

B&NES, Swindon and Wiltshire: Sustainability and Transformation Plan

Emergent plan

Our Emergent Plan has been developed through collaboration between the following organisations:

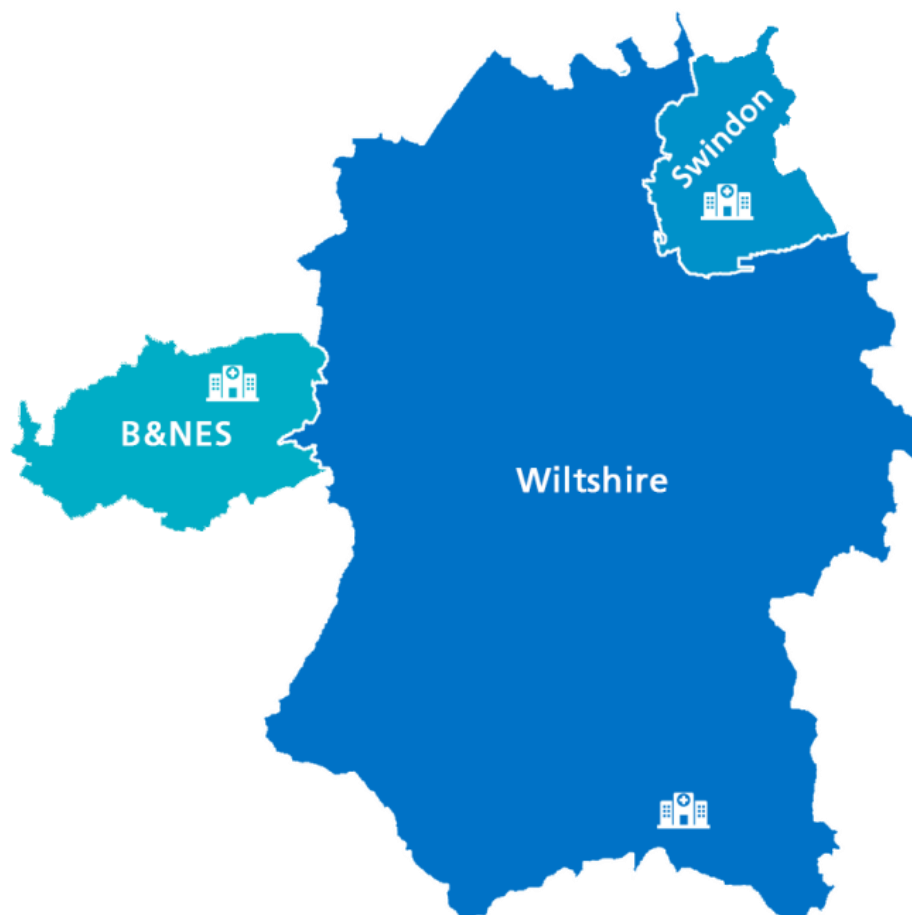


Key information

Name of the footprint:	B&NES, Swindon and Wiltshire (BSW)
Region:	Bath & North East Somerset (B&NES), Swindon and Wiltshire
Nominated STP lead:	James Scott, Chief Executive, Royal United Hospitals Bath NHS Foundation Trust
Contact details:	james.scott4@nhs.net

Organisations within the footprint:

- Bath & North East Somerset CCG
- Swindon CCG
- Wiltshire CCG
- Bath & North East Somerset Council
- Swindon Borough Council
- Wiltshire Council
- Great Western Hospital Foundation NHS Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Avon & Wiltshire Mental Health Partnership NHS Trust
- Wiltshire Health & Care
- South Western Ambulance Service NHS Foundation Trust
- Wessex Local Medical Committee
- West of England Academic Health Science Network
- Health Education England
- Health and Wellbeing Boards (B&NES, Swindon, and Wiltshire)



Executive summary

As our population continues to grow and people are living longer, often with long-term health conditions, the increasing demand being placed on our health and care services is falling out of line with the amount of available funding. At the same time, health inequalities are widening. Certain groups of people are more likely to develop particular diseases and more likely to die from them early. We also know that the way people experience their care can be different, with some areas benefiting from better quality health services than others.

Across B&NES, Swindon and Wiltshire, patients are facing long waits for hospital outpatient appointments and treatments in certain specialties, and the Emergency departments at our local hospitals are often under pressure. We also face significant financial challenges locally over the coming years. For instance, we already know that if we continue to provide services in exactly the same way we will have a financial gap of £74 million in 2017/18.

[The NHS Five Year Forward View published by the Chief Executive of the NHS, Simon Stevens, is a compelling vision and strategy for the NHS.](#)

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

In line with this, we are developing our local five year Sustainability and Transformation Plan (STP) for B&NES, Swindon and Wiltshire (BSW). We are publishing it to share our early thinking and to engage our wider workforce and residents in its future design. It describes our overall approach to achieving an improved and more sustainable health and care system.

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

- a growing population with more complex needs
- increasing demand for services and rising public expectations
- the escalating cost of drugs and new medical technology
- retaining and recruiting enough staff with the right skills and expertise
- considerable pressure on NHS and social care finances – the health and care community is facing a financial gap of circa. £298m over the next five years unless we make radical changes to the way we deliver services and support for local people

Our plan doesn't mean doing less for patients or reducing the quality of care provided. Neither does it mean shutting Emergency departments. It means working with you to enable you to take more responsibility for your health and wellbeing – finding new ways to meet people's needs, and identifying ways that existing services and organisations can work together to do things more fluidly and efficiently. We have identified, and will continue to seek opportunities, for health and care organisations to work together to solve these challenges.

The size of the challenge is significant and we can't do it alone. The following pages set out our initial thoughts and early priorities for doing this but we also need your involvement in co-designing services for the future.

We will work in collaboration with our third sector and community partners, patients, carers and the public to develop the detailed proposals for change. How people can get involved is explained at the end of our plan.

James Scott

BSW STP Senior Responsible Officer

Quick guide: STP in context			Further info on existing strategies		
The BSW STP provides a mechanism for accelerating delivery of improvements in health and care planning and delivery for BSW residents. This plan sets out our long term aims and early priorities. Our intent is not to use the STP to cover all aspects of care but to focus on issues where we can add value by collaborating at a footprint level. Outlined below is a summary of our position on key topics and links to existing plans and strategies already in place within the footprint.			B&NES	Swindon	Wiltshire
1	Closer working / Integration with Social Care	Each of the three CCGs in the footprint are currently working closely with their council partners with regards to ensuring health and social care services are aligned from the user's perspective. The STP will support the development of these relationships and enable collaboration across localities on key challenges such as domiciliary care capacity. Our plan provides an overview of each localities approach and further detail is available on the links provided.	Link	Link	Link
2	Acute / Hospital Services	There are no plans for merger at the three acute Foundation Trusts given the distance between them. There is agreement to collaborate to ensure 'at risk' services remain sustainable – particularly from a workforce perspective. The degree, and nature of, collaboration will vary depending on the challenges but this new approach heralds an unprecedented level of acute collaboration.	Details set out within this plan		
3	Joint Health & Wellbeing Strategies	Each CCG/Council has comprehensive Joint Health & Wellbeing strategies in place that set out plans for improvement in public health for their area.	Available from Council websites		
4	Community Services	We believe local engagement and ownership of clinical models will be critical if we are to meet the long term needs of our local populations. As a result, the development of community models of care will continue to be very much locality focused with sharing across localities on model design. Our plan is to continue to have separate contracts within each locality.	Link	Link	Link
5	Primary Care Models	Similar to the future model for community services, bespoke models of sustainable primary care provision will be developed in the three locality areas with sharing on learning and implementation across the STP to accelerate delivery.	Link	Primary care workshops underway	
6	Commissioning of GP services	There is likely to be collaboration across the three CCGs at STP level around the provision of commissioning support for primary care in 2017/18.		Link	
7	Care Models (Contractual)	The STP envisages having separate solutions for each locality (CCG area). The exact form of contract will be individualised to the three localities to reflect population need with sharing across the STP on learning. It is envisaged that the Swindon area will progress to an Accountable Care system during the planned period. In Wiltshire discussions are on-going in relation to how the new care models can best serve the needs of Wiltshire residents. B&NES has recently awarded a Prime Provider contract for a range of community and preventative services and is in discussions with local providers regarding the nature of care models.			
8	Mental Health Services Five Year Forward View (FYFV)	We are adopting a collaborative approach to the development of the Mental Health Five Year Forward View at STP level. Aspects of design may alter across localities due to the need to integrate with community and primary care models.		Link	
9	Public Health interventions	STP members have agreed to collaborate across the footprint in those areas where interventions would be more effective at system level. Initial priorities have been identified and work ongoing to develop our full work plan.	Link	Link	Link
10	Children's & maternity services	We are currently assessing the impact of the National Maternity Review: Better Births and have not yet set out an agreed approach at STP level. The workforce and estates challenges are being addressed through provider and commissioner dialogue with any changes subject to a separate public consultation process.		Link	
11	Back Office Services	There is a commitment to work at STP level to minimise expenditure committed to non-clinical services. The current scope of this project has recently been extended to cover some aspects of CCG support services.		Link	

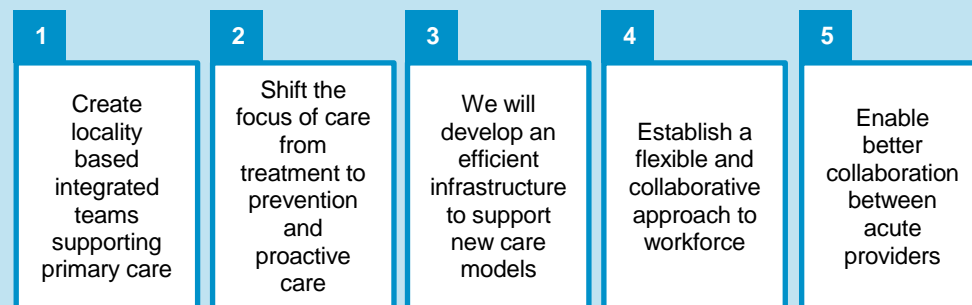
			Further info on existing strategies		
			B&NES	Swindon	Wiltshire
12	Specialised Services (including Cancer pathways)	All partners are committed to reviewing specialised care pathways; however, residents in the STP are served by three tertiary providers outside of the footprint. Cancer Alliance governance arrangements established but further work is required in understanding future benefits. An agreed priority for the parties within the STP is to secure high quality and accessible specialised services for residents.		Link	
13	Clinical Policies	CCGs have started to harmonise relevant clinical access policies to drive standardisation and reduce inequity of access across the STP.		Link	
14	Workforce	Individual organisational employment will remain however the organisations within the footprint have agreed to develop a single workforce plan and cooperate in areas such as training provision.		Link	
15	Estates	A single view of the NHS estate has been established and there's a commitment to plan our estate at STP level.		Link	
16	Digital	There are strong plans (Local Digital Roadmaps) in place at locality level. The STP has identified a number of areas where there would be added value in progressing these at STP level to accelerate delivery.	Link	Link	Available on request
17	Planned and Urgent Care Models	Our early work has identified that planned care models would benefit from a combined approach at STP level. Initial triage for urgent care services will be designed and contracted for at STP level however face-to-face aspects of service will be bespoke to each locality to enable integration with primary, community and mental health models.		Link	
18	Young People's Mental Health and Wellbeing	Significant work has already been undertaken between NHS and council bodies on developing transformation plans for their local areas.	Link	Link	Link
19	Learning Disabilities	Strategies are already in place in the three localities with effective collaboration between Wiltshire and Swindon Councils.	Available on request	Link	
20	End of Life Care	End of life care has been a focus within and across organisations. The STP currently does not set out detailed plans to extend this further however it will be included within our next wave of initiatives. Existing strategies on EOLC are set out here	Link		Link
21	Obesity	The STP is seeking to build on the strategies already developed by CCGs on tackling obesity and enabling health lifestyles. Further information on existing plans can be found on the following links.	Link	Link	Link

Plan on a page

Our footprint

- New Sustainability and Transformation Plan (STP) footprint formed in March 2016.
- Good level of partnership engagement in developing a strategic plan to address the projected growth in population and the impact of ageing population.
- Population of 0.9m people across 3 council areas, 3 Clinical Commissioning Groups (CCGs) and served by 3 acute Trusts (c40 miles apart).
- Annual budget of c£1.4bn – 2015/16 outturn position was £6m deficit.
- Relatively healthy population (with pockets of high health need) and relatively efficient (c0.9 through Carter benchmarking in each acute provider).
- Some small opportunities identified through Right Care benchmarking but overall each CCG benchmarks favourably.
- Good progress in agreeing delivery plans to stem growth, in the context of a highly plural elective care market.
- Further work and capacity needed in quantifying the impacts of our plans, developing our vision for clinical models and contractual models across the 3 CCG localities.

Priorities for the next five years



7 initiatives for 2017/18 and 18/19

1. Confirm the new models of care that support the sustainability of primary care.
2. Redesign the initial access points for urgent care – tailoring to each CCG / Council locality to ensure best fit with the population based care models.
3. Standardise elective care pathways to reduce variation in quality for patients.
4. Develop the organisational capacity to deliver systems change – particularly for engagement and capacity planning.
5. Agree and implement solutions to the workforce capacity constraints, particularly in social care support provision and within identified acute specialties.
6. Improve the IT systems so clinicians from different organisations can access and share patient information.
7. Develop a single Estates strategy for the footprint.

Summary financial analysis

- The system allocation for 2017/18 is £1.4bn.
- Relative to other health economies, the underlying financial position is robust however is coming under increasing pressure through 2016/17.
- We have assumed that providers will achieve their control totals in 17/18 and 18/19.
- Our assumption is commissioners will achieve 1.7% to 2.4% QIPP over the next two years.
- The three Foundation Trusts and our mental health provider require between 2%-4.3% efficiency savings over the next two years.

Enabled by

- A single digital strategy for the footprint that enables patients to engage better with their health and for staff to share and access information easily and securely
- An engagement plan that enables the co-production of change proposals with our workforce and communities
- Single Estates strategy for the footprint building on the 'One Public Estate' approach in Wiltshire
- A consistent approach to change management facilitated by the WEAHSN
- Further work and capacity needed in quantifying the impacts of our plans, developing our vision for clinical models and contractual models across the 3 CCG localities

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Context

The Bath & North East Somerset, Swindon and Wiltshire (BSW) STP covers a population of c.0.9m people, living within three unitary council areas.

Their health needs are met by 110 GP practices supported by three CCGs, three community providers, three acute Trusts, one mental health provider, one ambulance Trust, and other charitable organisations. All three acute Trusts are located on the fringe of the footprint and all three look to separate specialist centres for tertiary support.

Over the last eight months organisational leaders have worked together to identify the common challenges faced by this new health community and have agreed that fundamental changes are required as to how we work together to meet the current and future needs of local people. We believe that care should be designed around the needs of individual citizens and population groups, and that this is best achieved through collaboration at four levels:

1. Individual citizen
2. Neighbourhood
3. Locality (CCG/Council area)
4. STP footprint

We are committed to using the STP as a vehicle for accelerating progress at the level that delivers the best outcomes and experience for our citizens. Only those challenges that are most effectively dealt with at a footprint level will be addressed through the STP.

We have a strong and solid platform on which to build. The Health and Wellbeing Boards in each of the three localities have existing plans aimed at shifting the focus of care from treatment to prevention and self-care. Better Care Fund schemes have been commissioned with the aim of reducing the gap between health and social care. The underlying financial position for 2015/16 was relatively strong when compared to other areas, but when we model what the future needs of our population will be, and compare the cost of that with the resource we will have – we know that tough decisions lie ahead.

This plan frames those challenges and sets out a strategic framework for working with local clinicians and citizens to co-design the future models of care (including preventative measures). The models will enable us to maintain peoples' good health and wellbeing for longer and respond effectively and efficiently to their health and care needs when they require it. We have not set out our vision for every individual pathway; we know, for example, that caring for those with a form of dementia – and supporting their carers – will be one of the great challenges over the next 10-15 years. But we're seeking to establish mechanisms through which we can jointly plan and design truly integrated care pathways with local citizens.

Our journey and path forward

This plan sets out our unique and common challenges across health inequality, quality and performance, and finance.

It sets out our five key priorities for change as:

1. The development of locality-based integrated teams supporting primary care.
2. Shifting the focus of care from treatment to prevention and proactive care.
3. Redefining the ways we work together to deliver better patient care.
4. Establishing a flexible and collaborative approach to workforce.
5. Further enabling acute collaboration and sustainability.

The STP is determined to embed parity between mental and physical health care. This document should therefore be read with the implicit assumption that all initiatives relate equally to mental and physical health and social care.

Our starting position and key challenges

Our challenges – wellbeing & quality of care

The population size and health needs of local people varies across the BSW footprint.

The combined area of B&NES, Swindon and Wiltshire has a complex and extremely varied demographic structure and geography which poses challenges to the delivery of health and social care.

- It features large rural areas (particularly the mid-Wiltshire Salisbury plain area) as well as urban centres.
- Our main acute providers (i.e. main hospitals) and larger towns are located on the periphery of the footprint.
- The footprint features a largely affluent population but there are pockets of deprivation (6.4% of the population falls within the most deprived quintile).



Footprint context

By 2025/26 the footprint population is likely to exceed one million, with one in five people aged over 65 years.

We know that older people are at greater risk of diseases like cancer, CHD and dementia; and that people over 65 require more care.

We also know that one in four adults experience a diagnosable mental health problem in any given year, at an estimated cost to the British economy of £105bn.

There are also numerous demographic variations within the footprint. For example, B&NES significantly exceeds the England average for 20-24 year olds due to a large student population. But two issues unite the footprint: a growing aging population, and the impact of local housing strategies.



