Shropshire Council

Date: Thursday, 6 October 2016

Time: 2.30 pm

Venue: The Lantern Centre, Meadow Farm Drive, Harlescott, Shrewsbury

Contact: Karen Nixon, Committee Officer
Tel: 01743 257720
Email: karen.nixon@shropshire.gov.uk

HEALTH AND WELLBEING BOARD

TO FOLLOW REPORT (S)

6 Presentations (x2): SYSTEM UPDATE - STP OVERVIEW AND NEIGHBOURHOODS UPDATE

(Pages 1 - 40)

A presentation will be made.

Contact: Andy Layzell, Programme Director – STP, Shropshire CCG or Dave Evans, Accountable Officer, Shropshire and Telford & Wrekin CCG, Tel 01743 277500.

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Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin

Coverage

Geography

CCG boundaries

- NHS Telford & Wrekin CCG
- NHS Shropshire CCG

Local Authority boundaries

- Telford & Wrekin Council: Unitary Authority
- Shropshire County Council

Key Footprint Information

Name of Footprint and Number:	Shropshire and Telford & Wrekin (XX)
Region:	Shropshire and Telford & Wrekin
Nominated lead for the footprint:	Simon Wright, CEO Shropshire and Telford Hospitals
Contact Details (email and phone):	
Organisations within the footprint:	Shropshire Clinical Commissioning Group Telford & Wrekin Clinical Commissioning Group Shropshire Community Health NHS Trust The Shrewsbury and Telford Hospitals NHS Trust Robert Jones & Agnes Hunt Foundation Trust South Shropshire & Staffordshire Foundation NHS Trust ShropDoc Shropshire County Council Telford & Wrekin Council Powys Teaching Local Health Board

The Main Components

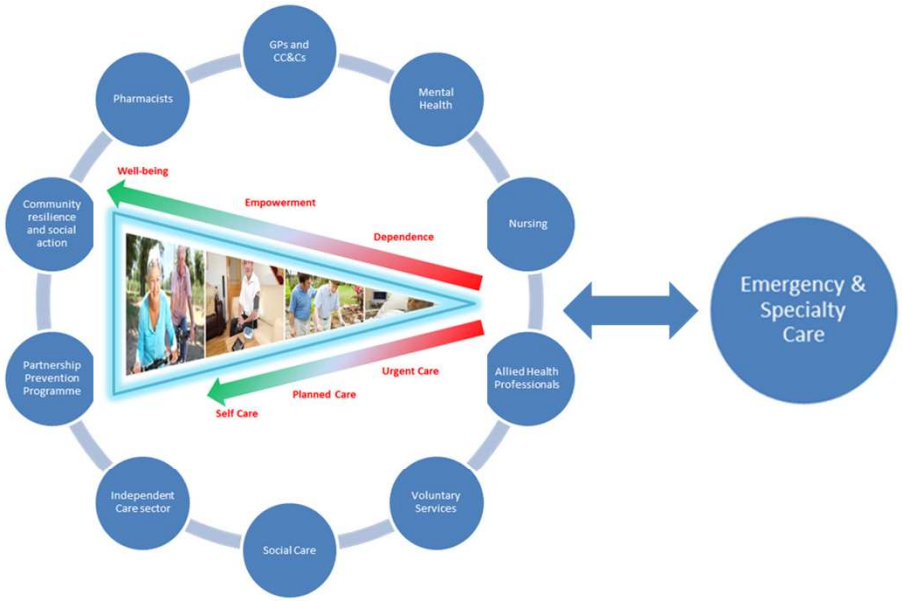
- The case for change
- Four main themes
  - The development of Neighbourhoods
    - Community resilience
    - Prevention of ill health
    - Neighbourhood clinical teams
  - The reconfiguration of acute services
    - Future Fit
    - A review of orthopaedic and musculo-skeletal services
  - The continuing development our other services
    - Mental Health, Learning Disability, Childrens services, Cancer etc
  - Making the best use of our resources
    - Financial sustainability
    - Merging of Back Office functions
- Enabling functions (workforce, Technology, Estate etc)

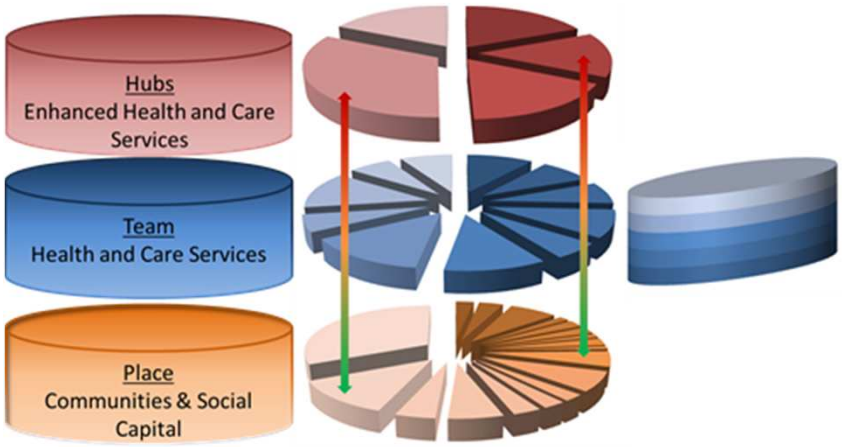
Neighbourhood working

Neighbourhood working – Shropshire

Objectives

1. To build **resilient communities** and develop social action
2. Develop whole population **prevention** by linking community and clinical work – involving identification of risk and social prescribing
3. Implement **neighbourhood care models** including teams and hubs





