SOMERSET

SUSTAINABILITY AND TRANSFORMATION PLAN
2016 – 2020/21

Technical Submission

Somerset's Blueprint for Accelerating the Implementation of the Five Year Forward View

Technical Submission - 21st October 2016
Somerset
Footprint no. 38
South Region

SOMERSET
SUSTAINABILITY AND TRANSFORMATION PLAN

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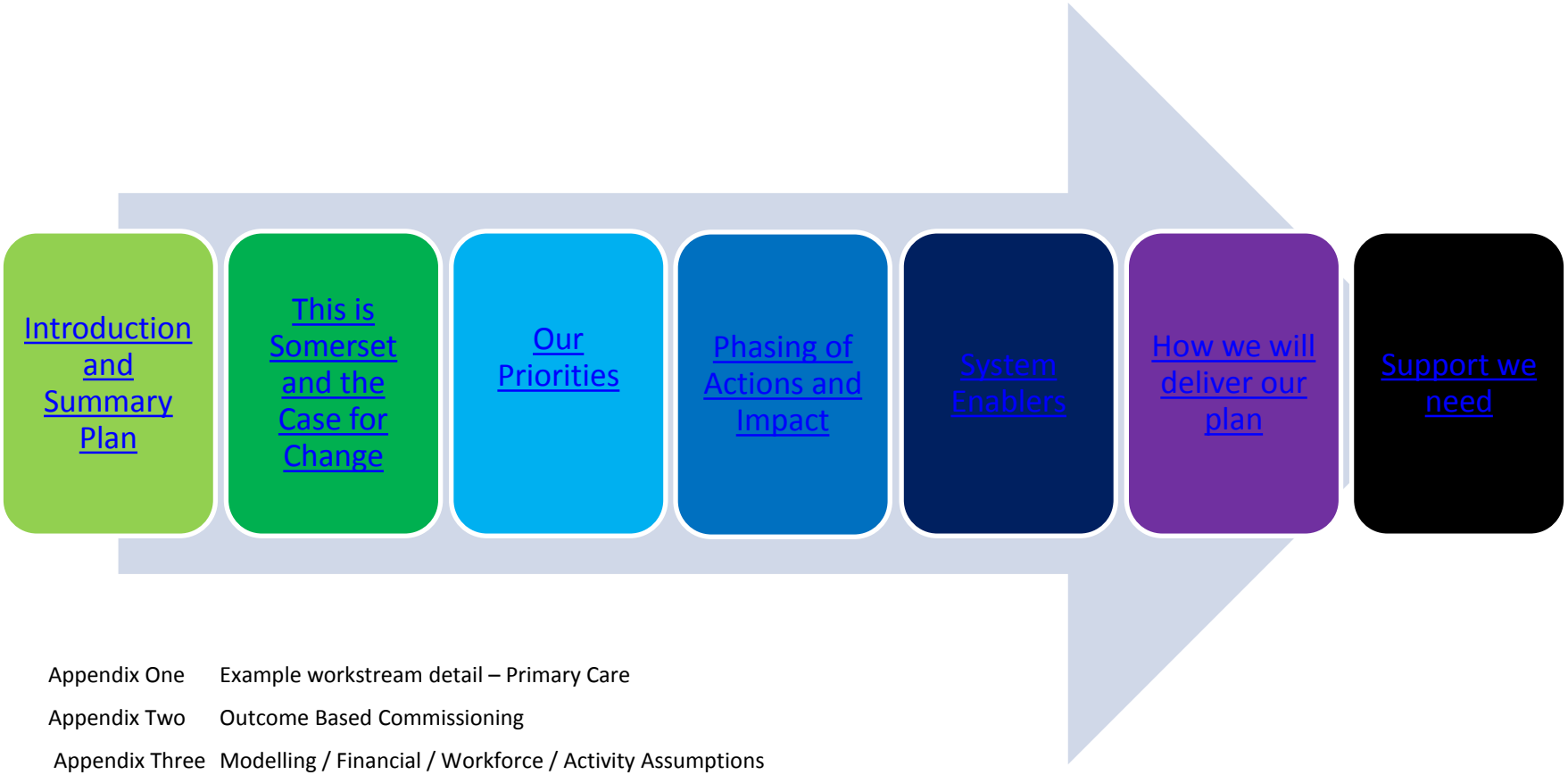

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Foreword

We have been working together as a health and care system and have an aligned **vision** and approach for our population:

'People in Somerset will be encouraged to stay healthy and well through a focus on:

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

When people need to access care or support this will be through joined up health, social care and wellbeing services.

The result will be a healthier population with access to high quality care that is affordable and sustainable.'

We aspire to be a true **'place-based system of care'** and the system's senior leadership is now committed to move to an **Accountable Care System for Somerset by April 2019**. This will not distract us from **the current imperatives**, but signals our shared understanding that the health and care system in three years will be **radically different**.

The challenges are significant but we are fully committed to working together in Somerset. Symphony, our **Vanguard programme,** and **Somerset Together** are national leaders in the application of data to identify the drivers of cost in long-term conditions; the development of complex care models; organisational integration through a **PACS model**; and exploring the introduction of **outcomes based commissioning**. This gives us confidence that by working in collaboration we can be a **high quality, high value system**.

Person centred care is critical, working with people and staff to empower them to understand the importance of self care and self management.

By focussing the entire system on the **prevention agenda** we intend to deliver a programme at scale and pace to address our gaps in health and wellbeing. **Working with communities and the voluntary and community sector will be critical.**

We are also making real progress towards delivering parity of esteem, developing integrated community teams, which will deliver a biopsychosocial model of care. We are committed to significantly changing the way we use our funding to **improve our mental health services** and deliver the Five Year Forward View for Mental Health.

However, services are not keeping pace with the changing needs of an ageing population and people with multiple long term conditions. It is becoming increasingly difficult to ensure local people have access to consistently high quality care that is affordable and sustainable. Local health and social care services are under **severe financial pressure and are likely to have an in year gap of £175 million by 2020/21 if nothing changes**.

This plan sets out our strategic vision and our intention to work together to mitigate the growing demand, and cost, of providing care. We need to maximise the impact of our **Digital Roadmap,** supported by our **global digital exemplar status,** and our **estate** and most importantly adopt **new workforce models**.

This is a new era for Somerset in which health and care system leaders are committed to work in a truly collaborative way, putting the system before the organisation.

Working with the national and regional bodies and engaging with our communities, we will now act with **urgency** to maintain momentum achieved through the accelerated STP process to ensure that each of our priorities **delivers** against our system objectives. We accept that this will challenge existing models and approaches but that this must be managed to achieve a **sustainable and transformed health and care system for the people of Somerset.**

Introduction

The person-centred, co-ordinated care we aspire to in Somerset will be based broadly on the "I" narrative set out by National Voices.
We asked people in Somerset what outcomes they most wanted from their health and care services.
This gave us the following "I" statements to guide our planning and service design:

- I want to feel part of my community
- I want it to be easier to get support close to my home
- I want to be able to find information, help and advice when I need it
- I am a person, not a client or a patient
- I want my family to be supported as carers
- I want the best trained care staff helping me
- I want to have good experiences when using services
- I want to plan my support
- I want to tell my story once

To meet these statements, our aim is to redesign the Somerset Health and Care system placing as much emphasis on prevention as on treatment so that people can better **manage their own health**. We plan to develop a wider range of services in out of hospital settings , so that more care will be available **near people's homes**. Making sure that only those people who are seriously unwell have to be treated in a hospital and that they are able to return home as soon as possible with **coordinated** support from community and primary care services, including support for **carers**.
Acute hospitals will provide only those elements of care that cannot be provided elsewhere, and this will allow us to move resources away from bed-based care. We plan to use digital technology to make **information and advice** available through apps or in other user-friendly formats and have a flexible, **well trained** workforce that can work in a range of places, in the community, care homes, in our hospitals or in people's homes and we will support **communities** to take a leading role in looking after themselves and the most vulnerable within them.

This plan sets out why change is necessary and our strategic plans to meet the future needs of the population. To radically change the way people are able to be supported to manage their own health and access care.

Over the coming months STP leaders, in collaboration with Healthwatch, look forward to engaging with the public, patients, carers and the wider heath and care workforce to shape and develop the plans further and deliver a shared vision for high quality, sustainable services.

Our plan on a page

Our Vision

People in Somerset will be encouraged to stay healthy and well

When people need care or support this will be accessed through joined up health and care services

Resulting in a healthier population with access to high quality care that is affordable and sustainable

The Case for Change

Services in Somerset are not keeping pace with the changing needs of local people and it is becoming increasingly difficult to ensure access to consistently high quality care that is affordable and sustainable.

There are a number of reasons for this:

- We have an ageing population with more complex needs who require more support from health and care services
- We have higher than average levels of overweight people and lower levels of physical activity.
- The current system is no longer affordable or sustainable. This year we are facing a gap in funding of £33m, by 20/21 this will run into hundreds of millions.
- We have significant work force challenges to be able to support existing services and are finding it increasingly difficult to meet key performance targets
- While the needs of our population has grown the way in which the NHS and social care services operate has largely stood still and we have not historically invested enough in prevention, out of hospital and mental health services

Our Priorities

Drive delivery of the system-wide financial and performance improvement

Focus on prevention to develop a sustainable system

Redesign primary and community health and care services to deliver care closer to home with a reduced reliance on acute services & community beds

Address clinically and financially unsustainable acute service provision

Create an Accountable Care System

Our Plans

Organisations are working together on projects to improve Referral to Treatment and A&E waiting times, and address the financial challenge - working more effectively and efficiently including addressing Delayed Transfers of Care, sharing back office functions and reducing agency spend.

We will:

- **Work with children, young people, adults and staff, to promote the importance of self-care, moving from a demand driven system to a prevention driven one, providing information and tools to keep people healthy and able to manage their own health.**
- **Prioritise our efforts to focus on the highest burdens of disease which are Mental Health, Dementia, Cardiovascular Disease, Cancer, Respiratory Disease and Musculoskeletal**
- **Reduce the complexity of the system making it simpler for service users and professional to navigate**
- **Deliver excellent care as close to home as possible, delivering the Primary Care FW and building a safe, sustainable integrated primary care system, enhancing GP services with new roles, supported by multidisciplinary and specialist teams to support patients with complex needs.**
- **Develop new care pathways to mitigate increasing demand and create services that offer an alternative to acute and community hospital care, reducing the need for hospital admission or attendance and supporting patients on being discharged from hospital**
- **Ensure parity of esteem and deliver the Mental Health 5YFW**
- **Increase the joint working between the hospitals to ensure that urgent and planned care services that rely on specialist skills can be sustained**

By April 2019 we will create An Accountable Care System for Somerset which uses outcomes to drive person centred care.

Financial Summary

There is system-wide agreement that continuing to provide care using existing models and form is not a sustainable option. Using a modelling partner and the Symphony data set there has been a joint development of the 'do nothing' scenario which has predicted a £596m cumulative gap between the forecast cost and funding over the 5 years, with an in-year gap of £175m in 2020/21.

The STP has identified a series of opportunities that we expect to contribute to closing the financial gap, thereby putting our finances on the necessary stable footing for the future. If the cumulative benefits of these can be realised the system improvement over 5 years would be £388m on top of the existing year one planned improvements of £42.4 million.

SYSTEM METRICS

Finance

- Performance against organisation-specific and system control totals

Quality Operational Performance

- A&E performance
- RTT performance

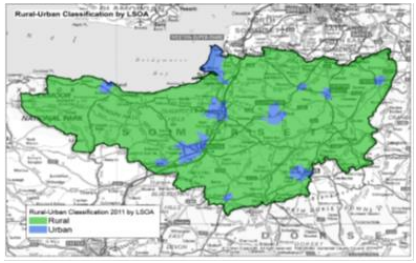
Health outcomes and care redesign

- Progress against:
  - Cancer Taskforce implementation
  - Mental Health Five Year Forward View
  - General Practice Forward View
    - Hospital total bed days per 1,000 popn
    - Emergency hospital admissions per 1,000 population

The challenges across Somerset are significant, but all organisations are committed to working together in a truly collaborative way, putting system before organisation to create a clinically, socially and financially sustainable health and care system for our population

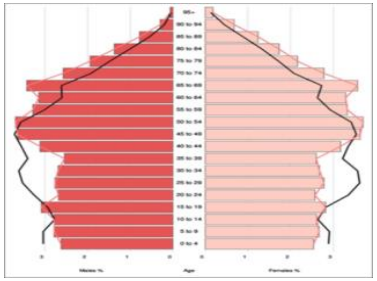
This is Somerset

Somerset is the 12th largest county in England, with a relatively low population density (560,000). The county is markedly rural, 48% live in the countryside, with border-to-border travel times east to west of two hours, and north to south of one hour.
We have no large urban areas or universities.



We have a higher than average older population, 10.4% of the population is over 75 years of age compared to 7.8% in England.

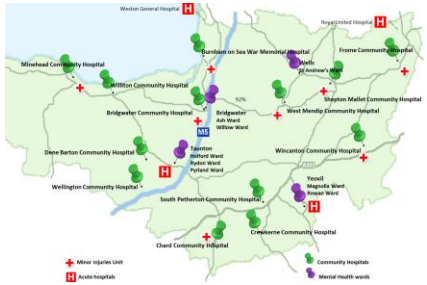
There is also a much lower than average working age population particularly in the 20 to 40 year age range.



This demographic profile presents complex challenges. The ageing population and gap between life expectancy and health life expectancy is driving an increased demand whilst the reducing working age population is further diminishing our labour market.

Service Provision

- 234 community hospital beds open over 13 sites
- 852 general beds across 2 DGHs
- 53 maternity beds
- 74 practices across 9 localities



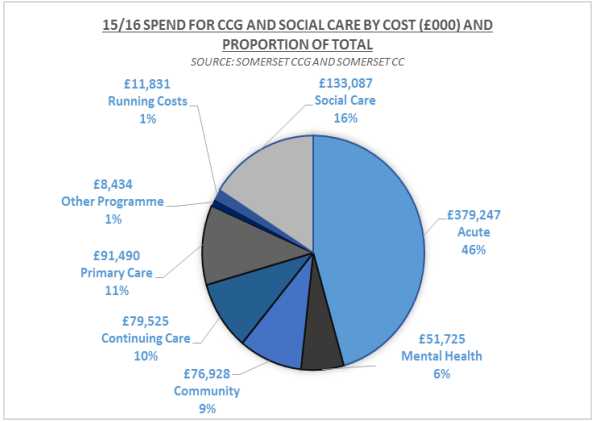
Commissioned Activity

Based on comparison against our Right Care peer group we spend per head of population:

- £662 on acute care which is 5% more than average
- £267 on community and mental health services. This matches the peer group spend, although combining these hides an acknowledged under investment in Mental Health services and a high spend on bed based care within our community services
- £84 on continuing healthcare which is 15% higher than average
- £153 on prescribing which is 12% below the peer group average.

Further analysis shows:

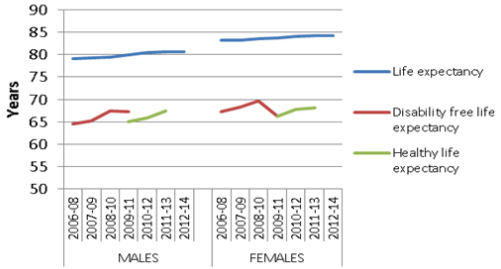
- We have 13% higher than average permanent admissions to nursing and residential homes.
- Only 9.25% of eligible users are using personal health budgets against a target of 23%.



