resilience (annex 3a) • Redesigning and investing in community based physical and mental health services to support care closer to home (annex 3b) • Redefining the role for community hospitals (annex 3 c)	
4 Establish **sustainable services** through development of the right networks and collaborations across and beyond the STP footprint to improve urgent care, cancer care, elective care, maternity services, specialist mental health and learning disability services.	• Investing in mental health and learning disability services (annex 4a) • Improving urgent Care (annex 4b) • Delivering improved maternity care (annex 4c) • Improving elective care and reducing variation (annex 4d)	

Arrangements for delivering the plan

Governance and delivery arrangements - A robust and inclusive framework has been developed to support the work undertaken to date on developing the STP. There is an independent chair of the programme board, which is comprised of all key organisational leads and stakeholders. Working to the programme board there is a programme management office (PMO) in place that will be enhanced as we move into the delivery phase. There is an STP wide communications and engagement strategy group and there are clinical references groups supporting both counties that will come together to agree on pan STP clinical issues. We will develop an STP wide transformation team to bring together transformation resources across the footprint to work in a more coordinated way. Where it makes sense to do so, programmes will be developed across the STP area, where there are local or geographic imperatives that require local solutions, these are and will continue to be managed within each county's tailored transformation programme structure.



Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
1. STP	• Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.	STP Priorities 1,2,3 & 4
2. Finance	• Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector and CCG Sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.	We have a significant challenge in achieving the system and provider control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals, Herefordshire would need to deliver a combined QIPP/CIP programme of £28.6m and Worcestershire £37.2m Through delivering our programmes of work we will; • Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market". • Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions • Reduce variation in prescribing patterns and increase adherence to approved use of medicines, allowing allocation of additional resource available for new and proven treatments to support prevention and demand control • To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.
3. Primary Care	• Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support and the 10 high impact changes. • Ensure local investment meets or exceeds minimum required levels. • Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors, pharmacists working in general practice by 2020,the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.	STP Priority 3	**Programme 3a: Developing sustainable primary care** • Work with patients to develop improved access to routine and urgent primary care appointments across 7 days a week through roll out of Prime Minister's Access Fund initiatives. • Local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with patients, community pharmacy, third sector and public sector services as well as community and mental health services. • We will implement the "10 high impact areas for General Practice" within and across practices. • With increased capacity within primary care we will work with patient to adopt new ways of working: Moving to a proactive model of care, identifying and case managing through an MDT approach adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access.

Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
4. Urgent & Emergency Care	• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.	STP Priority 4	**Programme 4b: Improving Urgent Care** • Improve urgent care pathways to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements • Deliver the four priority standards for seven-day hospital services for all urgent network specialist services **Programme 4a: Improving mental health and learning disability care** • Access will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Implement the crisis concordat action plan
5. RRTT and elective care	Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, Better Births, through local maternity systems.	STP Priority 3 & 4	**Programme 3c: The role of community hospitals** • More planned care will be available closer to home, e.g. outpatients and day case, reducing the need to travel for regular appointments **Programme 4c: Improving maternity care** • Citizens will have access to high quality, safe and sustainable, acute, women and neonatal and mental health services, localised where possible and centralised where necessary **Programme 4d: Elective Care** • Two aspects to improving elective care: 1. Effective commissioning policies and stricter treatment thresholds 2. Efficient organisation of services to meet demand, undertake more routine elective activity on a reduced number of "cold" sites
6. Cancer	• Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report. • Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards. • Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. • Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types. • Ensure all elements of the Recovery Package are commissioned	STP Priority 4:	**Programme 4d: Elective Care** • We aim to achieve deliver world class cancer outcomes for our population by delivering the national cancer strategy. This will mean fewer people getting preventable cancers, more people surviving for longer after a diagnosis, more people having a positive experience of care and support; and more people having a better long-term quality of life. • We aim to be better at prevention and deliver faster access to diagnosis and treatment. We aim to achieve consistent access of all cancer treatment standards . • There will be fewer diagnoses made through emergency admission or unplanned care provision and better patient experience of cancer care received.

Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
7. Mental Health	• Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages; additional psychological therapies, more high quality Children and Young people services, treatment within 2 weeks for first episode of psychosis, increased access to individual placement support, community eating disorder teams and a reduction in suicides. • Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. • Increase baseline spend on mental health to deliver the Mental Health Investment Standard. • Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. • Eliminate out of area placements for non-specialist acute care by 2020/21.	STP Priority 4	**Programme 4a:Improving mental health and learning disability care** • The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be embedded across our footprint – including crisis care, Mental Health liaison, transforming perinatal care and access standards . • Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 • The services in place will be responding to the health and wellbeing gaps and health inequalities identified. • People who require more tertiary care/specialist support will have their care planned for via managed clinical networks.
8. Learning disabilities	• Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. • Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population. • Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check. • Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.	STP Priority 4	**Programme 4a:Improving mental health and learning disability care** • Addressing Health Inequalities for people with LD – This is a priority for LD services its aim is to reduce barriers , promote inclusion and therefore increase access to health and social care services. • Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support. • Collaborating across Counties to provide Specialist services more efficiently/effectively.
9. Improving quality	• All organisations should implement plans to improve quality of care, particularly for organisations in special measures. • Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services. • Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.	Priorities 1,2,3 & 4	• The STP footprint currently has two acute Trusts in special measures. A key component of our STP is to ensure care is delivered of a standard and quality which is acceptable for our population and to the CQC and is on a trajectory to GOOD and aspires to be OUTSTANDING. • An impact of achieving this will be delivering safe, sustainable and productive services through transformation in general practice, primary care, urgent, non-elective and elective care as described in the annexes of this plan.

Key risks and barriers to the delivery of our plan

	Key risk	Mitigation
Delivery	Insufficient redesign and transformation skills to transform the system and design care pathways across the health and care system	Learn from best practice elsewhere including successful individual organisational experience of transformation Core group identified and leading the STP Partnerships with external organisations (Provex, CSU to date , future plan being considered) Establish system transformation programme resource and central PMO
		Identify and maximise the transformation skills we have across the economy and ensure key people are focused on STP priorities
	Lack of sufficient capacity to focus on the change programme	Structure and commitment post 21st Oct submission being explored to transfer core STP work streams into operational plans, Programme Board are focused on capacity being identified
	Failure to maximise the potential for integration	Joint conversations and AO meetings to enable challenge to each other Significant relationship work has been undertaken to build trust
	Do not seize the opportunities presented by collaboration and continue to work in an isolated way	Joint conversations and AO meetings, Best Value challenge agreed at each point
	Programme does not deliver as insufficient focus and capacity agreed within the economy to deliver	Central PMO structure supported to 21st Oct submission but refresh of requirements moving forward currently underway
	Organisations do not commit to the changes and continue to look after self interests	Continued focus on local needs and the need to work differently as a system, national imperative OD plan moving forward to support more joined up working Develop a system risk share arrangement to incentivise system wide, not organisational thinking
	Planning process becomes overly health focused and as a consequence the role of social care, communities and the VCS sector is taken for granted and the associated costs not factored in	Engagement of wide range of partners on the STP Programme Board All SROs to consider this within workstream discussions Review of draft plans to strengthen this aspect Social care and the Voluntary and community sector are actively involved in programme board
	Inability to meet the requirements of the national strategies such as the mental health, maternity, and cancer strategies/taskforces within the resources that will be allocated	Establish clear agreement at STP board level over funding priorities Application of the strategic intent for resource allocation to operational plan development Develop alternative strategies where funding requirements cannot be fully met
Workforce	Insufficient staff are recruited or developed with the requisite skills to deliver the plan	Workstream focus on "World Class Worcestershire " – making system wide roles attractive. Ongoing recruitment processes Ongoing training programmes and collaboration with Universities to shape training for the future
	Retention of staff deteriorates during the changes	Monitoring systems in place to identify deterioration Effective communication and engagement with staff about proposed changes
	Fragility of the domiciliary and residential care market	Local Authorities to review the sustainability of the private domiciliary & residential care market
	Insufficient primary care staff to deliver at the scale required for the future, (42% of West Mids GP workforce expect to retire or reduce hours in the next 5 years)	Primary care workforce strategy Consideration of new roles and extended roles to support a potentially smaller GP workforce in the future

Key risks and barriers to the delivery of our plan

	Key risk	Mitigation
Engagement	Inability to resolve fundamental barriers for primary care relating to indemnity and property liability that will compromise their ability to engage with partners in new models of care or contracting arrangements	Recognition of the significance of the challenge at STP Board Level Continue work to explore resolutions that could be achieved to reduce the risk to individual GP partners On-going discussions taking place nationally to reduce structural barriers
	Insufficient clinical engagement to own and deliver the plan	Clinical engagement to date through reference groups, internal briefings and input into specific workstream discussions Clinical engagement strategy for post Oct being developed
	Insufficient public engagement in the early stages of the plan may undermine support moving forward	Public and community engagement strategy in place. Comprehensive engagement milestones and approaches which recognise co production H&WBB briefed regularly
	Failure to maintain continued involvement and support of staff	Regular briefings / updates on progress to staff Engagement strategy in place
	Wider clinical engagement does not yield support for the plan	Identify and respond as part of the Engagement strategy
Political & Regulatory	Limited or no political support for the decisions	Regular updates to key forums, specific briefings to MPs National recognition of case for change
	Disagreement between regulatory bodies around the key proposals	Regular communication with Regulators about emerging themes
	The limited capacity of leaders could impact on delivery of the transformation required. Compounded by regulatory processes already in place distracting focus	Identify specific leaders for the transformation process who are not absorbed in delivery of regulator actions day to day
Financial	Inability to release the resources from the existing urgent care system to create the ability to invest in scaling up primary and community service investment	Workstreams in place to identify top priorities. Financial support to model impact with CEO oversight
	Savings opportunities identified may deliver less than planned	Continued rolling refresh programme to revise assumptions Governance processes in place to provide oversight and assurance
	In year financial positions deteriorate further	Organisational recovery plans in place
	Insufficient resources allocated to fund the cost of change – Including availability of capital to enable reconfiguration of services	Programme Board oversight of resource requirement at STP level AOs to review internal capacity and how individuals roles and priorities can be aligned to the change and identify where and external expertise will be required and enabled
	Inability to access sufficient transformation funding to drive the changes required to release the longer term benefits, including the investment required to deliver the national must do's	Implement a clear process for developing and assessing robust business cases for proposed changes
	Decisions made in isolation by partners have unintended knock on consequences to other parts of the system and result in cost shunting	Risks to quality will be identified early stage through existing arrangements incorporating quality impact assessments. Key risks around decisions made under the STP will be fully considered at STP board level so they are identified and decisions are taken. Explore new ways of aligning financial incentives and risk share arrangements

Next steps

There are a number of immediate next steps we need to take to move the STP forward:

- Refine the planning and financial assumptions based on the new control totals and STF funding allocations, with a particular focus on years 1 and 2.
- Identify the steps required to address the financial gaps related to the additional CIP and QIPP requirements identified on page 15.
- Develop our plan for stakeholder and public engagement plan to help us co-produce solutions to address the challenges set out in this document.
- Take immediate action and further development of the four key “at scale” prevention programmes.
- Take immediate action on the primary care sustainability workstream to increase resilience in core general practice and prepare for delivery of Primary Care at Scale.
- Continue to develop the new out of hospital integrated care models in each county.
- Participate in the West Midlands clinical review of the implementation of transforming urgent and emergency care services in the West Midlands.
- Seek NHSE support to review specific services and test proposals to address them which have a potential solution beyond the STP footprint– eg. Stroke, mental health and cancer.
- Establish the benefits and delivery plan for those benefits of being a rural pathfinder for new ways of commissioning specialised services.
- Explore how we can unlock the benefits of the STP through different contracting models to incentivise delivery and develop partner risk share arrangements.
- Agree the revised governance structure to enable us to complete the planning process and transition into operational planning and contracting
- Commission support to help shape the refinements of specific issues to include :
    - An understanding of the clinical dependencies needed to support an acute service in Herefordshire and the resulting costs, reflecting the challenges of rurality.
    - Undertake further analysis of the bed modelling work and assess the potential for change alongside our ambition to deliver more care at or close to home.

Detailed Plans

Name of footprint	Herefordshire and Worcestershire
Region	Midlands and East
Nominated Lead	Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust
Contact Email	whcnhs.yourconversationhw@nhs.uk

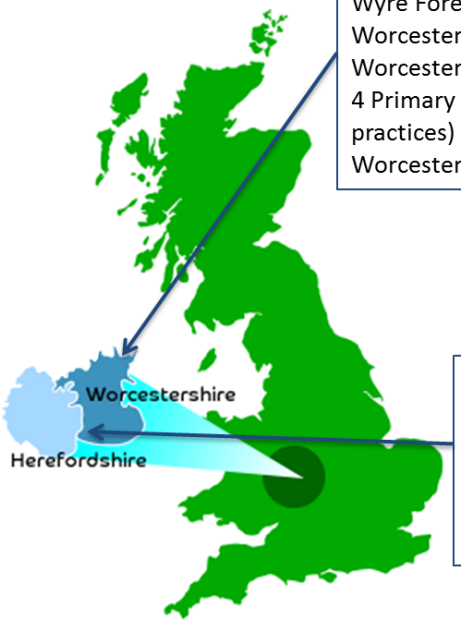
Partners involved	
GP Practices	90
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Health & Well Being Boards	2

Key Statistics	
Population	780,000
Area	1,500sq miles
Annual NHS Allocation – 2016/17	£1.168bn
Annual NHS Allocation – 2020/21	£1.327bn
STF allocation in 2020/21	£50m
NHS "Do Nothing" financial gap to 2020/21	£229.6m
NHS Residual Gap after applying national planning assumptions	£61.5m

Herefordshire and Worcestershire

Sustainability and Transformation Plan

(22nd November 2016 Draft)



Redditch and Bromsgrove CCG (R&BCCG)
South Worcestershire CCG (SWCCG)
Wyre Forest CCG (WFCCG)
Worcestershire Acute Hospitals NHS Trust (WAHT)
Worcestershire Health and Care NHS Trust (WHCT)
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council (WCC)

Herefordshire CCG (HCCG)
Wye Valley NHS Trust (WVT
2gether NHS Foundation Trust (2G)
Taurus GP Federation (representing 24 practices)
Herefordshire Council (HC)

Contents

Priority 1 – Maximise efficiency and effectiveness

Programme 1a	**INFASTRUCTURE AND BACK OFFICE**	**SRO**	Clare Marchant, CEO Worcestershire County Council
Overall aim	Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".		

What will be different between now and 2020/21

We intend to move to a place based model for commissioning support services, infrastructure and back office which results in the best value
The Back Office and Infrastructure Programme will both deliver improvements in service delivery and savings but will also enable the delivery of other STP work streams.

The key components are:

- **Single Procurement Strategy** - New contracting arrangements over longer time periods and single procurement framework for common services and products across all STP partners where beneficial.
- **Single Place Based Estates Strategy** – enabling co-location and service integration and the release of unwanted property and land. Careful consideration will be needed to see how the primary care estate can be included in this work given the different nature of ownership, financing and liability arrangements in place.
- **Single Transactional Services** – With end to end business processes and administration with joined up support services, commissioned and designed to meet the efficiency and STP programme agenda . – particularly in relation to consolidated approaches with an initial focus on:
  - Finance
  - Payroll
  - Procurement support services through making best use of NHS Shared Services or other competitive provider
- **"Virtual" Single Strategic Estates function** – making best use of collective resources, consistent with the "One Public Estate" ethos (and inclusive of wider partners eg. Police, Fire and DWP). To include considering the extension of Place Partnership Ltd in local NHS Property Management. Specific areas to be explored in wave 1:
  - Hospital Catering
  - EBME (Medical Device Management and servicing)
  - Courier & Taxi Services
  - Hard Maintenance
  - Help Desk
  - Waste Management
- **Joined up Digital Strategy** – with modern integrated technology ensuring 100% Digital Access, and paperless care by 2020 (ensuring all are digitally included and patients are empowered through technology) with a connected infrastructure and joined up access channels, including telephony. Overarching digital strategy which brings together the two Local Digital Roadmaps and future-proofs developments around five key areas: connected infrastructure, improving integration, empowering citizens, working collaboratively, enhancing our understanding.
- **Joined up Transport Strategy** – for patients and service users that ensures transport provision is optimised and a reduction in the number of vehicles on the road.

Priority 1 – Maximise efficiency and effectiveness

Programme 1a	**INFASTRUCTURE AND BACK OFFICE**	**SRO**	Clare Marchant, CEO Worcestershire County Council
Overall aim	Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".		

How will this be better for residents and patients in Herefordshire and Worcestershire

Before reviewing the provision of front line services within the STP we recognise the importance of maximising the value and impact, whilst reducing costs of our business support functions.

Through this programme, we aim to:

- **Reduce spend** across back office functions by more than 20% through more efficient infrastructure, organisation and reduced transaction costs. This will include fundamentally changing the way in which local NHS bodies contract with each other, by moving towards population based capitated budgets rather than having an internal market.
- **Co-locate and integrate services** with shared platforms and administration leading to the optimisation of resources across organisational boundaries and reducing unnecessary contacts and journeys.
- Achieve **intelligent estate planning** across the whole "one public estate" to reduce wasted space, enable the sale of surplus land and property and make better use of existing local facilities to support care delivery.
- **Standardise technology applications** to enable a one stop shop approach across all partners , including things like a single Help Desk.
- **Co-ordinate procurement**, bringing efficiency and standard approaches to maximise purchasing power and operational efficiency.
- **Integrate digital care records** to improve clinical management of patients and result in fewer handovers between services and organisations.
- **Coordinate existing transport** provision more effectively to Improve patient access and customer journeys and **Reduce vehicles** on the road and the associated environmental impact
- **Create a common digital infrastructure** with better digital links across organisations bringing enhanced understanding through new ways of data use, leading to earlier intervention and improved outcomes with enhanced and joined up access channels for customers.
- **Joined up channel and telephony** with integrated and effective channels for improved patient access and customer journey resulting in fewer handovers between services and organisations.

All of these programmes of work will provide the opportunity to explore joint working between a range of public sector partners including fire and police

Priority 1 – Maximise efficiency and effectiveness

Programme 1b	DIAGNOSTICS AND CLINICAL SUPPORT	SRO	Chris Tidman, CEO, Worcestershire Acute Hospitals NHS Trust

Overall aim	Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions

What will be different between now and 2020/21

There are critical changes to be pursued within the STP. (1) **Amalgamation of pathology laboratory** services across the STP footprint and beyond and greater functional sharing and consolidation of infrastructure in other clinical support services such as radiology and pharmacy. (2) **Development of agreed system demand management strategies** and delivery mechanisms, with the aim of eliminating unnecessary requests and reducing overall requested activity.