Mirroring national challenges, the growing population will increase demand for local services.

B&NES CCG estimates that 10 extra GPs will be required to cater for the housing growth. More significantly, the population increases will compound demand from the over 65s who already account for 40% of the NHS budget nationally.

Swindon CCG is short of 25 GPs compared to other areas with the same population size.

In addition, The West of England Devolution Agreement (agreed 29th June 2016) has potential implications for B&NES Council and CCG regarding the appropriate STP footprint for those organisations.



An aging, and a growing population

The population is older than the England average (0.8% more over 75 years), and we expect this gap to widen because the population of people aged over 65 is growing at a faster than average rate of 26.6%. At this rate, people over 65 years old will account for 22.5% of our total population in 2025/2026 (compared to 18.9% at present).

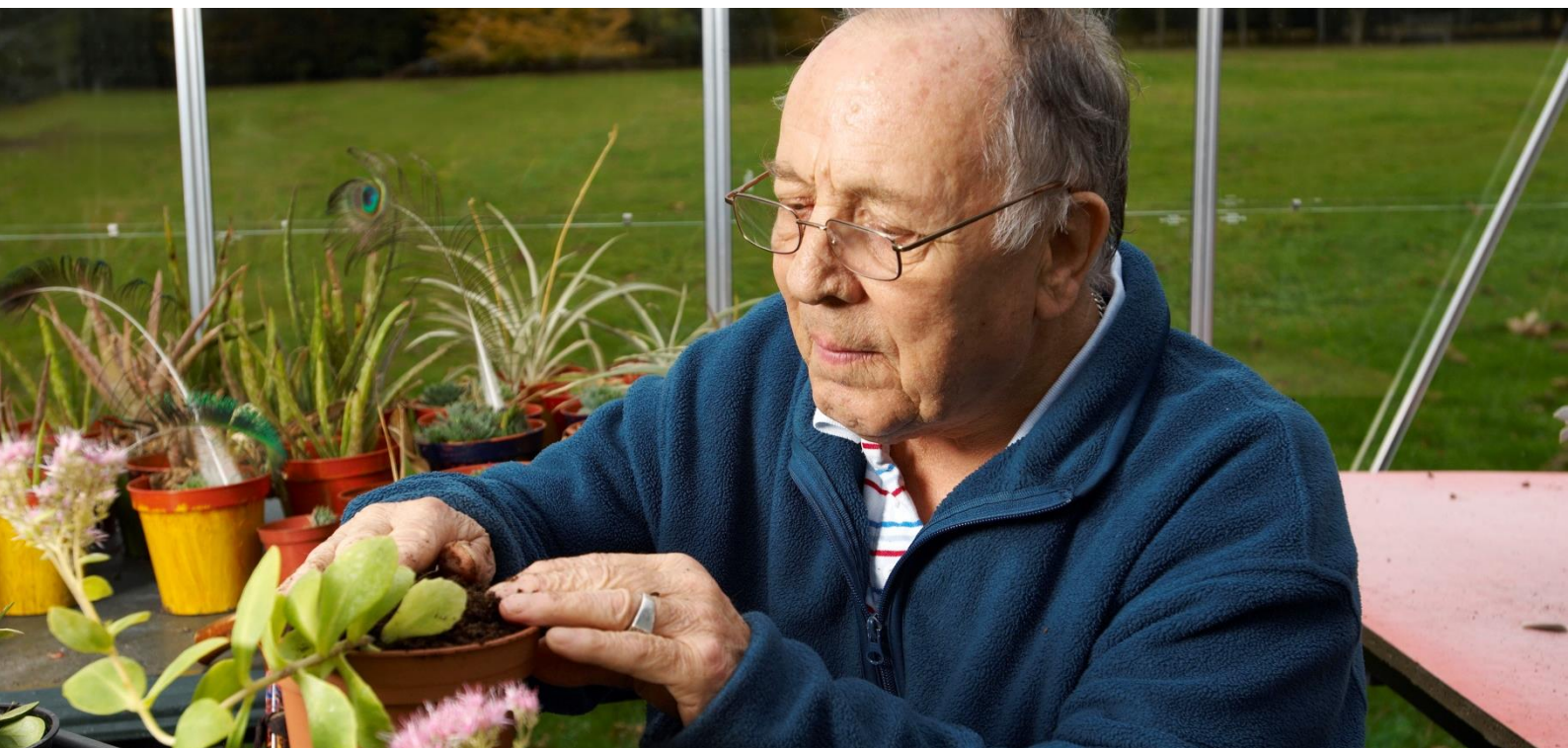
Current population forecasts (overall a 6.6% population growth in 10 years) do not factor in all of the known additional population changes that will drive growth above and beyond existing trends. In particular, and of greatest impact: housing increases.

The impact of local housing strategies

In B&NES the local housing strategy is expected to create an extra 13,000 dwellings by 2029, increasing the population by an estimated 16% which is not factored fully into ONS modelling. The emerging Joint Spatial Plan for the West of England may increase this further.

In Swindon, 22,000 new homes will be built between 2011 and 2026, increasing its population by an estimated 16% over the next 10 years.

Wiltshire has a large armed forces presence and the Army Rebasing plans estimate that c10,000 service people (including their families) will be relocated to the area over the next five years, increasing the population by c.2.0%. 12,981 houses will also be built in Wiltshire by 2026.



Outcomes and experiences can be improved by ensuring health and care services are designed around people’s needs, and by reducing the variation in quality across the footprint.

Our plan will support the following key challenges around quality and performance:

1. RTT compliance and the A&E four-hour standard waiting time.

These are the two major operational challenges facing all footprint providers. The BSW aggregate performance for 2015/16 was as follows:



- Meeting the increasingly complex needs of older people is creating flow challenges across the system.
- Elective (planned) services capacity is being compromised due to pressure on urgent care.
- We need to integrate care services around people’s needs, reducing variation and duplication.

2. Consistent delivery of Cancer Access Standards.

3. Commissioning arrangements for mental health services resulting in variable service and outcomes.

To improve patient experience, we will move from reactive responses to crisis, to an integrated social, mental and physical health care service in the community that prevents crisis and creates parity of esteem between physical and mental health.

4. Care not being delivered in the most appropriate setting, putting unnecessary pressure on acute and urgent care.

We will integrate primary and acute skill sets so that care can be delivered in the most appropriate setting.

5. A recruitment shortage, with many skilled staff near retirement

e.g. in general practice, nursing and midwifery

6. A financial shortfall across all sectors over the next 5 years:

Acute, primary, mental health, social care and local authorities



Across BSW

There are 5,759 people with undiagnosed diabetes



In B&NES

Five areas fall within the most deprived quartile in the country.



In Wiltshire

In some areas the gap in healthy life expectancy between the most and least deprived is 11.7 years



In Swindon

Long Term Conditions (LTCs) are associated with 50% of all GP appointments

The footprint performs well on various public health indicators, but there remain **core inequalities in care need and outcomes, which we will tackle.**

Lifestyle factors: Obesity and smoking prevalence in Swindon and hypertension prevalence in Wiltshire.

Mental Health: B&NES and Swindon admission rates for self-harm are significantly worse than the England average.

Disabilities: Not enough people with learning disabilities

are receiving an annual health check with their GP.

Healthy childhood: Maternal smoking at delivery remains high in Swindon, as does the percentage of children aged 10-11 classified as overweight/obese.

Independent lives: More falls can be prevented in people

aged over 65, particularly within B&NES and Wiltshire.

LTCs: A low percentage of diabetes patients are achieving all three NICE recommended treatment targets. Note: Swindon may appear to be the outlier for inequality progress, but this is due to a more homogenous population (less affluent dilution), and mirrors the challenges faced across more deprived areas of B&NES and Wiltshire

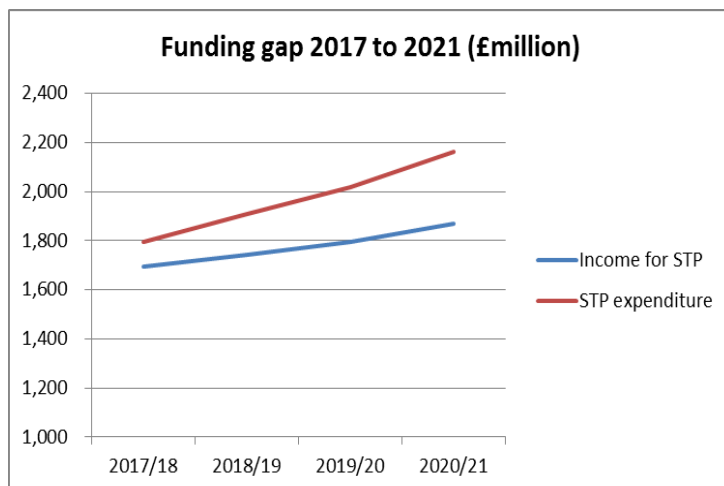
Our challenges – affordability of care

Current models of care will be unaffordable and health and social care services are not financially sustainable into the future. This is mainly due to the increase in demand, an aging population, an increase in more complex care needs and rising costs of care delivery.

The 2015/16 financial outturn position for all health organisations within the STP was a net deficit of £6 million. By September 2016 (month 6) the projection for acute and mental health trusts for 2016/17 is a surplus of £10.6 million. The target set by NHS Improvement is for these trusts to deliver a surplus of £12.7 million.

The gap between available funding and expected costs of delivering health and care services is rising. Based on our latest modelling, if no action is taken to deliver cost savings over the next four years, the STP will face an annual funding gap of £298 million by 2020/21. This includes £50 million projected gap in social care funding. This increasing gap is illustrated below:

Under the “do nothing” scenario, the gap between available income and cost of services will rise to £290 million per year by 2020/21



This “do nothing” scenario is based on financial data provided by each of the organisations in the STP footprint and is in line with national assumptions. The data reflects the financial plans up to 2020/21, after excluding cost savings programmes and £24 million total Sustainability and Transformation funding that has been offered to the three acute trusts and one mental health trust in 2016/17.

Trends in income and expenditure over the five years are based on national planning assumptions. These indicate that the key drivers extending the gap are:

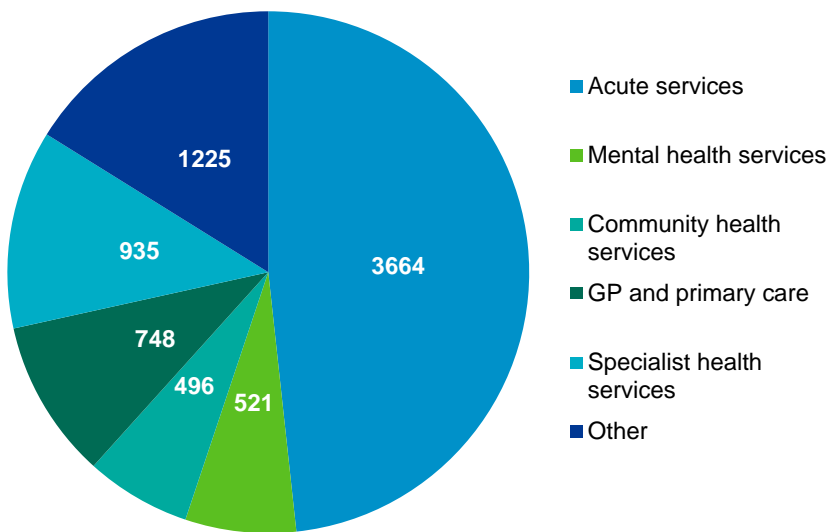
- Rising demand (limits to capacity have not been taken into account in these calculations)
- Cost inflation, particularly with respect to high cost drugs
- Increased reliance on high cost services such specialist health services and agency staff
- Efficiency savings expectations factored in to the funding total provided by NHS England to the STP’s CCGs, which are increasingly challenging to achieve

The STP is acutely aware that the more that can be done in the early years, the greater the impact on savings will be by year five.

The financial headlines are:

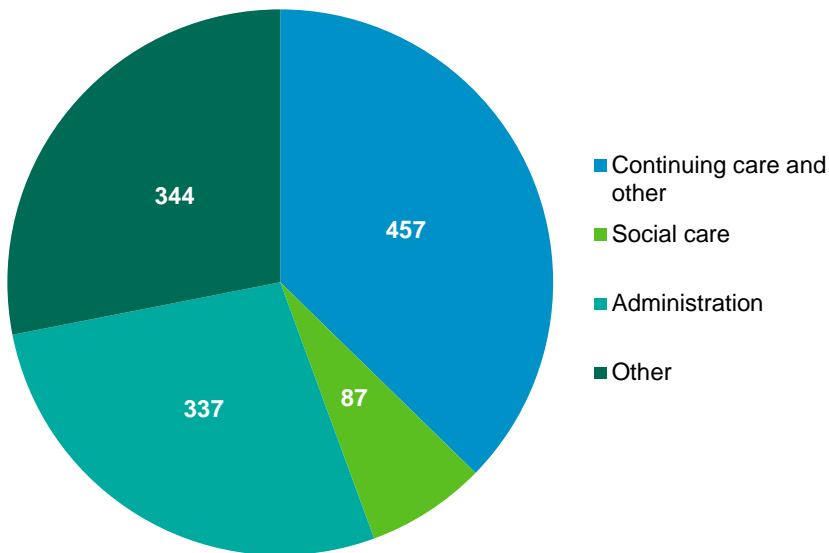
- **Funding (income) available to the STP rises from £1.7 billion in 2017/18 to £1.9 billion in 2020/21**
- **Expenditure projections rise from £1.8 billion to £2.2 billion over the same period**
- **The funding gap rises from £100 million (6% of income) to £290 million (15% of income) by 2020/21.**

Total expenditure 2017/21 (£million)



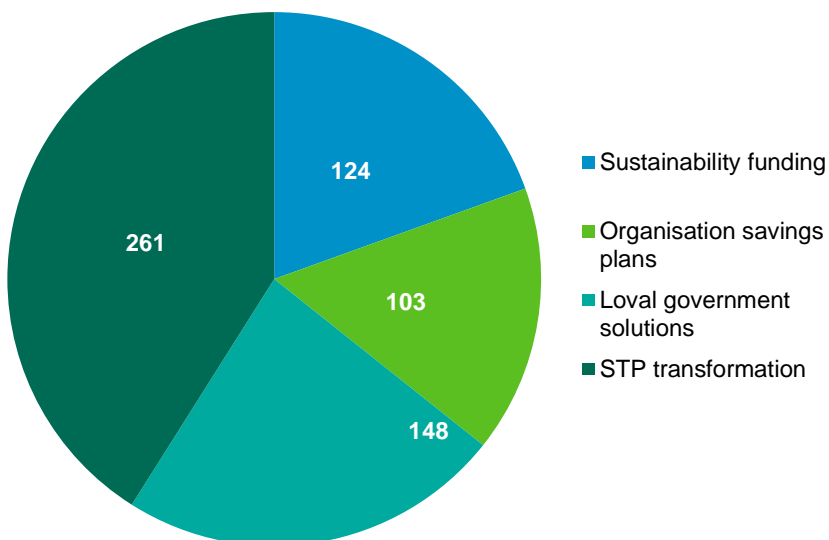
Almost half of the STP health expenditure will be on acute healthcare services

Other expenditure 2017/21 (£million)



Other expenditure is broken down as follows

Addressing the financial gap 2017/21 (£million)



Although organisations will continue to strive to achieve efficiency savings locally, around 40% of the financial gap will need to be addressed through transformational change to the way that we deliver services and our service users access those services.

Our priorities

Design principles that underpin our work

- To transform our services we'll put people at the centre of our healthcare planning, ensuring they receive the right information and access to services that will help them lead lives free from disease and ill health.
- Mental health, social care, community and hospital professionals will work more closely together, providing reliable services that are designed with input from patients and available closer to home. This will be achieved by planning at neighbourhood level, with GPs coordinating a range of care services.
- Acute, community and mental health services will work together to keep more people in their own home by improving access to specialist opinion and diagnostic tests.
- Providers of care will work together to reduce their own costs, while ensuring sufficient staff to see patients promptly. We will embrace technology to work more efficiently and reduce our costs by reviewing all of our property and buildings. These efficiencies will not affect patient care.
- Commissioners and providers will work together to establish whether we can provide improved access to specialist care within the region, reducing the need for people to travel to other areas.
- Our focus will be on ensuring consistent high-quality services for those that need it most, regardless of where they live in the area. We'll also work closely with the West of England Academic Health Science Network (WEAHSN) to share learning and resources across all of our organisations. While maximising the efficiencies afforded by coming together as a footprint, the distinct areas will remain responsive and accountable to local people's needs.