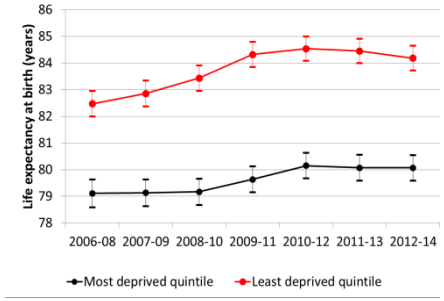
Case for Change – Health and Wellbeing

Life expectancy in Somerset is higher than the national average and is increasing. The latest figures (for 2009-11) put average life expectancy at birth at 80.0 years for males and 83.8 years for females.

However, healthy life expectancy (the average age at which we can expect to remain free from long-term health problems) has not increased to the same extent.

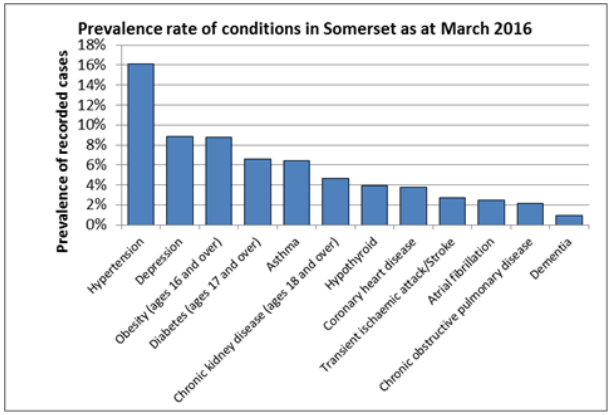


The gap between life expectancies in the most and least deprived quintiles in the county is not narrowing, with premature death and the prevalence of diseases being highest in the most deprived quintiles.



The major burdens of disease in Somerset, particularly those resulting in long-term conditions, have a contributory lifestyles factor and can be prevented. We need to focus on key health risks relating to lifestyle choices such as obesity, physical activity, tobacco dependence and alcohol use. We recognise the inextricable link between good mental health and physical health; tackling the inequalities and promoting good mental health will be cross cutting themes which run across the breadth of our prevention work.

The prevalence of conditions are detailed in the graph below:



Somerset has a higher prevalence of excess weight in its adult and reception age children population, higher number of injuries due to falls in those aged 65+, and hip fractures (Public Health Outcomes Framework Indicators), and higher than the England value for the estimated number of people with hypertension (PHE Hypertension Profile).

Somerset has a higher percentage of physically inactive adults than the South West average, and a higher prevalence of smoking in routine and manual workers than the national average.

Summary of the Health and Wellbeing challenge:

- **10% higher than average levels of overweight people and obesity, 5% lower levels of physical activity, and a 20% higher prevalence of smoking in priority groups.**
- **Higher than average levels of hypertension, falls and hip fractures, diabetes complications.**
- **An historic lack of investment in prevention that limits it being delivered systematically at scale and pace.**

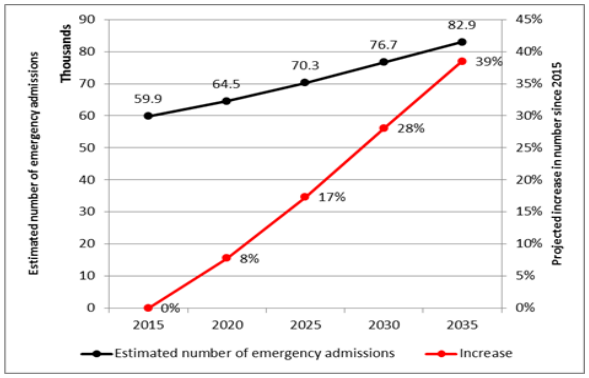
Case for Change – Care and Quality

Overall levels of elective, emergency and urgent care demand are placing significant pressure on Somerset services.

ED 4 hour waiting times

ED attendances increased by 3.5% in 15/16, leading to a reduction in the delivery of the 4 hour target from 94.49% to 93.8% (Aug-16) for all Somerset residents. Minor Injury Unit attendances also increased by 5% in the same year. The recent steep rise is caused by a range of other contributing factors:

- Increasing rise in demand for routine / non-emergency care during periods when 'normal' providers of such care are closed e.g. demand for GP Out of Hours services
- Risk aversion, which may be driving an increased referral rate, as practitioners, domiciliary care providers and nursing homes refer patients to hospital rather than make complex care and end of life decisions
- An overall increase in the number of patients attending ED units with minor ailments
- A complex range of access points into the health system, not understood by the public, leading to uninformed patient choices and default to ED departments
- Increasing demand for emergency ambulances.



Emergency admissions

In 2015/16, emergency admissions rose by 4,140 (7.4%) placing services under severe strain throughout the year with a deterioration of performance against key national standards. Pressure on urgent care is predicted to continue to rise over the next five years. If we do nothing, emergency admissions are projected to rise by at least 1.7% per annum, due to population increases and changes alone.

Delayed Transfers of Care

People are waiting too long in hospitals for other types of care, which impacts on their longer term health and independence.

Pressures on urgent care services are compounded by delayed discharges with levels in winter months rising by around 20% against the same months in 2015.

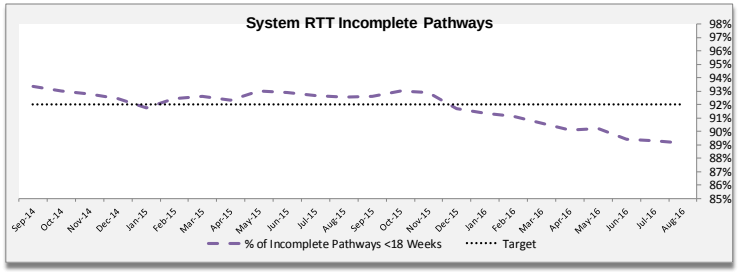
There are 2000 acute bed days lost per month due to delayed transfers of care (DTOC), costing £300k (based on average staffing cost of acute bed at £150 per day). There are a further 700 bed days lost per month in community hospitals

In 2015/16 the most common reasons for DTOC were:

- Waiting for nursing / residential home - 950 bed days
- Waiting for a care package at home - 750 bed days
- Waiting for further NHS non-acute care - 650 bed days
- Waiting for completion of assessment - 300 bed days

Referral to Treatment Time

The Somerset commissioned system successfully delivered against the 92% target for incomplete pathways until November 2015. Due to a combination of factors, including high emergency demand and high referral growth in certain specialties, particularly for cancer, the position has deteriorated. In August 2016, 89.1% of incomplete pathways were under 18 weeks.



Case for Change – Care and Quality

Cancer waiting times

Despite sharp increases in cancer referrals during 2015/16, Somerset met seven out of the nine waiting time standards, including patients seen within two weeks of urgent GP referral.

Diagnostic waits

Diagnostic activity in Somerset rose by 8.3% in 15/16 with a consequent reduction in delivery against the 6 week standard to 94.4% in August 2016.

Primary Care

There are significant challenges facing primary care teams in Somerset with the second highest level of GPs aged over 55yrs of all STP footprints. Recent figures show that 31% of GPs intend to retire in the next three years. This is compounded by the difficulties experienced in filling GP vacancies (50% of advertised posts remain unfilled).

Mental Health

There are significant gaps in mental health services. These include:

- the absence of Rapid Assessment Interface and Discharge (RAID) compliant liaison psychiatry services
- CAMHS, where demand outstrips the capacity of the service. There are shortfalls in levels of care and support available at tiers 1 and 2, including early intervention and prevention
- Eating Disorder Services which have insufficient provision to meet demand
- Lack of specialist perinatal mental health services
- Inadequate specialist inpatient provision resulting in high numbers of being treated out of area.

Community Services

There are demand and workforce challenges across community services, for example in District Nursing services where there are major challenges in recruitment and the age profile of staff. This is at a time when demand has risen by between 3.5% to 7.5% annually.

Social Care

In social care there are :

- Higher than peer average admissions to nursing / residential homes
- Delays in successfully completing social care assessments within 28 days
- Increases in demand for social care assistance, 6,000 referrals a month up 10% on last year and previous years
- Rapidly increasing cost of care due to the national living wage and complexity of care packages
- Lack of available care provision as provider market and workforce shrinks.

Other Workforce Challenges

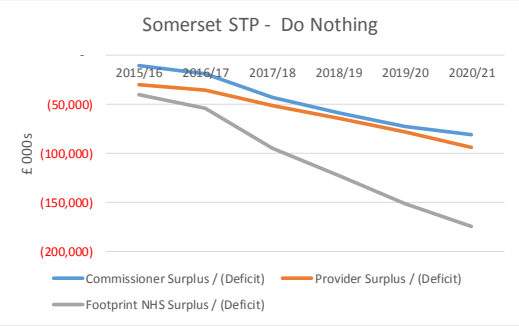
- A shortage of Nurses and Midwives across all sectors
- Medical workforce retention and recruitment challenges across services
- Retention and recruitment issues with regards to Community Pharmacists and GP Practice Nurses
- Significant locum/agency expenditure in Primary Care, Social Care, Community Services and elements of Acute service provision.

Summary of the Care and Quality Challenge:

- **Ageing population with more complex care needs**
- **Rising A&E attendances, emergency admissions and DTOC.**
- **Consequent pressure on hospital elective capacity leading to increased waiting times**
- **Investment required in mental health, primary care and home based community services**
- **Workforce recruitment and retention challenges**

Case for Change – Finance and Efficiency

There is full agreement across the system that continuing to provide care using existing models and form is not a sustainable option. Using a modelling partner and the Symphony data set there has been a joint development of the 'do nothing' scenario which has predicted a £596M cumulative gap between forecast cost and funding over the 5 years with an in year gap of £175M in the year of 2020/21.



For the year of 2016/17 the Somerset system has worked through the initial financial plans to understand the overall effect on the system, including areas of impact on other organisations.

2015/16 outturn and 2016/7 forecast as per 30th June Submission

	Somerset CCG £m	Taunton & Somerset FT £m	Somerset Partnership FT £m	Yeovil District Hospital FT £m	Somerset NHS Total £m	Somerset Social Services £m	Somerset Health & Social Care System Total £m
2015/16 Outturn	6.5	(9.8)	0.5	(18.6)	(29.9)	(6.5)	(36.4)
2016/17 Plan – Surplus / (Deficit)	6.5	(1.1)*	2.9*	(15.3)*	(7)*	(7.1)	(14.1)
Impact of Inconsistent Contract Outturn Assumptions					(7.9)		(6)
Impact of Assumptions re Penalties and CQUIN Delivery					(2.7)		(1.7)
Impact Cost Improvement Programmes on Partners					(0.4)		(0.4)
Unidentified QIPP					(15)		(15)
Net System Wide Position					(33)	(7.1)	(40.1)

*Position after allocation of £13.6m Sustainability and Transformation Funding

The 2015 Comprehensive Spending Review announced reductions in the public health grant allocated to Local Authorities from April 2016. These are challenging savings at a time when prevention activities require investment. To achieve the savings required, yet continue to improve health and wellbeing, there is a need to transform services to have a greater focus on population health gain and using the assets in our communities to a greater extent. Support for individual health gain will need to be embedded more into the roles of people working into the health and care system.

Total PH Funding	2016/17	2017/18	2018/19	2019/20	2020/21
Estimated Grant	£21,820,745	£21,275,226	£20,722,070	£20,183,296	£20,183,296
Cuts required per year	£1,815,100	£538,000	£553,000	£539,000	£0

Activity Changes based on historical data

Point of Delivery	Activity 16/17	Activity Forecast 20/21	5 Yr % change
Acute - A&E	226,564	259,558	15%
Acute - Non Elective IP	72,991	83,230	14%
Acute - Elective IP	90,162	98,277	9%
Acute - Outpatient	760,303	824,705	8%
Acute - Other [1]	317,155	334,489	5%
Mental Health	212,426	228,907	8%
Community Services	902,781	1,035,124	15%
Continuing Health Care	417,255	489,458	17%
GP (Primary Care)	3,352,311	3,606,412	8%
Prescribing Drugs	11,425,586	12,291,632	8%
Social Care	673,706	730,289	8%
Other Programme [2]	443,130	458,118	3%

Summary of the financial challenge:

- **Increasing demand across the main points of delivery for the system**
- **System spend for community benchmarks as average, however the majority of spend is in bed based care not community and primary care services leading to increased pressure and activity in acute services**
- **2 acute hospitals providing district general services for the county with limited service centralisation**

Our Priorities for Closing the Triple Aim Gaps

Services in Somerset are not keeping pace with the changing needs of local people and it is becoming increasingly difficult to ensure access to consistently high quality care that is affordable and sustainable.

There are a number of reasons for this:

- We have an ageing population with more complex needs who require more support from health and care services
- We have higher than average levels of overweight people, lower levels of physical activity and a higher prevalence of smoking in certain population groups
- The current system is no longer affordable or sustainable. This year we are facing a gap between allocation and expenditure of £33m, by 20/21 this could be in excess of £100m. We have significant work force challenges to be able to support existing services and are finding it increasingly difficult to meet key performance targets
- While the needs of our population have grown the way in which the NHS and social care services operate has largely stood still and we have not historically invested in prevention, out of hospital and mental health services

To tackle our triple aim gaps we will:

Drive delivery of the system-wide financial and performance improvement. Our plan is ambitious and rightly so. The challenges we face are considerable and the actions we need to take are multifaceted. We know that we will be more effective if we focus on a small number of things in year, concentrating our efforts on the actions that will have the most impact. We need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable.

Develop sustainable models of care across Prevention, Primary, Community and Acute Services. Through a structured programme of redesign, ensuring that funding flows to where it is needed, placing as much emphasis on prevention as we do on treatment so people can manage their own health more easily, and can take responsibility for their lifestyle choices. Prioritising early intervention and prevention, developing a greater range of well-resourced services in primary and community settings and designed around the needs of individuals a, reducing unwarranted clinical variation including in the management of long-term conditions.

Only those people who are seriously unwell will be treated in a hospital setting and where specialist care is required their assessment and treatment will be as efficient as possible aiming to return people home with support from primary and community based care as soon as possible. We will invest more in prevention, primary and community care,. We will ensure a holistic approach social, emotional , mental health and physical health considered together.
This means we will need to spend less on acute hospital based care, going forward our aim is to deliver, in the acute care setting only those elements of care that cannot be safely provided, either clinically or economically, elsewhere. To support this we will focus on developing our ambulatory and day case models of both planned and emergency care. Resulting in a redirection of resource from traditional bed based models of care into the community and a 'right sizing' of the whole system.

To tie our work streams together and ensure the development of a coherent model for Somerset we will develop an analytical framework building on the work of our existing vanguard programme, using right care, provider and commissioner data to model the impact of working across the system to change patient flows through the implementation of our new care model. We will use this information to inform a countywide analysis and to identify how we can move resource across the system.

Develop an Accountable Care System for Somerset enabling Health and Care commissioners and providers to plan and deliver integrated services that use outcomes to drive services which meet the needs of the whole population by April 2019.

Priority 1 – Drive improvement in the system-wide financial and performance position

Lead Accountable Officer – David Slack

Context

The 2016/17 forecast delivery in June for the Somerset Health System was a £33m deficit, which the system remains on track to deliver. This includes the delivery of the existing internal plans for CIP and QIPP that total £42.4m.

The two acute Foundation Trusts are forecasting deficits after the receipt of STF allocations and the Local Authority is also addressing a forecast overspend in 2016/17, with particular pressures in the care system. The CCG is forecasting a deficit of £3m, although this assumes that £7m of headroom funding can be accessed and that a further gap of £2.6m can be covered within the financial recovery plan.