Pathology:

- Early exploration of a consolidated service across both counties.
- Longer term plan to join forces with a larger regional provider or to explore the option of developing a private sector partnership model.

Radiology:

- Development of appropriate direct access initiatives to support ambulatory care outside of acute hospital settings.
- Shared arrangements for out of hours cover and diagnostic reporting.
- Centralisation of specialised services to align with emergency and elective centres.

Pharmacy:

- Development of a single stores, distribution and procurement function across the STP patch
- Options appraisal into medicines supply outsourcing at Worcestershire Acute.
- Other functional service consolidation such as medicines information.

How will this be better for residents and patients in Herefordshire and Worcestershire

- There will be fewer unnecessary requests for diagnostic imaging and laboratory testing, resulting in a reduction in unnecessary exposure to radiation and other harm.
- Workforce and processing of pathology samples will be centralised across a much wider footprint releasing costs, creating economies of scale and increasing purchasing power. These savings will offset pressures in other front line service areas.
- Patients will be able to access diagnostic services more local to them in their communities for less complex procedures and greater direct access will result in reduced need for unnecessary hospital stays.
- Some more specialised diagnostic services will be centralised in fewer emergency / major elective centres to ensure quality and sustainability of clinical skills.

Priority 1 – Maximise efficiency and effectiveness

Programme 1c	MEDICINES OPTIMISATION	SRO	Simon Trickett, Accountable Officer, RBCCG and WFCCG

Overall aim	To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources.

What will be different between now and 2020/21

- Standardised Care pathways to rationalise choice and place in therapy of medicines used.
- Redesign and recommission services to ensure appropriate prescribing/supply of medicines to address issues identified in the pharmaceutical needs assessment and to optimise outcomes and reduce waste.
- Greater use of IM&T to support appropriate use of medicines at every stage of care.
- Reduced variation in prescribing spend between practices.
- Virtual elimination of spend on low priority treatments.
- Enhancing pharmaceutical skill mix to optimise medicines use across all pathways.
- Improving patient reported outcomes that demonstrate effective medicine use.
- Investment into clinical capacity to implement change and deliver new service models, extending into community services.
- Robust and co-ordinated public engagement and communication strategy to support change messages.
- Significantly enhanced role for community pharmacies, including a review of dispensing practices in light of local population access and the most recent guidance and legislation.

How will this be better for residents and patients in Herefordshire and Worcestershire

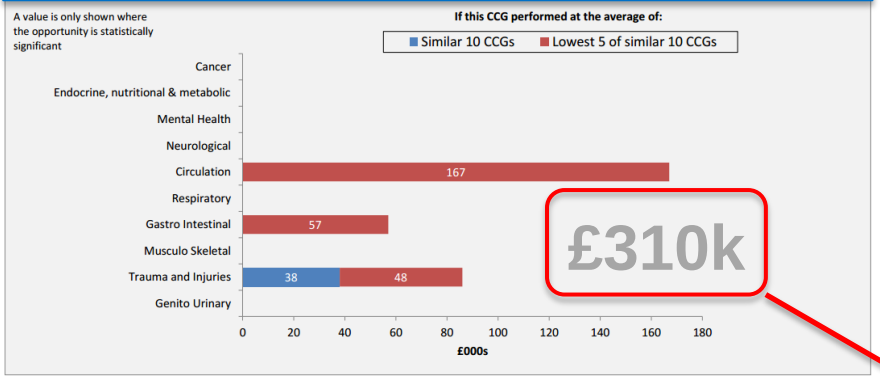
- Transformed access to medicines through service redesign, e.g. off- prescription supply models
- Greater integration and seamless care between all providers.
- Increased reporting of medication reviews across multiple care settings

Priority 1 – Maximise efficiency and effectiveness

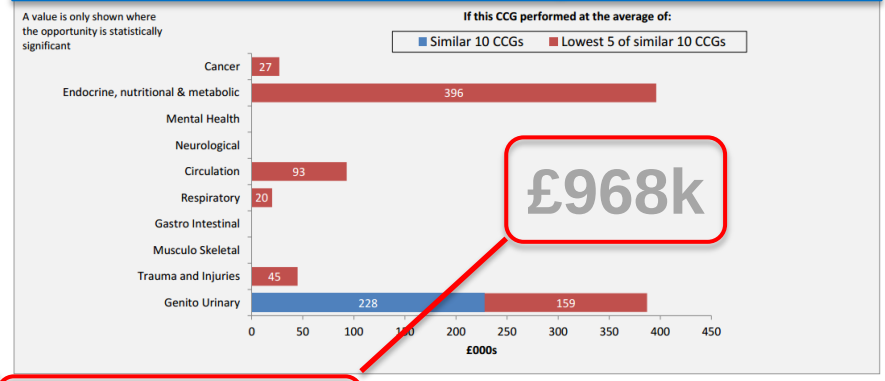
Programme 1c	MEDICINES OPTIMISATION	SRO	Simon Trickett, Accountable Officer, RBCCG and WFCCG

Overall aim	To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources.

Herefordshire



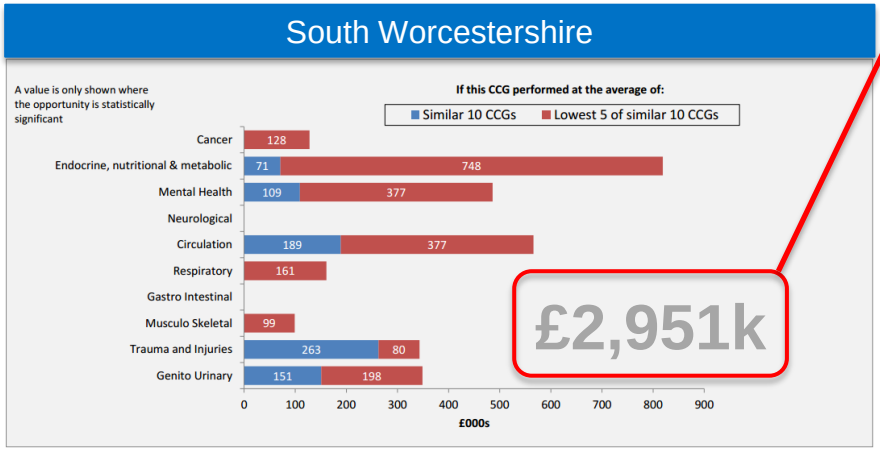
Redditch and Bromsgrove



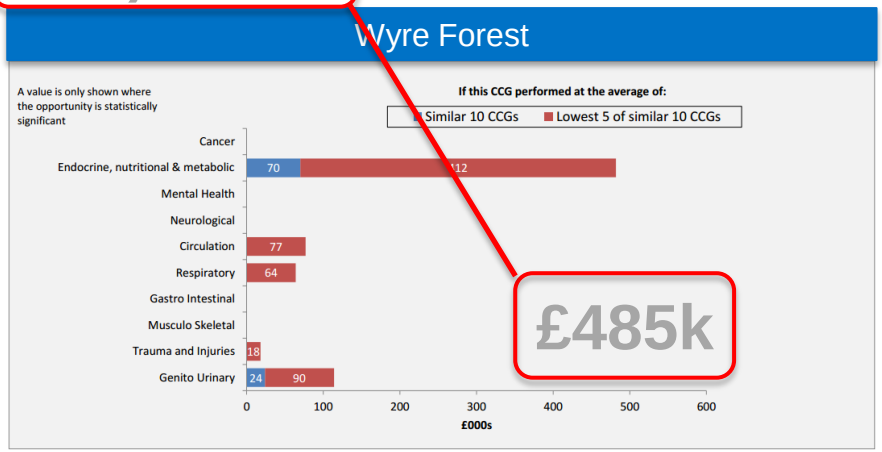
System total opportunity through achieving RightCare prescribing performance of comparable CCGs is a total **of £4.714m**

£4,714k

South Worcestershire

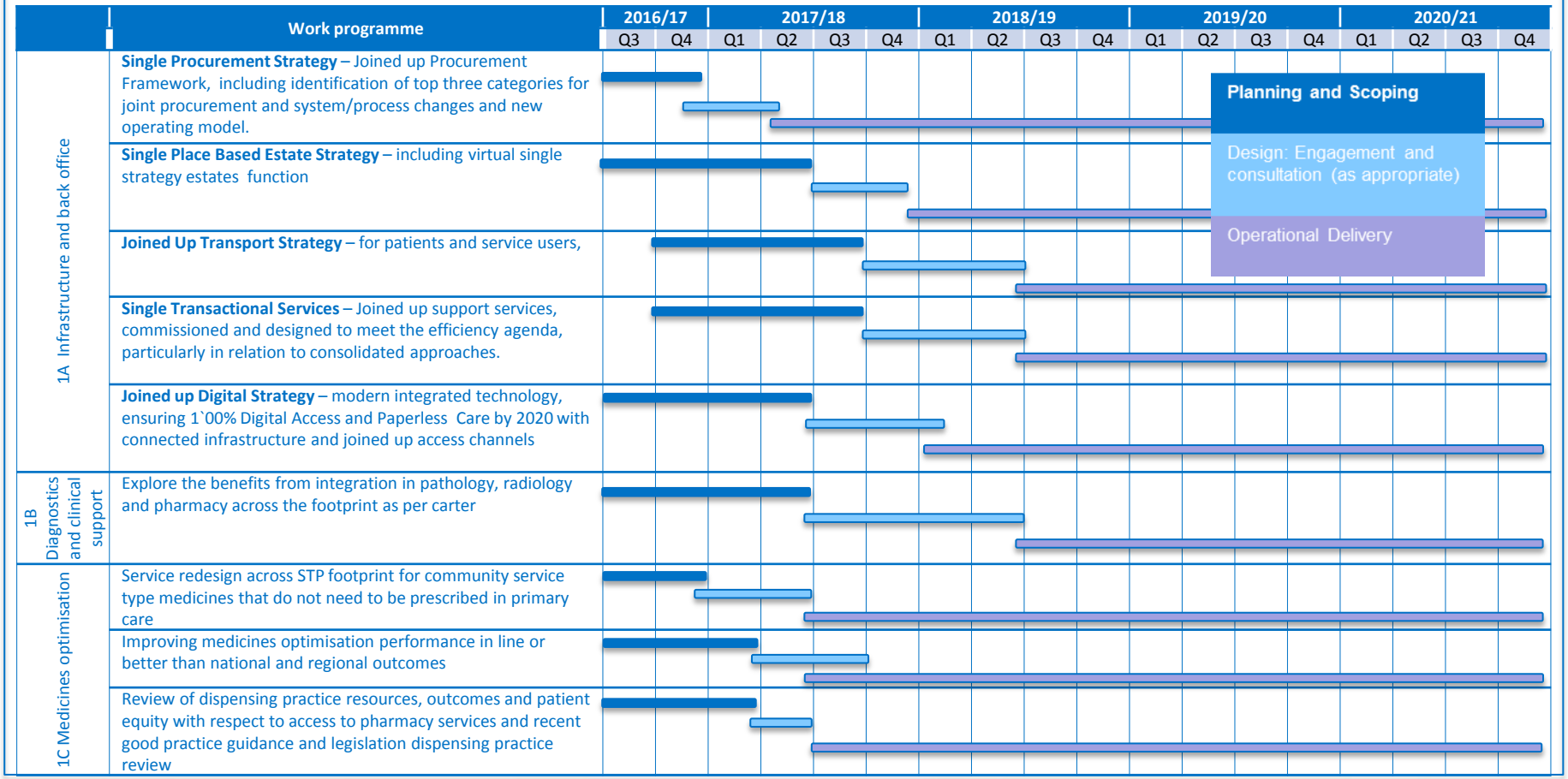


Wyre Forest



Delivery Plan – Priority 1: Maximise Efficiency and effectiveness

Infrastructure and Back Office SRO	**Clare Marchant –** CEO, Worcestershire County Council	**Programme Lead**	**Pauline Harris -** Programme Manager Worcestershire County Council
Diagnostics and Clinical Support SRO	**Chris Tidman** CEO Worcs Acute Hospitals NHS Trust	**Programme Lead**	**Richard Cattell** – Director Medicines Optimisation & Pharmacy Worcestershire Acute Hospitals NHS Trust
Medicines and Prescribing SRO	**Simon Trickett** Accountable Officer – RBCCG and WFCCG	**Programme Lead**	**Jane Freeguard** Head of Medicines Commissioning WCCG's



Priority 2 – Our approach to prevention and self care

Programme 2a	PREVENTION	Owner	Simon Hairsnape, Accountable Officer, HCCG
Overall aim	To embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change.		

What will be different between now and 2020/21

- Ensure evidence based prevention is delivered at scale across health and social care prevention is everybody's business
- 4 delivery platforms embedded across all health and social care services:
  - **Social prescribing**: reducing escalation of conditions, supporting recovery and reducing dependence on services.
  - **Making Every Contact Count (MECC) and "a better conversation" health coaching approach**: staff work in partnership with patients having a different type of conversation that guides and prompts individuals to be more active participants in their care and behaviour change to achieve goals and outcomes that are important to them.
  - **Digital inclusion**: preventing social isolation and supporting self-care and recovery
  - **Lifestyle change programmes**: focusing on obesity (diet and physical activity) smoking and alcohol harm reduction. National Diabetes Prevention programme rolled out across the footprint, as part of an integrated obesity strategy.
- System wide approach to tackling key local issues: **Uptake of flu vaccinations in vulnerable groups and carers** as well as both systematic and opportunistic immunisation by staff across all service groups**, Building resilience in parents and children** – redesigned health visiting, school nursing and family support services. **Prevention of Cancer and related Screening**: reducing both the incidence/prevalence of cancer and earlier diagnosis. **prevention of serious injury from falls** contributing to ageing well. **Extended healthy life expectancy**, and **narrowing the health inequalities gap** elimination of variation between practices.
- Developing **'asset rich communities'** where local people thrive in a network of families, neighbours and communities, getting involved in activities and organisations for the benefit of all', and where front line staff across the systems are able to link clients to their local assets easily and constructively. **Dementia friendly communities** – integrating with dementia services to provide dementia friends training and support for Dementia Alliances.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Staff are confident in undertaking motivational conversations about lifestyle and able to deliver brief intervention and signposting.
- Population behaviour change prevents ill-health - at population level and for individuals
- Reduced levels of preventable disease – reducing demand for both elective and non elective services
- Improved self care by patients and their carers – reducing demand for non-elective services and improving patient experience
- Reduced levels of social isolation – reducing demand for services and improving wellbeing and mental health
- Improved community support of individuals and their carers – reducing demand for services and improving well being

Priority 2 – Our approach to prevention and self care

Programme 2a	PREVENTION	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim

Promoting better long term life outcomes for children, young people and their families' needs to be at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future. It is important to remember that 'Later interventions are considerably less effective if they have not had good foundations' (Marmot Review 2010).

What will be different between now and 2020/21

Best start in life, Focus on full implementation and adequate resourcing of the healthy child programme and broader early childhood services offer including;

- Effective **early help** - to improve the early identification and response to critical issues affecting children and young people's development as well as supporting parenting and socialisation
- **0 to 5 early years in Herefordshire** – to improve the health, wellbeing, developmental and educational outcomes of children aged 0-5 years
- Through the redesign of the **Integrated Public Health Nursing 0-19 Service in Worcestershire**, all children, young people and their families on their Starting Well journey will have access to the Healthy Child Programme (HCP) delivered by skilled community Public Health teams at key development points
- Implement Connecting Families across Worcestershire taking a **whole system response** in overcoming challenges that prevent and/or delay positive outcomes for children, families and vulnerable individuals
- **Vulnerable Groups -** focus on vulnerable children and young people across the STP footprint who are more likely to experience difficulties in their lives and may need support to help overcome them. More can and should be done to address these health concerns through improving the quality of the workforce and range of interventions
- **Mental Health,** Focus on improving the emotional well being and mental health of children and young people
- Strengthening relationships with the **education and skills sector** as a key stakeholder in improving outcomes

How will this be better for residents and patients in Herefordshire and Worcestershire

In the short term:

- Improve information and support for children and families to enable self- management and independence
- Increase personalised care planning in partnership with children, young people and their families
- Strengthen information sharing across the system to enable a joined up approach and end to end care pathways
- Increase competency and confidence of staff across all sectors to manage children and young families needs in partnership with their parents
- Improve our 19-25 provision improving access to education for all (including recovery college)

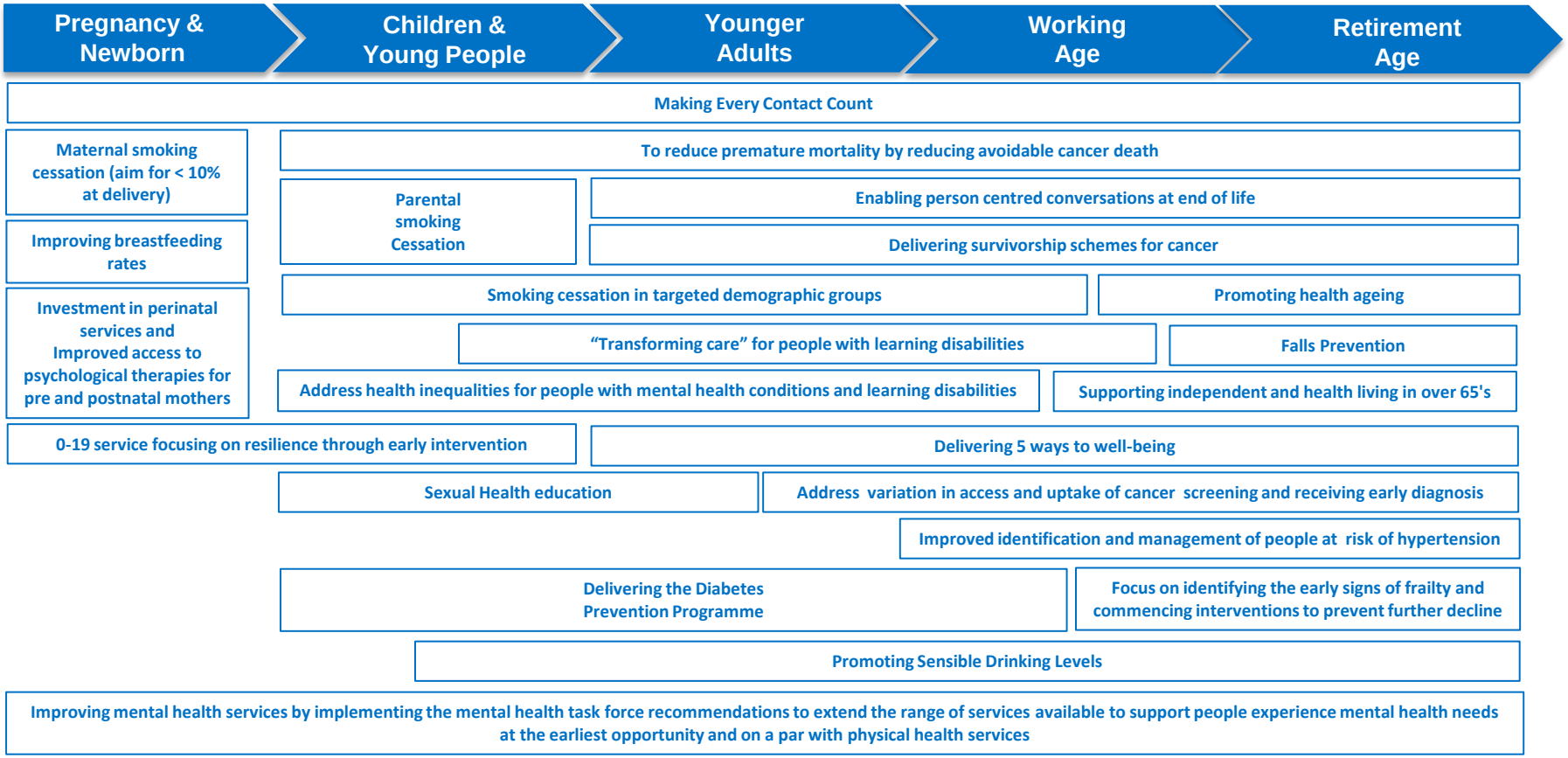
In the medium term:

- Increased choice and control through increased uptake of personal budgets
- Reduced referrals to specialist services
- Reduced out of county placements
- Reduced numbers of looked after children
- Improved educational achievement for vulnerable children and young people including those with SEND
- Reduced NEET and increased young people in education/training
- Improved wellbeing for children, young people and families

Priority 2 – Our approach to prevention and self care

Reshape our approach to prevention, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.