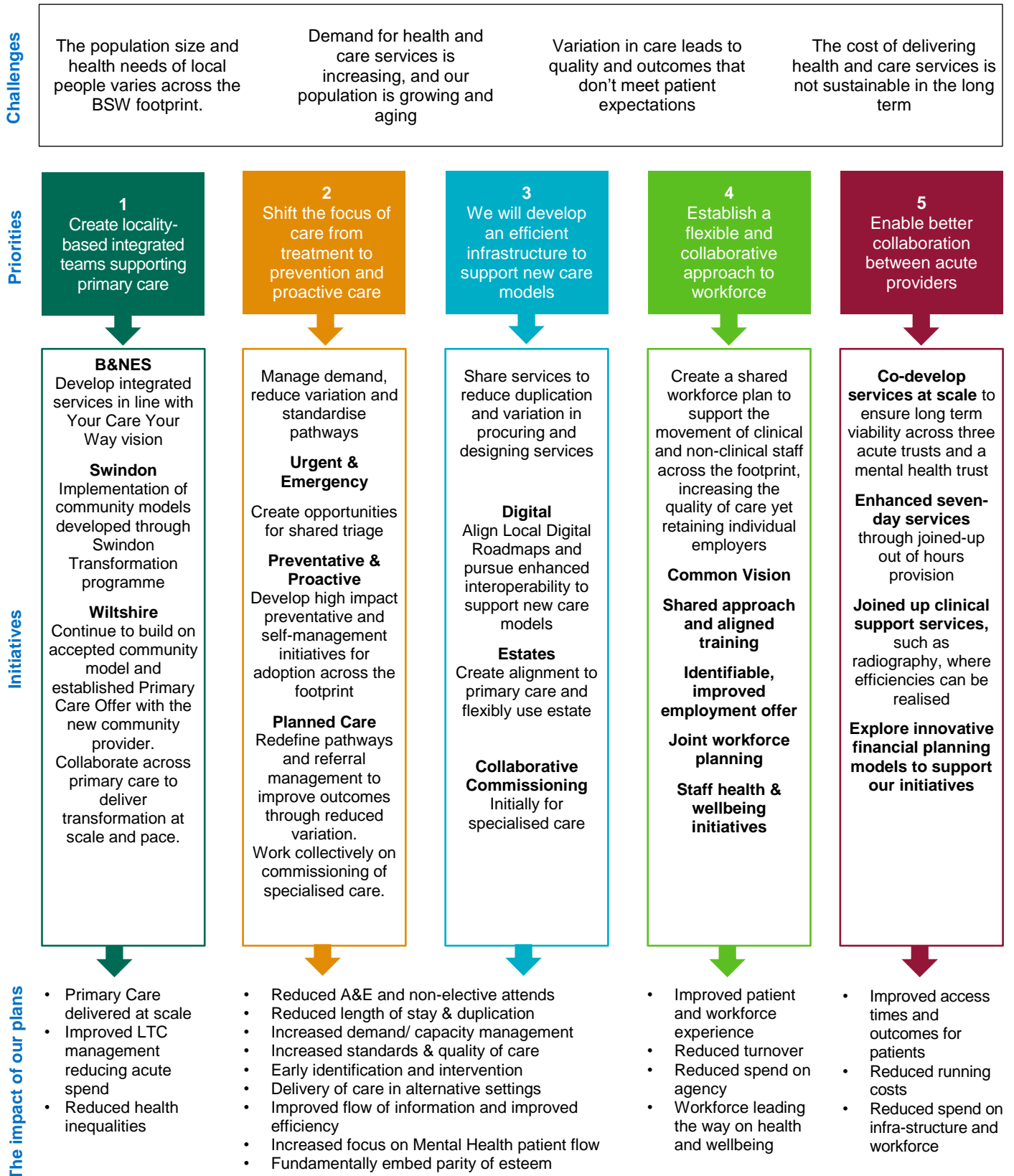
Opportunity

We've identified five priorities that will help us to align our ways of working for better patient care and increased efficiency.

- 1** Create locality-based integrated teams supporting primary care
Create a learning system of care, with our citizens at the very heart, ensuring high standards of care are met through a focus on continuous quality improvement, safety and the use of evidence to drive decision making.
- 2** Shift the focus of care from treatment to prevention and proactive care
Engage with local people and provide the necessary information and resources that will help them to stay healthy and well for longer, reducing the need for traditional healthcare treatment.
- 3** We will develop an efficient infrastructure to support new care models
Embrace technology and more efficient ways of working across the footprint, improving access to health advice, services and patient information where necessary and avoiding duplication of work. Undertake collaborative planning of our estate across the NHS and councils.
- 4** Establish a flexible and collaborative approach to workforce
Attract, develop and retain a workforce through collaborative workforce planning.
- 5** Enable better collaboration between acute providers
Reduce the cost of care by encouraging greater collaboration between acute providers and a matrix approach to partnership working, ensuring that services remain accessible and financially viable.

Plan Summary

This diagram shows how our five initial priorities of work will help to meet our set of critical challenges over the next five years.



Priority 1: We will create population-based integrated teams supporting primary care

Our aim is to ensure the sustainability of primary care across the footprint, encouraging local clinicians to develop appropriate models of care that feature a wider range of health and social care services working more closely together around the needs of patients.

The new models of care will be in line with those articulated in the Care Redesign section of the General Practice Forward View, requiring acute, mental health, primary and community care providers to adopt an unprecedented level of partnership.

The models will be flexible enough to cater for the specific and varied needs of each locality, such as large rural areas and densely populated areas. In some cases, General Practices will come together in networks, providing services to 20,000 to 50,000 people. This will enable the practices to share resources and host health professionals and specialist teams working across a wider geographical area.

Our goal is to provide a wider range of health and social care services in the community, coordinated around the needs of individual patients.

Organisational Forms

The overall models of care (extending beyond primary care) will be tailored to the specific needs of our three CCG/Council populations.

This approach will ensure the 'right fit' for the individual populations.

All three CCGs have recently tendered their community service contracts.

In Wiltshire, the three Foundation Trusts now provide Adult Community Services (since July 2016) through Wiltshire Health & Care. Discussions are on-going between health and

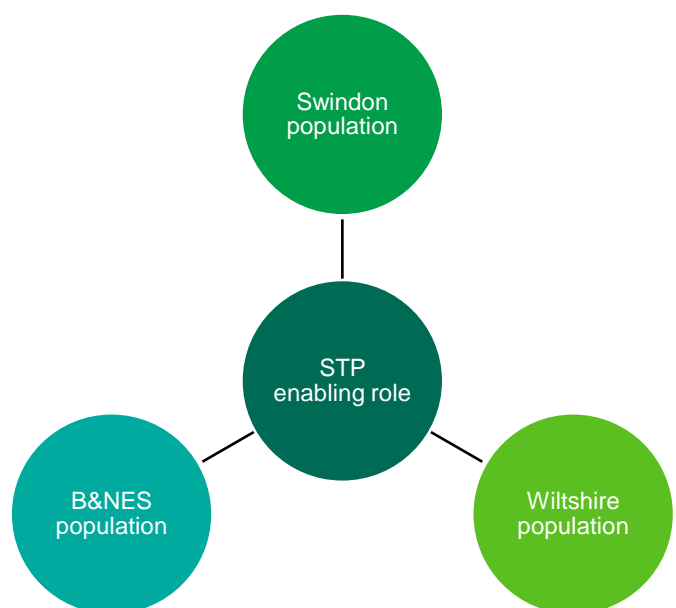
council partners in relation to how the new care models can best serve the needs of Wiltshire residents

Great Western Hospitals Foundation Trust has recently secured the provision of community services in Swindon. Discussions are ongoing as to what form of accountable care structure can best meet local needs.

In Bath & North East Somerset, the council and CCG recently awarded Virgin Healthcare a Prime Provider contract covering a range of community and preventative services. The Council and CCG are currently working with local providers to establish the supporting contractual arrangements.

Role of the STP

As our vision is for Accountable Care solutions at CCG/Council level, the development of new models for both primary care and the wider care models for each locality will continue to be led by CCGs. The STP will provide an enabling role in sharing learning and progress across the footprint seeking to accelerate progress towards completion.



Developing Primary Care at Scale

Each CCG has already been developing its own response to the challenges facing primary care - with an emphasis on the different challenges facing the three geographies. The STP will enable joint working across CCGs on how the pace and scale of transformation can be increased through closer collaboration over future clinical models and cooperation on delegated primary care commissioning for 2017/18.

Case for Change

The challenges facing primary care are well documented, including:

- workload pressures with an aging population and increasing complexity of presenting conditions and multi-morbidities;
- workforce pressures of recruitment, retention and skill mix; capacity and state of primary care premises;
- increasing bureaucracy and regulation demands;
- pressure on practice development;
- and the national and local resource challenge to maintain the level of high quality services provided by our general practices

Our common aim is to:

- Better manage workload and redesign how care is provided
- Implement the GP Forward View (including the plans for Practice Transformational Support, and the ten high impact changes)
- Ensure local investment meets or exceeds minimum required levels
- By no later than March 2019, extend and improve access in line with requirements for new national funding
- Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties)

Whole systems approach – role of primary care

There is an increasing awareness across the STP of the need to ensure the ongoing viability and sustainability of primary care – within their current remit, and secondly to consider what additional capacity, resources and infrastructure required to deliver the shift in care from urgent to planned to preventative.

The complexity in understanding the capacity and demand of the entire health system is a challenge facing all footprints and our current thinking reflects the need to take a population-based approach to planning.



Delegated Commissioning of Primary Care

By December 2016, each CCG has to consider the option to apply for the delegated commissioning responsibility for primary medical services, currently commissioned by NHS England, to take effect from 1 April 2017. This refers to the contracting / transactional functions related to GP GMS & PMS Contracts (107 across STP). The strategic commissioning and decision making would remain with each CCG.

The three CCGs are working together to understand the opportunities and develop a proposal to apply as individual CCGs for delegation from NHSE. We anticipate that Wiltshire CCG will host the service on behalf of B&NES and Swindon CCGs across the STP footprint, with a local agreement in place.

As part of this application process, the CCGs will be undertaking a 'due diligence' and impact analysis on the implications for CCG resources required to take on the delegated commissioning functions and responsibilities. A clear mandate is required from CCG membership GP practices, with Governing Body sign off.

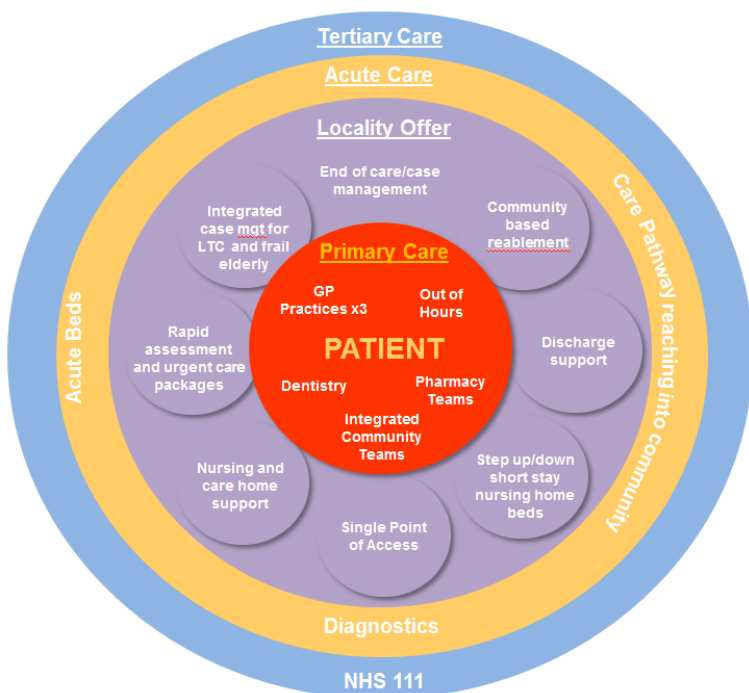
GP Forward View

The CCGs are working with the Local Medical Committee to establish the local opportunities and implications for the programmes and investment, and how this aligns with plans in place. The programmes include GP Resilience, Vulnerable Practices, GP Development, GP Improvement, and various training programmes. There is funding for new models of care and underpinning delivery plans are being developed to support this.

Work is ongoing to understand the return on investment of the £3 per head outlined within the Operational Planning guidance. Each CCG is triangulating their plans with their Estates & Technology Transformation Fund submissions to ensure there is consistent assumption throughout; bids have been reassessed against amended criteria and resubmitted at the end of September.

Wiltshire's Transforming Community Services programme is supporting the development of clusters of primary care at scale

Following a competitive tender process for adult community services, Wiltshire's Transforming Community Services programme is already supporting our goals:



- Multi-disciplinary teams working across community healthcare, social care, mental health primary care liaison service and voluntary organisations to provide integrated, accessible out of hospital care.
- Care Co-ordinators allocated to each GP practice, reducing unnecessary acute/care home admissions.
- Better rates of discharge to home or community care following a county-wide roll out of discharge principles with high performing intermediate care services.
- Bespoke training and development programmes for GPs and sustainable support for vulnerable GP Practices, as well as risk stratification toolkits available in each practice.

Wiltshire’s transforming community services is supporting the development of clusters of primary care at scale

We will look to maximise the opportunities from Wiltshire Health and Care and integrate with the Primary Care Offer:

- Adopting a principle of design once, implement locally, we will facilitate the development of multi-disciplinary teams with GPs central to provision.
- These will be clustered around the needs of market towns and more rural areas.
- We will also drive improved interfaces between secondary and primary/ community teams, including the development of rehabilitation in the community (through an acute/primary bed base review).
 - Central to this model will be closer links to social care and mental health providers to support appropriate earlier interventions and long term management.

Through the implementation of the Primary Care Offer (to commence 2016/17) we envisage the following benefits:

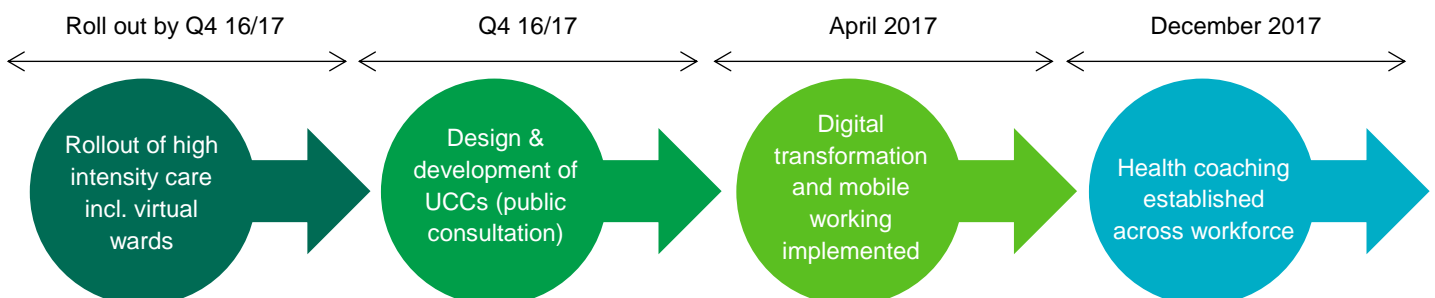
- Enhanced services from GP Practices, over and above core GMS/PMS services to deliver responsive, safe and sustainable services.
- To move towards “placed based commissioning” and the CCG vision of integrated out of hospital services (one framework, locally articulated).
- To move towards outcome based commissioning model
- Commission primary care services at scale, not by individual practices e.g. leg ulcer care, care homes, and Transforming Care of Older People (TCOP).
- Develop clusters, the full “locality offer” over the next three years, including 7 day services, same day urgent primary care hubs.

Dependencies

- General Practice Forward View implementation – development of the full “localities offer”
- Release of capital funding allocated to the CCG to assist with accelerating system transformation
- Recruitment and availability of staffing (new roles / relocated / growth areas)
- Modernisation of some elements of primary care estate

Roadmap

Wiltshire has already made good progress, including all GP practices signing up to the Primary Care Offer. A detailed milestone plan is also embedded in the Wiltshire Health & Care contractual Service Development and Improvement Plan, examples include:



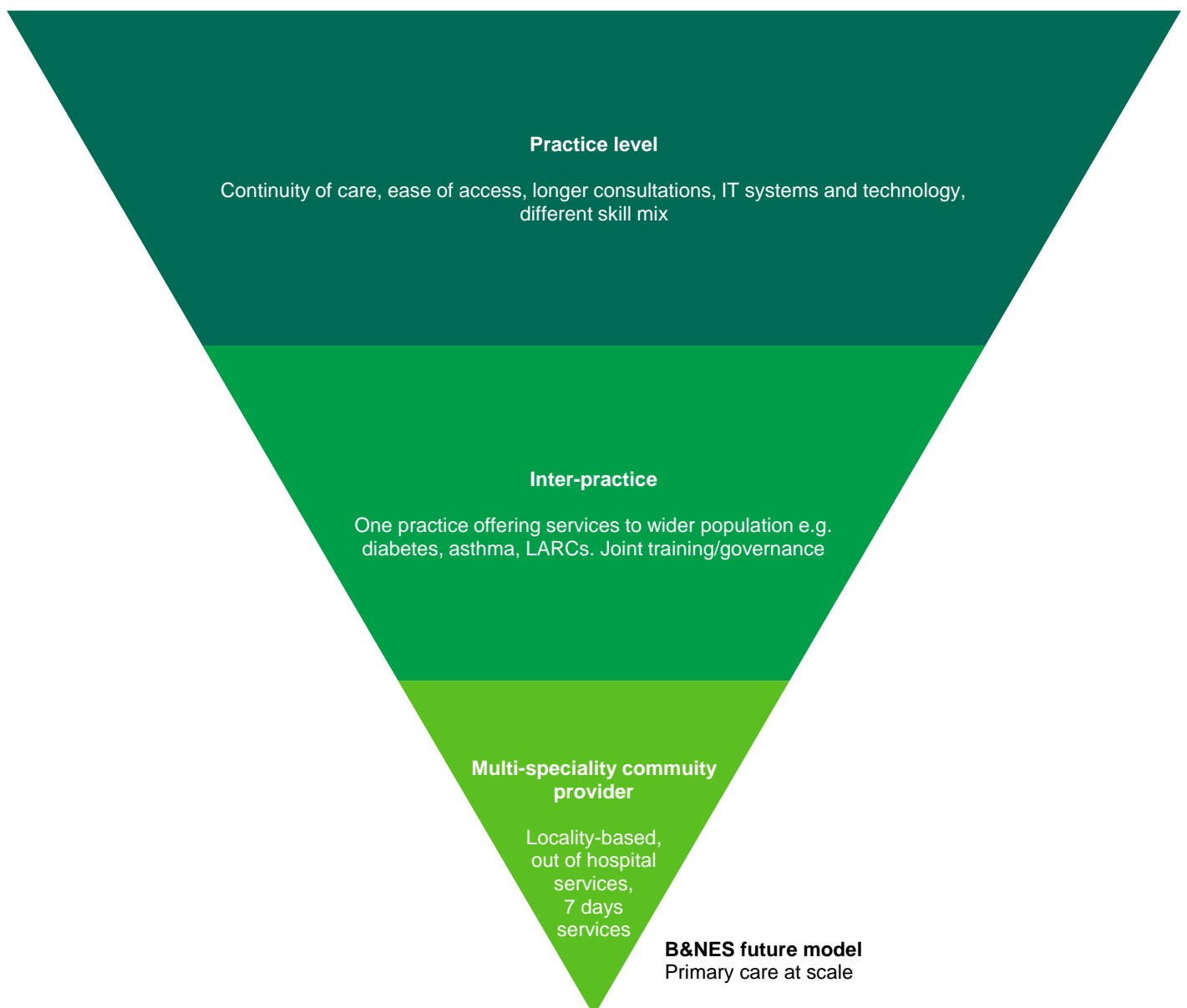
B&NES primary care vision complements the plans for delivery of community services under a Prime Provider

The current model of care within B&NES is not sustainable in the future.