A gap for 2017/18 and 2018/19 of at least £30m between the current version of the STP and the likely system control totals.

Additional in year pressures have been identified including the effects of the changes to the MSK pathway, delivery of recurrent savings, and the impact of the change in Funded Nursing Care.

The system recognises that it needs to work as a system towards a joint financial improvement goal, including the efficiency and effectiveness work stream delivering benefits in future years.

Priorities

A number of areas for improvement for the system have been identified, the most notable being a system investment in a Delayed Transfers of Care solution, and a joint agreement to undertake a system wide financial turnaround approach. The key objectives of this are;

1. To improve the overall financial outturn in 2016/17 for the system, irrespective of the individual organisations positions. This includes any opportunities to deliver one-off improvements in one or more organisations even if that results in the organisation(s) over delivering against their control total.

2. To develop a plan to improve the 2017/18 and 2018/19 forecast positions through the development of actions that are either over and above those already in the STP or increase the likelihood of their delivery within the period.

3. To establish mechanisms and ways of working that enables and ensures the delivery of financial improvement plans across the system.

Progress since last submission

The system has agreed to and produces a monthly open book system wide financial report for the leadership teams.

The system has agreed and implemented a system wide (including social care) mandate and funding of a DTOC solution as an in year and recurrent benefit, see DTOC slide.

The CCG has prepared, submitted and commenced delivery on a recovery plan with in excess of £10m improvement actions.

A turnaround support team has been selected to drive additional in year improvement and support improvement in 17/18 planning

Next Steps

October 2016 - Commence turnaround support

November 2016

- Align operational plans at organisational level with STP wide plan.
- Review back office plan for 2017/18

December 2016 - Agree two year contracts and finalised agreed system and operational plans (aimed improved system wide plan to October plans)

Priority 2 – Focus on prevention to develop a sustainable system

Lead Accountable Officer Pat Flaherty

Context

Increasing gap between life expectancy and healthy life expectancy

Health inequalities gap increasing rather than narrowing

Mental Health and Dementia, Cardiovascular Disease (including metabolic syndrome), Cancers, Respiratory Disease and Musculoskeletal conditions present the most significant burdens of disease for Somerset

Vision

A radical shift from a demand driven system to a prevention driven one, aligning our priorities to the most prevalent burdens of disease, ensuring physical and mental health parity of esteem and tackling health and social inequalities

Priorities

Overarching system priorities for primary, secondary and tertiary prevention:

- Mental Health and Dementia
- Cardiovascular Disease (including metabolic syndrome)
- Cancer
- Respiratory Disease
- Muscular-Skeletal Conditions

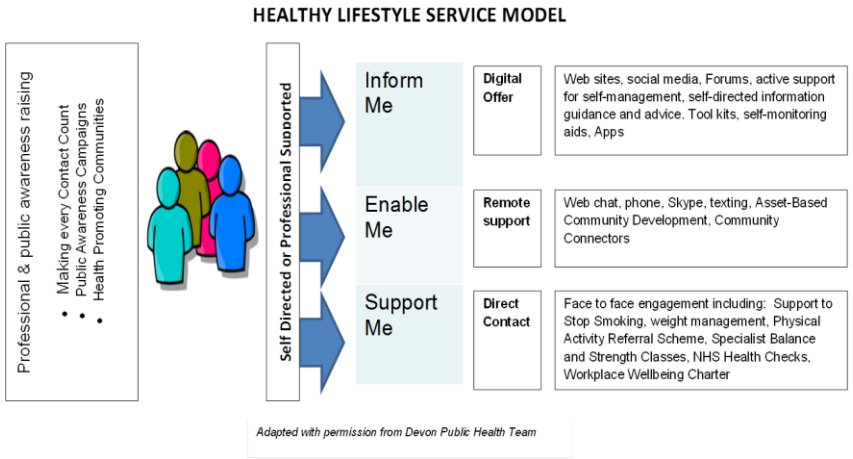
Related system priorities for primary prevention:

- Physical activity
- Healthy eating and weight management
- Smoking
- Alcohol

Priorities for infrastructure development:

- Development of stronger communities

Primary Prevention Model



Adapted with permission from Devon Public Health Team

Progress since last submission

- Prioritisation exercise completed
- Prevention Charter drafted
- New model of primary prevention developed
- Requirement for shared investment confirmed
- Initial benefits realisation modelled

Next Steps

October 2016 - Using a range of data sources including Symphony data
- Agree costs and benefits

December 2016 - Fully detailed & costed Prevention Plan in place overseen by the Somerset Health and Wellbeing Board with shared system investment confirmed

January 2017 – Prevention Charter Adopted across the County

Priority 3 – Redesign of Out of Hospital Services

Lead Accountable Officer Nick Broughton

Primary Care

Context

Workforce crisis – 15.1% of GP workforce over 55, with approx. 50% vacancies unfilled

Ageing demographic, increasing complexity of patients

Investment required in primary care

Vision

A resilient, flourishing primary care system as the foundation of joined up care, with the patient at the heart of all that we do

- A safe, sustainable, integrated primary care system
- Delivery of high quality patient centred care
- Patients seen by the most appropriate person in a timely fashion
- A safe, enjoyable working day for professionals

Approach

Delivering the General practice Forward View

Developing a new model for Primary Care with the following elements:

- Manages the work force constraints around GP recruitment
- Uses GPs skills and knowledge to full effect
- Broaden skill mix …. Paramedics, pharmacists, health coaches / navigators, development of complex care MDTs, embedding physiotherapy and mental health services
- Identify solutions to manage same day demand in a more sustainable way, enhanced / extended 7 day services for patients
- Support patients to do more for themselves including active involvement in care planning
- Maximise use of technology including eConsultation / Skype and information sharing through global digital exemplar work
- Ensure joined up / collaboration between practices and pharmacy
- Develop strong links with mental health, secondary care, third and voluntary sector

Plan

Build on the learning from the Symphony Programme and wider Somerset Test and Learn programmes through the following actions:

- Ensure patients have an individually tailored proactive care plan in place.
- Widen the primary care teams to include health coaches, pharmacy, MH professionals, MSK, and physician assistants.
- Develop community, social care, mental health and complex care teams supporting a cluster of GP practices, working closely with them through practice MDT meetings.
- Link to and strengthen voluntary and community resources to support patients to manage their health and wellbeing.
- Develop solutions to manage same day demand in practices in a more sustainable way, delivered through the model of enhanced primary care.
- Develop plans to provide enhanced / extended 7 day services for the patients who need it most
- Develop and extend the new organisational models available to practices to support each other
- Integrated working with community services in order to access enhanced intermediate care services/rapid access to reablement.

Progress since June Submission

Working group developed, support secured from practices, LMC and NHS England for the model.

Selected as national transformation system for extended access to general practice

Next Steps

- Complete new skill mix modelling and agree detailed rollout plan
- Finalise business plan for mental health support
- Review initial evaluation results in South Somerset and build in learning
- Agree plan to align community staff around practices to include optometry, dentists and pharmacy. LPC Lead for Somerset already engaged with STP
- Further develop plan for weekend working

Priority 3 – Redesign of Out of Hospital Services

Lead Accountable Officer Nick Broughton

Community Services

Context

- Aging population with more complex care needs
- Rising ED attendances, emergency admissions and DTOC blocking system 'flow'
- Consequent pressure on hospital elective capacity leading to increased waiting times
- Market for care provision struggling to respond to the workforce challenges
- Increasing demand across all sectors of system
- Significant costs tied up in provision of heavily bed-based community model

Vision

To shift more health care from hospitals to settings closer to people's home, and from reactive care to prevention. To develop proactive models based on early intervention

This includes mental health and social care having a rapid response and to work with hospitals to speed up discharge.

Greater level of community mental health services ensuring people with mental health problems have support for physical health issues including prevention.

Approach

- Reduce complexity – including simplifying the pattern of services
- Creating larger community teams with a shared set of skills that will include some staff with more specialist knowledge.
- Wrap services around primary care and build multidisciplinary care for people with complex needs, supported by digital information sharing
- Support multidisciplinary teams with specialist medical input
- Create step up and step down services that offer an alternative to acute and community hospital stays

Expected Benefits

The community work stream aims to reduce reliance on acute services and community beds and to introduce a model of care which is better for patients and more cost-effective than the way in which we currently provide services. It is recognised that spending per head of population in Somerset on home based community services and mental health services is low compared to the national average, and that additional investment in mental health services will be required over the life of the plan.

Progress since June Submission

- Work stream clinical strategy and steering groups established
- Hospital at Home model for step up and step down designed
- Hospital at Home team composition and staff mix designed
- Public engagement commenced

Next steps

November 2016

- Model the expected impact of the hospital at home service, confirming costs to be released from existing models of care
- Begin engagement and coproduction of community solution with the public

December 2016

- Assess the requirement for additional community services based on the impact of changes elsewhere in the system
- Develop proposal and plan for shared assessment processes
- Develop business case for the provision of support and staff training to nursing and residential homes

February 2017 Launch first test site for hospital at home service

Priority 3 – Redesign of Out of Hospital Services

Lead Accountable Officer Nick Broughton

Tackling Delayed Transfer of Care

Context

As at June 2016 there were circa 2,000 bed days per month across the two acute hospitals lost as a consequence of delayed transfers. This is costing between £300,000 and £400,000 per month. In addition, there are a further 600 - 700 bed days per month relating to delayed transfers within the community hospitals and circa 250 bed days per month relating to delayed transfers within mental health wards.

Plan

The aim is to reduce the acute and community hospital delays by 50%, with a saving of £150,000 per month based on a cost of £150 per bed, per day. The potential solutions that are being finalised include the establishment of new services including hospital at home, reablement homecare, rapid response and care home support. These solutions require the purchase of additional care home beds and an agreed system wide investment by all partners.

Expected Benefits

The agreed mandate for the system assumes solutions will be delivering from November with savings up to £0.5-0.9m this year. Any improvement greater than 50% of DTOC (or reduction in cost of solution) would save more. Workforce benefit to be realised through the reduction in staffing levels for beds required and movement from bedded care to home care.

Progress since June Submission

- System team established with agreed priorities for close collaboration and urgent remedial action
- Robust governance arrangements in place to manage DTOCs across the system including daily forums in each hospital to action the urgent transfer/discharge of DTOC patients during transition
- Community services mobilised to accept higher numbers of same day referral acceptance
- Reablement homecare operational capacity in line with recruitment, admission criteria and pathway jointly agreed by project group with initial capacity reserved to support daily discharge to assess initiative
- Mapping current process delays in detail as a precursor to designing and implementing new integrated and compressed pathway drawing on advice and experience of front-line staff and lessons to be learned from D2A three week initiative
- Finance open book review of benefits to test value for money

Next Steps

October

- Funding arrangements for social care funding agreed
- Additional step-down/reablement beds procured
- DTOC mandate finalised
- Recruitment completed for the two new community services decision making roles

November

- System evaluation with ongoing review and refinement of process
- Deliver 50% reduction in DTOC

Priority 4 – Address clinically and financially unsustainable acute service provision

System Accountable Officer Sam Barrell

Sustainable Acute Service Provision

Context

Significant work force challenges combined with rising demand means we are finding it increasingly difficult to maintain the provision of a full range of services across the two acute hospitals within the available budget. While quality and safety are key priorities, we need to balance this with ease of access, recognising that sometimes it is better to travel further to ensure access to high quality care.

In order to ensure future investment in prevention and admission avoidance radical new models of acute care are required that support investment in community based alternatives.

We are aware that even by working across the two acute FTs within Somerset we may still be sub-scale for some services and we are looking to our wider neighbours to ensure sustainability.

Plan

The key priorities are to:

- Complete a structured review using local and national data sources together with benchmarking and review of models working well elsewhere to inform the right sizing of the Somerset health and care system
- Develop alternative models of delivery for vulnerable services that consolidate services and / or shift care to out of hospital settings
- Address workforce challenges by looking at a wider multi-disciplinary approach, developing new roles and utilising technology. Where appropriate we will consider single-site, single workforce solutions.
- Explore systematised surgery model to deliver superior clinical outcomes, lower cost of care and specialisation opportunities for staff.
- Improve access and achieve sustainable delivery of referral to treatment targets an immediate priority is our orthopaedic pathway with the introduction of a streamlined MSK service.
- Implement a radical new model of outpatient delivery
- Tackle increasing demand through closer working between Primary Care and hospital specialists
- Test whether for cancer patients, targeting intervention early in a patients pathway improves outcomes and reduces overall cost of care to the system.

Progress since June Submission

- Applied local intelligence, knowledge and data including 'Right Care' metrics and the emerging Lord Carter metrics to identify initial list of 12 vulnerable service lines, with 2016/17 priorities agreed as Paediatrics, Maternity, Dermatology, Oral Maxillofacial Surgery, Urology and Oncology
- Developing a joint approach to service redesign for maternity and paediatrics with Dorset.
- Detailed systematised surgery business case developed for the East of the county . A partner has been identified to support the progression of this work, now exploring potential of expanding this across the county. Sharing learning regarding improving the efficiency of inpatient theatres.
- Given notice to decommission existing MSK interface service and two options for the future model of care have been developed.

Next Steps

December 16

- Finalise new service models for Dermatology, Oral Maxillofacial Surgery and Urology
- Agree new delivery model for MSK
- Complete technology appraisal and establish system-wide project team to develop new model for outpatient follow-ups
- Complete data analysis and identify areas of Somerset Cancer Programme focus
- Develop analytical framework, including Right Care to support system right sizing

February 17 – Complete Maternity & Paediatrics options and impact assessment
April 17 - Implementation of new cancer pathways

May 17- New MSK pathway in place

April 18 – Evaluate YDH systematised surgery model and consider MPH roll out

Priority 4 – Address clinically and financially unsustainable acute service provision

Redesigning Acute Hospital Urgent Care

Context

Demand for acute based urgent care services within Somerset has continued to increase – A&E attendances increased by 3.5% and emergency admissions by 8% during 2015/16. Year to date these increases are 3.8% and 8.6% respectively. Alongside this is a growing demand from people suffering from mental health crisis.

Key to reducing this increasing trend is the roll out of new models of care increasing access to support and advice to enable people to self-care wherever possible. There are significant links to other work streams – particularly the development of rapid response teams , hospital at home models and the work to standardise the management of urgent primary care.

In response our existing acute based models will need to change and we will need to be able to transfer resource from traditional bed based models of care into alternatives that prevent admission.

Plan

Having reviewed our priorities against the national urgent care 'route map' domains we have agreed the following areas of priority:

- Develop a consistent new model of urgent care across Somerset that focusses on integrating acute services, primary care and community urgent care
- Implement a new, enhanced Psychiatric Liaison Service that will support patients by providing rapid assessment and discharge services for service users with urgent mental health needs
- Redesign our acute front doors to ensure a consistent, single access point for patients, integrating acute, mental health, primary / community services and social care and providing seamless access both in and out of hours. Through this we will ensure consistency between in-hours and out of hours services.
- Focus on consistent implementation of Ambulatory Emergency Care pathways across the county
- Use technology to replace traditional 'face to face' urgent care models

Progress since June Submission

- Reviewed governance structure in line with the requirement to develop A&E Delivery Boards
- Agreed a set of principles to support a consistent new model of urgent care
- In Yeovil work is underway to develop an integrated front door for Yeovil (urgent care hub) and similar work is underway at Taunton and Somerset FT.
- Ongoing discussions with third sector provider to develop crisis house

Next Steps

November 16 Complete business case for Psychiatric Liaison Service

December 16

- Using analysis of unplanned activity to understand why demand is rising and confirm new urgent care model, high level financial benefits and overarching programme plan
- Develop overarching Urgent Care Implementation Plan for 17/18

January 17 Agree new front door model at each acute trust

March 17 New front door models operational

Spring 17 Strengthened Psychiatric Liaison Service in place

Review the emergency care services provided within Somerset with the SW Emergency Care Network and consider whether there are options to implement new pathways for more specialist care with the regional specialist centres.