Review of beds in the community (Shropshire)

Neighbourhood working will require some access to locally provided beds for patients. This will enable care to be delivered in the most appropriate environment and improves quality of care for patients . At present these are provided through community hospitals, local authorities and care homes. As Neighbourhood working develops, the local provision of beds is being reviewed. The stages in the review are:

- Complete stocktake of all non-NHS beds in the community – September 2016 (complete)
- Complete analysis of projected activity shifts from hospital by condition – Sept 2016
- Agree most appropriate ways of meeting current and projected activity in the community – Oct 2016
- Model number of beds needed at hub level to meet projected demand
- Model clinical and financial sustainability of different options – Dec 2016
- Agree future model for beds in the community – March 2017

Acute reconfiguration

Reconfiguration of Acute Services

Objectives

- The Future Fit model for acute hospital care describes an urgent care network, within which one central emergency centre works closely with peripheral urgent care centres; two urban urgent care centres and a number of rural locations where urgent care is provided on a locality basis. For planned care, a central diagnostics and treatment centre will provide 80% of planned surgery whilst the majority of assessment, diagnosis and follow up will be performed closer to peoples' homes
- The programme is focused primarily on acute service configuration between Shrewsbury and Telford Hospitals with the development of an OBC for a single Emergency Centre.
- The Neighbourhood model of care is an essential element of acute reconfiguration in enabling the left shift from acute to community provision.

Progress to date

- The Strategic Outline Case for the reconfiguration of services between Shrewsbury and Telford hospitals has been approved by the Boards of SaTH and the two CCGs. Shropshire CCG's approval was conditional on a number of issues being addressed in development of the FBC
- Significant public consultation has been undertaken
- A rural urgent care prototype has been established at Bridgnorth to help understand the extent to which urgent care needs can be addressed in rural situations
- Clinical pathway groups have been established for 6 long-term conditions to support the shift from acute to community care and will help inform the work of the Neighbourhood teams

Key Milestones

- Senate Review October 2016
- Review of Women and Childrens options – September 2016
- Pre-consultation Outline Business Case to NHS Boards – October 2016
- Gateway Review – November 2016
- Public consultation – Dec-Mar 2016/7
- Decision on OBC – May 2017

Outcomes

- 4,200 patients currently being seen in hospital would no longer need hospital care
- 27,218 outpatient appointments no longer seen in hospital

Developing our other services

People with mental ill-health

Objectives

- To work towards parity of esteem between physical and mental health , improving the quality of care for patients
- To implement the Five Year Forward View for Mental Health
- To promote good mental health
- Working in partnership with all organisations , voluntary, private and public
- To co-produce services/pathways with people with lived experience of services, their families and carers
- To ensure support is available to help people to help themselves
- To ensure support is available at the earliest opportunity to reduce the likelihood of escalation and distress and support recovery
- Effective Crisis pathway in place
- Proactive support for those within criminal justice system
- Effective services delivering person-centred care, underpinned by evidence, which supports people to led fuller, happier lives
- New payment mechanism in place to support effective outcomes

Progress to date

- Joint mental health strategy
- Plans in place to develop 24/7 mental health support
- Access and recovery targets for IAPT achieved
- RTT early intervention psychosis service
- System for monitoring out of area placements
- Rehab pathway under review
- Dementia strategy and action plan
- CQUIN to develop agreed clinical outcome measures
- All age psychiatric liaison in place 7 days a week 12 hours a day
- Third sector led employment event held
- Mental health stakeholder forum in place

Outcomes

- To have more people recovering from mental ill health
- Reduced stigma of mental health
- People access support (voluntary sector and primary care services) and reduced numbers requiring secondary mental health services
- Crisis pathway available 24/7
- No out of area placements for in patient care unless very specialist care required
- Hospital liaison in place for acute mental health, children and young people, substance misuse and dementia
- Referral to treat times aligned to physical health response times
- Increased employment rates for those with severe mental illness
- Increase in peer support in mental health
- Outcomes measured and reported for mental health services
- Payment mechanism in place that has an outcome payment for an agreed % of contract
- Reduction in suicide rates

Key Milestones

• Five Year Forward View Local Commissioning Strategy	• October
• Comprehensive needs assessment	• April 2017
• CCGs signed up to Time to change (Good mental health in workplace)	• April 2017
• IAPT access rate of 16% with recovery rate over 50%	• April 2017
• CBT available face to face and on line	• June 17
• RTT for early intervention psychosis 50%	• September 17
• Reduction in Out of area acute Mental health in patients	• Q4 16/17
• Second Sec 136 suite	• April 2017
• Plan for 7 day working April 17	• April 17
• Implemented 7 day working	• September 17
• Clear articulation of crises pathway	• December 16