Driving prevention through everything we do; The following diagram demonstrates how we are ensuring that a focus on prevention is inherent across our STP for all age groups and all work streams, delivering an improvement in health and well-being.



Priority 2 – Our approach to prevention and self care

Programme 2b	SELF CARE	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim

To support people to manage their own health, linking them with social support systems in their communities and identifying when a non-clinical intervention will produce the best experience and outcomes for patients. This approach should be led by communities with Health, Social Care and the Voluntary Sector working together to support.

What will be different between now and 2020/21

Building on the success of existing self care initiatives, self-care and care planning will continue to be regarded as a high priority area working in tandem with the prevention agenda. Greater benefits will be realised for local people and staff as the following key interventions are expanded and further innovation applied:

- More individuals will utilise the **range of solutions** available to manage their condition including information, peer support, informal and formal education, digital approaches (eg Map My Diabetes, Patient Management Programme).
- Care planning and self-management will be hardwired into how care is delivered. Care plans will be **digital and shared** between care settings, owned by and useful for patients, their families and carers (eg iCompass).
- People already at high risk of ill health will be identified and offered **behaviour change support** (eg Pre diabetes project, Living Well service).
- **Social prescribing schemes** will be systematic, connecting individuals to non-medical and community support services [eg care navigators based in primary care to signpost and link people to local support, Time to Talk).
- Extension of the roll out of national screening tools used to assess an individuals **motivation** to self-care- thus tailoring the needs of the intervention [eg Patient Activation Measure].
- Early **prevention** will be embedded within each service that the person comes in contact with thus proactively supporting self-care programmes, reducing social isolation and improving social integration [e.g. Health Checks, Falls prevention, Strength and Balance classes, Reconnections] tailoring and focussing services on those who have the greatest need.
- Organisations such as the **Fire Service, Housing Agencies** will be working alongside Health and care to deliver the prevention and self care agenda [eg Home Safety Checks].

How will this be better for residents and patients in Herefordshire and Worcestershire

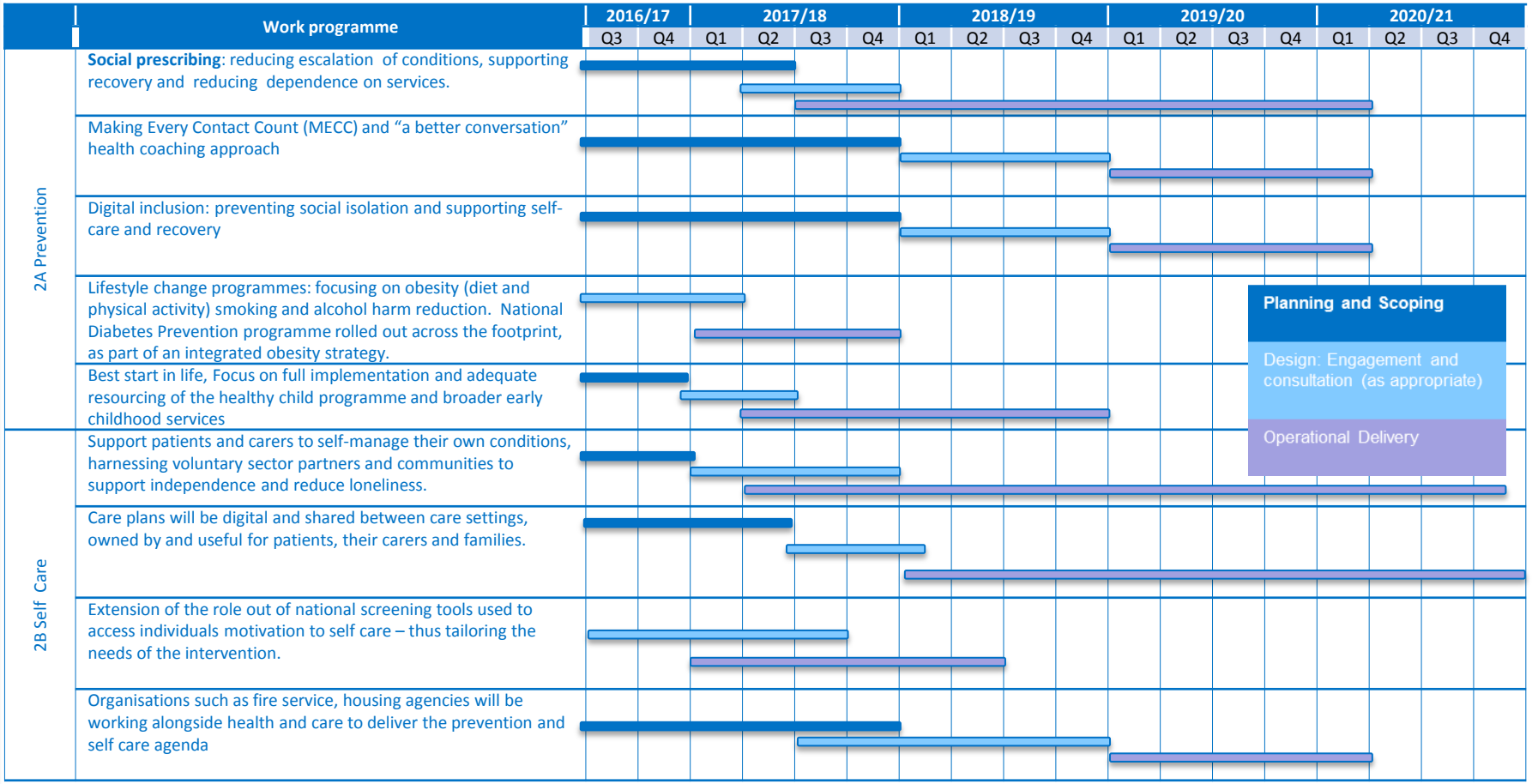
Individuals will be increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reducing dependency on the health and social care system and improve their wellbeing and lifestyle. Ultimately individuals will:

- Increase their sense of control in their lives
- Feel confident to assess and address their health and well-being needs
- Better symptom management, including a reduction in pain, anxiety, depression and tiredness, reduced stress
- Experience improved health and quality of life
- Are able to accept living with their health condition
- Are able to problem solve, make changes and manage their thinking, moods and behaviours positively
- Live as active participants in their communities
- Reduce their use of key services, with fewer primary care consultations, reduction in visits to out-patents and A&E, and decrease in use of hospital resources.
- Increase their healthy life expectancy

Every contact with a patient in primary, community and secondary care will be used as an opportunity to improve patients knowledge of involvement in their care on an individual basis.

Delivery Plan – Priority 2: Our approach to prevention and self care

Prevention SRO	**Simon Hairsnape** Accountable Officer – Herefordshire CCG	**Programme Leads**	**Frances Howie** – Director of Public Health, Worcestershire **Rod Thomson** –Director of Public Health, Herefordshire
Self Care SRO	**Simon Hairsnape** Accountable Officer – Herefordshire CCG	**Programme Lead**	**Menna Wyn Wright** - Transformation Programme Lead - Worcestershire CCGs



Priority 3 – Developing out of hospital care

Programme 3a	**DEVELOPING SUSTAINABLE PRIMARY CARE**	**Owner**	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

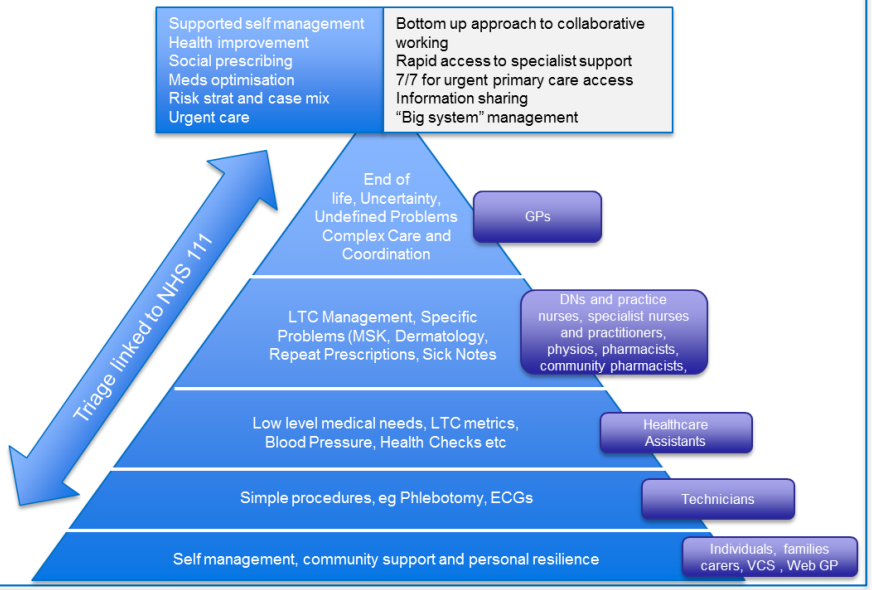
There are a number of fundamental challenges that need to be resolved to support primary care sustainability. Amongst the most significant of these are clinical indemnity, information governance and property liability. Successful delivery of the STP will be dependent on these issues being resolved in a way that enables full engagement of general practice in the new ways of working.

Implementing the GP forward view - Our system has long benefitted from strong primary care which has enabled us to adapt to change. We have a range of federations, including one of the most well developed federations in the country in Taurus. In Herefordshire there are already 7 day services delivered to the population and this is replicated in parts of Worcestershire. However the ability of primary care to continue to meet the changing needs of our population is at risk. Our approach will include investment from the transformation fund to ensure primary care remains sustainable and at the heart of delivery.

Our out of hospital care models will be based around the GP lists for local populations and this will support a shift of resource to enable out of hospital care to be a reality.

The models will recognise the differing needs across the "continuity of care spectrum" from those patients who absolutely need continuity of care to manage their conditions effectively and efficiently, to those with an episodic need where quick and convenient access is the priority. We will work with localities and practices to identify the "care functions" needed to provide holistic care across the spectrum.

The models will build on what is already working well and will embed social prescribing, health improvement and self-management, utilising digital solutions where possible to provide these at scale and support demand management in primary care. The model will seek to extend 7 day access to high quality primary and community care where needed. It will also deliver proactive anticipatory care, through risk stratification, case finding, case management and an MDT approach. The models are predicated on the sharing of resources and specialist primary care expertise across practices. We will work with localities and groups of practices to develop and implement these using a "bottom up" approach to identify what they will deliver (and be accountable for) at practice level, at locality level or at county level and beyond.



Priority 3 – Developing out of hospital care

Programme 3a	**DEVELOPING SUSTAINABLE PRIMARY CARE**	**Owner**	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

90% of all NHS contacts happen in primary care and it is widely accepted that if primary care fails then the whole health and social care system would be at risk. Therefore developing capacity and resilience in primary care, and particularly in general practice, is a priority for our STP. Resilient primary care with sufficient capacity and capability is also critical to our ability to improve health outcomes and to manage people closer to their own home/in community settings. It is a core building block to the development of our new model of care strategy

What will be different between now and 2020/21

- We will deliver this through local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with community pharmacy, third sector and public sector services as well as community and mental health services.
- We will implement the "10 high impact areas for General Practice" within and across practices. This will include:
  - Embedding prevention and health improvement to "Make Every Contact Count"
  - Embedding social prescribing, to connect patients and their carers with community support
  - Training and educating our staff to be able to support self care by patients and carers
  - Utilising digital solutions to enable social prescribing and self-management, as well as new consultation types such as skype consultations and these at scale
- We will encourage all staff to recognise when the end of life is approaching and to have frank and honest conversations with patients and their loved ones and carers. This will lead to development of shared expectations and clear guidance with a view to helping patients take control.
- Through "big system management" we will use real time data collection and analysis to support continuous quality improvement and demand management
- Through primary care at scale we will redesign the primary care workforce to support comprehensive skills and capacity across primary care. Through alliance contracts such as the One Herefordshire Alliance we will deliver this in partnership with acute providers through a delivery model that:
  - Enables seamless working across health/mental health community teams, social care and acute services to provide seamless out of hospital care
  - Enables sharing of resources (clinicians and managers) across organisational boundaries
  - Supports professional accountability, clinical governance, line management, education and development across organisational boundaries

Priority 3 – Developing out of hospital care

Programme 3a	**DEVELOPING SUSTAINABLE PRIMARY CARE**	**Owner**	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

What will be different between now and 2020/21

- With increased capacity within primary care we will adopt new ways of working:
  - Moving to a proactive model of care, identifying and case managing through an MDT approach those at risk of ill-health and/or emergency admission
  - Adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access).
- We will build upon the success of our "Prime Ministers Access Fund" pilots to provide 7 day primary care services, including 7 day access to Urgent Care.
- There will be a statute and regulatory compliant data-sharing model initially developed and delivered across Primary Care that will manage the risk of data breach. This will learn from existing service leading models and will need to be formally approved by the regulatory bodies and legal advisors. This will go on to form the foundation of the "Big Data" workstream ultimately sharing appropriate live data, throughout the Health and Social Care organisations in real time based on the point of individual need and express consent.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Improved access to primary care – for example in Herefordshire in 2016/17 an additional 24,106 appointments by the end of 2016/17 through the Prime Minsters Access Fund.
- Confidence that primary care can support their healthcare needs in a timely manner.
- Capacity and capability within primary care to meet their needs.
- Improved experience, and outcomes through support to prevent ill-health and self manage their own conditions.
- Continuity of care provided through consistent access to patient information.
- High quality care at every consultation, with reduced variation within and across practices.
- Resilient primary care, with the capacity to undertake proactive anticipatory care to prevent people becoming unwell.
- Continuity of care for those with complex needs
- Improved access to specialist opinion in primary care settings
- Patients consistently able to access the most appropriate help and support over 7 days, for both elective, urgent care needs and end of life care.

Priority 3 – Developing out of hospital care

Programme 3b	**INTEGRATED PRIMARY & COMMUNITY SERVICES**	**Owner**	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

What will be different between now and 2020/21

Care will be developed and enhanced through the implementation of new models of care . It is recognised that no one model will work for the range of communities that we serve across Herefordshire and Worcestershire. The following approach has been agreed by primary and community care leaders;

Localities representing General Practice across the STP have come together and agreed to develop a new model of care based on the principles of the emerging MCP vanguards. The local arrangements will be built around natural localities that either already exist or which are rapidly coming together. These localities will range in size from around 35k to potentially more than 150k population. There is widespread agreement about the scope and focus of these localities in bringing together primary, community, mental health and social care services as well as some aspects of acute services that could be more effectively delivered from a community base. There is agreement that there will need to be some form of infrastructure organisation to enable these localities to operate at the required scale to enable integration with county wide partners, to manage risk as well as to provide economies of scale around back office functions. It is agreed that the localities will have a central role in setting local strategy and priorities, but there is widespread recognition that planning and service delivery will need to be layered – with some consistent county or STP wide pathways operating alongside some very local pathways built around smaller groups of practices. Further work is planned to agree how do develop these arrangements into a suitable contracting mechanism and to understand the impact on organisational forms.

Priority 3 – Developing out of hospital care

Programme 3b	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

What will be different between now and 2020/21

- By April 2019 we anticipate having integrated primary and community services commissioned through an overarching Multi-specialty Community Provider (MCP) or similar alliance framework that supports the efficient functioning of locality based integrated teams.
- During 2017/18 and 2018/19 ideas will be tested and piloted before embarking on a formal commissioning process with a longer term outcomes based contract from April 2018.
- Our workforce will promote the wellbeing at every opportunity to reduce the impact of long term conditions. There will be a core focus on priorities such as immunisation programmes and falls prevention.
- Traditional organisational and professional boundaries will be removed, and a place-based model of care will be in place.
- The focus of the system will shift to an “own bed is best” model of care, using a proactive approach, optimising opportunities for independence to be maintained and reducing reliance on bed based care
- Care will be delivered by an integrated workforce, spanning primary, community, secondary and social care, organised around natural neighbourhoods
- Local hubs will be established as part of a coherent and effective local network of urgent care, managing urgent primary care demand across neighbourhoods – this includes a number of General Practices working collaboratively at scale, releasing GP capacity to care for patients with more complex needs
- Specialist support will be available nearer to patients, reducing the time taken to access specialist input and reducing steps in the pathway.
- Robust information about patients, carers and their circumstances will be available digitally to all professionals involved in delivering care
- Personalisation of care will be prioritised , supporting self management and improvements in population health, working proactively with wider place based partners around the determinants of health (e.g. housing, leisure , education, employment, community engagement)
- An integrated frailty pathway will be in place which ensures people living with frailty are at the centre of services, enabling them to live well with their condition, age well and supporting them to live well until the end of life. There will be a shift in focus on to what a person can do rather than what they can’t do.
- Individual care and support plans will include carer support and encompass emotional as well as physical needs.