Priority 4 – Address clinically and financially unsustainable acute service provision

Specialised Services

Context

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

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

Plans

The priority areas for Somerset have recently been defined as Spinal Surgery, Interventional Cardiology, Cancer Services, Neonatal Intensive Care and Specialist Mental Health Services

Progress since June Submission

- Work on CAMHS, Neonatal Intensive Care and Cancer Services are being picked up as part of the Maternity/Paediatrics and Cancer priority projects previously defined.
- Discussions around the future provision of Spinal Services are commencing between Musgrove Park Hospital and Bristol
- The opportunities include integrating pathways, developing local service alternatives and helping to crystallise opportunities for consolidation as part of reconfiguration plans.

Next Steps

In the next planning phase, the Somerset leaders wish to gain permission through the collaborative commissioning process to set out plans for a delegated commissioning approach to develop through 2017/18 and 2018/19. We are also seeking permission to develop plans that would reinvest efficiencies where plans control demand and produce service alternatives that prevent specialised interventions when they are not necessary.

With regards to Mental Health we are working with other South West providers to eliminate all clinically inappropriate out of area placements and to pilot a commissioning model for specialised Secure Care – identifying opportunities to shift resource from hospital care to community pathways.

Our aim is to continue to provide low secure and Tier 4 CAMHS beds to serve the STP footprint and in addition we are exploring the possibility of developing a PICU for children and adolescents

Somerset TOTAL SC SPEND - 111,231,086	
NPoC	Spend
B03 - Cancer	22,337,853
C02 - Forensic and Secure	7,953,724
A10 - Cardiac Surgery	7,301,870
D03 - Adult Neurosurgery	7,214,674
A09 - Complex Invasive Cardiology	6,019,409
E08 - NICU Inpatients	5,764,312
A06 - Renal Dialysis	5,157,357
Other - Drugs	4,848,336
Other	3,995,163
D10 - Orthopaedics	3,003,438
Total top 10 spend	73,596,136
Total top 10 spend as percentage of overall spend	66%

Somerset Specialised Services Spend 15/16

Priority 5 - Create an Accountable Care System by April 2019

Provider Reform Lead Accountable Officer - Paul Mears

Commissioner Reform Lead Accountable Officer - David Slack

Vision for the Somerset ACS

We aspire to be a true 'place-based system of care' and the system senior leadership is committed to move to an Accountable Care System for Somerset by April 2019. This signals our shared understanding that the health and care system in three years will be radically different.

Definition

Somerset Together is the name of our Accountable Care System and it describes the commissioner and provider function which work together to ensure place based delivery of health and care to meet the needs of the population within the available financial envelope

With the Accountable Care System there will be:

A **Strategic Commissioning Function** where the NHS and social care commissioners work together under a single commissioning arrangement to secure outcomes and pool budgets

An **Accountable Provider Organisation** where services are delivered by a provider, or group of providers (through a single governance structure), who have agreed to take accountability for all care and care outcomes for the population of Somerset under an outcome based contractual arrangement with the commissioner for a defined period of time.

Progress since last submission

- Agreed definition of ACS
- Defined high level system functions and responsibilities between Commissioner and provider and then APO and business units
- Sign up to an agreed a set of principles to support system working
- Defined system AO roles for commissioner and provider reform

Next Steps

Establish a Provider Collaborative Board bringing together the 3 FTs, Social Care and Primary Care

Define implementation timeframe for approach for rolling out the development of the APO

Build and develop implementation team to oversee APO development

Finalise approach for rolling out OBC across Somerset

Define the joint commissioning governance and infrastructure required to support a single strategic commissioning function

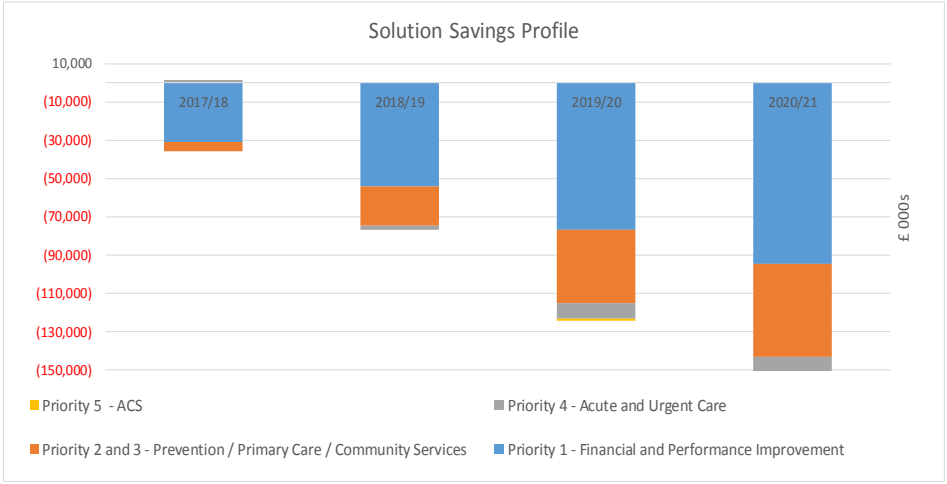
Expected Impact of our plans on returning the system to Financial Balance

The STP has identified a series of opportunities that we expect to contribute to closing the financial gap, thereby putting our finances on the necessary stable footing for the future. If the cumulative benefits of these can be realised the system improvement over 5 years would be £389 million on top of the existing year one planned improvements of £42.4 million.

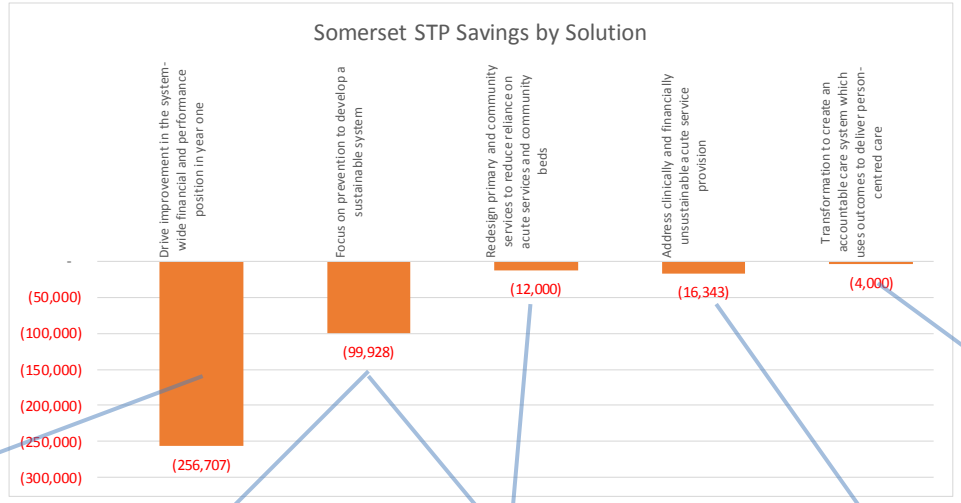
STP 2020/21 Summary (£ 000's)	Do Nothing	Solutions	Do Something
Commissioner Surplus / (Deficit)	(80,658)	68,993	(11,666)
Provider Surplus / (Deficit)	(93,967)	84,771	(9,197)
Footprint NHS Surplus / (Deficit)	(174,626)	153,763	(20,862)
Indicative STF Allocation 2020/21			37,000
Footprint NHS Surplus /(Deficit) after STF Allocation	(174,626)	153,763	16,138

The current position for year 5 in 2020/21 shows a small in-year surplus for the Somerset system, including the effect of the STF allocation. Each organisation has internal cost improvement plans within year 1 and these are being supplemented by further actions to improve the in-year position.

The savings profiles match to the current organisational plans including the mix between internal cost improvement and system wide savings schemes. As the organisations continue through the operational planning process they plan to continue to share and validate the values of the solutions internally and externally to ensure activity and contract values reflect the agreed changes.



Expected financial impact of our priorities



1. Drive improvement in the system-wide financial and performance position in year one

- 16/17 Improvements
- Internal delivery of CIP / QIPP
- Reduction in DTOC
- Reduction in IS activity
- Control and grip standardised across system to improve in year financial position
- Delivery of system wide cost reduction on top of internal efficiency year on year
- Continued reduction in CHC spend

2. Focus on prevention to develop a sustainable system

- Develop a place-based approach to promoting good health
- New models of care
- Whole system adoption of prevention
- Very specific focus to the needs of vulnerable groups
- Connect health and social care services

3. Redesign out of hospital services to reduce reliance on acute services and community beds

- Proactive Care: Enhanced Primary Care and Risk Stratification
- Front door and rapid response teams
- Increased mental health teams and focus
- Increased non-bed based care models and reduction in activity levels
- Significant reduction in the Community Hospital Bed Base
- Enhanced integrated community and primary care services
- Reduction in delayed transfers of care, length of stay and unplanned admissions

4. Address clinically and financially unsustainable acute service provision

- Service reconfiguration for priority list of vulnerable services
- Focusing on Maternity and Paediatrics, Musculoskeletal, Dermatology, Oral Maxillo Facial Surgery, Histopathology, Urology and Oncology initially

5. Transformation to create an accountable care system which uses outcomes to deliver person-centred care

- System wide shared services in line with Carter recommendations
- Move to an Accountable Care System and reduction in management overheads and organisations

Measuring Impact of the Plan - Delivering a high value health and care system

SYSTEM METRICS

Finance

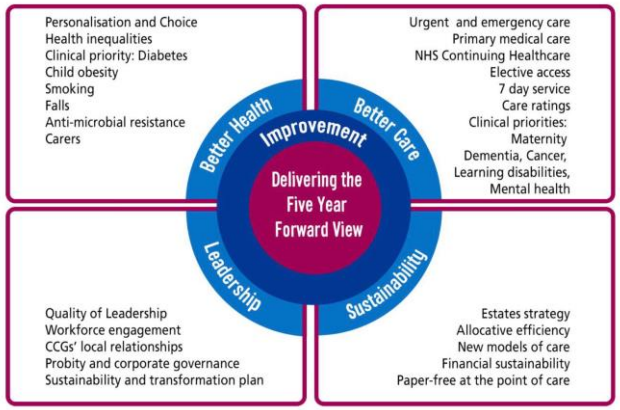
- Performance against organisation-specific and system control totals

Quality Operational Performance

- A&E performance
- RTT performance

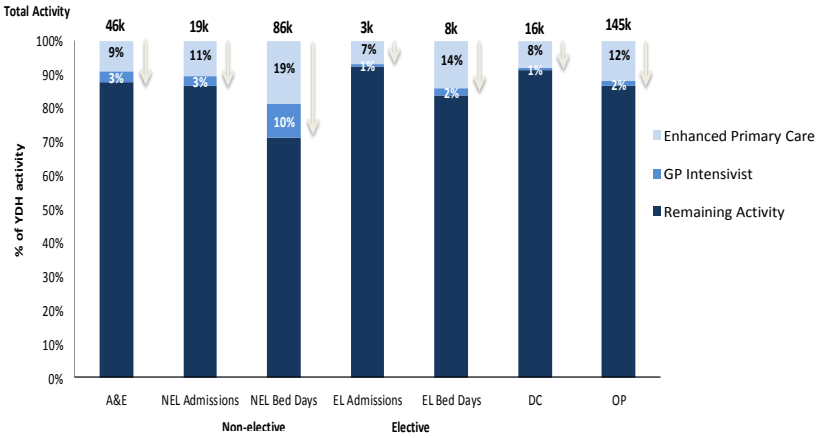
Health outcomes and care redesign

- Progress against:
  - Cancer Taskforce implementation
  - Mental Health Five Year Forward View
  - General Practice Forward View
- Hospital total bed days per 1,000 population
- Emergency hospital admissions per 1,000 population



Detailed metrics are identified in the workstreams and as the models evolve a shared system methodology using IHI Quality Improvement techniques will be used to mobilise clinical and professional delivery of the models.

Using evidence from the South Somerset Symphony model, the outcomes highlighted in the graph are expected to be achieved by implementing the new models of care . The financial impacts are largely driven by reduction in hospital activity with more provision of care delivered in out of hospital and primary care settings.



The importance of making the metrics and system costs visible and " real " to front line teams and the public will drive the delivery of a high value health and care system.

We need to get the best possible outcomes for the Somerset Pound.

Workforce

Implementing our STP will have a major impact on the existing and future health & social care workforce. We will require a smaller, more agile and digitally connected workforce able to work in new ways and locations to deliver :-

- integrated out-of-hospital care supporting and aligned to primary care
- networked hospital and out of hospital service provision across acute providers
- closer alignment of social and mental health services across hospital and community health settings

The challenges of implementing and supporting new ways of working will require us to work innovatively and pragmatically with our workforce, their representatives, education providers and service users. Mobilising voluntary, community and social enterprise sector will also be fundamental to the solution.

Heads of Workforce for all Foundation Trusts, the CCG and local authority have been meeting regularly to examine these challenges and this group will provide continuing support as new models of care emerge. There have already been some notable developments:

- Establishing closer links with education providers to support the development and delivery of health and social care training within Somerset to support a sustainable workforce across the county, including creation of a health & social care education campus for Yeovil and Bridgwater
- An innovative & effective recruitment campaign for social workers (www.socialcareandmore.co.uk);
- Completion of a promotional video and micro-site for recruiting health & social care staff
- A new benefits scheme for local authority staff, improving the employment offer with discussions to share across local authorities in South West
- Agreement to work in partnership with HEE SW to explore how best to support the widespread adoption of health & social care apprentices across the system, rotating between organisations
- Standardising workforce policies & procedures e.g. mandatory training, DBS & OH checks
- Limiting agency spend for staff (national agency rate & South West agreement on social worker locums)
- Sharing & developing workforce plans at organisational and system level

Recognising that consistent and robust workforce modelling will be required to support the identification of future optimal staffing requirements , Heads of Workforce, in conjunction with HEE SW have agreed to introduce a strategic workforce planning tool (WRaPT) across the system. This is a web based application that enables the collection, analysis and modelling of workforce information from providers across the whole health and social care economy and establishes the relationship between workforce capacity and service activity.

It is planned that implementation of this will be supported by existing staff from HR teams across the system thereby creating sustainable skills and experience for future use as new models of care are implemented and changed over time. It is expected that the tool will be functional by Q4 of 2016/17, supporting the development of the new workforce model into 2017/18.

The Heads of Workforce have also explored the increased efficiency that might be gained by integrated models of HR/OD delivery across the system. A pilot project is progressing between Somerset Partnership and Taunton and Somerset with the capacity for this to be expanded to other providers.

Working with the Voluntary Sector

The rurality of Somerset provides a need for a more dispersed support with many solutions provided and supported by local community groups and a self created vibrant voluntary sector.

Over the last two years work has been undertaken by community connectors to tap into this potential . There are example across health and social care which includes:

- Health Connectors
- The Village Agents
- Wellbeing Advisers
- Innovation Site West Somerset
- Living Better – West Somerset

Co-ordination across the many organisations has been critical to develop a strong voluntary and third sector model which has led to the development of the VCSE Strategic Forum

VCSE Strategic Forum

The role of the Forum is to develop a collaborative approach across the county which supports both commissioning and delivery, enabling smaller organisations to be supported and funded where possible, including the development of a shared communities agenda.