People with a Learning Disability

Objectives

- **To improve the quality of care** by ensuring people are cared for in an environment that is safe and secure
- Working in partnership with all organisations , voluntary, private and public
- To co-produce services/pathways with people with lived experience of services, their families and carers
- To improve the life chances of people with LD
- To improve the physical health of people with LD
- To ensure specialist support is available for those with profound and complex health needs
- To support people, with LD/autism with behaviours that challenge as close to home as possible.
- To support people in their own homes where possible
- To ensure reasonable adjustments are made when people with a LD are admitted to acute care
- To develop an integrated approach to learning disabilities commissioning across NHS and local authority

Progress to date

TCP plan written collaboratively across whole footprint
CCG commissioned beds within target
Case written to support development of an intensive home care team
Intensive support team for challenging behaviour in place
Care and treatment review procures in place
At risk of admission register and support mechanisms in place

Key Milestones

• Reduction in NHSe commissioned beds	Commence Q2 16/17 within national targets by 20189/19
• West Midlands Quality care review undertaken to understand management of patients in an acute ward	April 17
• New model of community learning disabilities service in place	September 17

Outcomes

- 7%% of people with an LD who are on the GP registers are offered an annual health check
- Care and Treatment reviews held for all people who are at risk of admission or who are admitted to an inpatient bed
- Personal health budgets offered and supported to people with a LD
- Reviews undertaken for all people with an LD who die (unexpected or expected) to understand how care could be improved
- Within national target for CCG and NHSe commissioned in patient beds for LD/ autism with behaviours that challenge

Children and young people

Objectives

- To implement a comprehensive CAMHS service with reduced waiting times and raised awareness of children's mental health issues amongst professional and other staff
- To develop an integrated paediatric model of care which provides the Right Care approach to include continuity of care and services closer to home.
- Special Educational Needs and Disabilities (SEND) Education, Health and Care Plan effective care delivery.

Progress to date

- 0-25 Emotional Health and Wellbeing service. Includes crisis support, CBT, Systemic Family Treatment, training for professionals and better access for Looked After Children. Tender across both CCGs issued in August 2016
- Redesign of neurodevelopmental pathways. Reconfiguration of existing CAMHS service to reduce waiting times
- Developmental programmes for workers in universal services
- Eating Disorder service, jointly commissioned with South Staffs CCGs and provided by SSSFT. Current caseload is 119; anticipated to increase by 100 referrals pa
- All age Psychiatric Liaison service. Hospital based to support children attending A&E or admitted with emotionally related disorders
- Perinatal Support programme to train professionals to recognise early signs of emotional problems
- Cross-cutting programme to provide robust needs analysis and approach to record keeping, engagement and transition
- Future Fit, Clinical pathways group, developing a 'Paediatric asthma pathway' for the Shropshire health economy.
- SEND self assessment gaps/areas for improvement identified and action plan in progress action.

Outcomes

- Reduced waiting times for assessment by CAMHS service
- Comprehensive Eating Disorder service
- Reduced hospital attendances and admissions for children and young people .
- Robust health response to EHCP including performance monitoring of providers.

Key Milestones

Implementation of the CAMHS programme: 0-25Emotional Health and Wellbeing service. Tender approved and new service commences Q4 2017

Paediatric Asthma Pathway

Pathway and supporting business case to be developed by 30 September 2016.

SEND

Action plan in progress to respond to gaps/areas requiring improvement by January 2017.

Making best use of our resources

Finance

- If we don't do anything, the health community (excluding local authorities) reaches 2020/21 with a deficit of £129.4m
- However, this is unrealistic because £62.3m should be achieved through normal annual efficiency savings
- There are plans to achieve a further £73.9m of savings through acute reconfiguration and through schemes targeted at reducing duplication, repatriating activity from outside Shropshire and specialised services.
- This can achieve financial break-even across the health community but not necessarily for individual organisations. This is an essential feature of the STP

Reducing Duplication

Objectives

To reduce costs without affecting service provision by rationalising organisations, back office functions and estate costs; and by greater exploitation of IM&T

Progress to date

- The health community has set a target to reduce Back Office Functions cost by £1.8m (inc Pathology)
- Payroll, Purchasing/Suplies, Estates (cleaning) already shared between SaTH, ShropCom and RJAH
- Scoping exercise has highlighted IT, HR and Complaints for further consideration