General Practices perform well as reported in the GP Patient Survey, however despite this they continue to face the challenges of an ageing population and have small geographical areas which have poorer health.

Developing a primary care strategy in 16/17

Vision	Enablers	Approach
Delivery at scale	Sustainable model of primary care Enhanced primary and community services delivered 7 days a week	Cluster working/MDT model, out of hospital care



The **'Primary Care – Preparing for the Future'** project has been in place since 2014 to locally pilot aspects of the Primary Care Strategy to inform development. There are four workstreams due to report over the coming months, which aim to:

- Support collaboration between practices by finding new ways of working together
- Develop the workforce to support recruitment and retention of staff as well as enhance workforce development opportunities
- Develop infrastructure, including telephone services and interoperable clinical systems
- Provide a proactive weekend service for vulnerable patients, known as the 'Focussed Weekend Working Service' (FWWS)

The CCG has also been supporting four smaller transformational projects proposed by clusters of practices, testing new ways of group working and use of clinical staff. The CCG has been working with GP practices, representatives from Your Health Your Voice and BEMS+ amongst others, and has drawn on engagement as part of *Your Care, Your Way* community services review to pull together common themes – which has resulted in the development of a *Statement of Intent* regarding Primary Care. This will help frame the CCG's recommendations to the 'Primary Care Transformation Fund,' and will in turn support the creation of a single primary care strategy in 2016.

Dependencies

- Principles of the *'your care, your way'* planning for the future model of community services
- Reinvestment of the PMS premium
- Outcome of bids to the Estates and Technology Fund is now understood and will provide investment in primary care premises and technology to support future population growth and service delivery.
- Digital Roadmap
- Outcome of 'Preparing for the Future' Project

Integrated Community Services

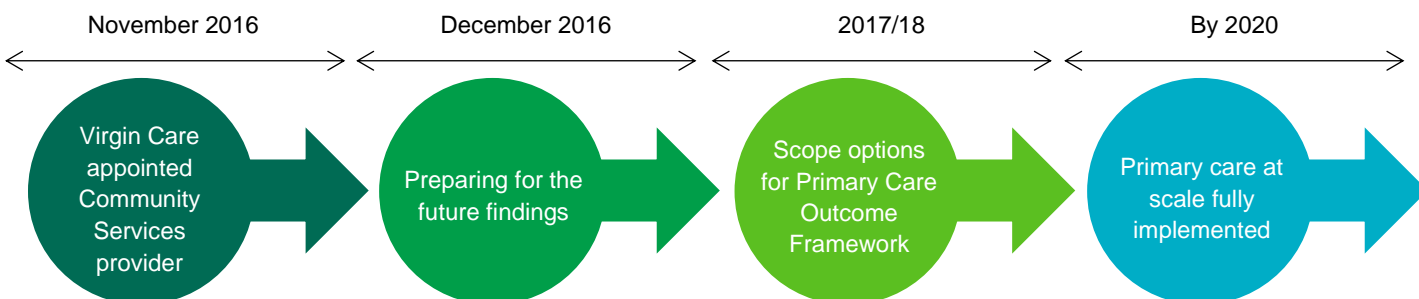
Procurement process nearing completion to join up 60+ contracts as step on journey towards place-based commissioning centred on a Prime Provider/ Dynamic Purchasing System Outcomes based contractual framework.

Your Care, Your Way will place greater emphasis on prevention & self-care, creating system sustainability through connecting and integrating health and care across service boundaries.

A Prime Provider has been appointed with a contract start date of April 2017.



Roadmap – how we will achieve our vision



Swindon primary care vision to develop improved access to services

Swindon Primary Care at Scale

The intention is to develop a mixed economy with some GP Practices working alongside Acute Services whilst others come together to develop a cooperative/federating approach where GPs work closer and share resources. The planned population increase in Swindon is driving the development of two health campuses now and a further one in 2 years' time linked to the residential development known as the Eastern Villages.

The national access monies are being used to develop on the day urgent access centres for adults and children in our health campuses at Moredon Health Centre and the new Swindon Health Centre. The development of Primary Care at Scale will:

- Improve and maintain morale of staff in a challenging environment
- Improve resilience of primary care aiming for a reduction in vacancies and turnover rates, developing portfolio careers for professional staff
- Co-ordinate development of use of new technologies across primary care in Swindon
- Extend access to a range of services through a health campus model

Dependencies

- Procurement of primary care services for growth areas of Swindon
- Working in partnership with other health, social care and voluntary sector organisations to develop new models of care
- Patient and public engagement as new models of care are developed
- Recruitment and availability of staffing (new roles / growth areas)

Investment requirements to support this will include:

- One shared, maintained & supported fast network
- Interoperability across organisations information systems to improve continuity of patient care
- Capital funding to operationalise the new Swindon Health Centre.
- Capital funding to develop premises for North Swindon area (Tadpole farm)

Swindon Community Transformation

Local health and social care partners have committed to work together to improve the delivery of integrated community and acute pathways. Community services were re-tendered and awarded to Great Western Hospitals NHS Foundation Trust in the first step to develop an Accountable Care Organisation in Swindon aimed at:

- A shift of focus towards whole population and prevention particularly for those with a LTC
- Services wrapped around primary care to improve resilience
- Integration of acute and community pathways
- Strengthening of governance, integrated leadership and collaborative partnerships
- Improved quality and increased patient satisfaction

Population based care models will address the three impacts

Our population based vision will address the three gaps of:

Health and wellbeing

- Improved patient wellbeing: emphasis on prevention and self-care
- Better co-ordination and facilitation of social capital and voluntary sector
- Preventing the deterioration of condition: reactive local specialised teams
- Local care where appropriate: expanded Primary Care services at pace

Care and quality

- Earlier detection: defined, centrally owned pathways
- Improved patient experience: single point of access
- Reduced rate of mortality: health inequality targets resources
- Consistent, equitable Primary Care provision: designed once
- Integration: Shared data and information systems

Finance and efficiency

- Reduced emergency and non-elective admissions: long term condition community pathways and same day GP appointments
- Reduced planned activity: Outcomes Indicator Set (OIS) pathway to promote de-escalation of need
- Investment in Primary Care: shift of resources as pathways implemented
- Optimisation of support services: IM&T, support services, estate management



Priority 2: We will shift the focus of care from treatment to prevention and proactive care

Urgent and emergency care

Pressure on urgent and elective capacity is expected to rise because there are insufficient suitable alternatives to acute admissions in our current model of care.

There is broad support for better coordination of Urgent and Emergency Care (covering both adults and children) across the footprint area. Our workstream is scoping alternative pathways and models.

Opportunities of focus include:



Out of Hospital Care (outpatient based) care model including access to specialists remotely and in person.



Integrated urgent & emergency care and triage through 111, ambulances & out of hours GP services



A commitment to seven-day services through system resilience and improving access to care



Provision of Mental Health Models for psychiatric liaison and crisis services



Enhanced Primary Care Model through the use of hubs, including sustainable domiciliary care services



We recognise the need to increase Out of Hospital care

We will extend our range of ambulatory care (outpatient) services, including a consistent, shared 'front door assessment' procedure, a trial geriatrician model to improve the care and management of frail and elderly people, better access to mental health assessments (CAMHS and adults), and improved assessment and prevention of admissions for alcohol-related conditions. We will model the number of beds required across the footprint to understand whether we require a similar or reduced number of hospital beds in the future.



Integrated urgent and emergency care services will improve patient experience by enabling appropriate triage and signposting to services, not always involving attendance at A&E

In line with the South West Urgent Emergency Care Network proposals, our aim is to establish one point of access for triage, with one call centre across the footprint, modified to fit local need and service provision. We aim to improve the management of 111 services and reduce the number of ambulances used. This will be supported by shared electronic access to patient records, enabling better continuity of care. This triage system will link throughout the care pathway to End of Life.



A commitment to seven-day services to meet the NHSE mandate, building system resilience across the footprint and improving access to care across all localities

Building on the work already started by our three acute trusts working together, we will continue to work on opportunities to provide services across the footprint that provide resilience and encourage a flexible workforce while meeting our statutory requirements e.g. within radiology, diagnostics and elderly care.

We aim to ensure that Primary Care staff can seek specialist opinion through a single point of contact when required, and the establishment of Primary Care Urgent Care hubs will support whole system seven day working.



Provision of Mental Health Models for psychiatric liaison and crisis services

We are currently scoping footprint-wide support and capability for urgent mental health across the community and acute care pathways. The aim is to increase responsiveness and provide consistent support to urgent mental health needs across the area to improve outcomes for patients. This review will make recommendations about Mental Health Liaison and Crisis service across the area to support the management of deliberate self-harm and the length of stay within inpatient acute environments.



Enabling access to alternative sources of urgent care through an enhanced Primary Care Model

Our model of primary care will be delivered through a series of Primary Care hubs located across the footprint, enabling provision at scale. Standardisation of language, hours and access will ensure consistency across the footprint, with clarity on pathways to alternative sources of support for patients.

In addition, the integration of key professionals within the hubs including community pharmacists and improved links between GPs and secondary care consultants will reduce unnecessary admissions.

In line with the GP Forward View, this supports GP practices including the integration of extended access with out of hours and urgent care services, including a single point of access via a reformed 111 service and local urgent care clinical hubs.

There is a need for sustainable domiciliary care across the footprint, and work has already begun on the implementation of a lead provider model for domiciliary care in Swindon and North Wiltshire. It aims to improve quality and consistency of provision and manage demand by working closely with voluntary and community organisations.

Further work is also required to support the financial stability of our independent and residential sector through training, developing and progressing staff (addressing issues regarding turnover of staff, lack of career progression and the lack of entry points from residential and domiciliary care into nursing and social care).

Impacts of our opportunities on the three gaps

Health and wellbeing	Care and quality	Finance and efficiency
<p>Through improved signposting for both professionals and patients (embedding 'every contact count') and increasing emphasis on ambulatory models of care, we will reduce dependency on A&E as the first choice for patients e.g. for frail and elderly people and for alcohol and mental health assessments</p>	<p>With implementation of a common language, single triage, consistent front door assessments and footprint-wide models of care, we will reduce unwanted clinical variation across the three urgent and emergency care networks, supporting delivery of the 4-hour wait standard and mental health assessment standards</p>	<p>Focusing on the entire patient journey – reducing the need to go into hospital and improving the flow out of hospital for those that need care packages and ongoing support, should enable us to shift resource within the system to support this. Further modelling is required to understand the element of dual running costs during this transition</p>

Dependencies

- IM&T capacity and pace of change: requires integrated electronic systems, shared care records, and access to Cloud based technologies.
- Workforce flexibility to build system resilience: requires ability to establish new roles related to domiciliary care, primary care at scale, volunteers, portfolio careers and rotational posts across all levels of health and care.
- Inter-dependencies with the other workstreams' progress on preventative care, long-term conditions management, and the embedding of primary care at scale services to support demand management.
- Estates: the footprint covers a wide geographical area which requires continuation of A&E units with support and access for patients to primary care urgent care hubs, minor injury and walk-in centres. Re-procurement of NHS 111 services across the STP will require a review of the number of triage and call centres.

How the urgent and emergency care model will change

Now	2016/2017 Opportunities	Key risks, assumptions and dependencies
NHS 111 call handling, with pathways	<ul style="list-style-type: none"> • NHS 111 call handlers will continue to give advice but with the ability to directly book GP appointments 	<ul style="list-style-type: none"> • New delivery model will be procured 2018\19 • IT dependency and practice capacity • Assumption that the Proactive and Preventative workstream will have picked up the need to encourage self care and management across all provision of care.
GP out of hours service with home visits and out of hours clinics	<ul style="list-style-type: none"> • Pilot integration NHS 111\Out of Hours into new Urgent Care Clinical Advice Centres with immediate clinical triage (CATT based models) ** NHS 111 backed up by GP triage and linked UC Centre (OOHs), co-located with community health and social care services 	<ul style="list-style-type: none"> • Decision required on benefits and costs of stand-alone call handling transferring to new out of hours for clinical triage – or fully integrated. • Assumption that workforce issues relating to “poaching” of in demand staff such as Paramedics will be picked up within Workforce workstream.
Ambulatory Care: Define units consistently across the footprint	<ul style="list-style-type: none"> • Design Geriatrician Model/align teams • Develop Consistent Metrics which define access times for out of hospital alternatives • Scope which out of hospital/integrated models/pathways would deliver the biggest gain in supporting patients in the community – Frail Elderly Integrated Pathway, rapid response respiratory 	<ul style="list-style-type: none"> • Implementation of systems to enable cross organisational working/passport. • IT systems and agreement of common definitions • Workforce planning & engagement of stakeholders. • Resource available (both in terms of people and time) to develop and ensure wide stakeholder engagement.
Primary Care Model: Urgent Care Model and use of Hubs	<ul style="list-style-type: none"> • Review existing set up and design an agreed emergency model. • Understand Domiciliary Care Plans • Agree common language across footprint for Staff \Public to access the system • Establish Mental Health Emergency “Fit” • Understand estates and digital requirements for greater integration 	<ul style="list-style-type: none"> • Consistency of reporting. • Assumption that the need for a common communication strategy and approach will be picked up through the Communications workstream. • Links with infrastructure workstream. • Resource available (both in terms of people and time) to develop and ensure wide stakeholder engagement.
Mental Health Models for Psych Liaison and Crisis Services	<ul style="list-style-type: none"> • To include acute physical inpatient liaison, emergency department liaison, care home liaison. Liaison aspirations should be to meet 'core 24 standards' across the 3 acute hospitals. • Crisis services should meet national specifications and should address the needs of younger, adult and older populations with defined access to alternatives to admission e.g. crisis houses. 	<ul style="list-style-type: none"> • Dependency on availability of appropriately trained staff (linking with Workforce workstream).

Urgent care – Work Stream High Level Project Plan

	2016/17				2017/18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Ambulatory care	Working group with TOR							
	Way forward for ambulatory care in footprint							
	Identification of ambulatory care patient flows and numbers							
	Negotiation of a mutually agreeable tariff for medical ambulatory care							
	Enhancement of ambulatory care offer							
	Proof of concept - delivery of geriatrician ambulatory care (RUH)							
	Proof of concept - delivery of geriatrician ambulatory care (GWHFT)							
	Use clinical and user engagement to inform next phase							
Integrated urgent and emergency care and triage	Project management structures							
	B&NES pharmacy trial to support x6 pharmacies receiving direct calls from NHS 111							
	Establish IUCH pilot within Wiltshire via OOH provider							
NHS 111 and OOH and OOH reprocurment	Undertake and implement tender process and outcome							
Provision of mental health models for psychiatric liaison and crisis services	Establish Working Group with membership identified to cover issues such as 24/7 access and psychiatric							
	Agree core model for assessment and treatment across STP footprint to standardise including outcomes of assessment times and LOS							
	To improve provision of assessment and admission prevention for alcohol related conditions (linking in with LA who currently lead on this element of service)							
Sustainable domiciliary care and care home provision	Establish baseline of current service provision							
	Complete implementation of lead provider model for domiciliary care in Swindon							
	Lead provider domiciliary care North Wiltshire							
	Development of a work programme to encourage workforce development, training and career progression options							

Shifting care to prevention – preventative & proactive care

We will adopt a collaborative approach across the BSW footprint as together on prevention and proactive care could have a significant impact on people's wellbeing and quality of life, as well as reducing demand for secondary care. Due to the universal nature of the issues being addressed, it is the workstream that requires the broadest collaboration from providers across the STP, from health and social care to tertiary and voluntary sectors. The initial three areas of focus have been set out below. However, the workstream will also review how approaches can be quickly and easily shared across the footprint, and how best to co-ordinate expertise and pursue standardisation when appropriate. Opportunities for collaboration include:



Ageing well: Supporting people to stay mentally/physically well and maintain their independence for as long as possible.



Tackling obesity through a collaborative approach to commissioning weight management services.



Proactive management of long term conditions by supporting people to manage their own conditions.



Ageing Well

Demographics highlight the growing pressures the frail and elderly will place on the BSW footprint over the coming years. Aging Well is an opportunity to address the needs of elderly people with a focus on those most at risk.

Priorities

- Consistent process to identify and support people to live independently using a single assessment framework for Safe and Independent Living, harnessing the voluntary sector's consistent approach to assessing frailty, including mental frailty across the footprint.
- Commission fracture liaison services from acute trusts based on national evidence base.