The focus is on delivering shared priorities which include:

- Reducing Social Isolation
- Building opportunities for Young People
- Support hard to reach and vulnerable communities
- Empowering individuals
- Facilitate Community Self Help
- Encourage innovation and collaboration
- Communications and Information sharing

The experience of the VCSE and its members provides clarity on how success can be achieved with a need to:

- provide community ownership and control
- support organic, evolving design, based on local needs
- provide independence & freedom to develop as local needs dictate
- appreciate that the solutions must suit the individual
- support creation of local champions

The work being undertaken with the voluntary sector is looking towards a joint approach to commissioning support services at scale, improving the ability for some schemes to recruit volunteers and paid coordinators and invest in future developments. This is not possible under the current contractual arrangements.

This approach is expected to build on the success that has already been achieved including:

- Supporting local communities by embedding the village agent and voluntary sector with the local social work team.
- Living Better sees Age UK leading a resilient network of support organisations to enable person centred care planning for people who would otherwise become users of health and social care services, working
- Village Agents and a Patient Participation Group piloting working with people who are isolated to engage with their local communities
- Community support is the key to the person centred care that people want and they want it delivered locally and by people they know.
- Build on social prescribing model through Primary and Community work streams.
- Developing our work with the Richmond Group of Charities

Our work with the Richmond Group of Charities

The Richmond Group of Charities is a collaboration of **14 of the leading health and social care charities** in the voluntary sector. It works together as a collective voice to better influence health and social care policy, with the aim of improving the care and support for the 15 million living with the long term conditions they represent.

In its recent research report, Untapped Potential, the Richmond Group presented evidence of the value that the charity sector can create in the health and social care sector. At the same time the research identified the **need for the health and care system to work better with charities** and vice versa. The Richmond Group is now working to put the findings of this research into practice in Somerset.

In Somerset we have a vibrant and diverse voluntary and community sector and we recognise the valuable contribution that our charities make – from the very smallest to the biggest. But **undoubtedly the findings of the Richmond Group research are true here**. We do not work closely enough with our charity sector and we recognise that we need to develop new and different ways of working together. Some efforts have already being made to develop closer strategic ties with our charities but we know we need to do more so that practical, collaborative plans for action are put in place and delivered.

As such we are delighted that the Richmond Group is committed to working with us and our charity sector to explore how we can better support and mobilise the voluntary and community sector across the whole county to improve the lives of the population.

No decisions have yet been made as to the precise shape or scope of this work but the shared vision of all partners is that it will be built on a genuine collaboration and bring to bear the national insights and experience of the Richmond Group to the benefit of people in Somerset. This , both in terms of service redesign and direct service delivery, into mainstream practice and the Somerset plans for sustainability and transformation themselves.

Our work with the Richmond Group has only just begun. The project will run for a **six-month exploratory stage**, ending in late March 2017. This will be followed by a delivery stage (the length of which will be determined by the exploratory stage). There may be areas where the process to identify the need or opportunity is more straightforward. In these cases we may be able to move to implementation on a faster timetable.

It is early days but we are confident from the initial discussions and approach being taken that there is significant opportunity for this work to support sustainable transformation in our relationship with all our charities and to drive transformational change with and for the people who use health and care services.

As partners we share the same ambitions. We all want people to live as well as they possibly can. We all agree on the important elements of a transformed system; including community-based coordinated care, the encouragement of healthy lifestyles, and a focus on personalised and holistic support.

Information Technology and Digitally Enabled Change

Context

Digital technology has the potential to enable a significant transformation in the way care is delivered. We already have moved forward in the county to implement new technology with both acute hospitals having introduced an electronic health record, community and mental health services moving to one electronic record and telehealth solutions having been deployed in the community. Our naming as a digital global exemplar, with national funding, will see a digital transformation at pace over the next two years.

The Somerset Digital Roadmap describes our ambition in full.

Shared Somerset Digital Vision

People of Somerset will have high quality care that is affordable and sustainable supported by:

- Digital systems which support individuals to maintain their health and wellbeing and take control of managing their conditions
- Individuals who have ownership of their record with is shared digitally at the point of care
- Digital systems that extend into, and connect, resilient communities enabling 'one system' to be efficient and effective
- Planning of care which uses joined up information
- Digital systems that provide paper free efficiencies, removing paper and fax flow of information" to reduce clinical bureaucracy and support clinical decision-making with real-time information available across the system

Somerset Digital Roadmap 2020 deliverables

To deliver the vision and objectives the Somerset Digital Roadmap identifies four key work areas:

1.A paperless system, with shared records and interoperability

2.Person facing services and digital inclusion

3.Real-time data analytics at the point of care

4.Whole systems intelligence

Progress since June Submission

Partner organisations are moving to implement an interoperability solution to enable the flow of patient information between providers which will be critical as we integrate care across traditional boundaries. This work is being supported by the South West AHSN.

We have mobilised an EMIS viewer into our Acute NHS providers and OOH provider to allow Primary Care records to be accessed using appropriate information governance protocols.

Taunton and Somerset NHS Foundation Trust have been awarded a Global Digital Exemplar to stimulate innovative digital strategy

In addition all our Providers are working with technology providers to develop new and transformational solutions including on-line appointment booking, on-line GP consultations, self-management for patients with long-term conditions, e-outpatient solutions and improved telehealth.

Digital solutions figure heavily in the Symphony Vanguard programme and sharing learning across our Community is being promoted through the STP programme.

Next Steps

- To model the financial implications of the Somerset Digital Roadmap
- To raise awareness and engagement of local population and staff members on information sharing and use of digital technology in providing health and social care services
- To use the Roadmap as the blueprint to move to delivery of the key elements to realise the 2020 ambitions

Estates

Delivering the major strategic priorities will require a substantial focus on the use of estate across Somerset. This will include developing infrastructure to support integrated out-of-hospital care and more effective co-ordination of infrastructure between primary care and community hospitals.

All organisations in the Somerset STP footprint are working together on a Local Estates Strategy which is approaching its final draft.

In reviewing the current performance of the estate across Somerset, there are efficiencies to be gained which, when combined with integrated service delivery will allow

significant savings. This includes:

- Reduction in the estate's running costs
- Maximisation of clinical space utilisation linked to new care models
- Review of non clinical space utilisation and developing integrated space across the system for administration and management accommodation

Better co-ordination of clinical services may also require a change in the use of parts of the two acute hospital sites and there are wider opportunities to rationalise and optimise the use of all estates across all providers, including primary, acute and social care, working flexibly and sharing accommodation.

In developing the new care models across the system, priorities have been identified with an understanding that these will have an impact on the estate that is current in use.

Specific areas of focus have been

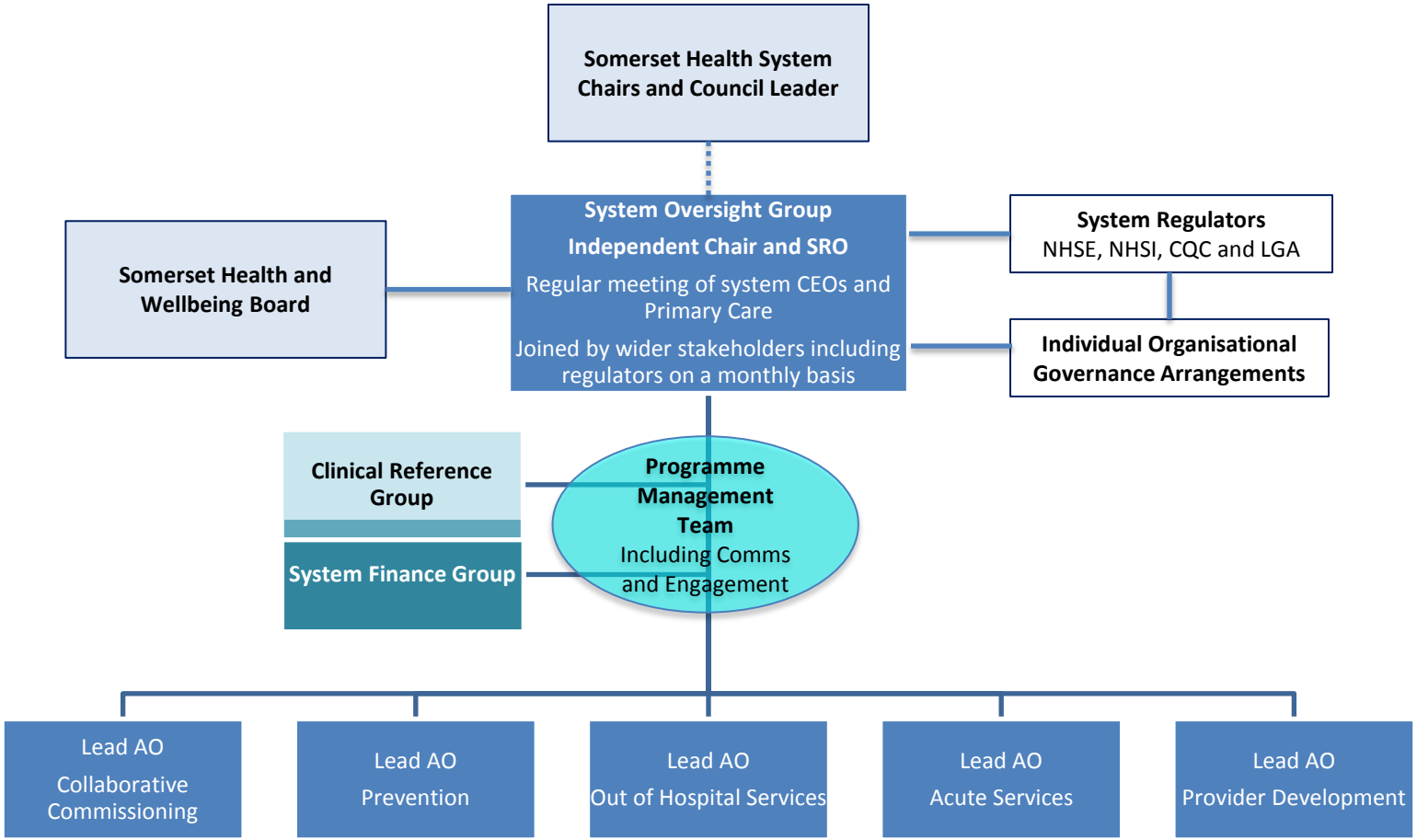
1. Prevention
- Transform health and social care estate through rationalisation of outdated facilities
- Integration into shared facilities to provide parity of mental health and physical health services

2. Redesign of Primary, / Community Health and Care Services
- GP Practices accommodating community, social care, mental health and complex care teams

3. Reconfiguration of Out of Hospital Services
- Redesign and invest in mental health and community care to support care closer to home and closer links with Prevention and Primary Care Services
- Enable stronger support for mental health services to be provided in out of hospital settings
- Establish more collaborative working across all system providers
- Support the development of infrastructure aligned to a more collaborative workforce, including optimisation of estate across all providers
- Support the development of hospital at home services where resources from all providers will be based across the community, improving accessibility as well as efficiency

4. Acute Service Reconfiguration
- Consider optimisation of estate and workforce to support better efficiency as well as collaborative delivery of services
- Develop options for shared back office functions

Programme Governance



Strengthening System Leadership

To strengthen the system leadership across Somerset we have:

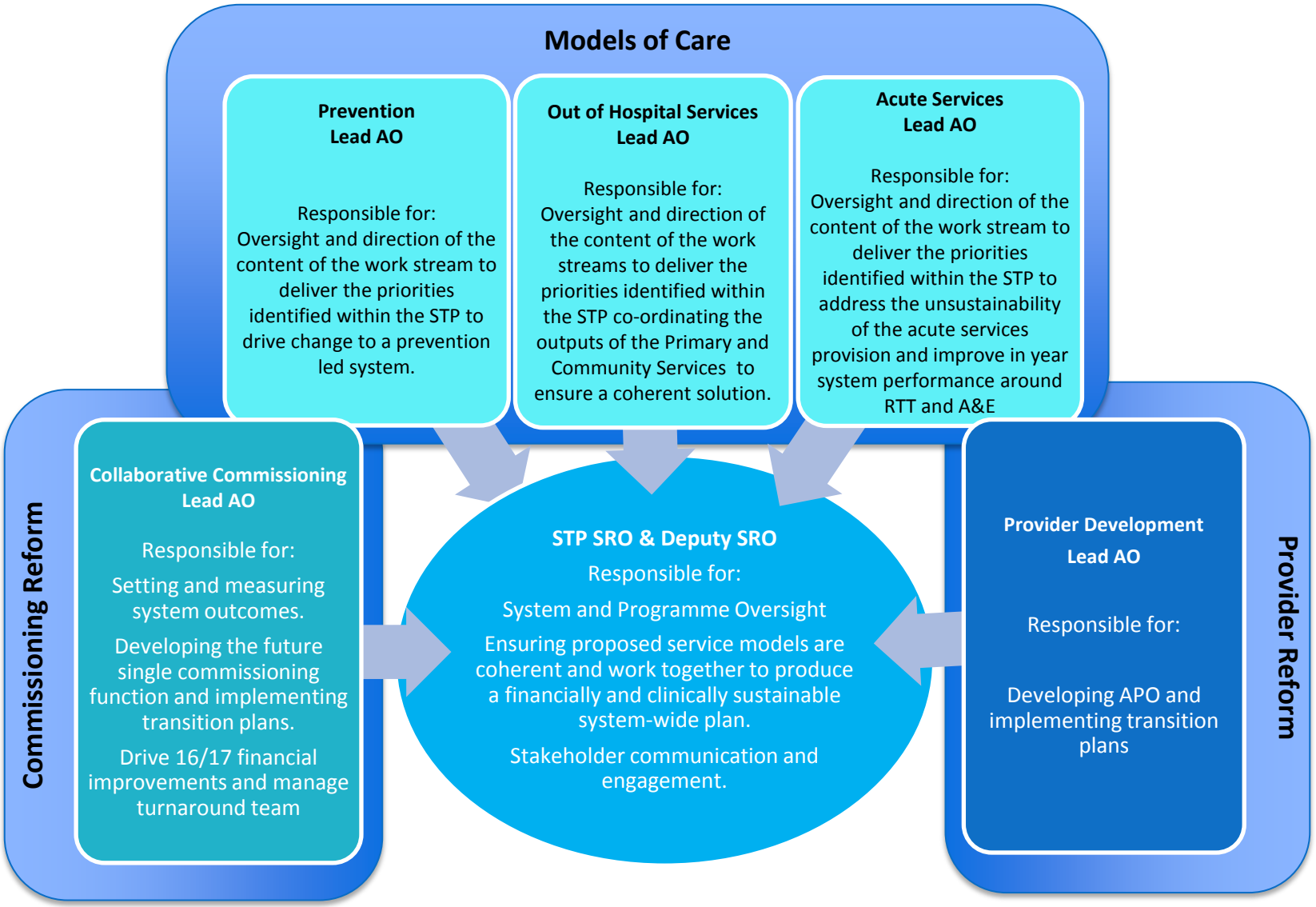
1. Started the recruitment process for an **Independent Chair** to chair the System Oversight Group and support the Senior Responsible Officer to recognise and manage the tensions between the Somerset STP, individual organisational strategies, operational programmes, enabling programmes and clinical reference group. Providing appropriate challenge and support to individual leaders to ensure all actions benefit the wider system and not just the individual organisation and escalate issues that cannot be resolved within the system to the combined group of Somerset Chairs and CEOs.