Key Milestones

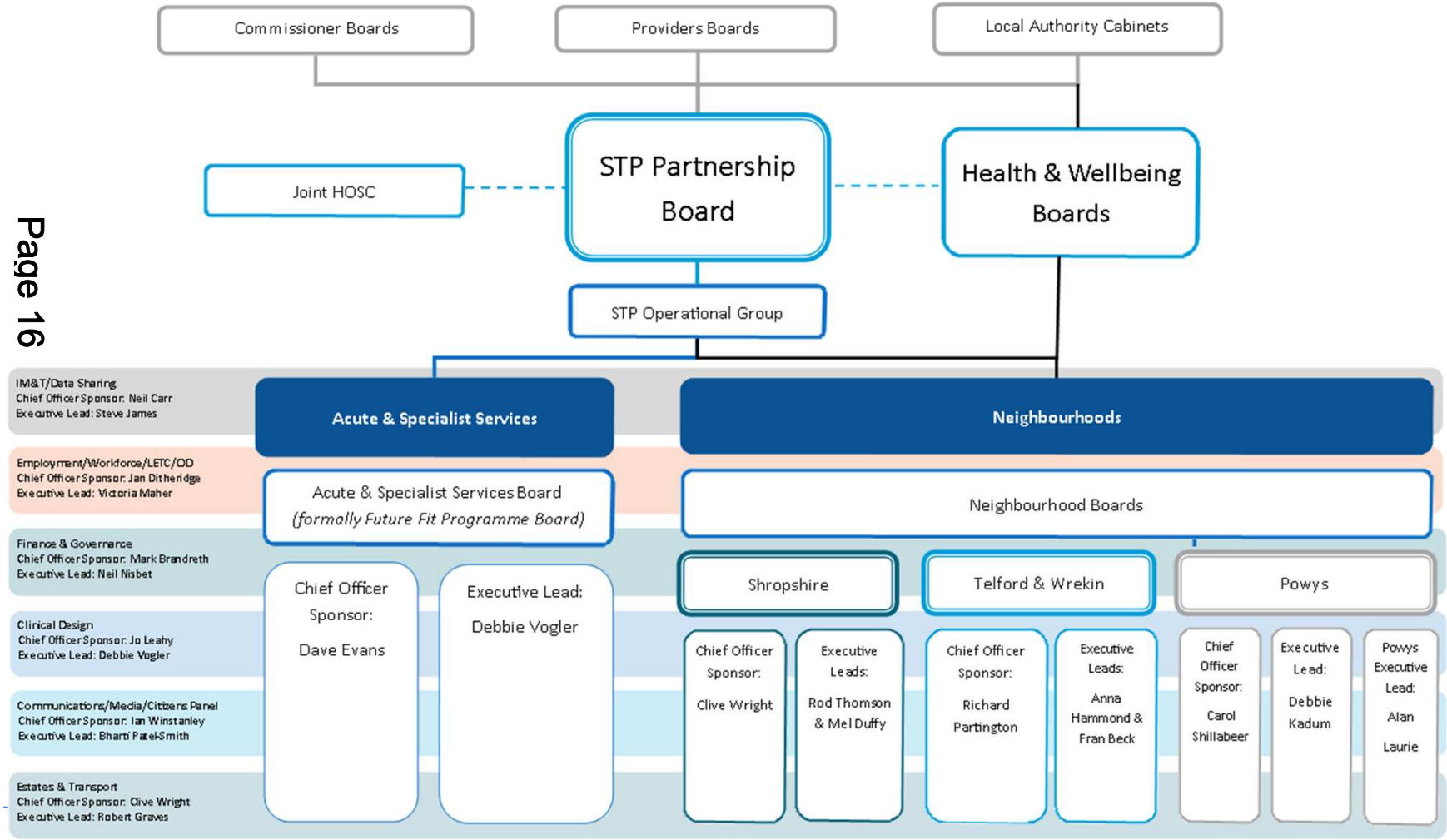
October 2016 –
Define ambition for consolidating Back Office functions.
Develop Business Case for further amalgamation and submit to NHSE

Outcomes

- Reduce costs by £1.8m through greater sharing of functions
- Fewer organisations to reduce overhead costs and increase efficiency

Service Area	Specific Aspect of the Service	Benefits	Barriers /Risks
IT services	Helpdesk and out of hours support	Could provide longer support periods and knowledge being shared. Cost savings from reduction in workforce.	Staff redundancies. Geography.
HR	Recruitment, workforce management, temporary staffing and ESR processing	Would create a knowledge sharing environment, reduce costs and provide consistency, resilience across the health economy and economies of scale.	Policies would need to be aligned. Staff redundancies. Geography.
Complaints		Consistency in approach. Cost savings from reduction in workforce. One central portal for patients to liaise with across the health economy.	Lack of local/organisational knowledge

STP Governance Structure



For the Health and Wellbeing Board

- The STP will continue to be developed until 20th October. However, this is the last scheduled HWB meeting before that date, so the latest version of the STP (as of Friday 23rd September) is presented.
- The Board is asked to discuss the STP and feedback their conclusions
- The Board may wish to delegate approval for the final submission of the STP

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Shropshire and Telford & Wrekin STP