Tackling Obesity

Obesity is a significant risk factor for many health conditions and complications, and areas of the footprint have higher than the national average rates. Obesity is a particular risk for people with severe mental illness. We will take both a short and longer term approach, balancing direct and indirect health and wellbeing initiatives.

Priorities

- Footprint-wide approach to commissioning weight management services – tier 2 to tier 4, starting with tier 4 and including a review of thresholds and the evidence base.
- Adopt Workplace Wellbeing Charter in all organisations within the footprint. Work with other employers and agencies to adopt the initiative.



Proactive Management of Long Term Conditions (LTCs)

LTCs put significant pressure on health care services with 10% of the NHS budget spend on diabetes care alone. In Swindon, LTCs are associated with 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient bed days.

Priorities

- Embed prevention and self-management along identified LTC pathways, including diabetes, recognising the needs of people with multi-morbidities, and drawing on the support of 'expert' peers within the voluntary sector.
- Diabetes Prevention Programme – statement of intent to work together across the STP.
- Collective campaigns for flu and pneumococcal vaccinations using social marketing to achieve behaviour change.

Preventative & proactive care impacts and dependencies

Across our three priorities we have identified key ambitions to reduce the three gaps with dependencies

	Ageing Well	Tackling Obesity	Proactive Management of LTCs
Health & Wellbeing	<ul style="list-style-type: none"> Keeping older people well for longer Maintaining independence and reducing social isolation 	<ul style="list-style-type: none"> Reduction in levels of obesity (mid-long term) Reduction in known long term impacts of obesity on health – cancer, MSK Improved wellbeing of NHS staff 	<ul style="list-style-type: none"> Keeping people with LTC's well for longer, delaying deterioration & improving confidence in self care management Reduction in number of people with pre-diabetes progressing to full diabetes
Care & Quality	<ul style="list-style-type: none"> Reduced variation in care delivery 	<ul style="list-style-type: none"> Reduced variation in care delivery Services commissioned based on sound evidence of effectiveness 	<ul style="list-style-type: none"> Reduced variation in care delivery Increasing the take up of evidence based vaccinations
Finance & Efficiency	<ul style="list-style-type: none"> Reducing demand for health and care services Harnessing the voluntary sector will reduce pressure on workforce Reduction in more serious fractures in older people and associated costs 	<ul style="list-style-type: none"> Reducing demand for wide spectrum of health and care services associated with obesity in the long term 	<ul style="list-style-type: none"> Reducing demand for health and care services Harnessing the voluntary sector will reduce pressure on workforce Reduction in levels of flu and pneumococcal infections and associated costs
Dependencies and links	<ul style="list-style-type: none"> Urgent Care: Options expand the Geriatrician Model to include mental health and psychological support via a single model in year 2/3 Planned Care: Consider implementing a consistent <i>risk stratification tool</i> across the STP are for use in community and acute services. Links to enhanced recovery programmes to prevent deterioration Infrastructure: Development of estates to maximise potential that are elderly/dementia user friendly (access/facilities/location) Workforce: Take a broad look at who is the health and care workforce and consider the way different roles work together. 	<ul style="list-style-type: none"> Planned Care: Links to weight management services. Infrastructure: There may be a requirement for access to community/LA based facilities for provision of lower level services. Support to identify & implement suitable technological support options for self-care and management. Workforce: MECC training and implementation of an approach to influence wider behaviour change will be very important. Support for implementation of Workplace Wellbeing Charter Local Authorities: To tackle to obesogenic environment influence the wider determinants of health via the built environment, spatial planning and access to unhealthy food option 	<ul style="list-style-type: none"> Urgent Care: Request to consider potential role of NHS 111 to include monitoring/text messaging in proactive care of at risk groups Planned Care: Support for integrated primary and secondary care service developments (such as the existing diabetes model) Infrastructure: There may be a requirement for access to community/LA based facilities for provision of education and support. Support to identify & implement suitable technological support options for self-care and management Workforce: MECC training and implementation of an approach to influence wider behaviour change will be very important. Possible support for training the voluntary sector. Support for integrated models workforce collaboration.

Preventative and proactive care –Work Stream High Level Project Plan

	2016/17				2017/18				2018/19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Safe and independent living	Development of draft PID											
			Agreement of PID									
			6-month pilot Wiltshire		6-month pilot B&NES							
					Evaluate B&NES pilot							
				Evaluate Wiltshire pilot								
Frailty	Scope current pathways											
	Development of draft PID				Pilot Frailty Pathway							
						Evaluate						
Fracture Service	Development of draft PID											
			Development of approach		Pilot Fracture Service							
								Evaluate				
Diabetes Prevention Programme	Development of draft PID											
		Prospectus submitted										
				Pathway development Workshops								
Flu vaccinations	Development of draft PID											
				Evaluate Winter 2016 uptake								
Tackling obesity	Development of draft PID											
			Focus Group									
				Proposal								
Workplace wellbeing*	Development of draft PID											
			Agree outcomes & impact									
					Rollout implementation							
							Evaluate					

Planned care

Our aim is to reduce the variation of patient experience and outcomes in planned care across the footprint, and significantly improve our capability to match demand with capacity.

We have analysed Right Care data, other health informatics data, and conducted a gap analysis across our systems operational plans to agree our goals. Opportunities for collaboration include:



Demand management enabled through a shared referral management system including: prevention, triage, advice and guidance, and demand and capacity intelligence



Alternative contracting including managing and co-ordinating supply from both NHS and independent providers across pathways and geographies, and using incentives to support the management of care delivery



Commissioning for outcomes through specifications and standardisation of evidence-based care delivery



We recognise the need to improve the way we manage demand to meet capacity.

We currently have no way of accurately managing demand and flow across our system.

To improve patient experience and make the system more efficient, all referrals will be routed through a new system-wide Referral Management Service.

It would be appropriately staffed with a strong clinical contingent and we will explore the best options for housing the service, whether that be a physical or virtual construct.

We also recognise the need to have much better visibility of what capacity exists in every area, discipline and speciality (including social care capacity), and plan to ensure that dynamic capacity information is available within the new

service. This includes the forward order book to allow much more dynamic demand and capacity matching to improve flow for the benefit of providers and patients. The service will help to direct treatment to the most appropriate setting, and leverage capacity and capability in both primary and community settings. And with appropriate clinical oversight, we could better manage conditions with appropriate advice and triage.

We will achieve this by 2018, and assume the standardisation and incorporation of exceptions and prior approvals within the structure.

This initiative would replace the Referral Support Services that currently exist and we envisage making referral via this new route mandatory. The service has the potential to both reduce clinical variation in referrals and reduce the total numbers of referrals into secondary care settings.



Acute Clinical teams collaborating over the new development of care models

We want our services to be efficient, effective and sustainable so we will focus our planning on specific specialities and pathways, not existing organisational forms. This will enable us to draw on specialist networks from beyond the STP when required.

We will also seek to establish standard systems across pathways, including standard referral criteria, common thresholds, standard operating procedures and common protocols, as well as shared criteria regarding ceilings of care and clinical policies.

Such an approach, supported by Urgent Care demand management, should enable us to ring fence elective capacity and improve flow through the system.

Through the STP we will operate a rolling programme of specialty-reviews, bringing clinical teams together across providers to collaborate over how we redesign care models and our workforce roles to ensure services are sustainable for patients. The first 6 specialties that will be progressed through the acute collaboration workstream are:

- Gastroenterology
- Dermatology
- Radiology
- Pain management
- Care of Older People
- Pathology



Commissioning for outcomes and alternative contracting

We hope to migrate over time to a model of collaborative commissioning with shared approaches to the development and implementation of secondary care services and the standardisation of care delivery where possible, allowing for local variation. This will include a 'parity test' as set out in Royal College guidance.



Facilitated by more collaboration in supply-side procurement, alignment of expectation and a common approach to contracting, we intend to seek alternative methods of contracting to encourage better management of supply across pathways or sub-geographies, using incentives to support the management of care delivery.

This may include commissioning networks of providers through a lead for a pathway or set of services within a geography, to collectively manage supply and move away from competing for market share. A further development would be to introduce programme budget methodology as a contracting model which takes away from some of the perverse incentives that exist within a PBR construct.

As a footprint, we use £105 million of specialised care. We will work with the NHSE team to agree a model of collaborative commissioning that incentivises optimum management of this resource. In the next planning phase, local STP 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.

Opportunities and dependencies

Health & Wellbeing	<ul style="list-style-type: none"> Reduced referrals into secondary settings Create a single point of access for clinical advice, with a potential to create a networked on-call system
Care & Quality	<ul style="list-style-type: none"> Reduced variation in care delivery, enhancing patient experience Reduced, stabilised and standardised waiting times Reduced referral variation Reduce variation in access Facilitate the provision of seven-day services across specialities
Finance & Efficiency	<ul style="list-style-type: none"> Reductions in intervention variation Reduce the forecast growth in this area Reducing demand for health and care services
Dependencies	<ul style="list-style-type: none"> Infrastructure: IT and data sharing systems for demand and capacity intelligence, referral information and templated solutions and e-referrals Better networking Investment to make shared service a reality Workforce to create the right skill mix ensuring mobility Improved community capability and capacity for both health and social care would also be necessary to help improve patient flow through elective capacity

Planned care – Work Stream High Level Project Plan

	2016/17				2017/18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Clinical policies	Complete review							
	Recommendations							
	Implementation plan							
	Review outcomes from contracting round							
	Establishment of additional contracts							
	Establishment of operational teams							
Referral management centre	Referral variation							
	Advice & guidance							
	RSS review							
Acute sustainability		First workshop A						
		First workshop B						
			Review priorities					
			Second workshop A					
			Second workshop B					

Priority 3: We will develop an efficient infrastructure to support new care models

Infrastructure aims

The STP presents an opportunity to accelerate our adoption of new technology and extend inter-operability across the footprint.

Along with the opportunity to develop integrated clinical models, we can improve efficiency by rationalising all of our estates/buildings, sharing our clinical and non-clinical information, and harnessing our purchasing power (as set out in the Carter Review).



Enhance inter-operability between clinical systems



Capitalise on the collective estate,



Capitalise on our collective buying power with a procurement hub



Assess options for clinical support services to generate economies of scale and deliver consistent, high-quality services

Collective purchasing for acute care has begun, and so we have framed our plans around these three aspects:

- Digital
- Estates



Digital

Drawing on local digital road maps, opportunities exist to promote more effective care through real-time, integrated health records across health and social care.

We will set out plans to develop patient-owned health records that promote self-care, facilitate interaction with health professionals, and encourage more widespread use of telehealth/telecare to manage more patients in the community.

Pockets of technological innovation exist to support people with long term conditions. These innovations should be adopted at scale to address the growing needs of people with dementia, and their carers. Further opportunities exist to pool our analytics capability to provide a systems view, improving population-based planning and system capacity and demand.

Our plan is to develop our predictive modelling ability to help identify patients at risk of escalation. Overall the STP will be supported by developing a public estate network to support workforce mobility, improved estates utilisation, mobile working, e-consultations and providing access to shared data.

We will also evaluate the benefits of collaborating between Informatics departments to reduce cost e.g. shared procurement, skills, training, operational delivery and information governance. In addition we'll

identify the most effective means of bringing together disparate strands of data to form a holistic view of patient needs and their health risks to enable effective care planning.

Impact

- Enhancing the interoperability of clinical information could have a profound impact on patient safety through reduced duplication and errors.
- It will deliver greater efficiency and reduce transaction costs of physically moving hard copy care records.
- It will support the underlying ethos of our plan, which is to empower people in the management of their health. Those people requiring clinical support will be clearer on the next steps in their care and how they can improve their own outcomes by taking more involvement in their care.



Better use of our estate

Our estate comprises c200 sites across BSW and costs £175m per year to operate.

The STP Estates Group has undertaken scoping work to map out the sites and properties within the footprint and to consider how much the existing buildings are used (utilisation) and the level of repairs and maintenance each requires. Much of our estate either does, or will, require significant investment to ensure it is efficient and provides a quality environment for healthcare.

The Group has also consolidated the existing estates plans within each organisation to establish what pre-existing plans are in place.

Whilst further work is needed through engagement with our workforce and public to design clinical and care services for the future, we know from early discussions that the overall direction of travel is a move from a reliance on hospital based care to self-care and management of individuals in a community setting and in their own home using assistive technology.

Given this strategic direction – including the desire for health and care professionals to work together in co-located teams – we envisage there being an opportunity to design buildings that enable these new ways of working.

From a funding perspective, we will simply not have the resource to maintain all our existing sites, invest in new buildings and invest in assistive technology and preventative support and services. Our priority is therefore to work with clinical teams and local citizens to design the care model for their area and to then target our investment to deliver a physical infrastructure that enables delivery of that care model.

There is awareness of the huge public attachment (and reassurance) in having a community hospital or health centre in close proximity to their home and therefore our estates plan is intrinsically linked to the design of new care models and establishing a compelling vision for the future.

Our estates plan will be developed in conjunction with the One Public Estate programme being led by Wiltshire Council.

Impact

- Opportunity to design buildings around future clinical models.
- Improved utilisation of NHS and Council estate.

Dependencies

Estates	<ul style="list-style-type: none"> • Clarity on availability of capital to enable changes leading to asset disposals. • Transparency to create a property register for the STP area available for stakeholders, including primary care. • Further work to establish accuracy of ERIC data in the NHS and property detail from other areas (e.g. council, primary care).
Digital	<ul style="list-style-type: none"> • Successful alignment of three local digital roadmaps (pre-committed programmes etc.) • OD work to ensure that 'digital by default' is supported by a suitably skilled and enthused workforce. • Investment availability to deliver a ROI for technology advances.

Infrastructure delivery plan

	2016/17				2017/18				2018/19				2019/20				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
EPR	PAS																
	e-Discharge																
	Order Comms (OCS)																
	eReferrals																
	Alerting and Clinical Comms																
	e-Whiteboards																
	Kiosks																
	e-Observations																
	e-Prescribing & Meds Admin (ePMA)																
	Specialist Systems Upgrades/Replacements																
						Devices Integration											
						Telehealth											
	Systems Integration and Apps Development																
	Medical Record eForms																
	Paperless Outpatients																
Interoperability	Patient Portal																
	SCR & eSCR																
	Population Health and Regional Analytics																
	Health & Care Interoperability																
Data Analytics	Clinical Coding																
	Automation & Standardisation & Rationalisation																

	Population Health and Regional Analytics																							
Corporate	Videoconferencing																							
	Electronic Staff Record (ESR) Development																							
	Website / Intranet																							
	eRostering																							
	Risk & Quality																							
	Finance																							
	Estates																							
	Paperless Meetings																							
	Fol & SAR's																							
	IT Infrastructure Alignment	Telecomms																						
Single Sign on																								
Networks																								
MDM & Mobile Devices																								
Backup Systems & Hardware																								
Data Centre																								
IT Service Desk																								
IT Asset Rolling Replacement																								
IT Asset Management																								
Server virtualisation																								

Priority 4: We will create a flexible and collaborative approach to workforce

Our workforce will be focused on the patient and defined by collaboration, with reduced duplication across our organisational boundaries.

The 40,000+ workforce within the BSW footprint (and their families) represent a significant group within our population and will act as advocates of our commitment to prevention, self-care and the delivery of care out of hospital.

Investment in our workforce will ensure flexibility to respond to changes in demand, emerging models of care and local recruitment and retention challenges.

Our workforce will be enabled to work flexibly, supported by IT, and will be sustainable and highly motivated.

The new employment offer will attract, retain and deliver an improved experience for our workforce:

We will look at the need for staff in all sectors to work differently in the future. For example:

- Acute care staff/specialists supporting primary care with advice and education for particular long term conditions.
- Use of more generic support workers working across health and social care.



Create shared vision



Maximise the approach to education, training and skills development



Promote the health and well-being of staff



Develop a compelling employee offer across the system



Create shared culture, definition, values and behaviours

We will align the workforce model to the other priorities identified within this STP. In particular, we will encourage the development of integrated working around a users' needs, and provide care out of hospital where possible. We will include the voluntary sector and assets already available within our communities (e.g. family and social groups) into our workforce planning as they can help people to stay in their own home and maintain their independence as long as possible.

We will encourage integrated, cross organisational working at every opportunity and at every level within organisations. In this way, we will develop a shared culture and vision. For example we will share opportunities for learning and development so people from health and care can learn together. This way they can learn about each other's roles and unique contributions.

We will reaffirm the vocational motivation of our workforce to provide high quality patient-focussed service, including encouraging patients to take more responsibility for their own health through health coaching and other behaviour-change tools made available to staff. We will encourage an activated workforce to support self-care and prevention, directly, indirectly and personally. We will promote BSW as a place to live and work for the whole family.

This approach will promote inclusion, zero tolerance of stigma, universal core skills in prevention, physical and mental health assessment.

We will use corporate levers where possible across all organisations by ensuring all new tenders are benchmarked against the STP ambitions. This will require the set-up of a system-wide benchmarking tool.



Maximise the approach to education, training and skills development

A hub and spoke approach of best practice will identify organisational leads for statutory/mandatory training, leadership and recruitment, amongst others. This will reduce duplication and increase standardisation.

We will develop leadership skills and knowledge at all levels so that everyone sees beyond their organisational boundaries and understands that they are part of a big system where decisions are made for the benefit of the patient, not the organisation or profession. We will ensure review and adoption of best practice across the Health and Social care sector influences all of our training and education decisions, including current vanguards.



Promote the health and well-being of staff

We will promote healthier staff through an attractive health and well-being offer, including occupational health and providing healthy work places. Additionally, a better development pathway for our own staff with an improved employment offer and career pathway will help us create a happier, more stable workforce with lower turnover, sickness and fewer temporary staff.