Priority 3 – Developing out of hospital care

Programme 3b	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients and their carers will be fully involved in the assessment of their needs, and integrated community teams will enable and support them to meet these needs whether they are health or social needs.
- Care plans will be person centred, and reflect specific needs and wishes. The plans should ensure that systems are in place to get help at an early stage to avoid a crisis.
- There will be continuity of care and support, patients will be able to build relationships with staff over time. Care will be delivered in an efficient and timely manner – things happen when they are supposed to and patients will know what to expect, and when.
- With patients permission, information from assessment and care planning is entered on to a digital record, and is shared with everyone involved including the patient. The professionals involved in care talk to each other and work as one team. Everyone has timely digital access to any updated assessments or changes to the care plans.
- Consistent information, is provided to patients and their carers at the right time, and in a format that is easily understood. Patients will have a consistent point of contact if they wish to discuss any concerns.
- Patients will be supported to be independent – our workforce are trained in coaching to enable patients to become more active in managing their own health, wellbeing and care. Staff have time to allow patients to continue to do what they can, make good choices and offer practical support where necessary rather than intervening because its is quicker. Clinicians work in partnership with patients to encourage lifestyle change, support self-management, increase medication compliance and aid complex decision making. This will be measured through Patient Activation Measures (PAMs)
- Patients are empowered to self manage their long term conditions using technology to achieve goals and outcomes that are important to them
- Patients at the end of life will be supported to have conversations about their choices, outcomes of the conversations will be shared and patients will be able to receive their care at home as long as it is safe to do so
- Patients will have one first point of contact in a crises. It will be clear to the patients who to contact day and night and care will be seamless.
- Teams involved in care will have a comprehensive understanding of the range of formal and informal support available, so that they can offer alternative support where appropriate including from voluntary and 3rd sector agencies who will be part of the community teams.
- Carer's needs are considered – the needs and preferences of my family and other informal carers are taken into account, and they are able to access support to continue to care for as long as they wish.
- Where an admission to hospital is necessary, community teams familiar to the patient will in-reach and manage the discharge into the community and provide holistic support tailored to their needs.

Priority 3 – Developing out of hospital care

Programme 3c	THE ROLE OF COMMUNITY HOSPITALS	Owner	Simon Hairsnape, Accountable Officer, HCCG
Overall aim	To develop community hospitals as local delivery facilities for an increased range of activity including outpatients, day case and support services and also to develop the potential of some sites becoming specialist centres for frailty, stroke care etc		

What will be different between now and 2020/21

- We will engage with patients, the public, local clinicians and other stakeholders to understand how we can make better use of our community bedded resources to support care closer to home in line with the principle "own bed is best", in line with what the public has told us. A range of activities could be provided from these facilities such as outpatient services and/or elective surgical procedures to support improved local access. Some sites might therefore become specialist centres or be points for new pathways of care (e.g. frailty assessment and specialist stroke rehabilitation).
- Some community hospitals may be able to operate as bedless, e.g. as a "locality hub" for domiciliary based community services integrated with primary care. This may include the co-location and integrated delivery of community teams with primary care based services and/or 24/7 primary care, as part of delivering the functions of an MCP across the STP footprint
- Some community hospitals may be able to operate with a defined role in the system of care, as part of an integrated care pathway and some may need to reduce the number of beds as services are provided in new ways such as domiciliary based care.

How will this be better for residents and patients in Herefordshire and Worcestershire

Our ambition is that any of the benefits of a new role for community hospitals are consistent with those for community services. In addition, our ambition is that:

- The model of care will move from a reliance on bed based care to care in peoples own homes/their usual place of residence, reducing crisis admissions, onward deterioration and poor outcomes at the point of discharge.
- More planned care will be available closer to home (outpatients and day care for example) reducing the need to travel for regular appointments.
- People will experience more of a "one stop shop" in their Locality Hub as their locality teams (including community, primary and social care staff) will all be co-located.
- People who are frail will experience a wrap around response designed to treat and stabilise so people do not have to go into an acute hospital.

This work will be undertaken based on the principle of co-production with patients, the public and wider stakeholders to ensure we meet the needs of local populations. We will also work with local clinicians to ensure services are integrated and work seamlessly across 7 days.

Priority 3 – Developing out of hospital care

Improving integration between health and social care

In order to transform our services it is essential that we find more effective ways of organising services to respond to the increasingly complex and chronic health and social care needs of our population. This is to reduce duplication as well as to deliver improved outcomes for people and their carers. The evidence indicates that integration results in improved clinical outcomes and a better patient experience (Ref: Stepping up to the Place, NHS Confed and ADASS, 2016). This is supported by our engagement with local people who live with long term conditions and/or multiple needs, which highlights that people want more joined up care. In particular they tell us that the divide between health and social care often impacts on the effectiveness and the efficacy of the support they receive.

Building on our existing joint work across health and social care we are committed to working towards services that work in a more integrated way; wrapping the necessary skills and competencies around people and their carers to enable them to live as independently at home for as long as possible. We believe that redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities whilst also helping to bring about financial sustainability.

The ambition is to liberate front line delivery; enabling our local workforce to come together effectively as multidisciplinary teams, who share skills, expertise and information. In doing so we will maximise the opportunity for an individual to have the right care first time as well as reducing duplication through a common approach.

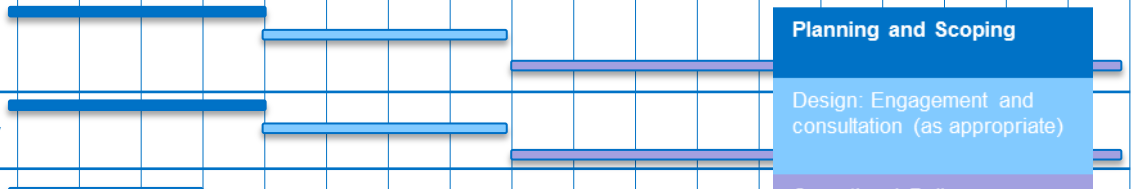
To deliver this we will:

- Improve early and consistent provision of advice and information to individuals, their carers and families, to enable proactive decision making that supports and enables independence and self care
- Offer more choice and control for individuals and their carers, including the wider adoption of Direct Payments/Integrated Personalised Budgets as appropriate
- Embed personalised care planning, in partnership with individuals and their carers, as the central tenet to our ways of working. We will ask' "what matters to you", as well as "what's the matter with you."
- Ensure joined up working across disciplines through the MDT approach, supported by shared information
- Develop a multi skilled workforce that can work across organisational and professional boundaries, whilst identifying tasks which can be shared across professional domains to reduce duplication and improve efficiency
- Work with local communities and the voluntary/community sector, to understand where and how partnership working can support individuals and carers to manage their own health and care needs
- Successful delivery will require us to nurture leadership across our workforces, to drive change in both culture and ways of working across personal and professional boundaries.

Delivery Plan – Priority 3: Developing out of hospital care

Primary Care SRO	**Graeme Cleland** Managing Director - Taurus Healthcare	**Programme Lead**	**Yvonne Clowsley** - Programme Manager Taurus Healthcare
Integrated Care SRO	**Sarah Dugan** CEO Worcs Health and Care NHS Trust	**Programme Leads**	**Sue Harris –** Director strategy Worcestershire Health and Care Trust **Matt Stringer –** Strategic lead new models of care WHCT **Alison Talbot-Smith –** Director of Transformation for One H **Nisha Sankey –** Associate Director of Transformation WCCGs
Community Hospitals SRO	**Simon Hairsnape –** Accountable Officer – Herefordshire HCCG		

	Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3A Developing sustainable primary care	Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health/mental health services.																		
	Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.																		
	Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.																		
	Share information across practices and other providers to enable seamless care.																		
	Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.																		
3B Integrated primary and community services	Through the Worcs Alliance Boards, develop population based integrated teams																		
	Through the One Herefordshire Alliance, develop population based integrated teams																		
	Commission services from between 1 and 4 locality based Multi-Speciality Community Providers or similarly formed new model of care alliances.																		
	Develop integrated frailty pathways in both counties																		
3C Community Hospitals	Co-design options for change with patients, the public, local clinicians and other stakeholders to support care closer to home, based on the principle that "own bed is best".																		
	Implement any resulting changes to inpatient beds, community based "hubs" and increased in planned care in community hospitals																		



Priority 4 – Establish clinically and financially sustainable services

Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

Context

Services in Herefordshire and Worcestershire need to develop to progress the National "Must Do's" set out in the NHS five-year forward view for mental health services (FYFVMH) published by the Mental Health Taskforce. The FYFVMH identifies a five-year programme of developments underpinning the transformation of mental health care and support, aligned to continuously improving the quality of care and support available to people with mental health needs.

We know that nationally :

- Many people with mental health problems are also affected adversely by Social Determinants e.g. Poverty, Social Isolation, Discrimination, Abuse, Neglect, Drug and Alcohol Dependencies, etc, which contribute to poor health outcomes
- A number of medications used to treat physical health care needs can have side-effects that produce psychiatric symptoms
- The side-effects of a number of medications used to treat mental health care needs can have detrimental effects on physical health such as Obesity, Diabetes, Cardiovascular, Nervous and Immune systems
- There are higher rates of unhealthy behaviours amongst people with mental health needs i.e. smoking and use of alcohol or other substances
- People with mental health needs are often less able to motivate themselves and less effective at seeking help
- There are barriers to accessing physical health care support relating to Stigma, Prejudice and Discrimination

PHE data suggests that well being outcomes generally are at average levels but IAPT spend and mental health prescribing in primary care is of concern across our footprint.

Priority 4 – Establish clinically and financially sustainable services

Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

What will be different between now and 2020/21

The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be implemented across our footprint . Within this we will work on the following priorities:

- A specific focus on Perinatal care as it delivers immediate benefits and evidence-based Mental ill-Health prevention
- Increased access to psychological therapies for a range of common mental health disorders and the management of 'Medically unexplained symptoms' to reduce demand within acute and primary care.
- Strengthened management of people with dementia in acute urgent care systems and primary care at scale
- Increased visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet focused on delivering integration rather than isolation
- Collaboration to deliver a range of care more locally at an STP/STP Plus level i.e. Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 CAMHS, Locked Rehabilitation, Complex Dementia services, eating disorder and personality disorder services
- Moving mental health care from Good to Outstanding with immediate priorities for delivery focused on talking therapies (IAPT) and Early Intervention Services (EIS)
- We will conduct coordinated work on reducing stigma through campaigns and communications

So that:

- Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision.
- The services in place will be responding to the health and wellbeing gaps and health inequalities identified within the Herefordshire and Worcestershire JSNA's and resultant Health and Wellbeing Strategies.
- Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support.
- People who require more tertiary care/specialist support will have their care planned for and provided across the STP and in partnership with neighbouring STPs via managed clinical networks.
- There is reduced expenditure in other programme areas, such as urgent care and complex care (ie CHC and social care packages) from the increased investment in mental health and learning disability services.

Priority 4 – Establish clinically and financially sustainable services

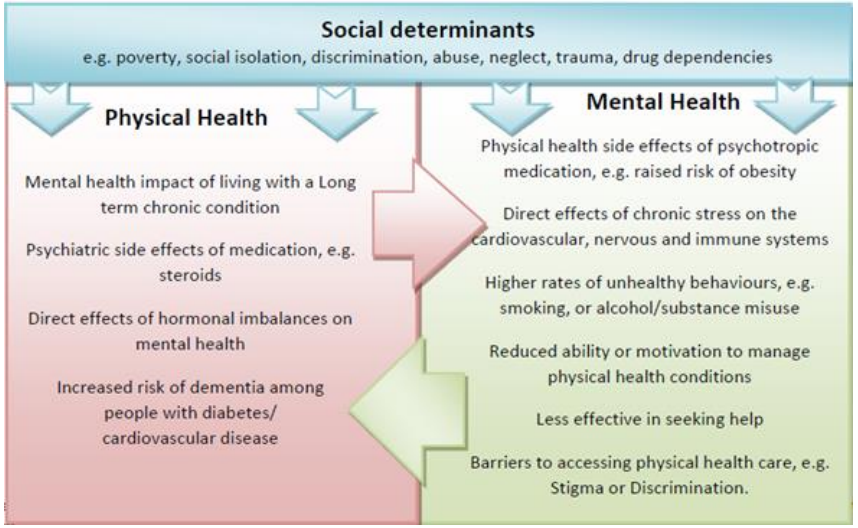
Programme 4b	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Citizens will have better access to information that promotes and supports positive mental wellbeing – social prescribing, MECC, digital inclusion and lifestyle change programmes – can all impact in the short to medium term. Longer term , tackling social deprivation through economic regeneration and the creation of healthy jobs has a significant role in improving population mental health and well being.
- The population's attitudes to individuals experiencing both common and more complex mental health difficulties will be better informed, more supportive and less stigmatised. This in turn will support earlier access to wellbeing services, diagnostics, treatment and better support and opportunities for recovery.
- Individuals who experience physical and mental health co-morbidities will experience well coordinated, education based packages of care that promote and enable self care and minimise the complications associated with comorbidities.
- Fewer people will need to access specialist services outside of the STP footprint.
- Improved rates of access to or sustained education, training and or employment consistent with local rates of whole population attainment.
- Improved access to and sustained stable accommodation consistent with local rates of whole population attainment.

Relationships between Social Determinants, Physical health and Mental health Adapted from "No health without mental health" by Prince et al in 2007



Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service delivery 2gether NHS Foundation Trust **Liz Staples** – Deputy director of nursing Worcestershire Health and Care NHS Trust

4a Improving mental health and learning disability care

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Increasing visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet																		
Collaboration to deliver a range of care more locally at an STP/STP Plus Level																		
Increasing access and availability of psychological therapy to 25%																		
Develop early intervention services in line with national proposals																		
Development of CAMHs community eating disorder services																		
Development of perinatal mental health services																		
Development of crisis care and 24/7 mental health urgent care services.																		
Development of dementia services – with a focus on early intervention, strengthened VCS links and interface with frailty pathway																		
Development of CAMHS emergency, urgent and routine pathways																		
Development of acute mental health care – reduce the need for admissions out of area and the number of re-admissions																		
Development of integrated mental health and physical health care pathways in line with MCP developments																		
Development of personality disorder services																		
Development of adult ADHD pathways subject to investment profile																		
Development of adult autistic spectrum disorder and neurodevelopment pathways subject to investment profile																		
With local authorities, develop joint outcomes and shared care for people with learning disabilities																		
"Transforming care" for people with learning disabilities – to reduce the number of people accessing services out of area																		
Improving rates of access to or sustained education, training and or employment - for people with learning disabilities - reducing health inequalities																		

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Introduction

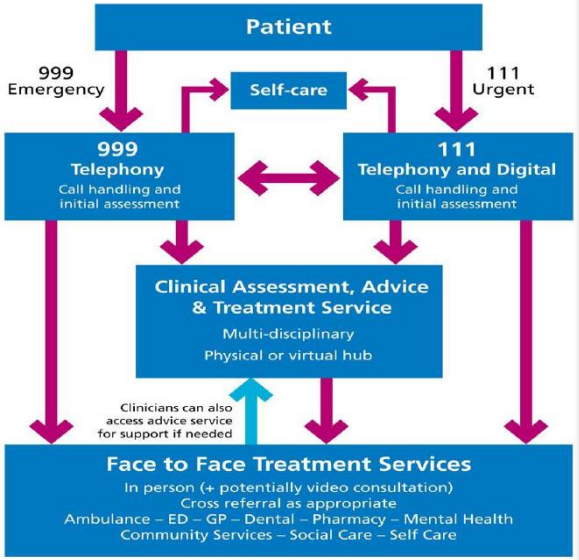
There are a number of key challenges that need to be tackled over the life of the STP, the most pressing challenge across both counties is to address the poor performance in terms of meeting the four hour emergency access standard. We will need to develop more effective streaming of patients to the most appropriate urgent care point and to continue to improve lean patient flow through the system. There are many important aspects to our strategy for achieving this, namely (1) Integrated Urgent Care , (2) Rationalisation of physical access points and (3) Development of seven day services

Integrated Urgent Care - Urgent Care systems across both counties already provide 24/7 access for patients that need it. There are three 24/7 Accident and Emergency Departments, two 24/7 Minor Injury Units, 24/7 support and referral mechanisms through NHS111 and of course, accessible ambulance services through 999. In addition to this, although not operational 24/7, there are GPs working with some emergency departments 8 hours a day on weekdays and 12 hours a day on weekends and GPs working with the ambulance service 12 hours a day on weekends and bank holidays. All of these services combine to provide a comprehensive urgent care offering. However, we recognise that we can do more to integrate services more effectively.

CCGs in both counties have recently participated in the regional commissioning of a new Integrated Urgent Care model and will shortly be launching the innovative new service. This new model will provide a single point of access and clear onward referral arrangements to improve patient experience and alleviate pressures across the health and social care systems. The model will include earlier clinical assessment and advice through the introduction of a clinical hub and will support closer working with the wider range of existing urgent care providers.

Within Worcestershire Care UK was selected to deliver both the NHS111 and the Out of Hours service, ensuring that the opportunities for integration are maximised. Within Herefordshire, whilst different providers were selected for the two services, both are required to operate to a service specification that is built around effective integration between the two services.