Shropshire Neighbourhoods Programme

Update to HWBB

Shropshire Neighbourhood

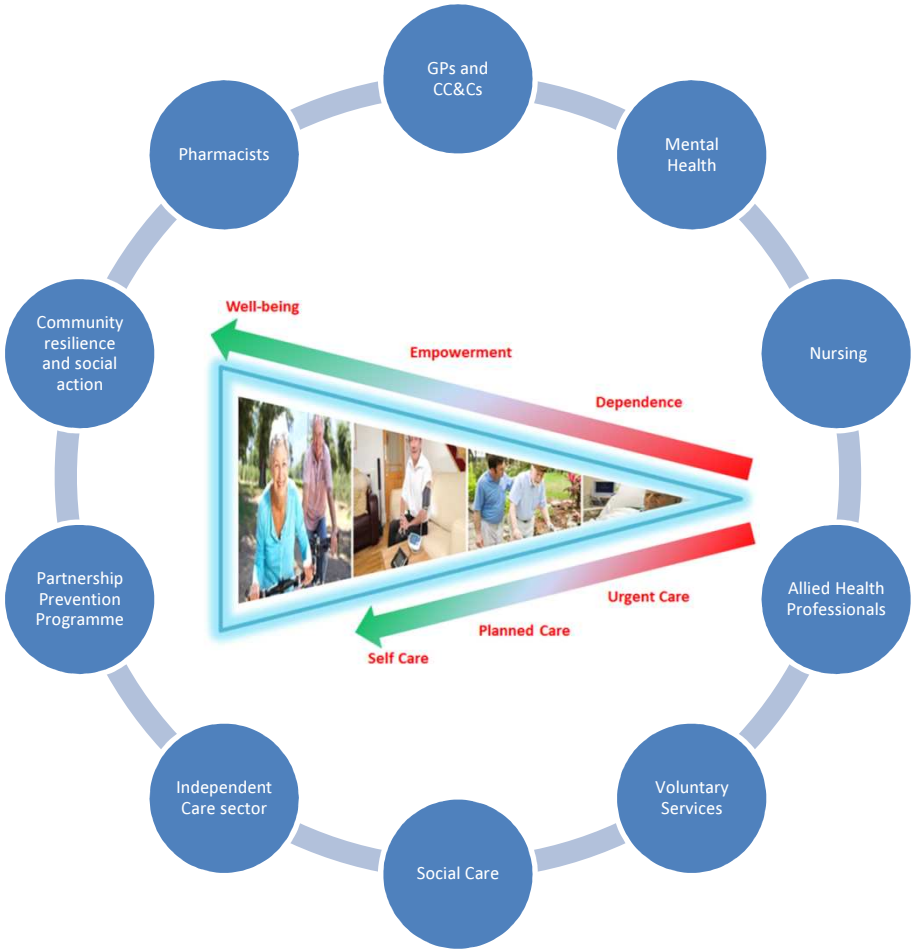
Improving the health and well-being of local communities

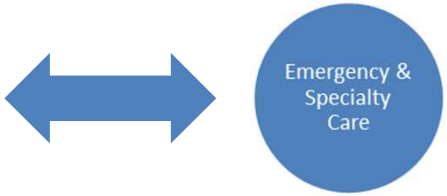
Delivering care closer to home through sustainable primary and community health and care services

The Shropshire Neighbourhoods Group will use place based planning to reduce demand on acute services by:

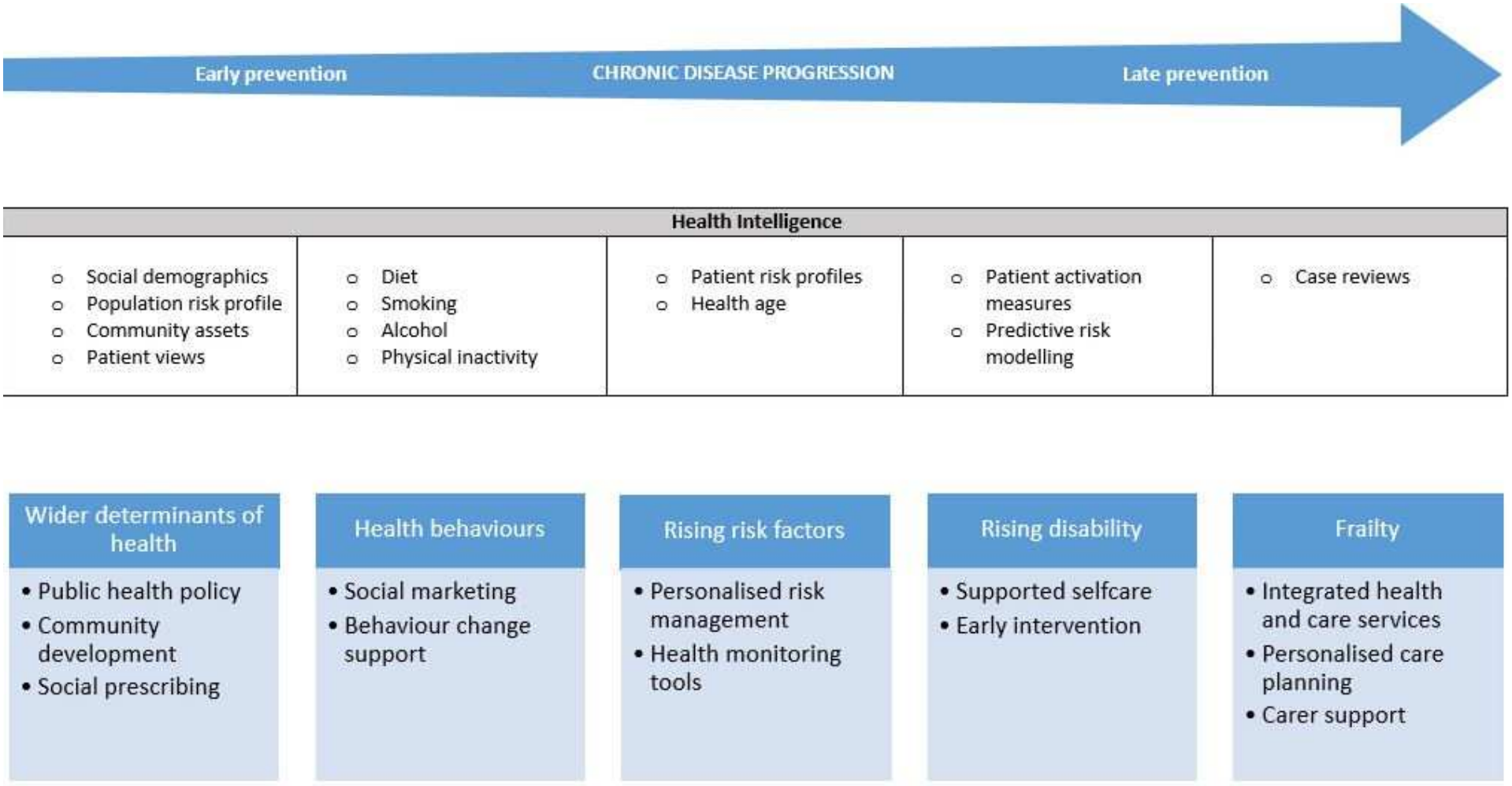
1. Building resilient communities and developing social action
2. Developing whole population prevention by linking community and clinical work – through identification of risk, behaviour change support, and social prescribing
3. Designing and delivering neighbourhood care models