We will involve staff in change design so that they are engaged, champion the change and feel empowered and valued for their contribution.



Develop a compelling employee offer across the system

We will create a positive and shared recruitment offer including harmonising of bandings, shared DBS, a footprint skills passport and shared support service functions. We will develop a multi-skilled workforce as a means to offering genuine career opportunities by developing generic job roles and job descriptions across the health and social care sector. We will offer rotations across different settings as part of the career development, including for students.

We will reduce the spend on temporary staff through a shared approach to recruitment for bank and agency. Additionally we will consider introducing retention benefits (e.g. repayment of nurses/AHP student loan).

Intended benefits of a flexible workforce

Care and Quality gap

Our approach will enable a BSW system-wide collaboration that will improve care quality through consistent service delivery and more positive outcomes for patients. Investment in the development of staff working in all health and social care settings will enhance care and support the prevention of ill health.

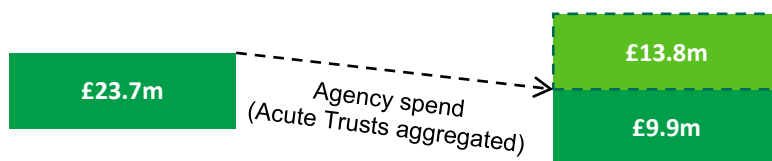
Health and wellbeing gap

Offering an attractive career to our workforce is crucial for the recruitment and retention of a skilled and sustainable workforce and reduces the reliance on temporary staff and the associated high costs. It will help to reduce staff turnover as it will help stabilise the age of retirement, critical in an area with an aging workforce. Improving the flexibility of the workforce through better use of digital technology in rural areas will also be crucial. A common talent management approach will build succession plans for key leadership roles.

Financial gap

Pay costs for workforce present a significant challenge to all organisations in the STP. For the NHS and Community providers these are in excess of £850M (15/16 figures). High turnover rates also result in high costs, as do duplicating transactional corporate functions including recruitment and training. For NHS

organisations and community providers within the STP, agency costs are in the region of £30M (15/16). We will continue to drive down agency costs.



Agency spend as % of total workforce spend varies from 1.9% - 6.4% across the three Acute Trusts. Potential reduction in agency spend of 41.7% if all three Trusts were at 1.9%

The 2015/16 figures (based on annual accounts for NHS; and best estimates for 2 community non-NHS providers look closer to £600m (£505m from 3 acutes; £65m from 45% AWP; £15m estimate for each of Sirona and SEQOL).

Agency costs for 2015/16 are around £30m from the 3 acutes plus the relevant portion of our mental health provider (AWP). Agency rates, based on 4 NHS organisations range from 3.12% to 7.4%.

The forecast outturn for 2016/17 (based on 2 year plan submissions from NHS trusts and estimated costs for community providers) shows a forecast pay bill of £611.7m.

Figures for 2016/17 show a total forecast agency spend of £28.63m. There remains significant variation across organisations in the use of agency that we plan to address. The organisation with the highest use of agency had an agency rate of 6.67% whilst the lowest rate was 1.93%. If we were to achieve, over time, a standard rate of 1.93% across the three acute Trust's alone this would deliver a £14m saving (41.7%). Clearly individual circumstances and challenges exist in local labour markets but our aim to work collectively to try and address these.

We will use the Apprenticeship Levy to enable collaborative and innovative opportunities for new recruits. Through sharing support services we can review the number of corporate and support service staff.

Developing the skills of those working out of hospital - in health, care homes and domiciliary care - will enable more people to be cared for at or closer to home, and contribute to reduced hospital admissions and quicker patient discharge. These are both key drivers of urgent and emergency and planned care costs.

Support for workstream

Health Education England (HEE) will offer continued support to the workforce planning elements of the STP. HEE are also working with the WEAHSN in providing funding for the Community Education Provider Network (CEPN) which helps underpin education for the wider community and primary care team working across the STP.



Workforce – Work Stream High Level Project Plan

	2016/17				2017/18				2018/19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Joint workforce planning	Analyse baseline data											
	Design STP workforce											
	Gap analysis against HEE current demand forecast											
	Identify priorities for modelling											
			Conduct scenario modelling for endorsement									
Common understanding and purpose					Review voluntary and independent sector (VAIS) workforce data							
					Deliver systems Masterclass series							
	Deliver staff engagement events											
Improve staff health and well-being (H&WB)					Support to workstreams on workforce implementation planning							
	Build STP capacity											
	Complete baseline data				Define 'good' staff H&WB							
						Provision of H&WB support (particularly smaller organisations)						
Improved employment offer					Evaluate and reset							
	Scope shared across trusts											
Shared training	Build STP capacity											
	Produce apprenticeship											
					Opportunities for out of hospital student placements							
						Explore shared training provider opportunities						
	Enhancing skills and competencies for new models of care											

Priority 5: Enable better collaboration between acute providers

Vision

Our vision is to ensure the clinical and financial sustainability for the three acute NHS Foundation Trusts and AWP, and the continued provision of secondary care services to the populations of Bath, Swindon and Wiltshire over the short, medium and long term. This will require close collaboration across a range of clinical and non-clinical services.

Meeting the challenge of sustainability

The BSW STP footprint has already identified a collective financial deficit over the next five years in a 'do nothing' scenario, beyond the normal individual organisation cost containment assumptions. Individual organisation as well as system financial performance is likely to significantly worsen over the same time period as a result of cost inflation, reducing tariff and redesigned services to provide more proactive care to reduce hospital admissions.

Acute Trusts currently facing high demands and limited capacity are challenged with regards to constitutional performance targets. They also face a difficult workforce market with a lack of supply in a number of vulnerable clinical specialities. Best practice, care pathways and standards for services, current clinical quality, patient outcomes, experience and satisfaction across the footprint is also variable.

The three acute providers readily acknowledge the need to lead change across the acute sector through close collaboration and a broader system-wide view.

Acute collaboration – Opportunities and impact

Opportunities for collaboration broadly fall into two categories: Back Office reconfiguration and shared services to reduce corporate cost base and running cost efficiencies, and Clinical Collaboration for service affordability and quality improvement, through Clinical Review Groups. For Back Office reconfiguration, there is a close alignment to Priority 2: Shifting the focus to prevention and Proactive Care – Planned Care element.

The BSW geography and demography is varied. The following examples are not exhaustive but indicate our early priorities:

Clinical collaboration

Sustaining specialities where there is a debate about scope, scale and service viability and where national guidance indicates a change in local services to maintain clinically suitable local provision e.g. Cardiology / Stroke (aligned to Planned Care)

Sustaining smaller specialities to ensure local access where recruitment difficulties are common across the three providers e.g. Dermatology

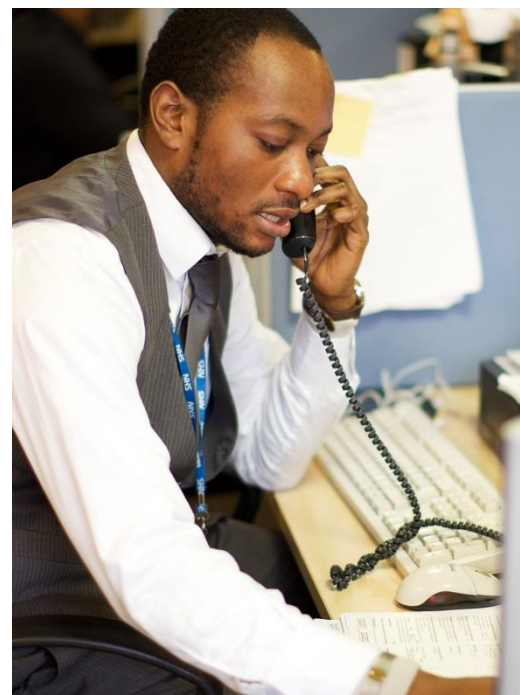
Deliver **enhanced seven-day services** by assessing opportunities in out of hours provision e.g. Radiology, Tele-Radiology, Tele Health and Specialist imaging (aligned to Urgent Care)

Scope opportunities for closer working in clinical support services for **out of hours provision** where practicable to do so e.g. Labs, Pharmacy

Booking and Referral management system arrangements to offer visibility and make best use of available **capacity across the footprint**

Potential for **repatriation** of some tertiary (specialised) services that are currently referred to services outside of the footprint

Key considerations for collaboration opportunities will be securing local flexibility and responsiveness to individual Trust business needs; and whether there is opportunity to support the changing **commissioning** landscape in the longer term, as new responsibilities are set out nationally.



Acute collaboration design principles & governance

Design principles

The three acute providers have agreed the following design principles:

- Each Trust retains its own governance arrangements and accountability to its own Board of Directors
- Open and transparent
- Aim for improved clinical/non-clinical collaboration, not organisational merger
- To supplement each provider's own natural links and synergies with other providers i.e. Salisbury with Southampton, RUH with Bristol and GWH with Oxford.
- All back office functions will be looked at to scope the potential to share services.
- There may be more natural local non-clinical links and relationships, for example between individual Trusts and commissioners in some areas which will still be pursued.
- There may be opportunities that an individual organisation does not wish to be involved with. Whilst all opportunities are open to all parties, bilateral arrangements (not just tripartite arrangements) will also be pursued.
- Shared service models will require pump priming to establish and this will be a key component of business case development for this priority, to determine financial viability.
- The impact on the estate will be scoped as a key component of outline business cases for collaboration opportunities, and will need to be aligned to the STP single estates strategy via the infrastructure workstream (Priority 3).

Governance

A Joint Collaboration Steering Board has been established to oversee the delivery of this agenda. All business cases will be evaluated and considered by the Board to review the identified infrastructure support elements and whether they are aligned to the agreed outlined timings of development in the wider STP roadmap or whether key elements will need to be expedited more quickly in order to implement new models of care; e.g. IT and mobile working support, information sharing etc. (Please see STP Infrastructure road map).

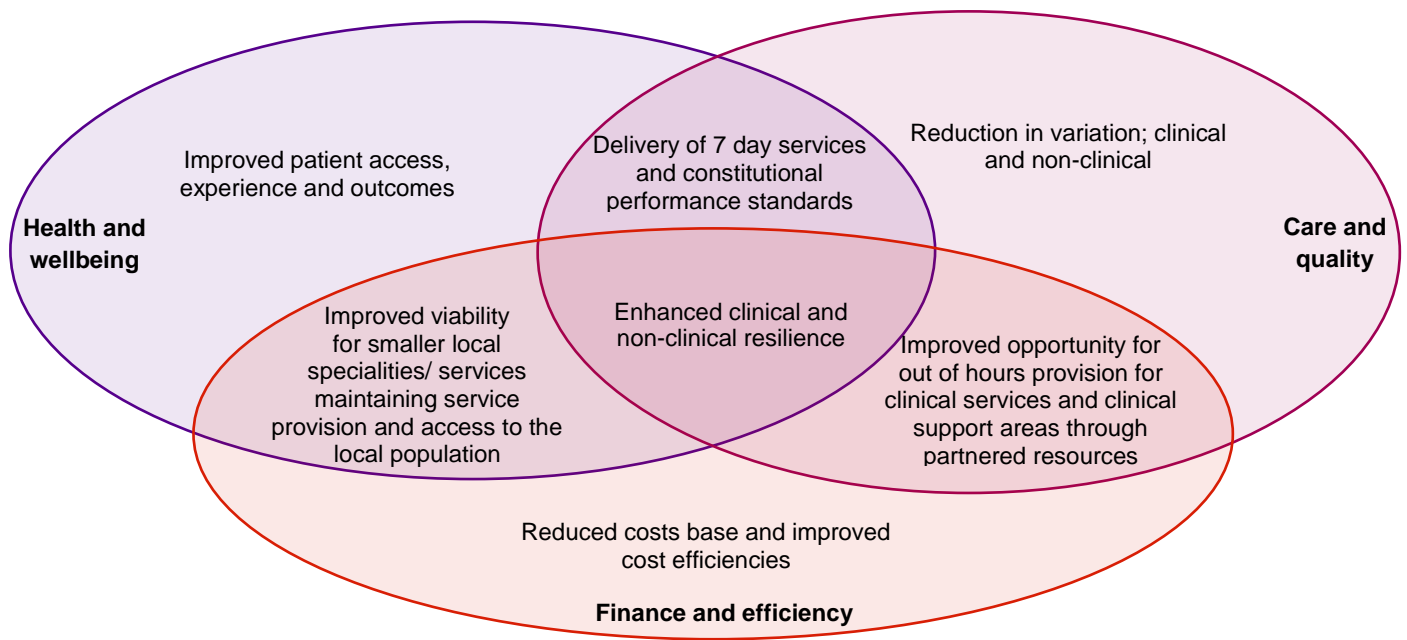
Financial benefits will be assessed compared to baseline metrics following conclusion of small Task & Finish Groups / Clinical Review Groups for collaboration, when agreement is reached on size, scale, scope and model of care. This will be a key component of the outline business case, which each Group will deliver at conclusion, to a Joint Collaboration Steering Board.

Whilst taking a system-wide view, each organisation will remain responsible to its respective Board and therefore the appropriate level of delegated authority will be gained to assist the pace of collaboration.

The key next steps for 2016/17 are outlined below. The formal relationship between the three providers is underpinned by a Memorandum Of Understanding (MOU) setting out the approach which all acute providers will be party to.

Impact on the 3 gaps: Assumptions and Benefits

Through close collaboration across clinical & non-clinical functions:



Acute collaboration

Progress made to date

- Governance structures in place including weekly steering group
- Project Initiation Document developed
- Priority programmes together with key opportunities identified
- Progress, risks, issues and milestones log developed
- Submission made to NHSI outlining progress to date
- Three data submissions made to NHSI/E for pathology and back office/corporate services

Clinical redesign

- Six specialities have been identified by the Chief Executives, Chairs and Medical Directors of the three acute trusts for the first round of clinical review group workshops, based on sustainability concerns from one or more providers
- Process for clinical / non clinical staff engagement and workshops developed
- Two clinical review group workshops for each specialty arranged to scope issues and develop solutions
- A Case for Change business case for each speciality will be developed for January 2017
- Four further specialities have been identified for clinical review – MSK, cardiology, rheumatology and ophthalmology. Clinical review group workshops are being set up for January and February 2017

Back office and corporate services

- 10 back office and corporate services functions have been scoped to identify opportunities across the three acute trusts to deliver services at scale through shared services or collaboration in order to deliver a reduced cost base, improve quality of services, and support service resilience
- Meeting held with PA Consulting (providing support on behalf of NHS Improvement) to understand opportunities being considered elsewhere
- A case for change has been developed identifying opportunities that have been prioritised, the benefits they will deliver and the timescales for delivery (quick wins, short, medium and longer term developments).

Early Priorities – Summary of Key Objectives

A summary of the objectives for our early priorities is set out below. The table also sets out the intended benefits from each project.

		Project	Objective	Anticipated benefit
Prevention and Proactive Care	Ageing Well	SAIL (Safe & Independent Living)	We will increase signposting to support services through partner agencies (such as Fire service) so that they access early intervention	Reduced and / or delayed need for more intensive services
		Frailty	We will provide a consistent pathway across the STP for people identified with frailty, providing early interventions and care guidance to delay or prevent admissions to hospital	Reduction in excess bed days / DTOC, reduction in primary and secondary care contacts, reduction in patient harms (Inc HIA, pressure sores.)
		Fracture Service (reducing secondary fractures)	We will reduce the number of fractures and hospital admissions by systematically identifying and treating all eligible patients over 50 years old within a local population who have suffered a fragility fracture	Patient experience benefits plus reduction in T&O demand within acutes
	Proactive Management of LTCs	Diabetes PP	We will refer c3,700 patients into the National Diabetes Prevention Programme during 2017/18	Reduction or delay in those people developing type 2 diabetes. Reduction in more intensive primary, community and acute services
		Flu Vaccine	Increase uptake of seasonal flu vaccination rates to at least the recommended level advised by the Chief Medical Officer from 2016/17 to 2019/20 flu seasons	Individual benefits plus reduction in GP, community attendances and hospital admissions as a result of flu / PPV
		LTC management priorities	This may be an end-to-end Integrated Care Pathway project guided by population analytics	
	Tackling Obesity	Standardised Obesity Pathway	TBC	
	Workforce Wellbeing	Workforce Wellbeing	By March 2018 to have reduced staff sickness by 0.5% in appropriate STP partner organisations	Reduced agency use and turnover, improved productivity
Planned Care	Commissioning-led	Standardised INNF Policies	We will standardise INNF policies across the 3 CCGs to drive consistent and equitable access	Reduction in outpatient activity at all providers Reduction in selected procedures at all providers *Provider cost impact not yet developed
		Demand management	We will introduce mandatory use of Referral Management	Reduction in outpatient activity at all providers

		Project	Objective	Anticipated benefit
			Centres and ERS, and increased advice and guidance to reduce GP referrals by 2.5% in 2017/18	Reduction in outpatient costs
		MSK	Through engagement we will redesign pathways to ensure they are cost and clinically effective with an aim of reducing the need for outpatient attendances by 10% in 2017/18	Overall aim to bring the level of spend on these pathways in line with benchmark
		Cardiology	Through engagement we will redesign pathways to ensure they are cost and clinically effective with an aim of reducing the need for outpatient attendances by 30% in 2017/18	Overall aim to bring the level of spend on these pathways in line with benchmark
		Rheumatology	Through engagement we will redesign pathways to ensure they are cost and clinically effective	Overall aim to bring the level of spend on these pathways in line with benchmark - 50% reduction in HCD spend in 2017/18
Acute Sustainability	Fragile Services	Gastro	To increase service resilience and sustainability	Case for change will inform
		Care of Older People	To increase service resilience and sustainability	Case for change will inform
		Dermatology	To increase service resilience and sustainability	Case for change will inform
		Pain	To increase service resilience and sustainability	Case for change will inform
		Radiology	To increase service resilience and sustainability	Case for change will inform
		Pathology	To increase service resilience and sustainability	Case for change will inform
Urgent Care	Ambulatory Care	Extended Amb Care	We will achieve 30% of urgent care activity being delivered through Ambulatory Care by March 2018	Impact on emergency admissions and reduced length of stay
	Integrated Urgent & Emergency Care & Triage	Reduce threshold of ambulance dispatches	To reduce the threshold of ambulance dispatches as a % of total calls to NHS 111 by 10% across the STP footprint	Single point of access, increased self-management and care
		Reduce NHS 111 calls directed to ED	To reduce the threshold of NHS 111 calls directed to ED to 5% in Swindon, 7% Wiltshire & 8% BANES by March 2019/20	Single point of access, provision of alternative service provision other than higher acuity services