The New Integrated Urgent Care Model From November 2016 onwards



Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Access to Urgent Care –
Alongside the new integrated urgent care model, we need to review physical access to urgent care services and the provision of specialist facilities – including the number of hospital beds required to support the demand. Changes to physical access is required because the system simply contains too many options, too much duplication; is too confusing for patients and the population and professionals to navigate effectively:

The complex array of ways to access urgent and emergency care across Herefordshire and Worcestershire

Current Provision	Herefordshire	Worcestershire
Telephone access	**NHS 111 and 999**	**NHS 111 and 999**
Main A&E departments	**Hereford**	**Worcester and Redditch**
Minor Injury Units	**Ledbury** (7 days / 24 hours a day) **Kington** (7 days - *8am to 8pm)* **Leominster and Ross on Wye** (5 days, 8:30 to 5:30)	**Kidderminster** (7 days / 24 hours a day) **Evesham, Malvern and Tenbury** (7 days, *9am to 9pm)* **Bromsgrove** (*Mon-Fri – 8am to 8pm, Weekends – 12pm to 8pm)*
Walk In Centres	**Hereford** (*7 days a week – 8am to 8pm)*	**None** (*Worcester's was closed in 2014)*
GP Out of hours hubs (dial NHS 111)	**Hereford, Leominster and Ross on Wye** *Weekdays - 6:30pm to 8:00am,* *Weekends – 24 hours a day*	**Evesham, Malvern, Kidderminster, Redditch, Worcester** *Weekdays - 6:30pm to 8:00am,* *Weekends – 24 hours a day*
Prime Minister's Access Fund	**Primary Care Access Hubs in** **Across Hereford, Leominster and Ross on Wye** *Mon-Fri 6.30pm to 8pm, Weekends 8am to 8pm*	**Clinical Contact Centre (Telephone and face to face)** *Mon-Fri 8am to 8pm, Weekends 8am to 12 noon* **Patient Flow Centre**
GP Practices	**24 Practices** *Mon-Fri 8:00am to 18:30pm*	**67 Practices** *Mon-Fri 8:00am to 18:30pm*

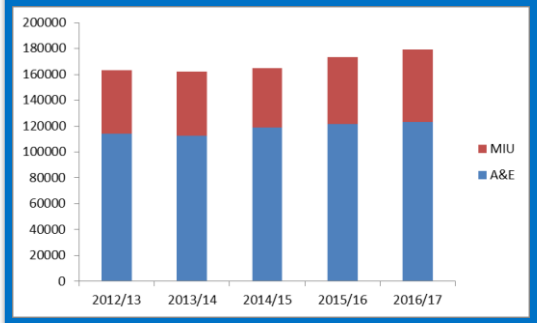
Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Access to Urgent Care – A&E and MIU Attendances during the last five years

A&E and MIU Attendance Trends - Worcestershire



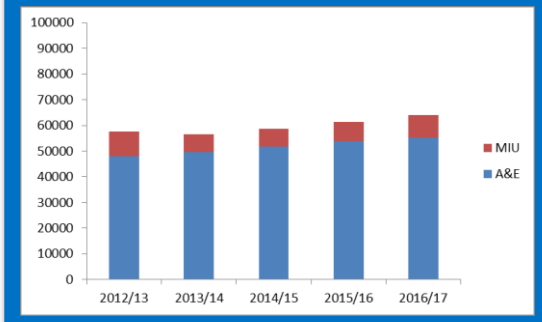
Trend over 5 yrs

A&E = +7.8%

MIU = +14.1%

Amb conveyed patients to A&E +26.5%

A&E and MIU Attendance Trends - Herefordshire



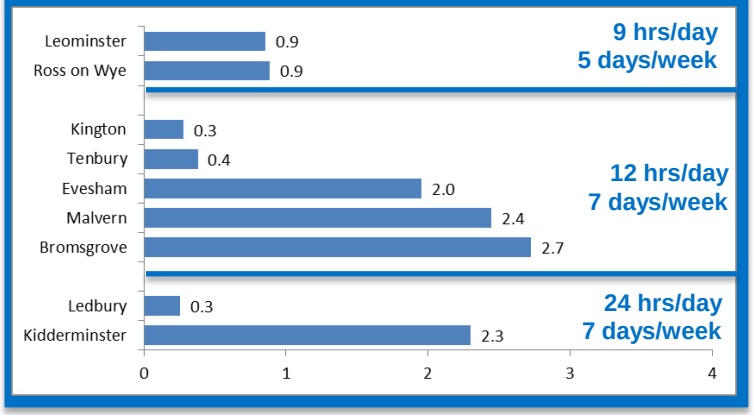
Trend over 5 yrs

A&E = +14.9%

MIU = +24.6%*

From 2013/14 otherwise opening hours not comparable

Average number of MIU attendances per hour open



- Activity in urgent care facilities has increased over the past five years across both counties. In Herefordshire the growth has been higher in main A&E department and MIUs than it has been in Worcestershire.
- Usage of MIUs varies significantly across the two counties, with not surprisingly, the busier units being based in larger population centres.
- There is a clear need to review the demand and capacity match across all sites to ensure that best use of resources is obtained from the facilities that are provided.
- Through implementation of the integrated urgent care model we expect to see this recent annual increase in demand mitigated initially before seeing actual reductions in later years of the STP as the service becomes embedded.

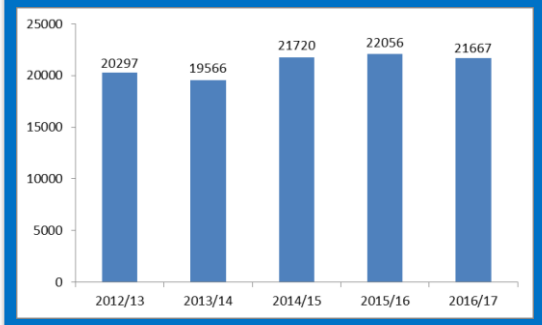
Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

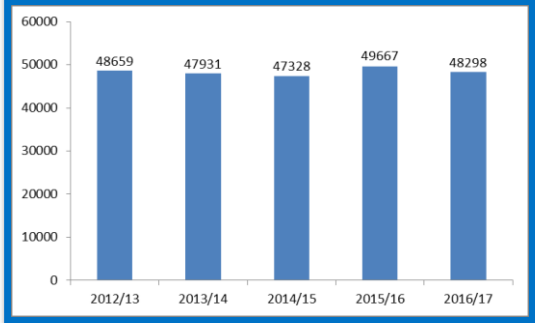
Access to Urgent Care – Emergency Admissions during the last five years

Emergency Admission Trend - Herefordshire



Trend over 5 yrs
Emergency admissions have increased by 6.7% over the last 5 yrs, but have steadied this year

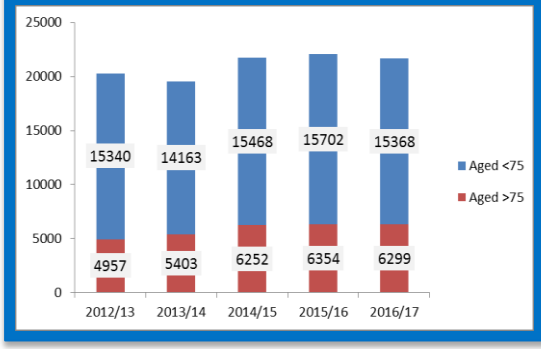
Emergency Admission Trend - Worcestershire



Trend over 5 yrs
Emergency admission have been flat over the period, but there has been a 6.8% increase in >75 admissions this yr compared to last yr.

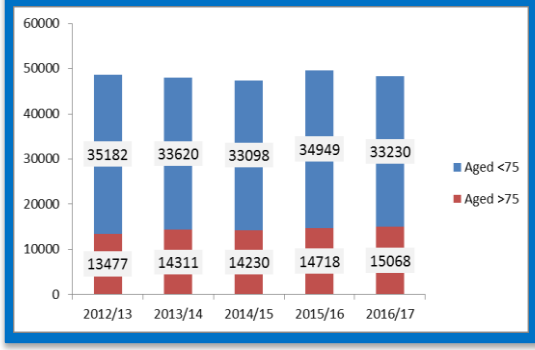
Successful delivery of our strategy to improve out of hospital care will relieve pressure on main A&E departments and the need for emergency admissions.

Emergency Admission Trend – Herefordshire Age Group



Trend over 5 yrs
>75 admissions have increased by 27% over the period and now represent 29% of all emergency admissions

Emergency Admission Trend – Worcestershire Age Group



Trend over 5 yrs
>75 admissions have increased by 12% over the period and now represent 31% of all emergency admissions

2016/17 extrapolated from first 6 months and previous annual profiles

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Implementing the seven day service standards

We expect to achieve roll out of the 4 priority clinical standards by November 2017:

Standard	Our Baseline	Our Plan
2 - Time to consultant review Demonstrate evidence there is a clinical patient assessment by a suitable consultant and a first consultant review within 14hrs,7 days a week.	Target Compliance – 100% Current Compliance – 43.9%	All patients admitted through emergency portals will be reviewed by a consultant within 6 hours, supported by AEC and OPAL services.
5 - Access to diagnostics Access to diagnostic services 7 days a week for x-ray, ultrasound, CT and MRI, ECG, endoscopy, bronchoscopy and pathology.	Currently mainly 'day time' access to a number of these services x-ray available to Emergency Departments 24/7. Target Compliance – 100% Critical Care Current Compliance Within one hour – 100% Urgent Care Compliance Within 12 hours – <50%	95% of all patients requiring access to diagnostics will receive this within 12 hours . Direct access to a range of diagnostics will be available for GPs to support admission avoidance
6 - Access to consultant-directed interventions Hospital inpatients have timely 24 hour access, 7 days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements.	Currently quite a traditional model of consultant availability prevails with ad-hoc GP to consultant telephone consultancy. Target Compliance – 100% Current Compliance – 33%	To utilise independent sector consultant telephone support (consultant connect) for urgent care with agreed pathways to AEC, OPAL, and direct diagnostics before March 2017.
8 - On-going review Patients on the AMU, SAU, ICU and other high dependency areas are seen and reviewed by a consultant twice daily. General ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours.	Target Compliance – 100% T Twice daily ward rounds Current Compliance – 29%	By July 2017 twice daily ward rounds will be undertaken on MAU, SCDU and ICU with 90% compliance 7 days a week.

Note: this table reflects the Worcestershire position, the equivalent audits have not yet been completed in Herefordshire.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

As part of the West Midland Urgent and Emergency Care Network we expect to participate in a fundamental re-organisation of our existing urgent care system. In line with national guidance we aim to secure, for all patients with urgent care needs, a highly responsive service that provides care as close to home as possible and for those patients with more serious or life threatening conditions we will ensure they are treated in centres with the right expertise, processes and facilities to maximise their chances of survival and a good recovery. Key aspects will be:

- Working collaboratively with all system partners to further develop our urgent care commissioning strategy, clearly defining 'what good looks like', with clear mapping & matching of demand and system capacity and clearly understood outcome measures. Refresh to be undertaken beginning of November
- As part of this strategy we will include the further development of seven day services, including a comprehensive workforce plan to support urgent and patient flow.
- Building on the digital infrastructure across Worcestershire, we ensure all urgent, emergency, physical and mental health partners are connected and that effective and prompt communication underpins and facilitates excellence in urgent care and end of life care.
- Reducing hospital admissions through the local adoption of well proven methodologies; e.g. reducing care home admissions,
- Influencing the regional ambulance commissioning strategy to ensure the provision of an 'urgent care' model of ambulance provision with ambulance clinicians increasing their use of see & treat, making better use of alternatives to ED and therefore reducing ED activity and emergency admissions
- Continuing to progress current improvement initiatives
  - Urgent Care Connect
  - Review of ED GP support
  - 111 - Increased referral to clinical advisors
  - Improving patient flow; e.g. - Streaming at the front door - AEC, OPAL, strengthening D2A and Trusted assessor models and extending to care homes.
  - Reviewing and updating escalation and de-escalation plans, focusing on cross system escalation and rapid de-escalations actions.
  - Exploring benefits of further integration of access points into one single point of access for professionals within Worcestershire

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

Given our STP geography and system challenges, there are different but related review areas that we will need to explore locally to address our immediate pressures. These will need to be explored as part of the next phase of redesign and it is important, at this early stage, to identify their potential impact:

- **Review area 1** – Better use of telephone review (NHS 111 or local streaming through clinical contact centres), web based services and clinical navigation in providers to ensure people can either self- direct or are directed to the most appropriate facility. This action is core to our strategy and will be supported through the implementation of the new Integrated Urgent Care Pathway
- **Review area 2** – Review of existing access points and with the potential consolidation onto fewer individual sites. This would enable the scarce staffing to be co-located, resulting in a significantly reduced demand for expensive agency resources and simpler access routes . The sites that would need to be considered as part of this option in Herefordshire are the existing minor injury units, the out of hours GP hubs, and the Herefordshire Walk in Centre, in the context of the development of 7 day access to primary care . This option would have an impact on improving performance, better clinical outcomes through more specialisation and reducing cost through more effective use of existing resources. Within Worcestershire FOASHW will alter the provision of A&E services for certain conditions. The next stage will be to review the Worcestershire Urgent Care Strategy, taking into account national guidance, which may provide the opportunity to review the number of access points further, by creating 3, at least 16 hour, Urgent Care Centres ensuring the best possible match between availability and urgent care demand. We are planning for the provision of an 'urgent care' model of ambulance provision, in line with 'Clinical Models for Ambulance Services' with ambulance clinicians making better use of alternatives to ED, the new UCC's would strengthen this approach, further reducing conveyances to ED.
- **Review area 3** – This would explore the establishment of a single **Emergency Centre with Specialist Services** (ECSS) for Herefordshire and Worcestershire, alongside two **Emergency Centres (providing A&E functions)** (EC-A&E). Based on current configurations, capability and geography, the ECSS) would need to be in Worcester, with EC-A&Es in Hereford and Redditch. Alignment of clinical management and governance systems across the three sites would support more integrated working and mutual support. For seriously ill patients needing transfer we would need to examine the option of air ambulance or dedicated transfer service.

It is important to emphasise that any work to explore alternative options to the current model of provision would be subject to a full public consultation process.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

The number of hospital beds required to support the system

Whichever model is pursued, there will need to be access to the right number of hospital beds to support patient care needs. Detailed modelling has been undertaken by an independent organisation (Strategic Healthcare Planning) to help identify the bed requirements for Herefordshire and Worcestershire over the life of the STP. This has identified that if partners can achieve the transformational changes that are sought in out of hospital and social care provision, there will be a significantly lower number of hospital beds required than there are now.

The modelling, which is based on the agreed system assumptions shows the following:

- **Herefordshire** - The need for a **+15%** increase the number of acute beds in Herefordshire, but the potential for a reduction of **-62%** reduction in the number of community hospital beds.
- **Worcestershire** – There is potential for a small reduction in the number of acute beds and a **-44%** reduction in the number of community hospital and resource centre beds. In terms of acute beds, the main issue to address is location, with more beds required in Worcester but less required in Redditch. In addition to the community bed numbers, there is scope to reduce the number of NHS commissioned beds from the private care home sector from 86 in the base year to 9 in 2020/21.

	Herefordshire		Worcestershire	
	Base yr	2020/21	Base yr	2020/21
Acute Beds	226	260	743	740*
Community Beds	97	37	324	182
Total Beds	323	297	1,067	922
		-26		-145

**FoASHW pre-consultation business case projection for 2018/19, all other numbers from the STP strategic model for 2020/21.*

The strategic bed modelling and reconfigurations show that there will be capacity in Redditch to develop a wider range of community services on the Alexandra site. Linking primary, community and mental health services may create the opportunity for a new health campus.

In order to facilitate this scale of reduction in beds overall, the out of hospital care offering needs to be optimised. A proportion of the savings realised from these reductions will be reinvested in community services (modelling not finalised, initially modelled at c50%). This will lead to more care being provided in home based settings, leading to better clinical outcomes and improved independence.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

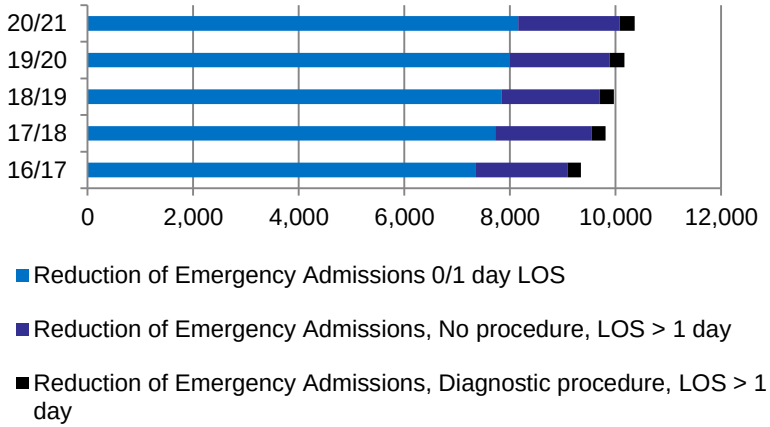
Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Communities will be able to access more convenient alternatives to hospital based urgent care services, such as community pharmacies which are close to home.
- People will have better access to primary care support and advice for their urgent care needs, 7 days a week
- We will have invested in public education to help communities navigate the new services ,making it easier to get the right care, first time by the right person
- Patients who are at heightened risk of emergency admission will have their care more coordinated to reduce the likelihood of a crisis occurring.
- Less patients will be admitted to acute hospitals, meaning they can receive care closer to home and remain in more familiar surroundings
- Patients who require emergency care from acute and/or mental health specialists will be quickly assessed and streamed into the most appropriate management, with fewer delays
- Patients receive supported discharge from hospital into an appropriate community environment, once the acute phase of their care is over
- Waiting time performance for access to key services – such as response to 999 calls and 4 hour waits in A&E will be significantly improved
- People will receive improved outcomes and experience of using urgent and emergency care services in Herefordshire and Worcestershire

The chart below shows the activity that would be removed from the acute sector as a result of a full implementation of an integrated frailty pathway, described within priority 3b.By 2020/21 there would be **10,359 fewer** hospital admissions as a result of these interventions within Worcestershire.

Admissions that will be avoided as a result of the new integrated frailty pathway.



The chart above shows that the most significant reduction in emergency admissions will be for those where the length of stay is one day or less.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Stroke Services - The aim is to deliver a more consistent and resilient stroke service across the STP footprint. A sustainable solution cannot be found across the Herefordshire and Worcestershire STP footprint alone due to the consistent workforce issues affecting all providers of stroke care. Consideration has been given to solutions that will begin to address the provision of a seven-day TIA service, support thrombolysis treatment, provide specialist assessment for the inpatient beds and ensures the provision of specialist stroke rehabilitation . Providers are currently rated as Band D under the Sentinel Stroke National Audit Programme (SSNAP) and the plans we are taking forward should achieve B in Worcestershire by 17/18 and B/C-B in Herefordshire once fully implemented.

What will be different between now and 2020/21

- Joining the existing telemedicine service operated by the University Hospitals North Midlands - brokered through the West Midlands Stroke Network
- Collaboration across three counties (Herefordshire, Worcestershire and Gloucestershire), to deliver a consultant rota and a seven-day TIA service
- Looking at alternative stroke workforce models including assessing the impact of the County Stroke Therapy Consultant in North Worcestershire.

Specific short term goals for Worcestershire:

- Improvement of the identification and treatment of atrial fibrillation across Worcestershire
- The acute trust will have in place the capacity and skill mix to achieve TIA service requirements
- A stroke pathway, workforce plan will be developed and agreed that crosses organisational boundaries and uses an appropriate skill mix to deliver an efficient stroke care pathway.
- Agreement to the consolidation of community hospital beds providing inpatient stroke rehabilitation with seven day services.
- Agreement to the consolidation of community hospital beds providing inpatient stroke rehabilitation on one site ensuring maximum capacity available 7 days a week.

Specific short term goals for Herefordshire:

- Access to TIA clinics for those at risk of Stroke across seven days
- 24/7 thrombolysis treatment
- 24/7 access to specialist inpatient care advice
- Consistent access to therapists whilst an inpatient
- Consistent access to step-down community services

How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients will receive improved access to best practice stoke rehabilitation in their own home and where not possible in a dedicated stroke rehabilitation unit
- Long term care and outcomes for disability associated with stroke will be maximised
- There will be a reduction in the incidence of stroke
- There will be increased levels of long term care at home
- Care will be delivered as close to home as possible
- Improved stroke outcomes by timely access to hyper-acute stroke services
- The ability to recruit and retain specialist stroke professionals

Priority 4 – Establish clinically and financially sustainable services

Programme 4c	IMPROVING MATERNITY CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

Overall aim	Our vision is that our citizens have access to high quality, safe and sustainable, acute, women and newborn/neonatal and mental health services, localised where possible and centralised where necessary.