Shropshire Neighbourhood Model





Whole population approach to prevention



Community Resilience and Social Action

- Asset based community development
- Community based approach to shape the local factors that have an impact on health and well-being
- Generating social value and social action
- Community Enablement Team
- Established local governance
- Locality commissioning

Community Resilience and Social Action

- Active and effective VCS – at risk from reducing grant/contract funding
- Active community groups - need support to thrive
- Formal and informal volunteering – needs strategic development
- Resilient Communities
- Care & Community Co-ordinators
- Compassionate Communities
- Let's Talk Local hubs
- Early Help Strengthening Families

Resilient Communities – BCF workstream

‘Communities First – services second’

Place based governance and delivery – cross-cutting across sectors and themes

Hyper-local directories of activity and services

Networks of Community Connectors

Well developed in Oswestry – using the above -

CET, C&CCs, Let’s Talk Local Hubs, C&YPS Early Help hub of services, volunteers to support these, local voluntary groups, community activity

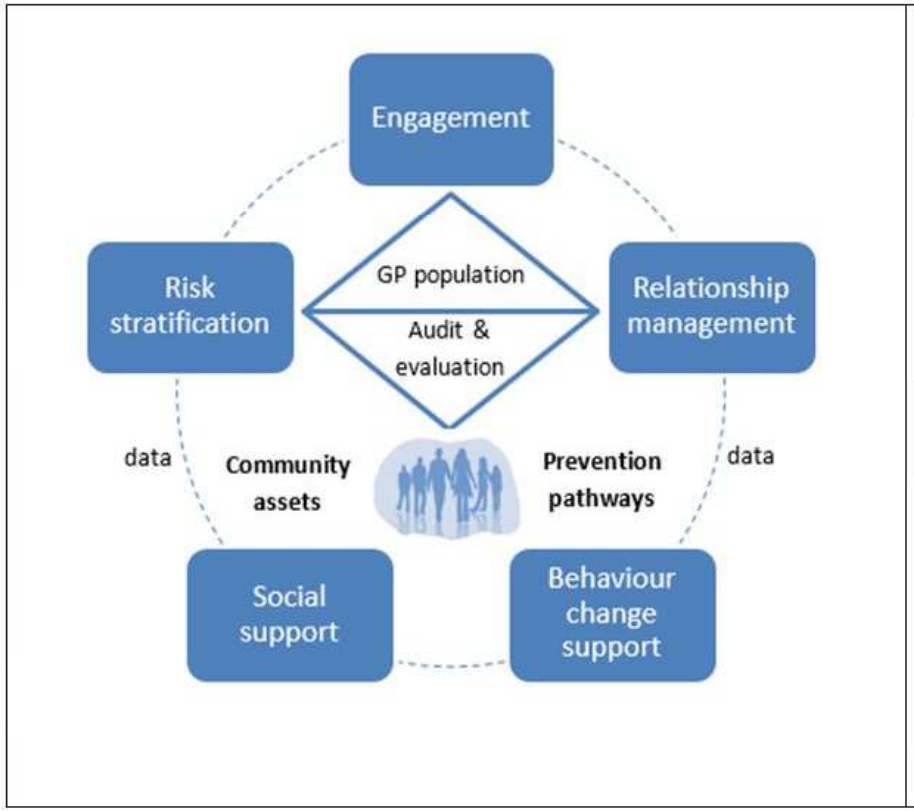
Partnership Prevention Programme

- Linking clinical world to the community through behaviour change support and social prescribing
  - Community and Care Coordinators, community enablement
  - Community assets (health, care, vcs, buildings, groups etc)
  - **Healthy Lives** model in development

- Key prevention programmes include
  - Social prescribing
  - Diabetes & CVD Prevention
  - Mental Health
  - Falls Prevention
  - Carers & Dementia/ UTIs
  - Future planning & housing
  - Respiratory & Fire Service Safe and Well

Healthy Lives programme

The Healthy Lives programme aims to support individuals, families and communities to take control of their health, viewing health as a positive resource on which they can build their future and achieve their potential. It provides a bridge between GP practice populations and communities, and seeks to reduce dependence on treatment services.