		Project	Objective	Anticipated benefit
	Seven Day Services	Seven day services enabled by workforce and technology	To deliver the 4 clinical priorities by November 2017	Improve patient flow
	Review Mental Health Models	Mental Health models for Liaison and Crisis	Ensure all people requiring mental health support at ED or in crisis receive appropriate support within 1hr 30mins of referral by March 2019	Reduced number of ED attendances for patients presenting with crisis
	Enhanced Primary Care Model	Primary Care Models	To deliver 30mins p. 1000 population for urgent on the day service within Primary Care to be delivered within the extended hours period, in the evenings and Saturday and Sunday by March 2019	Improved system resilience, reduction in number of ED attendances
	Domiciliary Care & Care Home Provision	Sustainable Domiciliary Care and Care Home provision	To reduce staff vacancy rates in domiciliary care by 10% by March 2020	Reduced emergency admissions and improved patient flow
Digital	Corporate Systems	Corporate Systems	We will achieve standardisation in the application and use of corporate systems use e.g. ESR, eRostering, Datix	Expanded digital footprint and associated efficiencies in corporate services. Improved purchasing power. Shared learning, benefits achieved more quickly.
	Interoperability / data sharing	Interoperability / data sharing	We will work collaboratively to deliver the regional interoperability strategy for the Electronic Patient Record and the patient portal	Admission avoidance, enabling patients to be managed in the community reducing demand for emergency services. Reduced length of stay as clear plan of post-admission treatment can be developed between hospital and community and then enacted.
	IT Infrastructure Alignment Group	IT Infrastructure Alignment	Establishing shared infrastructure and collaborative working for IT Data Centre(s), Licencing, Contracts, Communications, hardware & software procurement	Establishing shared infrastructure and collaborative working for IT Data Centre(s), Licencing, Contracts, Communications, hardware & software procurement
	Data Analytics	Data Analytics	Rationalisation and efficiencies in data reporting & assoc. services. Ensuring the use of data for service demand and capacity, performance management and predictive care planning & management is achieved.	Improved management of capacity and demand. Ability to benchmark and identify unwarranted variances. Produce analyses of patients at risk of secondary care usage.
	Local Digital Roadmaps Delivery Group	Local Digital Roadmaps Delivery (LDR) Group	Monitoring and supporting the delivery of local and regional LDR plans	Reduced transaction costs in provider organisations. Improved efficiency for primary care

		Project	Objective	Anticipated benefit
Workforce	Work stream Modelling	Work stream Modelling	Quantifying future gaps in workforce roles Responding to the outcomes of the STP care model and other enabling work streams.	Pan system workforce development and a capability to inform and respond to STP transformation
	Joint Workforce Planning	Joint Workforce Planning	Creating a system-wide workforce modelling capability – utilising tools such as WRaPT Ensuring Information Governance arrangements are in place Developing detailed baseline data across the footprint including primary care, social care, CHC and NHS providers.	Reduction in the incidence of service closure due to workforce capacity. Improved patient outcomes and satisfaction. Improved financial planning.
	Common Vision and Values	Common Vision and Values	To provide a common vision and purpose for our workforce to support recruiting and retention on a footprint basis. To provide for staff engagement events in conjunction with the communications work stream. Develop opportunities for staff participation in STP development and workforce transformation. To support system leadership development.	To better engage our workforce in systems redesign. Improved success of improvement through greater engagement and ownership.
	Shared and Aligned Training	Shared and Aligned Training	Enhance skills of care home and domiciliary staff. Universal skills for health and care staff. Develop a collaborative approach to training and development across the STP. Explore opportunities for shared provider for apprenticeships.	Reduce duplication Improve quality Optimise benefits
	Improved Employment Offer	Improved Employment Offer	Shared Bank (Acute Trusts initially) Development of E-Rostering	Reduce use of agency in the absence of bank supply Improved efficiency and productivity of workforce rostering

Further refinement of our plan

Development of our strategic plan

Our plan for the Mental Health FYFV

BSW STP leaders recognise that sustainability and transformation present an opportunity to address the holistic health and care needs of our populations, including mental health and wellbeing. Current mental health service commissioning arrangements result in variable access, varying service specification, waiting times and treatment outcomes across three CCGs. We have not yet developed fully integrated social, mental and physical healthcare, focussed in the community and pro-actively delivered at the earliest opportunity. There are fragmented care pathways, with both duplication and gaps in provision.



Nationally, mental ill-health accounts for 28% of the burden of disease and receives roughly 13% of NHS budget.

Our aim is to ensure that all forms of care consider and value mental and physical health equally, so that people receive the treatment to which they have a right and are supported effectively in their recovery.

Our approach for mental health rests on five core principles:

1. We will standardise and operate at scale

The fact we have a single mental health provider delivering the majority of mental health services within the footprint allows mental health to standardise service specifications e.g. a single 'offer' from IAPT for long term conditions.

We will develop regional specialist provision e.g. perinatal inpatient care, and will work in partnership to create maximum impact for the most vulnerable populations across the region, including Secure Services and other specialised services.

2. We will develop system-wide pathways of care

For mental health, this means we will address the current gaps in service lines across the three CCGs. We will ensure equity of access to services, prioritising investment in those areas with least access. Starting with prevention, and through closer working with Public Health and primary care, our actions to reduce harm from alcohol, smoking and obesity will improve population mental wellbeing yet will include targeted attention for those with severe mental disorder (SMI).

Similarly, screening programmes will proactively identify mental ill-health in schools, acute hospitals, care homes and pregnant women, and will positively target those with SMI. In year one, our plan will begin to address geographical disparities in specialist provision for children and young people, perinatal women, early intervention in psychosis, liaison services and crisis services. The five year plan will refocus provision away from hospitals and into the community.

3. We will develop a new relationship with the population

Simplifying access to all services through reducing health and care boundaries across the footprint ensures the earliest, most appropriate signposting to care. Staff and patients will perceive fewer interfaces in their health and social care pathway and the implicit cultural message is inclusive, reducing stigmatisation.

4. We will develop new relationships between organisations and staff

We will increase and simplify access, reduce stigma and improve health outcomes through a deliberate focus on integration of physical and mental health provision. Early success with street triage has created common understanding and has changed behaviour in favour of least restrictive interventions. Inter-organisational, multi-disciplinary teamwork in liaison, and perinatal and primary

care, will encourage mutual aims in prevention and early intervention, will reduce duplication and will result in 'whole person' care.

Our workforce enablers include IT and shared HR systems but a more radical change comes from the focus on staff development, retention, health and wellbeing. STP partners are developing the mechanisms: harmonised terms and conditions, training passports and core skill sets enable staff to work and move across organisations. Training for all staff groups in brief intervention and psychologically minded treatment will equip our workforce for the future as will training to work with older people.

Apprenticeships, roll out of STP-wide quality improvement training, extended, rotational and innovative roles will attract and retain staff for whom the workplace offer includes stress reduction, psychological support and clinical supervision.

5. We will build on our existing digital work as a driver and enabler of cultural change

Access to care records across STP partners will facilitate safe, coordinated care planning and delivery for all patients and will promote integrated care, including shared and co-created risk assessment.

In the context of primary and community services, as in others, 'parity' between mental and physical healthcare is best achieved through integrated delivery. This will require a change in resourcing and skills to ensure that the physical and mental health needs of patients are addressed fully and together.

Integrated delivery will be achieved in the following ways:

- We will include mental health professionals in the locally-based multi-disciplinary teams at 'GP cluster' level. As we improve productivity through technology and adjust skill mix towards non-medical health professionals (nurses and therapists, mental health nurses, pharmacists), we will create efficiencies. These resources will be redeployed to increase mental health capacity.
- All staff within multi-disciplinary teams will have skills to provide psychologically informed interventions and signposting to community and voluntary sector support. Some will additionally provide talking therapies, counselling and social prescribing to address mental health issues, including depression and anxiety. These steps will improve mental health and wellbeing directly, will improve physical health through increased resilience and through better compliance with lifestyle advice and treatment regimes, and will reduce GP, outpatient and ED attendance.
- Mental Health professionals will provide training, advice and guidance to colleagues, in particular healthcare assistants and assistant practitioners, who will develop skills to recognise where mental health support is needed and skills to address the needs of individuals with co-morbid mental and physical health problem.
- The mental health and wellbeing needs of patients who present at ED, who are at risk of admission, or who require specific support on discharge will be met in an integrated, timely way.
- Co-ordinated induction and training for all staff in BSW will ensure a psychologically minded workforce with core skills to promote mental wellbeing, and staff who recognise their role in prevention and facilitating people to care for themselves.

STP Governance and mental health

We will ensure our governance structures are designed to deliver:

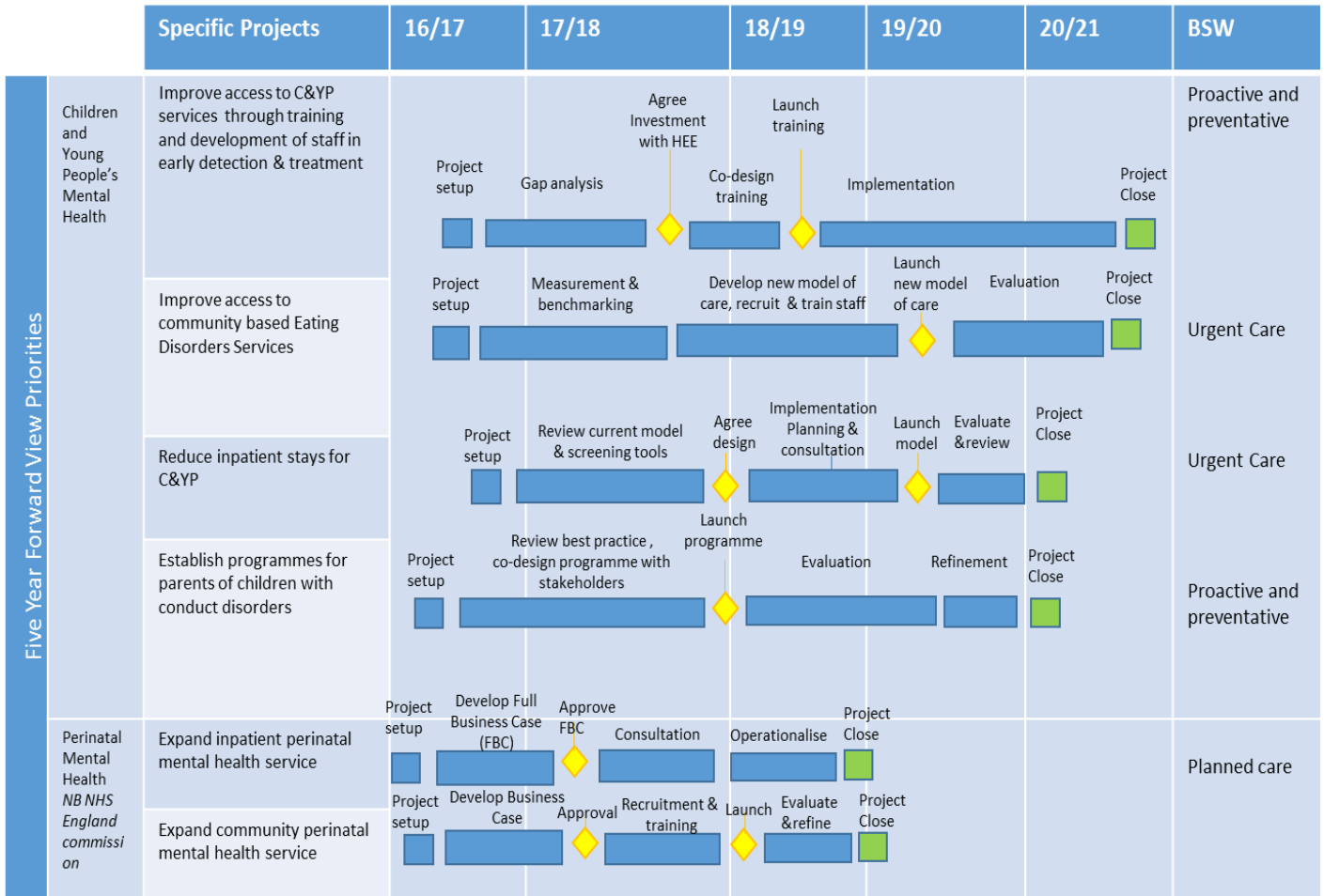
- parity of regard, investment and innovation between mental and physical health, to improve the mental health, wellbeing and physical health of the population
- increasingly integrated services
- national mental health indicators
- The Five Year Forward View (FYFV) for Mental Health, and

- The mental health oversight group of key senior clinical experts will apply a 'parity test' to new developments and will assess pathways against the aims of integration and the FYFV for Mental Health.

As the largest NHS provider of mental health services across the STP footprint, AWP will work with accountable officers through the Mental Health Strategy Group, to advise both on strategy for local and specialist regional and national provision and to align trust clinical strategy appropriately.

A draft outline of the projects within scope is set out below however discussions are ongoing between mental health providers and commissioners to finalise this workplan:

Mental Health – Women, Children and Families



Mental Health – Adult Mental Health & Specialised Services

Specific Projects		16/17	17/18	18/19	19/20	20/21	BSW				
Five Year Forward View Priorities	Adult Mental Health Services	Increase access to Psychological Therapies	Project setup	Gap analysis & model development with partners	Finalise model	Deployment of model, co-located and co-deployed	Evaluation	Project Close	Proactive & preventative		
	Improve access to Early Intervention Psychosis (EIP) services	Project setup	Deploy existing model, evaluation and refinement		Project Close				Planned Care		
	Reduce premature mortality for people with Severe Mental Illness (SMI)	Project setup	Co-design new model	Launch 1 st wave	Evaluate and refine	Launch 2 nd wave	Evaluate and refine	Launch 3 rd wave	Evaluate & review	Project Close	Proactive & preventative
	Provide community based Crisis Resolution and Home Treatment Teams (CRHTTs)	Project setup	Review and align existing services		Agree final model	Deploy with partners			Project Close	Urgent Care	
	Establish hospital based mental health liaison services to meet Core 24 standards	Project setup	Analysis and review of models	Agree model & investment	Recruitment & training	Launch new model	Evaluate & extend		Project Close	Urgent Care	
	Develop and deliver suicide prevention strategy	Project setup	Gap analysis and review	Co-develop strategy	Launch consultation	Refine	Publish strategy	Implementation		Project Close	Urgent Care
Specialised Mental Health Services	Improve secure care pathway (in partnership with secure network)	Project setup	Gap analysis and review	Commission and deploy new model	Evaluation			Project Close			
	100% of people accessing liaison and diversion services	Project setup	Gap analysis and review	Co-develop new models with Ministry of Justice colleagues	Launch models	Evaluation and improvement against standard			Project Close		
	Improve access to bespoke services for armed forces	Project setup	Test new service	Launch model	Evaluate and refine			Project Close	Planned Care		

Our plan for Learning Disabilities

The strategic aim is to deliver the National Directives of Transforming Care by:

- Working in partnership to reduce the need for people with learning disabilities to be admitted to specialist hospital placements outside of the area
- Ensuring equal access to the health, mental health and social care services available within the area
- Developing integrated training programmes to ensure all providers of care are operating to the same excellent standards including friends, family and carers
- Developing a skilled workforce across all healthcare provision

The following principles will be enshrined within the culture of the STP:

- Service users with learning disabilities have a right to be able to access mainstream services
- Information will be in an accessible format for all people accessing services
- Service users with learning disabilities will be able to access all premises
- All staff will have the knowledge and skills to work with people with learning disabilities
- Service user involvement will be at the centre of strategic developments

Our plan for Maternity services

A Maternity Forum has been established across the STP footprint. Meetings have started and the terms of reference and membership of the group have been drafted. This Forum will link directly into the STP Planned Care Programme Board.

There is increased focus on maternity services via the Improvement and Assessment Framework and the four key areas of focus for this group are:

- Neonatal and still birth
- Maternal smoking at time of delivery
- Women's experience
- Choice in maternity services

In addition to these areas of focus, the forum is also taking the opportunity to evaluate the services provided across the STP more generally to identify ways to work together across the footprint to improve maternity services. There is a range of local and national drivers for change which have highlighted areas of inconsistency in service provision and practice across maternity services. The next stage of this work will include engagement of local people in some early evaluation work which has already been undertaken.

Our aim will be to ensure that the services we offer can sustainably meet the needs of our women, families and staff and are equitable and appropriate across the STP footprint.