2. Supplemented the current **STP SRO** arrangements with additional senior leadership in a Deputy SRO role, to ensure 5 day a week presence and adding CEO level operational and programme management skills and experience. To ensure system and programme oversight and to lead stakeholder communication and engagement. Facilitating and enabling cross-organisational working.

2. Developed a **Collaborative Commissioning Lead AO ,** accountable to the System Oversight Group to undertake the required commissioner reform, with responsibility for setting and measuring system outcomes, developing the future single health and care commissioning function and implementing transition plans and leading any required public consultation.

3. Establish Lead AOs for the Models of Care Development, accountable to the System Oversight Group:
   - An **Acute Services Lead AO**, who will oversee and direct the content of the work stream to deliver the priorities identified within the STP to address the unsustainability of the acute services provision
   - An **Out of Hospital Services Lead AO**, who will oversee and direct the content of the work streams to deliver the priorities identified within the STP co-ordinating the outputs of the Primary and Community Services to ensure a coherent solution.
   - A **Prevention Lead AO,** who will oversee and direct the content of the work stream to deliver the priorities identified within the STP for prevention

4. Established a **Provider Development Lead AO ,** accountable to the System Oversight Group, for leading the development of the emerging model of the Accountable Provider Organisation across Somerset and the subsequent provider configuration which will deliver the new care models defined through the STP.


Models of Care
Prevention
Lead AO
Responsible for:
Oversight and direction of the content of the work stream to deliver the priorities identified within the STP to drive change to a prevention led system.
Out of Hospital Services
Lead AO
Responsible for:
Oversight and direction of the content of the work streams to deliver the priorities identified within the STP co-ordinating the outputs of the Primary and Community Services to ensure a coherent solution.
Acute Services
Lead AO
Responsible for:
Oversight and direction of the content of the work stream to deliver the priorities identified within the STP to address the unsustainability of the acute services provision and improve in year system performance around RTT and A&E
Commissioning Reform
Collaborative Commissioning
Lead AO
Responsible for:
Setting and measuring system outcomes.
Developing the future single commissioning function and implementing transition plans.
Drive 16/17 financial improvements and manage turnaround team
STP SRO & Deputy SRO
Responsible for:
System and Programme Oversight
Ensuring proposed service models are coherent and work together to produce a financially and clinically sustainable system-wide plan.
Stakeholder communication and engagement.
Provider Development
Lead AO
Responsible for:
Developing APO and implementing transition plans
Provider Reform

Communications and Engagement

Context

Engagement and communications activity relating to the design, development and delivery of the STP will be planned, coordinated and overseen within the Programme Team to ensure coherence and consistency of messages. With key partners working to the following principles:

- Supportive, collaborative planning for the benefit of the whole community, a whole population focus, children , adults , families and carers.
- Flexible capacity to support on-the-ground delivery
- Open and honest dialogue – with constructive challenge
- Public engagement and involvement at all stages

Approach to engagement

Effective patient and public engagement will be crucial to the successful implementation of system and service changes and it is intended that there will be a strong community voice throughout the programme. The STP will undertake a focused period of patient, public and wider stakeholder engagement following publication of the plan to coproduce the detailed solutions for each workstream.

All plans will be fully impact assessed to ensure they align with the JSNA and meet equality duties. Discussions will be held with the HOSC in relation to significant service changes arising from the plan and pre-consultation business cases will be prepared to include plans for public and clinical involvement and engagement and formal public consultation for significant service changes arising from the STP. We will learn from the experience of other STPs including through links established with the AHSN.

The four tests for service reconfiguration

Where significant reconfiguration of services is proposed, the STP partner organisations will ensure this meets the four tests set out in the Government mandate to NHS England.

Approach to communications

Communications expertise will be embedded within all working groups to support the design and delivery of communications and engagement activity, including engagement, involvement and consultation planning. The scale and pace of change required through the STP risks fragmentation of messages. The programme team will therefore own and provide core lines for the STP Programme, ensuring consistency and clarity in messaging. The majority of STP communications content will be developed centrally, for distribution and use across all local partner resources and platforms

Communications will be in a variety of formats; including web based and social media platforms as well as print and face to face opportunities. We will use technology to support a transparent two way conversation with stakeholders and interested groups, offering a responsive mechanism to support change while maintaining confidence in existing services and staff during the change programme.

Communications and Engagement

Engagement Progress since June

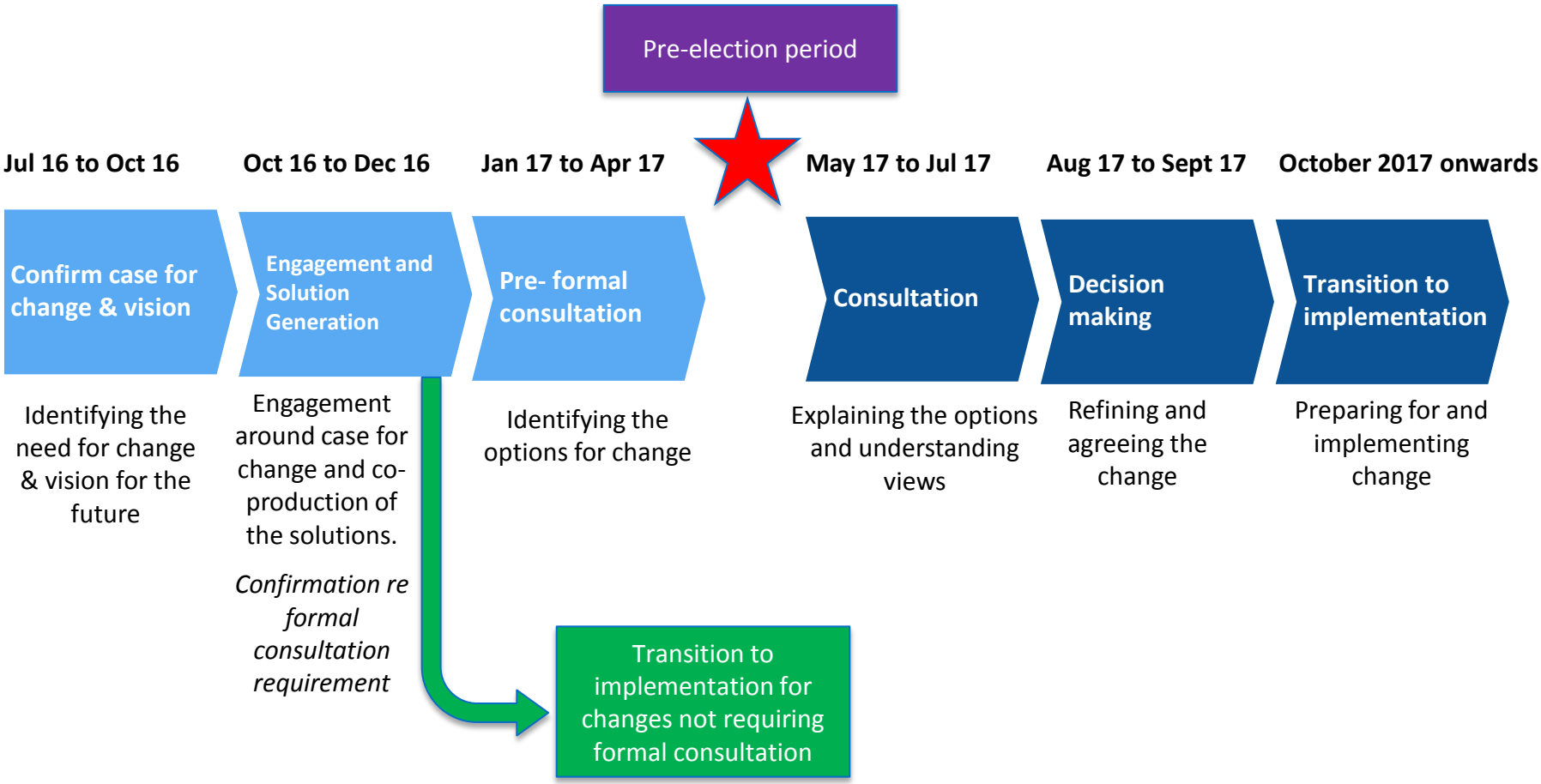
The development of the STP has built on engagement work undertaken over the last two years which has set out a direction of travel with patients, carers and community stakeholders. Although not specific to the STP, conversations with the public about reviewing community hospitals and community services, development of the primary care strategy and work on outcomes-based commissioning and the wider prevention agenda have all been relevant in the lead-up to the development of the STP.

Communications Progress since June

- A set of communication tools have been developed to support the STP programme including:
- Core presentation for system leaders
- Lines to take and communications activity plan
- Patient and Public Involvement Charter

See attached file for further Communications and Engagement supporting information

Outline Engagement and Consultation Timeline



Strategic Risk Register

Risk Description	Rating	Mitigating Actions
Unable to deliver change within required timeframes	Amber	• Agree governance structure with identified system-wide accountable officer responsible for the delivery of projects • Ensure projects are resourced adequately and staff are empowered to make decisions and implement work • Advice and support on potential consultation resulting from service changes, particularly around managing to tight timeline and preparation required to facilitate smooth transition through NHSE gateway process
Regulation of individual organisations prevents 'system first, organisation second' approach to transformation and sustainability	Amber	• Rapidly implement full governance structure • Develop of system-wide financial deficit control and performance management processes • Put robust mechanisms in place to review and ensure system alignment of individual organisational plans
Lack of clinician / care professional input to programme	Amber	• Establish models of care reference group, led by senior clinicians and care professionals • Provide backfill support to ensure primary care input • Engage local clinicians and care professionals in work streams and projects • Develop communication and engagement plan
Stakeholders and public / political challenge to proposed service changes	Amber	• Fully resource communication and engagement plan • Transparency around planning and decision making • Appropriately manage any pre-consultation processes and engagement with wide range of stakeholders • Central support to engage with politicians to facilitate delivering significant change • Alignment of national and local messaging to the public around increased self-care and the need to change how we use the health and care services • Promote outcome benefits flowing from service redesign
Balance between delivering 2016/17 improvements and medium term transformation	Amber	• Integrate plans into a single programme with clear plans and robust programme management
Failure to return system to balance within 5 years	Red	• Establish regular reporting and review meetings to monitor progress • Apply internal system turnaround approach to identify and realise the benefits from additional opportunities

Overview of progress to date and next steps

Overview of progress to date

- System wide governance arrangements in place including effective monitoring of system wide financial performance
- Open book system-wide financial reporting and forecasting on a monthly basis in place
- Realignment of key workstream to lead accountable officers

  Strengthened the system leadership across Somerset, with leaders meeting weekly to oversee delivery of the programme
- Implemented a Somerset-wide response to managing DTOC, something we will be building on to deliver further system-wide strategic change
- Developed closer, networked arrangements through a clinical reference group including lead clinicians (secondary and primary care), Public Health and Social Care (including LMC) focussed on the STP

Next Steps:

- Build on 16/17 plans using system turnaround to identify additional solutions to close the remaining gap and improve short-term performance and deliver the 2016/17 financial savings
- Complete the detailed evaluation of the opportunities, validating the assumptions made and refining our plans accordingly
- Engage widely around the case for change and the strategic vision to ensure coproduction of our plans
- Develop the detail to be able to describe our longer term strategic solution as an Accountable Care System

Support we need

- Support to move towards the developing a single accountable care system, using outcome based commissioning and capitated budgets to drive provider and service reform
- Advice and support on potential consultation resulting significant service changes, particularly around managing to tight timeline and preparation required to facilitate smooth transition through NHSE gateway process
- Support to engage with politicians at a senior level to facilitate the delivery of significant change
- Communication advice and support – including national messaging change to services available from the health and care community
- National messaging to the public around increased self-care and the need to change how we use health and care services
- Support aggregating the local and national overall work including more engagement with nationally commission services

Appendices

Appendix One	**Example workstream detail – Primary Care**
Appendix Two	**Outcome Based Commissioning**
Appendix Three	**Modelling / Financial / Workforce / Activity Assumptions**
Appendix Four	**Lead Accountable Officer Roles**
Appendix Five	**Estates**

Appendix One Examples Work stream Detail – Primary Care

What is the future care model you are working toward?

Key characteristics of a future model

- As part of the previous submission we set out a future model of primary care in Somerset having the following characteristics:
- B1 Ensure all patients have a proactive care plan in place tailored to individual circumstances. 16/17 priority will be to focus on the cohort of complex patients.
- B2 Widen the primary care teams to include health coaches and pharmacists and see mental health practitioners and physiotherapists working more closely with practice teams
- B3 Develop community, social care, mental health and complex care teams supporting a cluster of GP practices, working closely with them through practice MDT meetings ('huddles'), which become the prime means of coordination.
- B4 Link to and strengthen voluntary and community resources to support patients to manage their health and wellbeing.
- B5 Transform the way technology is deployed as described in the Somerset Digital Roadmap, focusing on interoperability, digital records sharing and expansion of online services and apps for patients to access services and support for self-care.
- B6 Develop solutions to manage same day demand in practices in a more sustainable way, delivered through the new model of enhanced primary care described above.

Work in progress

- Since the last submission a number of key developments have taken place:
- Workstream leads have met with local practices and NHS England and received overall support for the model together with helpful feedback on areas to improve or needing further detail. These are detailed in the Co-production Section of the document. A key request was to set out the work programme using the main domains within the GP 5YFW w
- A working group has been established with key system leaders, including from the voluntary sector, to work together to lead workstreams for each priority and be responsible for successful engagement with primary care
- A number of practices have taken forward themselves the employment of a wider skill mix of staff in alignment with the model
- A model of Enhanced Primary Care will cover 17 out of 20 practices in South Somerset by the end of December 2016 in addition to three Complex Care teams. In total 19 out of 20 will be covered by March 2017.
- A detailed financial and activity model has been developed and will track essential elements of the model.
- A model for focused weekend working tailored to those patients who would benefit most (end of life, complex patients, frail elderly) will be finalised by the end of 2016/7, as part of the move to delivering NHS England's Extended Access commitment by 2019/20
- Workforce modelling is underway to establish the degree to which staff from the different groups will be available to match the model. The group have a good understanding of the likely availability of GPs and are extending this to assess the availability of paramedics, pharmacists, health coaches and navigators
- Voluntary and third sector support for patients in the community is being mapped. This is most comprehensively done in Mendip, North Sedgmoor and West Somerset. South Somerset and Taunton are developing this in line with their Symphony Care Models.
- Initial discussions on the management of urgent / same day demand were held within the working group and a number of principles established. The group also identified that a single model for Somerset would not be advantageous given the geography and variations in the way services are arranged in different locations.
- New links have been established with the South West Academic Health Science Network in relation to their regional work on workforce mapping and professional indemnity
- New links have also be established with the LPC through which discussions about future joint working between pharmacies and local practices can be taken forward
- A project team has been confirmed with key roles clarified

Appendix One Examples Work stream Detail – Primary Care

The clinical model is fully consistent with the General Practice Forward View:

Care design

- endorse and promote a person-centred approach, utilising care planning and supporting patients to acquire the knowledge, skills and confidence to self-manage their health and care. This will include a much greater focus on prevention.
- Ensure all patients have a proactive care plan in place tailored to individual circumstances. During 16/17 priority will be to focus on the cohort of complex patients.
- Continue with the local House of Care training during 2016/17. A key outcome of the training is that professionals endorse the House of Care approach and working in ways which promote patients and professionals to work as partners. Extend the strategic ownership of the training to STP leadership organisations to ensure system uptake from 2017/18 onwards
- Roll out the use of the Patient Activation Measure and make full use of the CCG's allocated 30,000 PAM licences. The key focus of this is to support patients to increase their knowledge, skills and confidence to manage their own health and care
- provide person-centred planning appointments which give adequate time for an appropriate healthcare professional to find out what matters most to the patient, their goals, life situation and how medicine and other community support can best help them
- see different pathways and approaches adopted to managing same day demand and planned care. In some areas it is expected that same day demand would be managed collectively by a number of practices. It is also anticipated that, through optimising the model of care, urgent demand will fall as there should be a greater emphasis on, and time for, proactive management. It should be noted that on the day demand covers both clinical and non-patient facing work. Whilst the ambition was a single urgent care model within primary to be adopted by the County, what has become clear from the engagement work is that this is not possible, for a variety of reasons including rurality. However, a core set of principles has been developed. Linking closely with the STP acute workstream will be essential in relation to this.
- Links have been established with the Local Pharmaceutical Committee as stated above. This is a critical relationship to develop from which care redesign can take place, for example the collective provision of flu vaccinations or other preventative measures by both pharmacies and local practices working collaboratively.
- Develop, in collaboration with education providers, a local training package to support clinicians to de-prescribe / reduce poly-pharmacy. The key outcomes associated with this are improved patient safety, reductions in avoidable emergency admissions and reduced costs. This would involve working with NHSE as the current commissioner of pharmacy and local LPC to support this education.
- support patients to access a range of support in the community through social prescribing and related schemes. We will continue to support the development of the following current schemes and develop a strategic plan to ensure reasonable equity of access for patients for psycho-social support
- Health Connections Mendip
- Village Agents who work directly with practices
- The West Somerset Living Better
- The psycho-social elements of the South Somerset Symphony
- enable a range of staff from voluntary and community organisations, who are working directly with patients to update the primary care record, following the expressed consent of patients.
- provide enhanced / extended 7 day services which meet locally determined demand, in line with national funding arrangements set out in the planning guidance. The complex patients and those with palliative needs are the first cohort of patients we will target and extended access will come through a network of existing mechanisms such as complex care "hubs" (virtual or physical) linking with resource already in existence as needed.
- see the development of complex care multi-disciplinary team working and care coordination for patients with complex needs and who are at risk of avoidable admissions to hospital

Appendix One Examples Work stream Detail – Primary Care

At a high level what does the future care model require in terms of workforce, estates, IT etc.