Risk stratification
- Audit tools
- NHS Health Check
- JSNA & Place Plans
- Adult Social Services
- Children's Social Services
- Other health and care professionals

Engagement
- Community and Care Co-ordinators
- Every Contact Counts, Safe and Well & FPOC
- Let's Talk Local
- Social marketing
- Website- inlcluding Shropshire Choices

Relationship management
- Digital health platform- Shropshire Choices
- Telephone support line, FPOC
- Membership incentive scheme
- Mobile health clinic
- C&CC

Behaviour change support
- Help2Quit
- Help2Slim
- Alcohol services
- Future Planning and self care, One You,
- other health, care and council services including Leisure services, EXPERT course, OT services, other...
- VCS - prevention services , advice services

Social support
- Social prescribing
- Compassionate Communities
- Resilient Communities
- Let's Talk Local
- Benefits advice
- other supportive services through the VCS, volunteering

Healthy Lives Model Pilot - Oswestry

Working with:

- GP practices (3 in Oswestry)
- Community Enablement Team
- Community health services
- Social Care
- VCSE
- Elected Members
- Private sector

To:

- Proactively identify those at health risk (e.g. Pre-diabetes, isolation, CVD)
- Connect people with risk to behaviour change options, community support, clinical support (where necessary), social support
- Awareness raising - communicate and engage with the population about how to reduce health risk

Aim of the Neighbourhood Care Model

To design and implement a community based care model and neighbourhood services that:

- delivers more care in the community and closer to patients' homes
- supports more people to take control of their own health and wellbeing
- enables the shift from people becoming acutely unwell and requiring care in acute hospitals.

Neighbourhood Care Model Scope

Urgent Care

- Supporting people in crisis with access to rapid response care and interventions in their home or a community setting
- Supporting patients who have accessed Emergency Care to return to their home as soon as clinically appropriate

Planned Care

- Supporting the left shift from acute to community settings, delivered though lower cost care delivery models.

Maintenance and Prevention

- Supporting people living with an existing health issue(s) to manage their chronic condition and live well thereby preventing or delaying complications

Neighbourhood Care Model Development/ Community Fit

Progress to date

- Neighbourhood definition and service mapping
- Identification of health needs
- High Level Care Model development
- Identification of
  - Levels of Care, Activities and Interventions
  - Skills/competence gap analysis
  - Critical success factors

  for Neighbourhood Teams and Hubs
- Engagement with key partners

Identifying Levels of Care for Partner Services Neighbourhood teams – Community Health

Maintenance and Planned Care

- Long term condition management
- Domiciliary Care
- Point of Care Testing
- End of Life
- Early intervention for Mental Health conditions
- Interface between teams and Social Capital/Voluntary Sector (step up & step down)

Identifying Levels of Care for Partner Services Hubs – Community Health

Urgent and Specialist Community Care

- Same day response to crisis, including
  - Urgent Care
  - Comprehensive Geriatric Assessment
  - Admission avoidance