What will be different between now and 2020/21

Within Worcestershire maternity services are temporarily suspended on the Redditch site and re-provided on the Worcester site due to the Trust not being able to recruit sufficient staff to provide clinically sustainable services across two sites. The Future of Acute Services at Hospitals in Worcestershire (FOASHW) is about to commence consultation on the permanent centralisation of these services on the Worcestershire Royal Site. This is a critical component of the clinical and financial sustainability of the Worcestershire service.

Beyond this **we plan to develop a single maternity service to delivering Better Births**, locally across both counties. This will result in:

- The removal of traditional county boundaries with sharing of community and hospital based resources across a wider area. This is not expected to result in a change to the provision of obstetric services in Herefordshire.
- A joint maternity care offer with common clinical pathways that guide women to the most clinically appropriate place of birth.
- A maternity specification that is jointly commissioned from Herefordshire and Worcestershire CCGs, and delivered locally by the most appropriate provider.
- Shared maternity service management structure and leadership.
- Integrated specialist/clinical teams (such as Antenatal Screening team, Governance team etc) to increase skills and ensure adequate access for women.
- Development of community hubs for maternity care.
- Integrated neonatal pathways between Hereford and Worcester.
- We will focus on improving the initiation and sustainability of breastfeeding in a coordinated way and will train midwives on skills to be used at 12 week appointments to begin early discussions with parents on breast feeding and identify peer support to increase pre-decision on breast feeding.
- We will also focus on ensuring that all staff who come into contact with pregnant women have a role to play to trigger quit attempts by delivering brief advice on smoking. This will include training all maternity staff in MECC (Making Every Contact Count).
- The use of MECC and motivational interviewing skills of midwives will also support better information sharing and highlight the importance of vaccination to protect the health of the newborn.
- Shared approach for perinatal mental health offer for families.
- Shared end to end electronic maternity information system.
- IT links between the hospitals services .

Priority 4 – Establish clinically and financially sustainable services

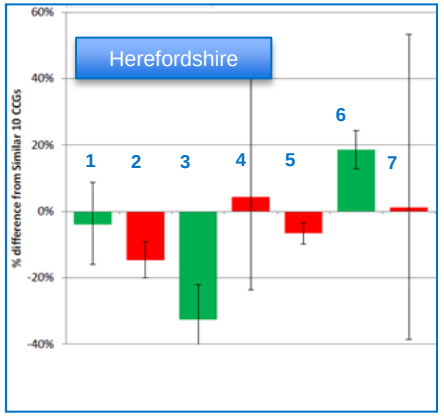
Programme 4c	IMPROVING MATERNITY CARE	Owner	Richard Beeken, Chief Executive, Wye Valley NHS Trust

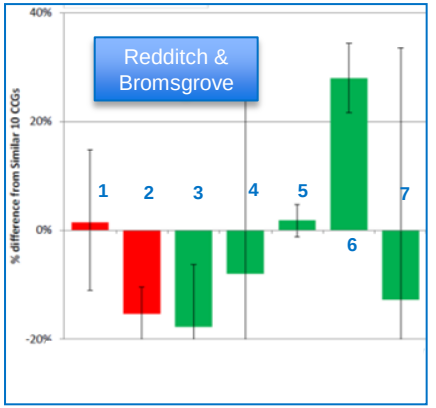
Overall aim	Our vision is that our citizens have access to high quality, safe and sustainable, acute, Women and newborn/neonatal and mental health services, localised where possible and centralised where necessary.

How will this be better for residents and patients in Herefordshire and Worcestershire

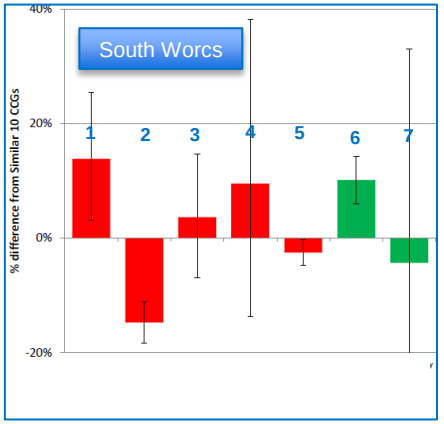
The overriding benefit to the local population will be a higher quality, more sustainable service that achieves improved health and well being outcomes for babies and young children. This will be achieved through:

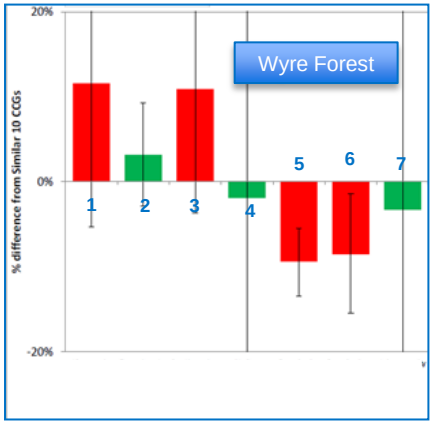
- Increased midwife led care and home birth numbers
- Improve women's access to birth in the most appropriate birth setting
- Reduce out of area neonatal transfers for sick and premature infants
- Increased specialist community based Perinatal Mental Health care
- Improved availability of access to specialist teams across both counties for women and babies
- Retaining local services for women and families within the counties
- Raised profile for maternity and newborn services across the West Midlands
- Reduction in Perinatal mortality rates
- Reduced number of emergency caesarean sections
- Improved learning from strengthened governance will lead to a greater safety culture.
- Shared learning and development opportunities to increase and maintain knowledge and skills.





1 < 18 Conception rates	2 Flu vaccine take-up by pregnant women	3 Smoking at time of delivery	4 % of low birthweight babies (<2500g)	5 Breast-feeding initiation (first 48 hrs)	6 Breastfeeding at age 6-8 weeks	7 Infant mortality rate





Priority 4 – Establish clinically and financially sustainable services

Programme 4d	ELECTIVE CARE	Owner	Carl Ellson, Accountable Officer, SWCCG

Overall aim

Non – life threatening conditions - Reduce clinical variation in referral and treatment, reduce the number of procedures performed where there is a limited clinical benefit or enhanced risk of harm and work with patients to improve their overall well being by seeking lifestyle improvement as part of the elective pathway.

What will be different between now and 2020/21

There are two key aspects to improving elective care – in terms of clinical effectiveness, achievement of performance standards and financial sustainability.

- **Effective commissioning policies** and stricter treatment thresholds
- **Efficient organisation of services** to meet demand.

During the allocative programme budgeting work, the STP programme board recognised that significantly tightening commissioning policies and treatment thresholds for elective care would be required to support financial balance with the STP. In order to progress this, there were two distinct categories of elective care identified – treatment for life threatening conditions such as cancer, cardiac and renal services and treatment for non-life threatening conditions. The programme board agreed to prioritise investment in the former, in order to do this the following has been agreed:

- Develop a system wide (commissioner and provider across both counties) policy and treatment threshold on procedures that:
  - Have a relatively limited impact
  - Are probably linked to an aesthetic benefit
  - Are perceived to have a close ratio of benefit to harm.
- Develop a policy to support lifestyle improvement by providing prevention interventions and alternatives such as social prescribing with regard to healthy weight (where possible), smoking and alcohol consumption to improve the likelihood of positive clinical outcomes following surgery.

Potential savings from achieving top decile rates

Elective procedures for non-life threatening conditions

CCG	Probably Aesthetic	Probably lower cost alternative	Limited Effect	Close Benefit to Harm Ratio
HCCG	£64k	£521k	£26k	£439k
RBCCG	£14k	£362k	£0k	£546k
SWCCG	£133k	£784k	£0k	£1,025k
WFCCG	£149k	£397k	£48k	£271k
Total	**£4,779k**			

Elective procedures that are likely to be wholly attributable to

CCG	Alcohol	Obesity	Smoking
HCCG	£0k	£28k	£72k
RBCCG	£124k	£57k	£153k
SWCCG	£599k	£59k	£478k
WFCCG	£279k	£50k	£199k
Total	**£2,098k**		

- Achieving top decile performance in these areas against comparator CCGs will release **£6.8m** worth of expenditure.

Priority 4 – Establish clinically and financially sustainable services

Programme 4d	ELECTIVE CARE	Owner	Chris Tidman, CEO, Worcestershire Acute Hospitals NHS Trust

Overall aim

Life threatening conditions (cancer and others) -Increase funding to meet demographic pressures and increasing illness burden. Improve efficiency and reduce waste and waits across pathways and for all critical complex elective care, for clinical sustainability and quality outcomes, we will concentrate provision in centres of excellence

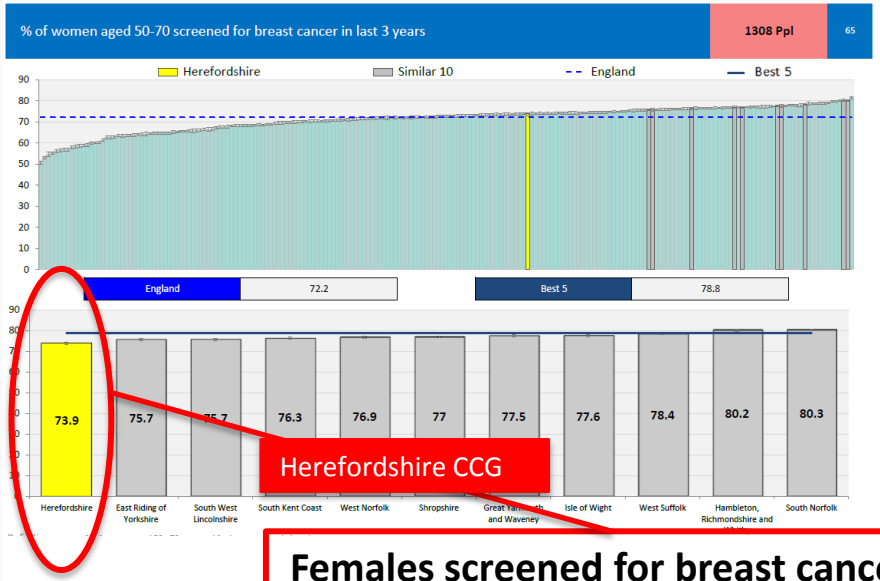
What will be different between now and 2020/21

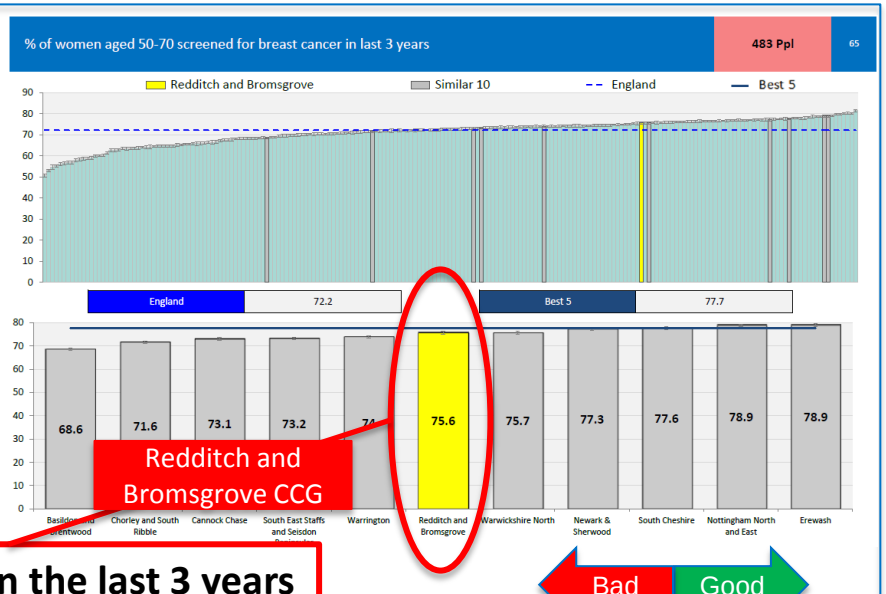
- We will have implemented the key changes required from the national cancer strategy
- There will be much greater alignment between prevention strategies and treatment, but adopting a more integrated approach, where driving the prevention and healthy lifestyles message is the responsibility of all partners in the system.
- Far greater uptake of screening programmes across the population, where local performance is currently poor (see overleaf)
- We will ensure that we maximise the use of the diabetes prevention programme pilot currently being implemented across the STP and use the learning from this for other possibilities for using risk identification to target intensive lifestyle interventions.
- Revised pathways with increased pan-STP working, particularly with UHCW and Gloucestershire to enhance clinical sustainability and specialism to improve outcomes.
- Joint staffing appointments to specialist roles across the STP or Pan STP footprint (for example interventional radiology).
- Concentration of specialist complex surgery on fewer sites to secure clinical sustainability and improve outcomes.
- As part of the Specialised Services Rural Pathfinder we expect to redefine existing pathways to be locally commissioned, repatriate some current pathways including renal, some cancers and cardiac care, working closely with regional specialised providers.
- Implement alternative models for cancer survivorship through remote monitoring and supporting patients in out of hospital environments.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Local services will be better placed to deliver world class outcomes for cancer care.
- The system will achieve consistent access of all cancer treatment standards.
- Earlier recognition and faster diagnosis of cancers and other life threatening conditions.
- Faster treatments times and improved survival rates.
- Reduced diagnosis through emergency admission or unplanned care provision.
- Better patient experience of cancer care received (which is currently poor – see 3 pages overleaf)

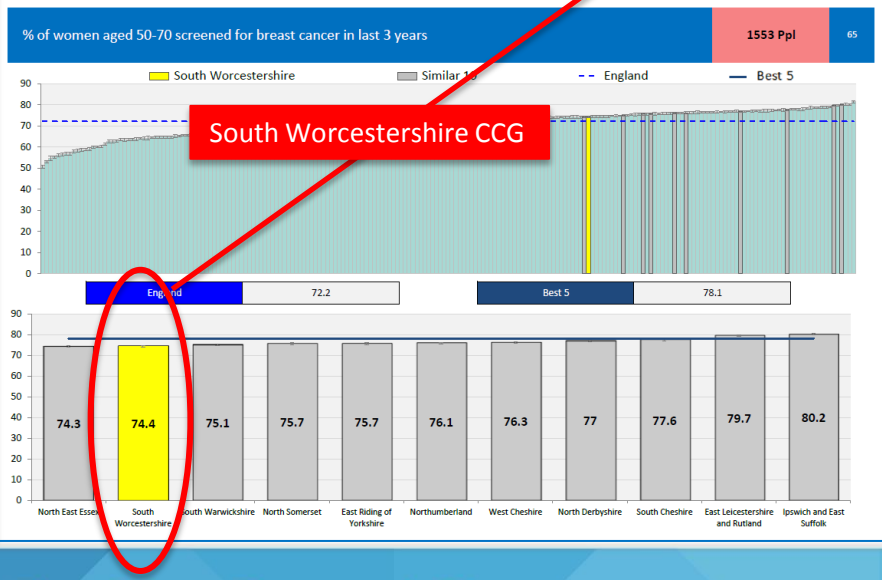
Breast cancer screening

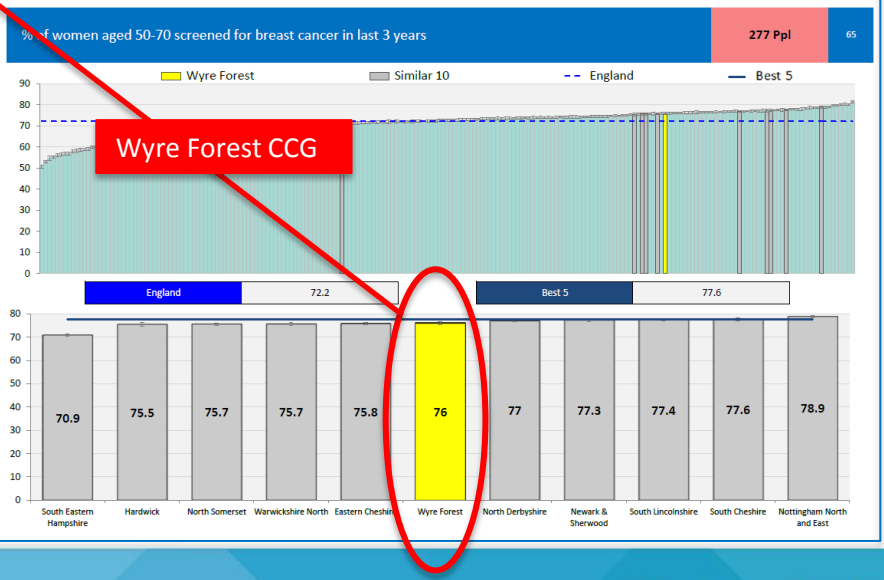




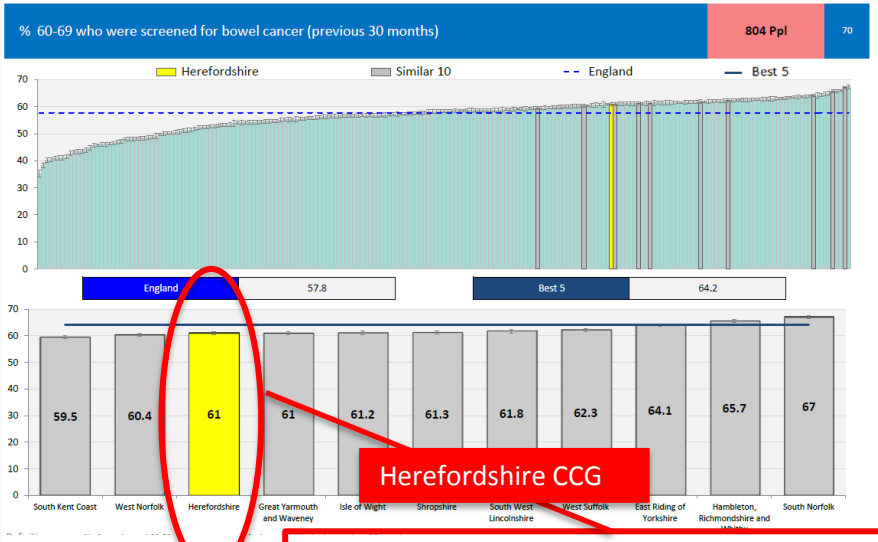
Females screened for breast cancer in the last 3 years