There are five main enablers needed to achieve the model over the next 5 years:
•Practices taking forward changes themselves
•Other providers and strategic partners working differently with primary care
•Commissioner actions, removing contractual and other barriers, utilising new forms of contract which support an outcome-based multi-agency approach
•Actions by patients and public for example in utilising technology and making use of a wide range of community resources
•Actions by professionals in advocating and explaining the new model and leading by example
Examples of each are provided below.
In line with the CCG's intention to move towards outcome-based contracts with accountable provider organisations, practices and other providers will lead on delivering the care model and the operational changes required to make this happen. Commissioners will help to put in place the right local system conditions to enable this.

Examples of key enablers

Practices taking forward change:

Investment	• making different choices about the employment of staff and staff groups, functions that remain within the practices, those that are provided jointly or outsourced, personal profit margins
Care design	• introducing a person-centred approach and new ways of working • scheduling some longer appointment times for planned care • providing integrated out of hospital care with a range of other organisations and promoting multi-disciplinary working • introducing a different approach and pathway for same day demand • working with other practices to manage same day demand • enabling third and voluntary sector organisations to work with patients in drawing up and implementing their care plans and in making maximum use of community resources
Workforce	• employing a range of staff and putting in place appropriate arrangements for employment, indemnity, supervisory and continuing professional development • designing new clinical positions based on portfolio working across a number of practices and areas of care
Workload	• actively promoting and encouraging patients to book appointments and order medications on line, ensure this facility is switched on • changing the way some of the needs of the patients are met through the new skill mix arrangements, ensuring the knowledge and skills of GPs can be used to full effect • having in place different types of appointments, scheduling and access for same day demand
Practice infrastructure	• embracing and implementing innovations e.g. shared document scanning, development of EMIS templates • making best use of premises e.g. sharing back office functions, freeing up space for clinical activity, enabling other organisations to use space when working jointly • Sharing or outsourcing back office functions including payroll, HR, accountancy • Sharing staff with other practices • Adopting more sustainable organisational forms through for example mergers and formal collaborations with other organisations. This is necessary to provide larger pools of staff, greater buffering from organisational pressures • Enabling other practices to access EMIS records where require to jointly provide services, e.g. where practices agree to a shared approach to managing same day demand

Appendix One Examples Work stream Detail – Primary Care

Other providers and strategic partners working differently with primary care

Investment	• Committing to deploy staff to work directly within and with practices in providing coordinated care for patients
Care design	• Helping to fundamentally redesign healthcare services to ensure that patients only go into hospital settings where the specialist medical resources and equipment are needed.
Workforce	• Redesigning job roles and job descriptions which support new collaborative ways of working • Ensuring the availability of the new skill mix staff groups are accurately mapped and projected and that training places are influenced and maximised • Having in place a countywide accredited training programme for health coaches / navigators • Promoting Somerset as great place to work using a range of media and marketing avenues • Making available prompt access to specialist advice • Moving outpatient clinics into the community
Workload	• Helping to reduce inefficiency in the system / handoffs by having staff working directly within practices and seeing patients as a first port of call
Practice infrastructure	• Putting in place information sharing agreements based on patients' consent • Enabling clinicians who need to access patient information, following their consent, to do so quickly and efficiently through one log in arrangement and smart card access • Having a shared approach to estates between providers ensuring premises are used to full effect across an area

Commissioners

Investment	• Delivering the funding commitments set out in the GP Forward View • Delivering CCG investment in primary care in line with the planning guidance • Having permission from NHSE to continue with the Somerset Practice Quality Scheme in support of local GPs to free up time and space to work with patients with more person-centred approaches
Care design	• Leading and coordinating a countywide educational / engagement campaign promoting the benefits of the new broader skill mix within general practice • Supporting practices to give a consistent message to patients around the prescribing of Over the Counter Medications
Workforce	• Having in place a return to work scheme for GPs and a delayed retirement scheme • Engaging with training providers to ensure adequate numbers of skill mix will be available to support the new model
Workload	• Reducing practice burdens and unnecessary bureaucracy e.g. preventing hospitals ordering tests which require primary care to follow up without adequate knowledge of the clinical rationale
Practice infrastructure	• Utilising new forms of contract enabling practices to provide some services and share some resources in future e.g. the MCP and PACS models. • Put in place information sharing between providers via the SIDeR programme • Supporting the roll-out of EMIS viewer and the development and use of health related 'apps'. • Endorsing the use of the Summary Care Record available to all Somerset pharmacies, GP practices and urgent and emergency care centres. • Put in place new arrangements where GPs who are providing services together are able to access the primary care clinical records for any patient who gives their consent for this to happen

Appendix One Examples Work stream Detail – Primary Care

How are you planning to deliver the long term change, what are the component projects ?

The component projects are: Investment, Care design, Workforce, Workload and Practice Infrastructure. Implementation is covered in the above section.
In addition, significant educational and engagement activities are required to support achievement of the new model. These will be approached at many levels including: individual conversations with patients and professionals, practice level initiatives, locality-based initiatives and county-wide approaches.
For example, the Primary Care Working Group has identified the need for a positive marketing / educational campaign explaining how primary care is changing and how a range of professional disciplines can often provide safe and effective care for patients presenting to primary care i.e. to move away from expectation to always see my, or a, GP.
We will also ensure there are clearer pathways for patients to follow in requesting same day access depending on what is available in the area. Ensure this is widely published and has involved patients in its development.

How have you worked with key stakeholders and the public to date to ensure co-production across the system?

The elements of the model have been co-produced with a range of local stakeholders. For example:

- **They build on developments already in progress in the county., including South Somerset Symphony programme and considerable patient involvement in the design of the model. The STP is working closely with South Somerset Symphony and other test and learn projects across the county which are delivering elements of the new model**
- **It is based on the experience of the Mendip practices in having in place a robust and effective social prescribing service and a well used local Directory of Services**
- **The model has been endorsed by a wide range of local clinical leaders**
- **The CCG has specifically engaged with member practices at the countywide members meetings and locality meetings and received positive support for the direction of travel**
- **Member practices have consulted with Patient Participation Groups and openly discussed the potential for practices to provide some services and share some resources in future.**
- **Members of the local healthcare community have visited primary care in other parts of the country to learn about the experience of collaborating elsewhere**
- **The Workstream group has engaged with the Local Medical Committee and NHS England who have supported the model**

Some of the feedback gained from this engagement includes the following questions and issues:

- **to reframe the workplan according to the 5 Year Forward View**
- **to strengthen the links with pharmacies and the LPC**
- **make reference and link to the national work being led by NHS England around better indemnity arrangements**
- **to reconsider the levels of administration staff in the model as they are currently considered to be too low**
- **further assurance about the affordability of the model**
- **how a practice with a full complement of partners could be supported to take forward the model**
- **how training for GPs and other staff might need to be changed to support a broader skill mix**
- **fears that the new skill mix could generate additional work for GPs as well as reducing it. This relates to the supervisory time required for example.**
- **ensuring continuity for patients if they are seen by a range of staff**
- **fears of GPs becoming de-skilled and how only seeing patients with complex needs can be draining**
- **the importance of ensuring appropriate clinical governance and CPD arrangements exist for the new staff groups**
- **strengthening the access to acute support**

Appendix One Examples Work stream Detail – Primary Care

Project plan with actions detailing expected benefits

The key benefits of the model are:

- Sustainable, more resilient general practice
- A safe, enjoyable working day for health care professionals
- Improved patient experience
- A better use of skills and time
- GPs feeling more support and part of a broader team
- The achievement of savings for practices through group indemnity schemes, reduced locum costs,
- Efficiencies of scale achieved through shared functions – telephony, booking, some staff (clusters of practices around 30,000)
- Cost savings for commissioners in relation to de-prescribing, changes in acute hospital activity

Timetable

Key milestones over the next 3 months are as follows:

Element	Lead / To be achieved during
Working closely and linking with other workstreams given the significant overlap and interdependency of issues	Dr Emma Keane - Ongoing and already commenced
Gain consensus on overall model / direction of travel	Dr Emma Keane - October 2016
Workforce modelling complete	Annie Paddock - November 2016
Financial modelling complete	Ian Lumbard - November 2016
Implementation Group formed, remit finalised and authority to take forward confirmed	Dr Emma Keane and Andy Hill - November 2016
Agreement by strategic partners in principle about their contribution to the model (e.g. deployment of staff to work more closely with practices)	Dr Emma Keane - December 2016
Clarity about Commissioner investment	Tanya Whittle / NHS England - December 2016
Clarity about commissioner's use of new contracts including MCP and PACS	Steven Foster / NHS England - December 2016
Local working consensus achieved on aspects practices would reasonably be expected to take forward	Dr Emma Keane + LMC - December 2016
Model for urgent / same day demand drawn up and consulted on	Dr Emma Keane - December 2016
Public, patient and professional engagement about key headline messages	Dr Emma Keane + Communications Leads at various levels
Incremental implementation of model by practices	Tracked by Working Group – Andy Hill - Ongoing and started

Appendix One Examples Work stream Detail – Primary Care

Detailed modelling work is underway, led by the CCG finance team. This includes:

- Demographic growth
- Commissioner income and expenditure for primary care
- The number of staff in place according to the new staff mix and the number of practices that adopt the model over time
- Increases in patient contacts available per week across the county
- Number of traditional partnership practices (inc. mergers) reducing
- The number of practice integrated with local Foundation Trusts – set to increase
- The number of practices providing primary medical services through MCP and PACS contracts
- The number of staff registered as prescriber – set to increase
- The number of practices at risk of closure – set to decrease
- The number of telephony / booking 'units' – set to decrease
- The proportion of patients booking appointments and ordering repeat prescriptions on line – set to increase
- Indemnity costs – set to decrease for practices
- Locum costs – set to reduce for practices

The proposed staffing model based on a practice list size of 10,000 patients is as follows:

The model assumes that physiotherapy support, CBT/ psychological support and mental health practitioners are already in the county and could be assigned to work more closely with practices. An initial scaling up of the model up to a patient population of 560,000 suggests a potential cost of around £8.3m compared to the cost of the current staffing model. It is assumed that these costs could be accommodated through service redesign and consolidation by practices themselves and through commissioner investment. The next table illustrates how these staffing numbers will need to grow across the 5 years of the STP to achieve the model:

Note 1: number of paramedics, pharmacists, physiotherapists and mental health practitioners relate to those working directly with practices. The numbers do not refer to the total number of these practitioners in the county

Note 2: the numbers of health coaches / navigators includes the 43 wte currently funded through Vanguard monies. The table assumes that these would be funded by local partners from 2018-19, i.e. after Vanguard funds have ceased to be available.

Primary Care Skill Mix (Optimal if Filled)		**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Number of GPs		*414*	*399*	*384*	*379*	*354*
GP numbers (wte)	Decreasing	310	296	282	267	254
GP Return to Work/Retention/Portfolio Working	Increasing	0	5	10	15	20
Physician assistants	Increasing					
Health Coaches / navigators (Numbers of wte)	Increasing	60	65	112	168	224
Paramedics (Number of wte)	Increasing	0	28	56	84	112
Pharmacists (Number of wte)	Increasing	0	28	56	84	112
Counselling / CBT, psychological support	Increasing	11	36	61	87	112
Advanced Nurse practitioner (Numbers of wte)		109	116	123	130	137
Nurse (Numbers of wte)		109	116	123	130	137
Health Care Assistants (Numbers of wte)		109	116	123	130	137
Physiotherapy (Numbers of wte)		0	14	28	42	56
Mental health practitioners (Numbers of wte)		0	14	28	42	56
Administration / clerical (Numbers of wte)		547	547	547	547	547
Total WTE		**1,256**	**1,382**	**1,551**	**1,727**	**1,905**

Appendix One Examples Work stream Detail – Primary Care

Activity Levels at point of delivery (Primary Care)

Activity levels are set to rise significantly as shown below and it is assumed that these would offset demographic demand growth:

The next table estimates the number of patient contacts per week as the workforce moves towards the new model and how the time available to see patients also increases:

Note 3: The contact time relating to physiotherapists and mental health practitioners in not included as this, in the main, already takes place as part of community services provision. The new primary care model does however seek for this activity to work more closely and directly with practices'.