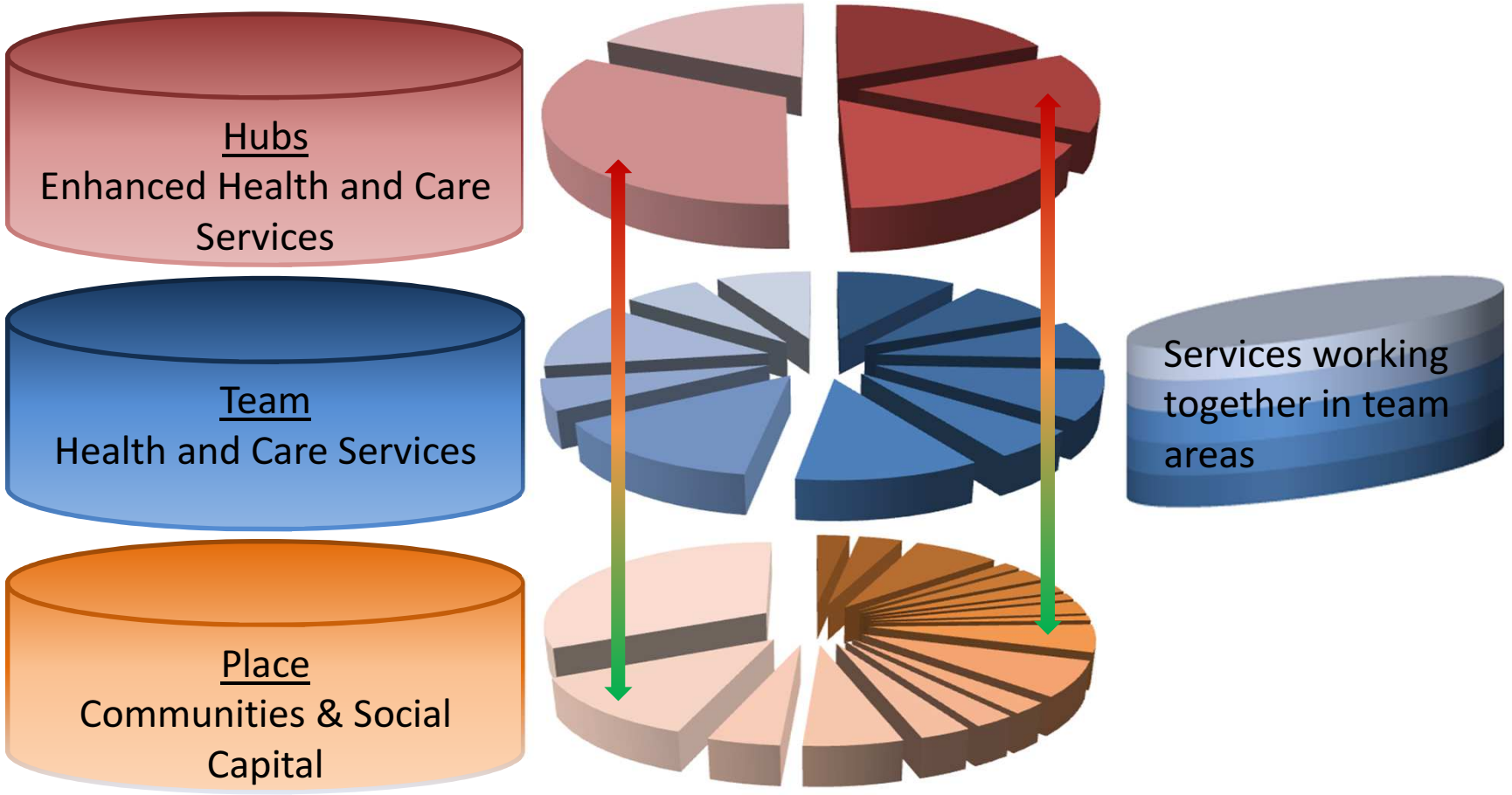
Hubs will also provide a focal point of care in the community, delivering specialist community services, closer to home. Services to be provided will include:

- Ambulatory Care and Intervention
  - Specialist Nursing
  - Mental Health Specialists
  - Point of Care Testing
  - Diagnostics

Examples of Neighbourhood Care Model Initiatives in Development

- Extended Urgent Care in Bridgnorth focussing on frailty and same day urgent access to local assessment, diagnostics and treatment
- Extended Urgent Care in Ludlow through closer working between primary care and MIU
- Community Hub development in Market Drayton
- Virtual clinics between GPs and Community teams in Whitchurch to review patients and case loads
- Integrated community nursing teams in Alveley

Neighbourhoods



Impact on equalities and social inclusion

Need for redesign to consider:

- Impact on groups with protected characteristics
- Rural proofing of services– a vital consideration in Shropshire
- Accessible Information Standard
- The wider public sector financial position going forward

Communication and Engagement:

- How to engage with communities of place and of interest
- Importance of engaging with, and through with elected members and Local Joint Committees
- Aligning these messages with current or planned large scale current engagement e.g. new Carer's Strategy, Big Conversation

Programme Implementation

- Community Resilience, Social Action and VCS
  - 4 pilot areas implemented, roll out for rest of county ongoing
  - Development of Oswestry as pilot for linking community activity with behaviour change support, social prescribing and service redesign (Autumn 2016)

  - Assumption – continued funding available for community enablement teams, community care coordinators, housing support/ prevention activity

Programme Implementation

- Partnership Prevention Programme
  - Social Prescribing model development –Autumn 2016
    - Engagement with GPs, VCS, and all stakeholders Autumn 2016
    - Pilot November 2016
    - Roll out Spring 2017
  - 6 key additional programme areas
    - Pilot Diabetes & CVD Prevention– Oswestry Autumn 2016
    - Mental Health – Suicide prevention strategy (in development)
    - Safe and Well visits – January (T&W and Shropshire)
    - Future planning – Autumn 2016
    - Carers/ Dementia/ UTIs – all age carers strategy and action plan November 2016
    - Falls Prevention – roll out of Community PSI (start Autumn 2016), New Service Specification (April 2017), link to Fire Safe and Well
  - Assumption – continued funding available for community enablement teams, community care coordinators, housing support/ prevention activity

Next steps

- Continuing to map the services/programmes in scope
- Aligning this activity to available and potential social action
- Set out the elements of services and programmes in a consistent way to understand outcomes, impact and metrics
- Develop placed based governance, e.g. working groups to
- understand demand/activity for each Neighbourhood Team/Hub and scope potential redesign
- Sense testing within localities (eg clinical pathways, prevention programme)
- Secure additional resources to meet our identified needs in this development work
- Develop our approach to understanding impact in relation to equalities and rurality