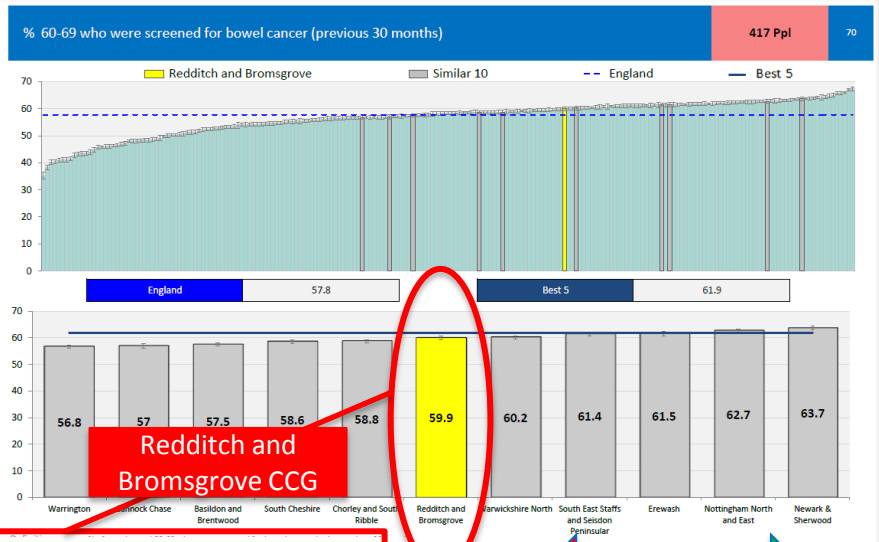
Bad Good





Bowel cancer screening



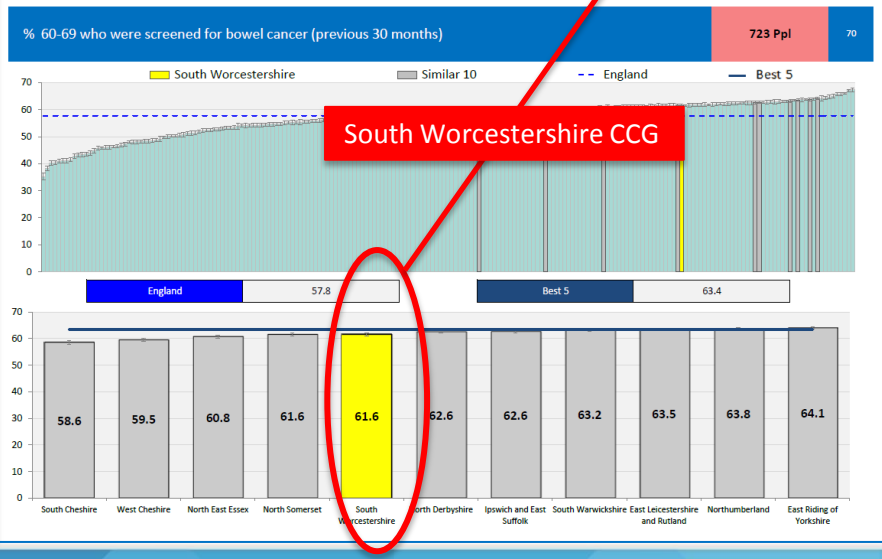


Herefordshire CCG

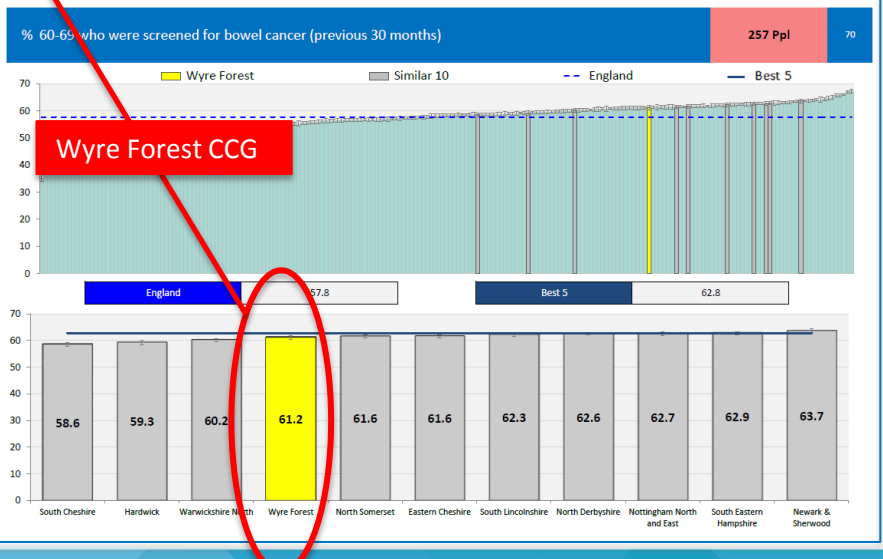
Redditch and Bromsgrove CCG

Population screened for bowel cancer in the last 3 years

Bad Good

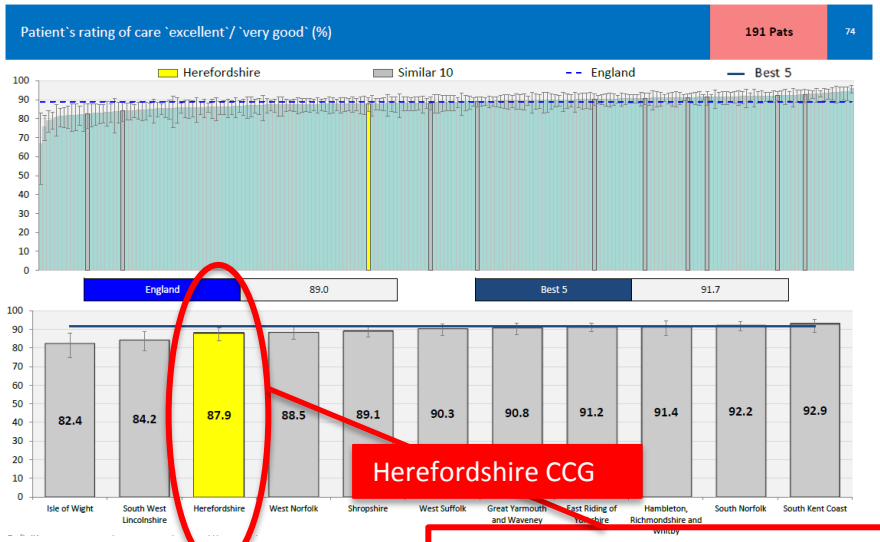


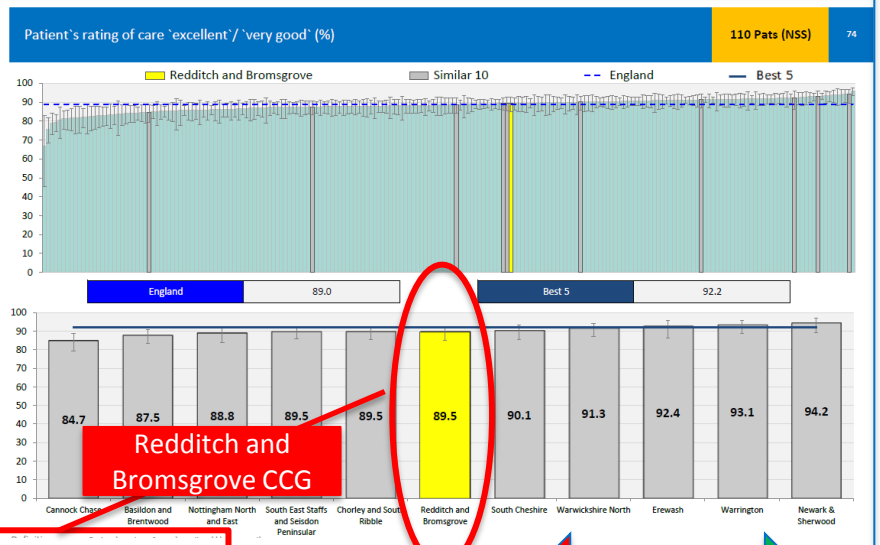
South Worcestershire CCG



Wyre Forest CCG

Patient experience of cancer care



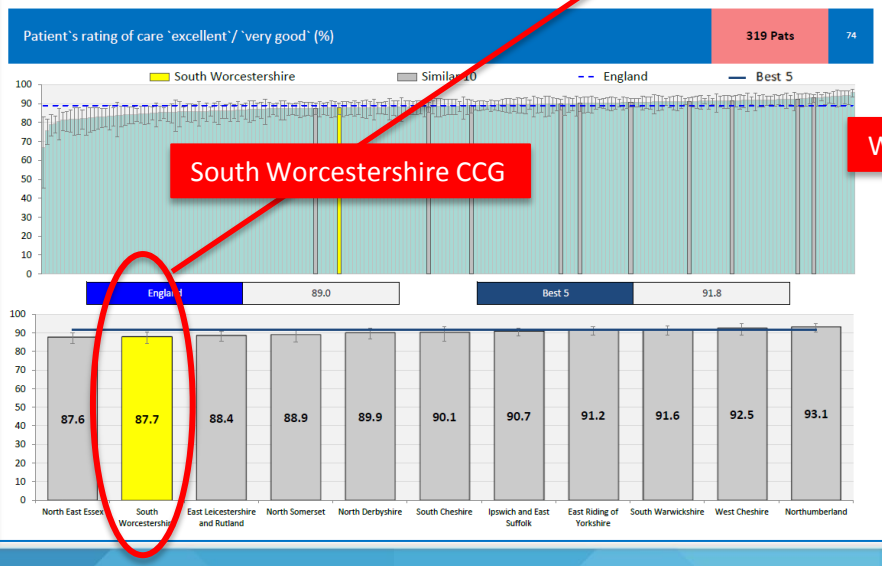


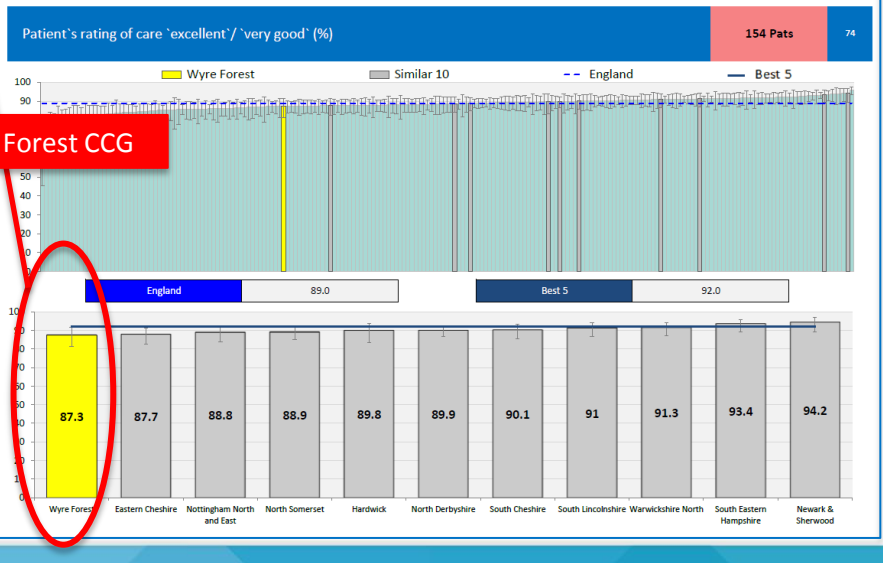
Herefordshire CCG

Redditch and Bromsgrove CCG

Patient's rating of quality of care given

Bad Good



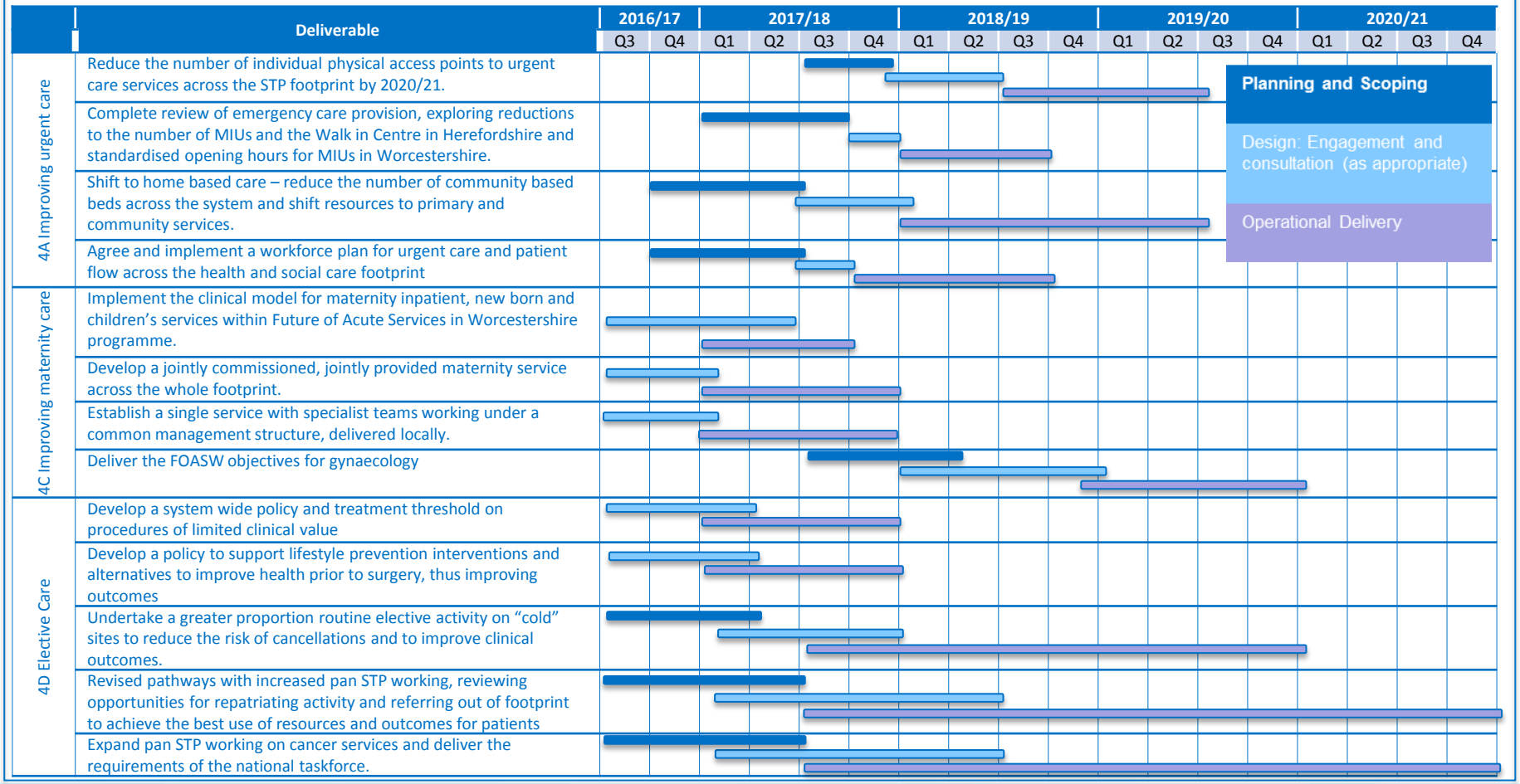


South Worcestershire CCG

Wyre Forest CCG

Delivery Plan – Priority 4: Establish clinically and financially sustainable

Urgent Care SRO	**Richard Beeken –** Chief Executive – Wye Valley NHS Trust	**Programme Leads**	**Stuart Ide –** Urgent Care Lead – Worcestershire CCGs **Hazel Braund –** Operations Director – Herefordshire CCG
Maternity Care SRO	**Richard Beeken –** Chief Executive – Wye Valley NHS Trust	**Programme Lead**	**Fay Baillie –** Deputy Director Nursing and Midwifery Worcs Acute Hospitals NHS Trust
Elective Care SRO	**Carl Ellson** Accountable Officer - SWCCG	**Programme Leads**	**Sarah Smith –** Worcestershire Acute Hospitals NHS Trust **Simon Gartland -** Deputy Director of commissioning WCCGs



Enabling change and transformation

Workforce and OD

Enabler 1	WORKFORCE AND ORGANISATION DEVELOPMENT	Owner	Shaun Clee, Chief Executive, 2gether NHS Foundation Trust
Overall aim	Develop the right workforce and Organisational Development within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face.		

There are approximately 350 different professional demarcations of role in the NHS. As the recruitment pool becomes more shallow and as workforce challenges threaten clinical viability, Herefordshire and Worcestershire need to be in the vanguard of the introduction of new clinical roles. In Herefordshire a "vacancy harvesting" process will be used to trigger plans to review the lines of demarcation and introduce new clinical roles. In Worcestershire, there is, for example, a well advanced programme for the introduction of Physician's Associates into key aspects of hospital delivery.