Contacts per week

Estimate of patient contacts per week	Contact time	2016-17	2017-18	2018-19	2019-20	2020-21
GP face to face	15 mins	23,650	22,963	22,277	21,514	20,904
Health Coach / navigator face to face	60 mins	1,526	1,653	2,848	4,272	5,696
Emergency care practitioners / Paramedics face to face	20 mins	0	2,136	4,272	6,408	8,545
Pharmacists	30 mins	0	1,424	2,848	4,272	5,696
Advanced Nurse practitioner	15 mins	11,128	11,840	12,552	13,264	13,976
Nurse	15 mins	11,128	11,840	12,552	13,264	13,976
Health Care Assistants	15 mins	11,128	11,840	12,552	13,264	13,976
Other		7,433	7,433	7,433	7,433	7,433
Total		**65,994**	**71,130**	**77,335**	**83,693**	**90,203**
% Increase Year on Year			*7.8%*	*8.7%*	*8.2%*	*7.8%*

Estimate of patient contact time per week (Hours)		2016-17	2017-18	2018-19	2019-20	2020-21
GP face to face		5,913	5,741	5,569	5,378	5,226
Health Coach / navigator face to face		1,526	1,653	2,848	4,272	5,696
Emergency care practitioners/Paramedics face to face		0	712	1,424	2,136	2,848
Pharmacists		0	712	1,424	2,136	2,848
Advanced Nurse practitioner (Numbers of wte)		2,782	2,960	3,138	3,316	3,494
Nurse (Numbers of wte)		2,782	2,960	3,138	3,316	3,494
Health Care Assistants (Numbers of wte)		2,782	2,960	3,138	3,316	3,494
Total		**15,785**	**17,698**	**20,680**	**23,871**	**27,101**
% Increase Year on Year			*12.1%*	*16.8%*	*15.4%*	*13.5%*

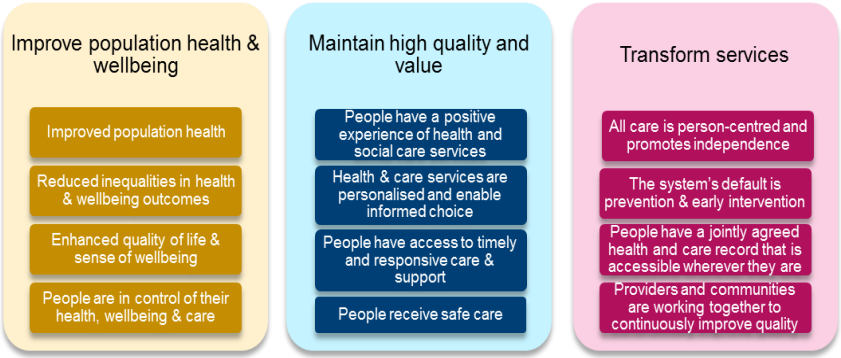
Appendix Two Outcome Based Commissioning

In Somerset, as seen nationally, the use of traditional annually negotiated block and activity-based contracts (Payment by Results [PbR]) has been identified as a barrier to delivering the required service change. Traditional systems of payment do not reflect the system goal of maximising value. The evidence is clear: systems in which incentives for individuals, teams and organisations are more closely aligned to system goals, are more likely to deliver the system's goals, and do so efficiently, than systems in which incentives are not properly aligned.

There is an increasing emphasis on the delivery of improved outcomes via health and care organisations working together within locally determined organisational forms, and the need to reform the commissioning incentives to achieve these objectives.

To make this transformational change commissioners recognise that an alternative approach is needed to commissioning services, and they want to encourage collaboration and integrated working arrangements among the providers. Somerset Together is a programme to introduce, from April 2017, Outcomes Based Commissioning (OBC), that will offer providers the contractual incentives to collaborate and develop the delivery of care around the individual, and will provide the means to improve outcomes that matter to the people using services.

The following three core themes are being used to develop the expected outcomes for the whole population of Somerset. The outcome measures will be developed through the communication and engagement process with the public and stakeholders and in particular at the co-design workshops:



The implication is that in order to move towards a more person-centred, coordinated and integrated system of care:

- commissioners must seek to promote and enable clinical and organisational behaviour change through alignment of financial incentives (among other factors) with the goals of the system i.e. maximising the improvement of outcomes that matter to tax payers and service users from the capitated budgets they are allocated
- providers need to consider what organisational reform is required to support new models of care
- service delivery reform needs to be led by clinicians and other professionals , working together with voluntary sector organisations, patients and carers
- the whole process needs to be centred around and driven by patients and carers to ensure outcomes for individuals and populations are improved.

Appendix Three Modelling / Financial / Workforce / Activity Assumptions

Financial modelling

- Modelling undertaken using the system wide Symphony Data set (historical data including 15/16)
- Full detail and profile of investments for years 2-5 to be finalised through agreed system financial review process
- Where identified through planning double running / implementation costs have been covered. Further implementation costs may be identified through detailing of plans which would have a non-recurrent deterioration in the applicable year.
- Cross organisational financial implications have been inserted where understood. There may be further implications as plans are detailed for future years.
- Savings for future plans are currently planned to be realisable with no costs or delays
- Cross priorities savings / investment and implications have been covered where understood. The full assumptions behind these plans will be monitored throughout the delivery of the STP.
- Growth in line with national assumptions and will require system review each year in line with delivery
- Specialised commissioning savings for future plans are not detailed and may influence current plans. The STP and specialised commissioners will continue joint development of plans
- Where savings are identified unless specifically noted there are based on a recurrent change.
- Internal cost improvement activities will not include making any changes as identified in the STP
- Current plans are based on the engagement and consultation timelines currently planned.
- Acute reconfiguration plans are dependant on capital changes
- Organisational impacts of the changes have been considered and will be developed in line with the operational planning timeline.

Activity

- Activity modelling has been undertaken using the system wide Symphony Data set (historical data including 15/16) in detail for the clinical pathway and models of care
- Activity growth in line with national assumptions and will require system review each year in line with delivery
- Additional activity will have to be undertaken to deliver performance targets on a recurrent basis.
- Where reconfiguration of services is undertaken the activity will remain the same unless the clinical pathway is also reviewed.

Workforce

- Growth in line with national assumptions and will require system review each year in line with delivery
- Workforce availability has been consider as part of the delivery of changes
- Where plans have not detailed workforce changes assumptions for the staffing groups affected and number of whole time equivalents involved to outline the scale of change.

Appendix Four Lead Accountable Officer Roles

Collaborative Commissioning Lead Accountable Officer Role Description

The Collaborative Commissioning Lead AO, accountable to the System Oversight Group is responsible for:

- Setting and measuring system outcomes.
    - Define outcomes for contract(s)
    - Develop and manage contracting and performance mechanisms
    - Assess provider capability to deliver contract
    - System reporting for regulators

- Developing the future single health and care commissioning function and implementing transition plans.
    - Define the joint commissioning governance and infrastructure requirements for single strategic commissioning
    - Develop legal and commercial arrangements for ACS

- Leading the delivery of the 16/17 Efficiency and Effectiveness Programme

- While each organisation will maintain responsibility for the own BAU efficiencies the lead AO will have oversight of the turnaround process and ensure that the work of the Turnaround Team is aligned to the wider STP programme

The Lead AO will:

Use their influence to champion the delivery of complex implementations, some of which may be closely related to other work streams.
Develop and maintain robust relationships with all parts of the system and work with the other AOs.
Be a member of the Health and Care Leaders Group
Ensure appropriate levels of engagement with key stakeholders as part of their work.

Appendix Four Lead Accountable Officer Roles

Acute Services Lead Accountable Officer Role Description

The Acute Services Lead AO, accountable to the System Oversight Group will oversee and direct the content of the Acute Services work stream to deliver the priorities identified within the STP to address the unsustainability of the acute services provision:

- Developing sustainable service models for urgent and planned care
- Consolidating and reducing the costs of specialised services
- Leading the system-wide improvement in quality operational performance including RTT and A&E waits

Supported by a work stream lead, professional lead, project and modelling support, the Lead AO will oversee the work to:

- Turn each of the identified opportunities into detailed projects
- Capture the expected impact
- Outline the areas where reinvestment is likely to be required
- Iteratively test the work stream thinking with a group drawn from across the system
- Work with the modelling team to ensure the model reflects the assumptions
- Oversee the implementation of the projects to ensure the benefits are realised in a timely fashion

The Lead AO will:

Use their influence to champion the delivery of complex implementations, some of which may be closely related to other work streams.
Develop and maintain robust relationships with all parts of the system and work with the other AOs.
Be a member of the Health and Care Leaders Group
Ensure appropriate levels of engagement with key stakeholders as part of their work.

Appendix Four Lead Accountable Officer Roles

Out of Hospital Services Lead Accountable Officer Role Description

The Out of Hospital Services Lead AO, accountable to the System Oversight Group, will oversee and direct the content of the Primary Care and Community Services work streams to deliver the priorities identified within the STP that focuses on the redesign of primary and community services to reduce reliance on acute and community bed based care:

- Sustainable primary care solution, at scale provision to manage urgent and planned primary care demand
- Risk stratification and proactive care management of complex patients
- Reduce reliance on acute services and community hospital beds through redesign and investment into health and care community teams

Supported by work stream leads, professional leads, project and modelling support, the Lead AO will oversee the work to:

- Turn each of the identified opportunities into detailed projects
- Capture the expected impact
- Outline the areas where reinvestment is likely to be required
- Iteratively test the work stream thinking with a group drawn from across the system
- Work with the modelling team to ensure the model reflects the assumptions
- Oversee the implementation of the projects to ensure the benefits are realised in a timely fashion

The Lead AO will:

Use their influence to champion the delivery of complex implementations, some of which may be closely related to other work streams.

Develop and maintain robust relationships with all parts of the system and work with the other AOs.

Be a member of the Health and Care Leaders Group

Ensure appropriate levels of engagement with key stakeholders as part of their work.

Appendix Four Lead Accountable Officer Roles

Prevention Lead Accountable Officer Role Description

The Prevention Lead AO, accountable to the System Oversight Group, will oversee and direct the content of the Prevention work stream to deliver the priorities identified within the STP to ensure a radical shift from a demand driven system to a prevention driven one, aligning the priorities to the most prevalent burdens of disease:

Overarching system priorities for primary, secondary and tertiary prevention:

- Mental Health and Dementia
- Cardiovascular Disease
- Cancer
- Respiratory Disease
- Muscular-Skeletal Conditions

Related system priorities for primary prevention:

- Physical activity
- Healthy eating and weight management
- Smoking
- Alcohol

Priorities for infrastructure development:

- Development of stronger communities

Supported by a work stream lead, professional leads, project and modelling support, the Lead AO will oversee the work to:

- Turn each of the identified priorities into detailed projects
- Capture the expected impact
- Outline the areas where reinvestment is likely to be required
- Iteratively test the work stream thinking with a group drawn from across the system
- Work with the modelling team to ensure the model reflects the assumptions
- Oversee the implementation of the projects to ensure the benefits are realised in a timely fashion

The Lead AO will:

Use their influence to champion the delivery of complex implementations, some of which may be closely related to other work streams.
Develop and maintain robust relationships with all parts of the system and work with the other AOs.
Be a member of the Health and Care Leaders Group
Ensure appropriate levels of engagement with key stakeholders as part of their work.

Appendix Four Lead Accountable Officer Roles

Provider Development Lead Accountable Officer Role Description

The Provider Development Lead AO will be accountable to the System Oversight Group and will work closely with the Chief Executives of the other Somerset health and social care providers as well as GP provider groups and the LMC to ensure the full engagement of primary care in the emerging accountable provider model.

- Developing the emerging model of the Accountable Provider Organisation across Somerset and the subsequent provider configuration which will deliver the new care models defined through the STP.

Key Work Areas:

- Define and develop a new Provider Collaboration Board which will bring together the three Foundation Trusts, Social Care and Primary Care to provide strategic oversight of the provider system in Somerset and agree the implementation plan for the Accountable Provider Organisation
- Work with existing Foundation Trusts, the CCG, County Council and Primary Care to develop the Accountable Provider Organisation taking into account the individual organisational circumstances and ensuring that the new model takes into account national and international best practice
- Define the implementation timeframe and approach to deliver the APO by April 2019 whilst meeting the obligations set out in the Vanguard programme in Somerset
- Liaise with boards of Somerset organisations to ensure all boards/governing bodies understand the legal status of the proposed APO model and the implications for their existing organisational governance
- Work with the CEO and senior team of Somerset County Council to design how to ensure adult social care services are included in the new APO whilst recognising the statutory responsibilities of the council.
- Liaise with NHS Improvement, NHS England, CQC and others to ensure that the APO model meets any national regulatory requirements and shape how the regulatory approach is adapted to the new provider structure proposed
- Work with the Somerset STP executive group to ensure alignment between the STP workstreams and the development of the APO structure
- Work with the STP executive group to establish any external support required to assist in the development of the APO in the initial start-up phase and beyond
- Build and develop an implementation team to oversee the APO development bringing together skills and expertise from across providers and external partners as appropriate
- Ensure a clear programme plan is in place to deliver the APO in Somerset and report any exceptions to the STP Board and individual organisations

Appendix Five Estates Implementation Priorities

Key next steps towards implementation

Key next step	Challenges	Resources	Indicative timeline	Comments
Yeovil District Hospital – Systemised Surgery	Appointment of Design Team	Project being delivered through Yeovil Estates Partnership.	FBC approval by July 2017 Operational late 2018	YDH Joint Venture.
Shepton Mallet – Campus Development	Combined vision for site to be developed including Primary, Community and hospital services	Dedicated team including technical support to undertake option appraisal work	Within 12 months	Identified as priority within Somerset CCG Local Estate Strategy
Musgrove Hospital – Urgent Care	Completion of STP . Capital funding	Immediate need is project design team resources to develop business case	Within 12 months	Outline scope / principles have been developed but this now needs to be developed into a Strategic outline case. No further action is being undertaken until more certainty is available around provision of funding. Mobilisation of the project and completion of the planning stages of the project is dependent on external funding.
Musgrove Hospital – New Theatre and Critical Care Facilities	Completion of STP . Capital funding. Current buildings are not fit for purpose. Service resilience is at risk	Immediate need is project design team resources to develop business case	Within 12 months	Outline scope / principles have been developed but this now needs to be developed into a Strategic outline case. No further action is being undertaken until more certainty is available around provision of funding. Mobilisation of the project and completion of the planning stages of the project is dependent on external funding
Musgrove Hospital – New Maternity Unit	Completion of STP . Capital funding. Current buildings are not fit for purpose. Service resilience is at risk. The plans for maternity services in surrounding footprints also needs to be understood to establish the predicted number of births relating to MPH .	Immediate need is project design team resources to develop business case	Within 12 months	Outline scope / principles have been developed but this now needs to be developed into a Strategic outline case. No further action is being undertaken until more certainty is available around provision of funding. Mobilisation of the project and completion of the planning stages of the project is dependent on external funding
Capacity and implementation of ETTF bids	Fund is not sufficient to cover all projects. Management arrangement required to ensure delivery	Resource required to manage ETTF programme and ascertain non-ETTF options	ETTF due diligence decisions are anticipated by Oct-16	Alternative funding route required to pick up short fall in ETTF funding

Appendix Five Estates Critical Decisions

Critical Decisions

Decision Required	Significance/ impact on STP strategic objectives	Owner	Action By:
Yeovil District Hospital – Systemised Surgery. YDH board approval of FBC	SSU will enable greater level of efficiencies in elective services as part of acute work stream.	YDH	July 17
Shepton Mallet – Campus Development: Customer Capital approval with commissioning revenue support.	Delivery of enhanced primary care in northern area of STP and site/service consolidation.	NHS PS	Within 12 months
Musgrove Hospital – Urgent Care: STP needs to be confirmed. Funding is required to provide resources to develop the business case	Improving flow through the hospital and the contribution towards achieving A&E targets are dependent upon a reconfiguration of urgent care facilities	T&S	Within 12 months
Musgrove Hospital – New Theatre and Critical Care Facilities: Funding of c £51.5m needs to be made available. Resources need to be provided to develop the SOC, OBC and FBC	There is a significant risk to the service provision at MPH. ITU / HDU bed provision is in pre 1948 buildings (WW2) Four general theatres are also in similar accommodation with the risk of service failure from leaking roofs and or critical infrastructure failure.	T&S	Within 12 months
Musgrove Hospital – New Maternity Unit: Clarify STP and intentions of neighbouring footprints. Funding of c £27m needs to be made available. Resources need to be provided to develop the SOC, OBC and FBC	Our ability to deliver the number of births required of the STP in an acceptable environment	T&S	Within 12 months