What will be different between now and 2020/21

- Erosion of traditional boundaries between organisations and services to **'teams without walls',** supported by a multi-disciplinary learning environment for the existing and future workforce across the system
- Increased **investment** in the **mental health and learning disability** workforce
- **Less** reliance on **agency and temporary staffing**
- **Integrated multi-disciplinary teams** based around the person, supported by access to specialist advice and support e.g. frailty teams
- Increased use of apprenticeship levy to ensure **appropriate training** for existing staff and 'new' roles, alongside work experience and **career pathways** to build the **future workforce**
- A **more diverse skill mix**, with 'new' roles embedded within teams across the system, for example Physician Associates and Advanced Clinical Practitioners
- A shift to a workforce **culture focused on prevention and self-care**, utilising, health coaching conversations across the workforce, improved signposting and better links to public health
- Flexible employment contracts, annualised hours, portfolio careers, and **incentives to recruit and retain staff** across the system
- **GPs** will have more time to focus on patient care by reducing the administrative burden and developing the primary care skill mix
- A more significant role for the voluntary and community sector, the public sector and the unpaid workforce (family, neighbours, carers, volunteers) **working together to deliver better outcomes for local people.**

How will this be better for residents and patients

- "**Tell my story once**" with fewer 'hand-offs' between clinicians and other practitioners
- **More care will be provided out of hospital**, with greater continuity of care and care wrapped around the person
- Health coaching conversations will support people (patients, residents, workforce) to develop their knowledge, skills and confidence to **enable healthy behaviours, self- management of care** and to access health and social care services appropriately and when required
- People will co-produce and **'own' individual care and support plans**
- People with on-going conditions will have more control over their lives and receive **more care provided closer to home**
- Improved access to **specialist care and expertise will be available when people need it**

Digital and Technology

Enabler 2	DIGITAL	Owner	Clare Marchant, CEO Worcestershire County Council
Overall aim	Invest in digital and new technologies to enable our workforce to provide, and patients to access care in the most efficient and effective way, delivering the best outcomes		

What will be different between now and 2020/21

- **We have two aligned Digital Road Maps within the footprint,** successful delivery of our digital roadmaps for Herefordshire & Worcestershire will be critical to improving access, increasing productivity and changing clinician /practitioner behaviour.
- **Creating a connected Infrastructure** e.g. modern and connected infrastructure enabling practitioners and linking services; e.g. better use of telemedicine and increasing use of e-consultations to improve access to specialist services
- **Improving integration** e.g. Integrated Digital Care Records for patient's and citizens across health and care - providing integrated records that have the ability to be interlinked care settings across the footprint; establishing a consent and information sharing model and robust data standards, security and quality.
- **Empowering residents and citizens through technology** e.g. creating a consistent user and patient experience – including common, digital front doors to our services, complementing traditional interactions. Enabling increased public and patient control and empowerment (i.e better use of apps, wearables and assistive technologies), moving away from a paternalistic culture of care; and supporting self-care and increasing levels of patient activation. A key enabler is consistent local access to broadband / digital options.
- **Enhancing our understanding**: New insights using health & care intelligence - Using data in new ways to lead to earlier intervention and enabling improved outcomes and wellbeing for people and the population
- **Working collaboratively** – ensuring we are reading as a system to work together and to deliver technological changes for the benefits of residents and patients, including using resources smartly and sharing good practice

How will this be better for residents and patients in Herefordshire and Worcestershire

- **Patient data access and information sharing**, care planning and transitions plans available across providers meaning patients will only have to tell their story once
- Patients access to own care records, giving a **better understanding of care received**
- Improved access to specialist services via telehealth and tele/video conferencing across acute and community, providing **faster access to specialist care**
- Use of tele/video conferencing in GP practices & nursing homes enabling **joined up care**
- Interoperability of systems across footprint allowing **patient choice**
- Use of apps and wearables to support empowerment of patient and residents and **increase levels of patient activation**
- Better sharing of information
- Seamless care for patients
- Patients more engaged and self-sufficient
- Better use of pharmacies and review of medications

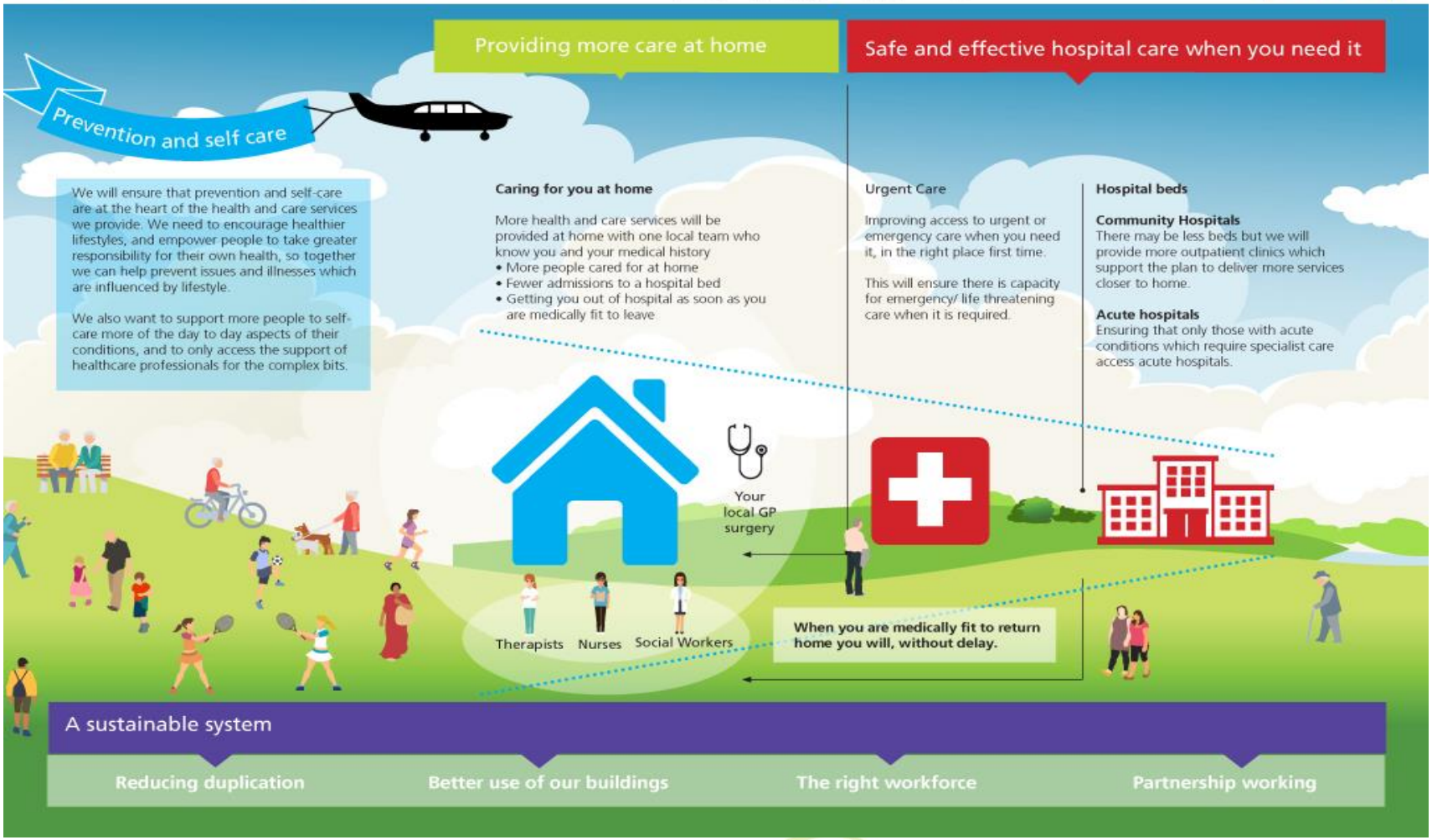
Engaging communities and the voluntary sector

Enabler 3	HEALTHY COMMUNITIES AND THE VCS	Owner	Martin Samuels, Herefordshire Council

- We recognise the importance of reengineering our system so that health and care services work alongside thriving communities to realise the value of individuals, their informal networks and wider communities. Being able to respond to the new landscape ahead requires the vision and commitment of all and embracing different partners into a new way of working. In particular this includes listening and responding to different solutions that are presented by the VCS, who often have effective methods, if not the means, to support those facing multiple disadvantage.
- The adoption of “a better conversation” approach across the wider system; including volunteers, community champions to develop a lay coaching model to focus on what is important to the individual in managing their day to day lives with a health condition.
- We recognise the depth of understanding that the sector can bring and the significant benefits of prevention. There are numerous asset based activities already implemented across our STP, creating social capital across our communities and we want to scale up this approach to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster positive communities and networks.
- The VCS has a vital role in reducing demand on formal services such as unplanned hospital admissions for example through care navigation/bridging roles, peer support and group activities . The sector also helps to address health inequalities by contributing to wider social outcomes such as employment and school attendance.
- Therefore, we need to find ways to tap into the energy, enthusiasm and innovation of the VCS in a coordinated manner, including a simplification of the commissioning process to enhance the contribution that the VCS can make, particularly those grassroots community organisations who struggle with complex commissioning arrangements. We will also strengthen how we support volunteering, recognising the assets and capacity of the workforce in our wider system planning.

Communications and Engagement Plan

Communications and Engagement Plan



#YOURCONVERSATION

Your Health & Wellbeing #YourConversation

Communications and Engagement Plan

Our STP priorities are not new; they have been central to our engagement for a number of years and include extensive engagement around our strategies for Urgent Care, the reconfiguration of acute hospitals services, increasing out of hospital delivery and the promotion of self care and prevention. The collaborative focus of the STP process has enabled us to bring the learning from these activities together to develop a consistent approach to our future work, namely to effectively scale up the engagement and interaction with our local communities, clinicians and staff from 22nd November.

- Our collective experience from previous engagement around "the left shift" in the delivery of care is that the majority of stakeholders understand and support both the need for change, as well as the necessity for improvement, especially for older/ more vulnerable people. From April 2016, as STP partners we have been using all our existing engagement events to talk to members of the public and stakeholders about this system wide strategic case for change; providing us with over 100 engagement opportunities across the 2 counties to outline the Triple Aim challenge, our local gaps and gain feedback on some of emerging issues . These early discussions reflected the position above, namely that the rationale for change is supported but there are specific themes that require more exploration and assurance, for example transport and capacity of our workforce to deliver much more care at home.
- The Communications and Engagement workstream is well established and has leads from all partner organisations that meet every fortnight to coordinate activities and feedback, both internally and externally. Each workstream also has an identified communications and engagement lead to ensure consistency of messages.
- From September our STP communication has been branded as #yourconversation and a dedicated website was launched in September www.yourconversationhw.nhs.uk. The website includes some of the previous engagement activities and content, FAQs, details of our engagement events and a questionnaire. There is a weekly #yourconversation bulletin which is issued to all staff and stakeholders.
- Staff engagement in all partner organisations is being increased in preparation for the next phase of STP development. The 'Back Office' and 'Workforce and Organisational Development' workstreams have the potential to affect the working lives of many of our staff and we are engaging with them to help them devise solutions which will make the back office of all our organisations more efficient. Each partner organisation has taken responsibility for engaging with their staff and staffside organisations using agreed messages.

Communications and Engagement Plan

We have now reached a point on our STP journey where it is critical that we engage more fully on our emerging thinking, including the ways in which we might work differently to address our priorities if we are to realise onward success. Although we will be formally consulting on Worcestershire's acute services over the next few months, the other areas being explored in our STP are still in formation and we want to facilitate early discussions around the likely direction of travel, the development of local solutions and co-design around more formal engagement going forward (as per the NHS publication on "Engaging Local People - a guide for local areas developing Sustainability and Transformation Plans" September 2016).

This approach will be cascaded into all formal meetings, stakeholder forums, and staff events, supplemented by roadshows, briefing, social media campaigns and proactive media coverage.

The Sustainability and Transformation Plan for Herefordshire and Worcestershire will be formally launched by the counties' four CCGs at their Governing Body meetings in November and December 2016. The Plan will be published on all four CCG websites on Tuesday, November 22nd as part of the Governing Body Board papers. This will be supplemented by our most recent Public Summary document going out to all staff as well as face to face briefings for key stakeholders in each county.

Date	Audience	How	Supporting materials
22-11-16	Public	CCG Governing Body papers published on websites	#yourconversation
22-11-16	Media	Press Release Face to face briefing (Herefordshire)	Public Summary Full STP FAQs #yourconversation
22-11-16	MPs, HWB and HOSC Chairs	Face to face briefing	Public Summary Full STP FAQs #yourconversation
24-11-16	Public	Redditch and Bromsgrove CCG Governing Body meeting South Worcestershire CCG Governing Body Meeting	Slide Deck Public Summary Full STP FAQs #yourconversation
29-11-16	Public	Herefordshire CCG Governing Body Meeting	Slide Deck Public Summary Full STP FAQs #yourconversation
06-12-16	Public	Wyre Forest CCG Governing Body meeting	Slide Deck Public Summary Full STP FAQs #yourconversation
December	Public	Provider Board meetings	Slide Deck Public Summary Full STP FAQs #yourconversation
Ongoing	Staff	Written briefs Drop in sessions on mobile bus Webinars Blogs Team briefs and meetings	Slide Deck Public Summary Full STP FAQs #yourconversation
Ongoing	Voluntary and Community Groups	Attendance at existing meetings by agreed spokespeople	Slide desk Public summary FAQs
Ongoing	Public	Roadshows using mobile bus, Interactive webinars and Phone slots to provide feedback	Public summary

Communications and Engagement Plan

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Clinical Engagement

There are two countywide clinical reference groups which provide advice to the Partnership Board on all aspects of the STP. In addition there is a joint clinical engagement oversight group which straddles both counties to come together to discuss specific items and concerns. In addition each workstream has clinical input and have plans to involve the wider community in the further development of their ideas and concepts, including an professional Innovation and Engagement section of #YourConversation. Clinical engagement also forms part of the staff engagement programmes in all partner organisations.

Key stakeholder engagement

Throughout the year we have updated key stakeholders in the development of the plan, emerging themes and priorities. From 22nd November we will be widening our engagement and we are proposing an open event in the New Year to map current opportunities to work together, join up engagement where possible and identify gaps around engagement and potential solutions. It is also proposed that a more formal group could be established to advise on all STP communications and engagement with the public or alternatively use established meetings (for example sub groups of HWBs) to advise on these issues.

A briefing was held in October in London for the eight MPs who represent Herefordshire and Worcestershire. This was in addition to the individual briefs which they have received from partner organisations. All partner organisations receive updates at their Boards/Governing Bodies and support the STP direction of travel as well as specific briefings as required.

Engagement with the public

As partners we will continue to use all our existing engagement events as opportunities to talk to members of the public and stakeholders about the case for change and the emerging thinking in our STP. #yourconversation will be scaled

up as our interactive tool to discuss the issues stakeholders have around STP priorities . This will be supported by awareness raising social media activity, proactive media campaigns, our mobile bus and publicity through open events and forums.

Future strategy for communications and engagement

As the conversations around our STP develop it will become clear that some elements of the emerging plan will need formal public consultation. Once the need for public consultation is identified for a specific element of the plan a detailed public consultation plan will be drawn up which will include all the steps which will need to be undertaken before, during and after consultation, the audiences to be engaged and consulted with, the consultation materials that will be needed and the consultation activities and events which will be arranged.

Healthwatch Perspectives

Engaging communities and the voluntary sector

The Chairs of Herefordshire Healthwatch and Worcestershire Healthwatch are members of the programme board and asked for the following content to be included in the STP submission:

healthwatch Herefordshire

Healthwatch Herefordshire (HWH) would wish to place on record its thanks to all involved in the production of the Herefordshire and Worcestershire Sustainability and Transformation Plan (2016 - 2021).

Regarding the Plan itself, there has been involvement across the entire Herefordshire's and Worcestershire's Health and Social Care system which has involved key parties such as GP's, The Herefordshire Council, Worcestershire County Council, Acute Hospital and Community Trust and Mental Health Providers, Clinical Commissioning Groups, NHS England, Representation from both the Voluntary and the Community Sector and from both Healthwatch Herefordshire and Healthwatch Worcestershire.

HWH wishes it to be noted that Herefordshire remains the most sparsely populated area of England. NHS England will need to address a number of key issues in relation to the needs of the population of Herefordshire and the future provision of the County's health and social care services.

Firstly, that there is increasing demands from the public/patients for health and social care services. Secondly, the impact and effects of the budget reductions to the Herefordshire Council and its social care will need to be considered. Thirdly, the demographic changes and age profile, will also need to be taken into account, when it comes to the provision of services in the County. Finally, if there is an expectation that the voluntary sector can assist in the future regarding any transformation, then resources need to be made available to the respective organisations, for them to deliver additional work/activity.

In HWH's view the sensitive issue of funding and the particular special case of rurality and rural sparsity is something which NHS England should take into account when it considers overall budget provisions. The final agreed budget will need to fund the particular challenges involved within the rural County of Herefordshire regarding the delivery of its Plan for overall future health and social care provision.

What is also important in this process is that there is honesty, transparency and openness so that the public and patients are fully appraised and briefed on the implications and consequences of any final decision/s which is/are made by NHS England in relation to agreed budgets.

There will also be a series of engagement events/activities for patients and the public to provide feedback on what will eventually be delivered, and HWH will be assisting with these events. HWH believes it would have been a better option to have had discussions, consultations and engagement with the public/patients at a much earlier stage, rather that after the plan had been produced.

Engaging communities and the voluntary sector

healthwatch Herefordshire

There is no doubt that there will be a number of challenges as well as opportunities regarding the delivery of the Plan within the communities. HWH makes a special a plea to NHS England that in order to reduce the bureaucracy in relation to overall plans being required to be produced, that there be only one plan to be agreed, delivered and actioned for the period 2016 to 2021.

HWH values and appreciates the work undertaken by all the staff involved in the NHS and the wider Health and Social Care System across Herefordshire and HWH thanks them for their dedication, commitment and professionalism. It is interesting to note that in a recent *survey and the question 'What makes us proud to be British?' the top answer was "The NHS."

* Statista - The i newspaper - 18.10.2016.

Engaging communities and the voluntary sector

healthwatch Worcestershire

Healthwatch Worcestershire [HWW] has been engaged in the process to develop the Sustainability and Transformation Plan for the Herefordshire and Worcestershire footprint since January 2016. HWW's contribution has included membership of the Programme Board since the Board was set up, and on which it is represented by its Chair who has significant experience of working at a strategic leadership level in health and care matters across both Worcestershire and Herefordshire, and in the communications and engagement group in which HWW has provided advice, guidance and support to the NHS and Local Government stakeholders.

HWW recognises the inclusive approach the STP leadership team has taken to engaging with Local Healthwatch as the voice of patients and the public in developing STP proposals, given the constraints we understand have been placed on engagement by NHS England, and welcomes the positive response the team have made to HWW's comments during the process. HWW therefore welcomes the opportunity to make the following comments on the final STP submission:

- HWW recognises the need for change and has a track record of arguing for safe, sustainable and integrated health and care service provision in Worcestershire which, for example has enabled HWW to support the recommendations for the future delivery of acute hospital services in Worcestershire and the developments in primary care such as 'care at home' and MCP new models of care. HWW therefore welcomes the incorporation of these and associated initiatives into the STP, building on Worcestershire's 'Well Connected Programme' as a pioneer and the review of future Acute Hospital Services in Worcestershire.

- HWW is principally concerned with championing the interests of those who use health and care services in Worcestershire. In that context, from the outset HWW has been concerned about the potential implication for Worcestershire's patients and public of 'pooling' the funding allocations to the Worcestershire CCGs with the allocation to the Herefordshire CCG.

In response to HWW concerns the 2020 financial position as between Herefordshire and Worcestershire has been detailed in the STP submissions, which reflects that Herefordshire's potential gap will be £435 per head as opposed to Worcestershire's gap of £246 per head.

HWW welcomes the recognition from STP stakeholders that achieving financial balance across the STP footprint would result in significant subsidy to Herefordshire from Worcestershire, with a consequent impact on service provision for patients and the public in Worcestershire.

- HWW believes the patients and public in Worcestershire expect the NHS to make efficiency savings in the 'back office' and in the delivery of support services as a pre requisite to making savings in patient services. This should include consideration as to the number of commissioners and providers operating in Worcestershire, as well as the STP footprint.

Engaging communities and the voluntary sector

healthwatch Worcestershire

- HWW is concerned that NHS plans to deliver care at home could place additional burdens on social care services and have raised an issue about domiciliary care based on its knowledge of the review of the existing care market in Worcestershire.
- HWW recognises that the proposals relating to Self-Care and Prevention require significant behavioural change by the population at large and within the NHS, and considers that this is unlikely to be achieved without a national communications/engagement exercise because of the resources that will be required.

NB The restrictions on publication of information relating to the STP have prevented HWW from taking the views of the public into account in formulating the above comments.