Our plan for Specialised Services (incl. Cancer)

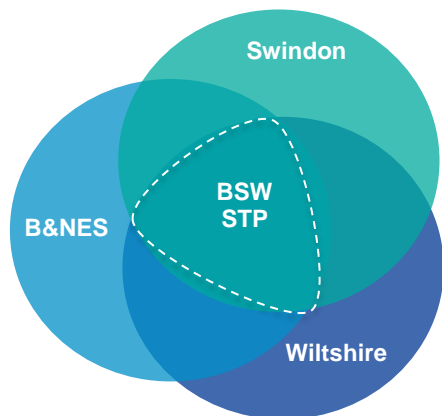
STP has links with three specialised commissioning hubs, but is using the South West hub as its main interface.

Following the tri-angulation meetings the key areas of opportunity for joint work are:

- Spinal surgery
- Pain services - opportunity to disinvest in very complex high cost activity to invest in new community services
- Variation in chemotherapy linking with the Cancer Alliances
- Mental health placements

The footprint has a long-established Cancer Forum that has now expanded to include all BSW stakeholders. This group will operate as a sub-group of the STP Board and will have representation on the SWAG Cancer Alliance Board. The footprint has significant cancer flows (and working relationships) into Wessex and Thames Valley alliance footprints and our planning assumption is that these flows will remain. The clinical and commissioning leads for the STP are already engaged with SWAG over the production of our work plan in line with the Ops Planning guidance.

Engaging stakeholders



The development of the BSW STP is one of collaboration. Across our combined area, we already have a wealth of patient insight and useful data from recent consultation and engagement activity.

However the STP offers our stakeholders a new opportunity to inform our plans and we are committed to ensuring everyone's views are taken into consideration at all stages of the process.

By engaging patients, staff and communities we can develop services and new models of care that reflect the needs of patients and improve outcomes by 2020/21.

Our ethos is to place people at the centre of our planning; to enable and empower people through information, education and access to resources so they can lead lives free from disease and ill health.

That when they need them, reliable services will be available local to them, designed by them and delivered by mental health, social care, community and hospital professionals working together. That providers and commissioners will work together to:

- keep more people in their own home
- see patients promptly
- reduce their own costs of providing care
- use technology and work smarter
- reducing the need for patient travel

Our engagement plans are also in line with legal requirements for commissioners to involve the public in planning, managing and making decision about their care as part of the NHS Act 2006 (section 14z2 (2)) and Health and Social Care Act 2012.

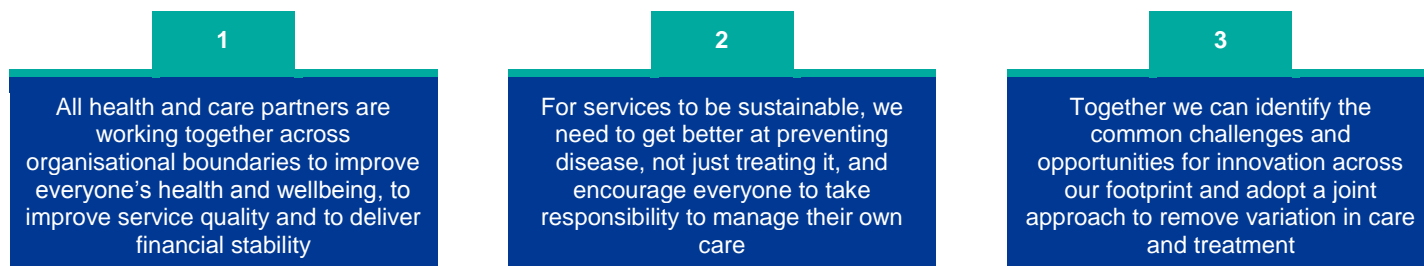


The BSW STP has been developed and will be implemented in line with the six principles agreed by the Five Year Forward View People and Communities Board:

1. Care and support is personalised, coordinated and empowering
2. Services are created in partnership with citizens and communities
3. Focus on equity and narrowing health inequalities
4. Carers are identified, supported and involved
5. Voluntary, community, social enterprise and house sectors are key partners
6. Volunteering and social action are recognised as key enablers

Our three key engagement messages which address our footprint's challenges

Our communications plan is underpinned by consistent, coherent and resonant messaging that will seek to stimulate positive debate both off and online about health and care:



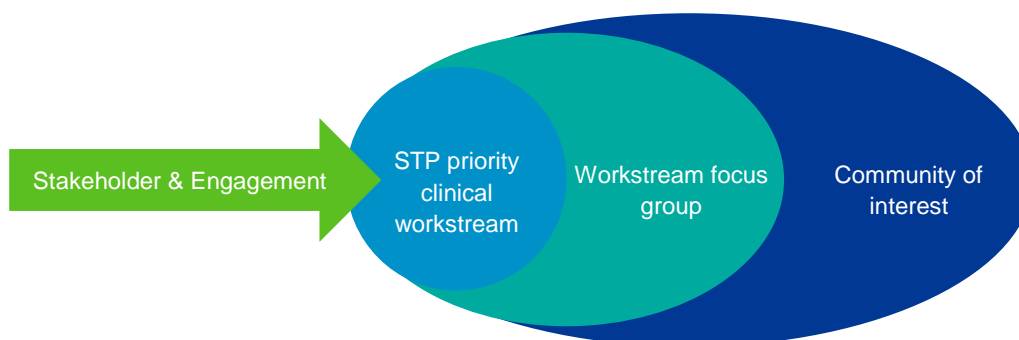
Our engagement programme

We are planning a detailed programme of engagement and ensure that we listen to and involve all our stakeholders effectively and systematically in the further development and implementation of our local plan.

The workforce will be a major focus for communications activity. They need to be briefed and mobilised to help shape and implement future changes in services. The voluntary and community sector are also a key participation partner for supporting delivery of our STP and developing prevention and wellbeing approaches.

This programme of activity will be delivered by the communications leads for each partner organisation in our STP area, and will be assured by CCG PPI lay members, Healthwatch, and where applicable, patient and public forums and committees.

Healthwatch in B&NES, Swindon and Wiltshire is the independent body representing the voice of patients and public, the three local Healthwatch organisations are now acting in an advisory capacity for our STP as our plans begin to take shape. Healthwatch sits on the STP Board and communications work stream as 'critical friend' to health and care leaders and they will play an invaluable role in our approach to patient and public participation.



Engagement activity will be relevant and meaningful to those people who have characteristics protected under the Equality Act 2010. 6.4 per cent of people in B&NES, Swindon and Wiltshire live in the most deprived areas of England. It will be important to engage people in these communities to explore how the STP can help them access services and get more involved in decisions relating to their care.

Communications and engagement activities will be accessible, inclusive and tailored to be relevant to each target audience. A range of digital and print media channels will be used to broaden reach e.g. social media, advertorials and web copy. However the value of face to face communications cannot be underestimated.

To date focus has been on briefing staff groups across the footprint. Local people were updated about our plans at the Wiltshire Stakeholder event in June and a stakeholder event for the voluntary and private sector

was held in September. There have also been presentations to Health and Wellbeing Boards and Scrutiny committees across B&NES, Swindon and Wiltshire throughout 2016. A summary of our draft STP was published in November 2016.

How you can give your views

A programme of public events and briefings about our STP will start in **January** 2017 and will continue over the next three months. Please check on the CCG website for either B&NES, Swindon or Wiltshire for future updates about our engagement programme. We expect that this period of engagement will then inform the next version of the STP to be published in May 2017.

Any future potential NHS service reconfigurations would still require their own case for change and formal consultation process in their local area, in line with NHS statutory duties (and other NHS policy guidance) to engage and consult.

This offers a number of opportunities for local authorities, NHS organisations, community and voluntary sector organisations and other interest groups to consider the draft plans as they develop and for their views to inform the next stages.

In the meantime, if you have any queries or feedback about our emerging STP please email: ruh-tr.STP-BSW@nhs.net



Key milestones to developing our STP

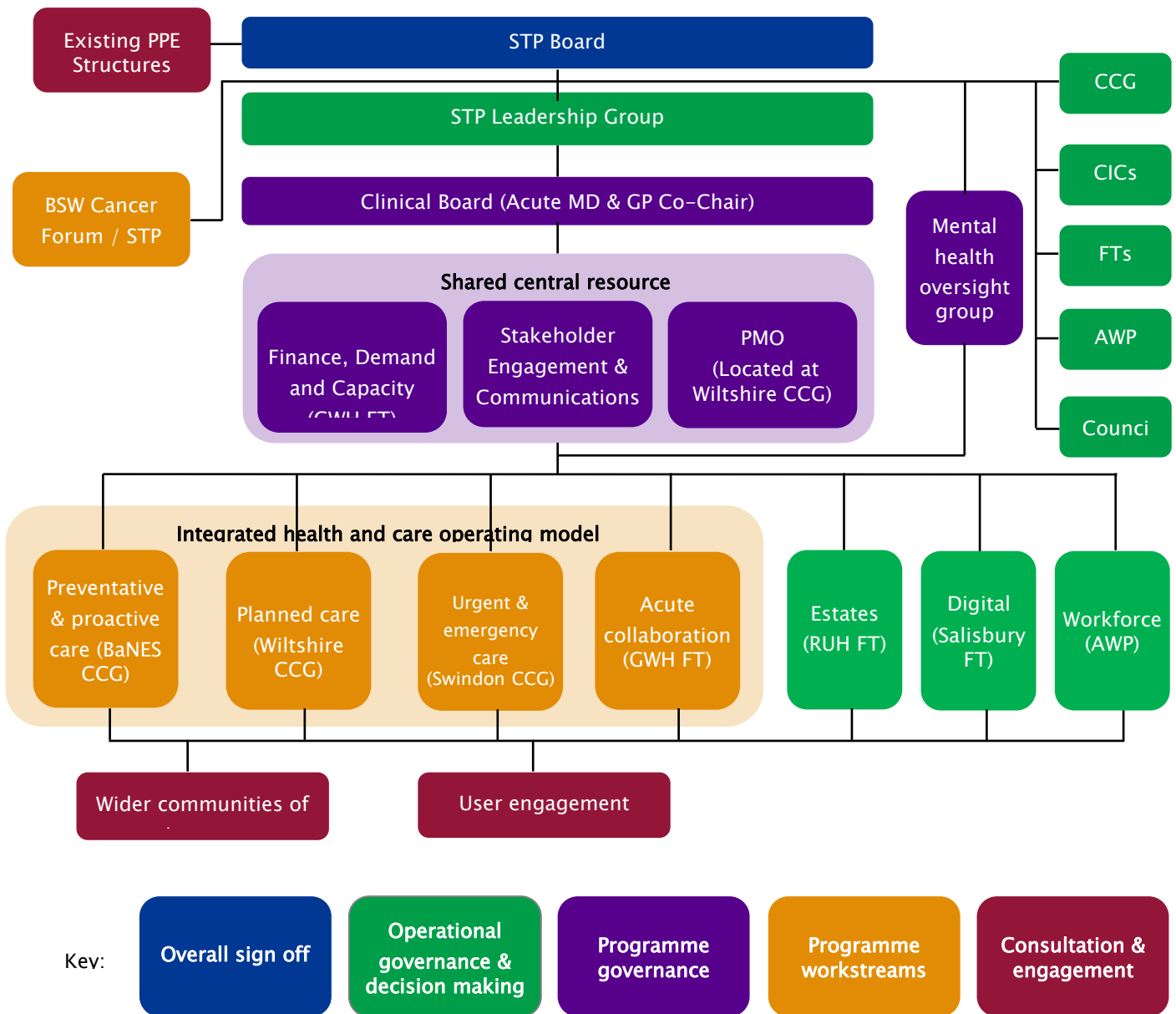
To deliver our plans, we have established workstreams and identified key milestones & opportunities. Each workstream has a senior responsible officer.

Opportunities	2016/17	By 2020/21
Primary care BaNES, Swindon & Wiltshire	<ul style="list-style-type: none"> Respond to recommendations of <i>Preparing for Future Project</i> Finalised BaNES Primary Care Strategy Commence Wiltshire 3 year Primary Care Offer programme <ul style="list-style-type: none"> Development of locality teams, and facilitation of collaborative working across primary care, linked with already established integrated MDTs Establish integrated multi-disciplinary teams 	<ul style="list-style-type: none"> Commencing programme of change to an outcome based commissioning model Commissioning services at scale not by individual practices Enhanced range of 'out of hospital' services Fully developed framework for cluster/federation "locality offer", i.e. 7 day services, use of hubs
Urgent & emergency care		
Ambulatory care: Define units consistently across the footprint	<ul style="list-style-type: none"> Design Geriatrician Model with community mental health services Developed consistent metrics for out of hospital alternatives Scope delivery of 2/3 hospital/integrated models/pathways for community patients; Frail Elderly Integrated Pathway, rapid response respiratory 	<ul style="list-style-type: none"> Establish Community Geriatrician Model as default for care of Frail and Elderly population Implementation of the chosen 2/3 integrated models
Primary care model: Urgent Care and Use of Hubs	<ul style="list-style-type: none"> Agree an emergency model & guiding principles Establish Mental Health Emergency "Fit" Establish a Domiciliary Care Plan Establish use of 'hubs' Agree to common language & signposting on access for behavioural change via social marketing 	<ul style="list-style-type: none"> Establish shared care record
Mental Health Models for Psych Liaison and Crisis Services	<ul style="list-style-type: none"> To include acute physical inpatient liaison, emergency department liaison, care home liaison. Liaison aspirations should be to meet 'core 24 standards' across the 3 acute hospitals. 	<ul style="list-style-type: none"> Develop and establish single model of mental health liaison into acute hospital services
111/OOH/Ambulance Services: Shared triage for response consistency	<ul style="list-style-type: none"> Commission appropriate technology to support self care and access to services e.g. apps 	<ul style="list-style-type: none"> 100% access requirement to seven-day services Re-procure 111/out of hours Develop hospital use estate plan
Preventative & proactive care		
Ageing Well	<ul style="list-style-type: none"> Develop single service specification for assessment of Safe and Independent Living Agree Frailty Tool 	<ul style="list-style-type: none"> Agree to Frailty tool implementation & evaluation of effectiveness Evaluate SFT fracture liaison service & national evidence (incl funding) Assessment & evaluation of Safe and Independent Living tool Final implementation, monitoring & evaluation of proven approaches
Tackling Obesity	<ul style="list-style-type: none"> Agree to current thresholds & evidence base Agree common approach to commissioning weight management services and implement Agree to common evaluation & monitoring 	<ul style="list-style-type: none"> Evaluate effectiveness of approach Agree to implementation leaders and evaluation of the <i>Workforce Wellbeing Charter</i>
Proactive Management of Long Term Conditions (with other workstreams)	<ul style="list-style-type: none"> Conduct readiness assessment for Diabetes Prevention Programme Agree LTC for priority focus Establish messaging to influence vaccinations behaviour 	<ul style="list-style-type: none"> Agree to phase rollout of pathways for LTC, evaluation & monitoring Evaluate effectiveness of vaccination campaign Implement Diabetes Prevention

Opportunities	2016/17	By 2020/21
		Programme- cost prohibiting
Planned care		
Alternative contracting	<ul style="list-style-type: none"> Perform options appraisal around lead provider/ supply control for each pathway Define incentives or risk share 	<ul style="list-style-type: none"> ACO / Incentivised programme budget and supply control
Sustainability of provision	<ul style="list-style-type: none"> Establish mechanism for capacity planning Agree to Phase 1 rollout, evaluation and monitoring process (i.e. dermatology, radiology, etc.) 	<ul style="list-style-type: none"> Full pathways rollout, evaluation, and monitoring
Demand management & shared referral system	<ul style="list-style-type: none"> Design of referral management service methodology Transparency of data to reduce clinical variation Design consistency of thresholds, ceiling of care and clinical priorities 	<ul style="list-style-type: none"> Establish formal inclusion of every pathway starts with prevention
Commissioning for outcomes & standardised care	<ul style="list-style-type: none"> Identification of opportunities to remove transactional activity and develop collaborative commissioning Define pathways to prioritise standardisation and outcome based measurement 	<ul style="list-style-type: none"> Develop system wide approach to collaborative commissioning & provider side procurements
Infrastructure		
Shared Services	<ul style="list-style-type: none"> Agree to a shared MOU & principles Further establish collaborative procurement opportunities across providers Establish non-clinical services provision Develop business case setting out options, benefits, and risks assessed against clear criteria 	<ul style="list-style-type: none"> Implementation of key support service opportunities Continuous review against criteria to ensure identified benefits are realised
Estates	<ul style="list-style-type: none"> Agree common estates strategy & principles Identify quick wins & implementation plan Business cases for PFI put to NHSI Wiltshire community estate to NHSPS 	<ul style="list-style-type: none"> Fit for purpose estate with high utilisation
Digital	<ul style="list-style-type: none"> Achieve common strategy & principles Extended access to primary care data Improved digital capabilities in secondary care Established common interoperability standards 	<ul style="list-style-type: none"> Fully operational & paper free Established system wide data analytics Established integrated patient record Developed patient portal
Workforce	<ul style="list-style-type: none"> Agree a vision for shared and aligned training Define & establish scope of services for skills passport and key players Increase non acute care student placements & inter organisational rotations Establish Joint Workforce Planning team Define ways of working with other workstreams Inclusion of mental health, primary care workforce, and a system to enable e-rostering 	<ul style="list-style-type: none"> Established shared approach and aligned training Model workforce to new models of care Implementation of skills passport Define skills required for new care models Established improved employment offer, staff health & wellbeing
Acute Sustainability	<ul style="list-style-type: none"> Develop MOU defining our approach and guiding principles Agree 3-4 areas for clinical collaboration and support service reconfigurations Develop a Joint Collaboration Steering Board Develop Clinical Review and Task & Finish Groups 	<ul style="list-style-type: none"> Implement non-clinical shared service arrangements as identified through the business case process Implement collaborative model for vulnerable specialities as identified through the clinical case for change and the business case process

Annex

STP delivery structure



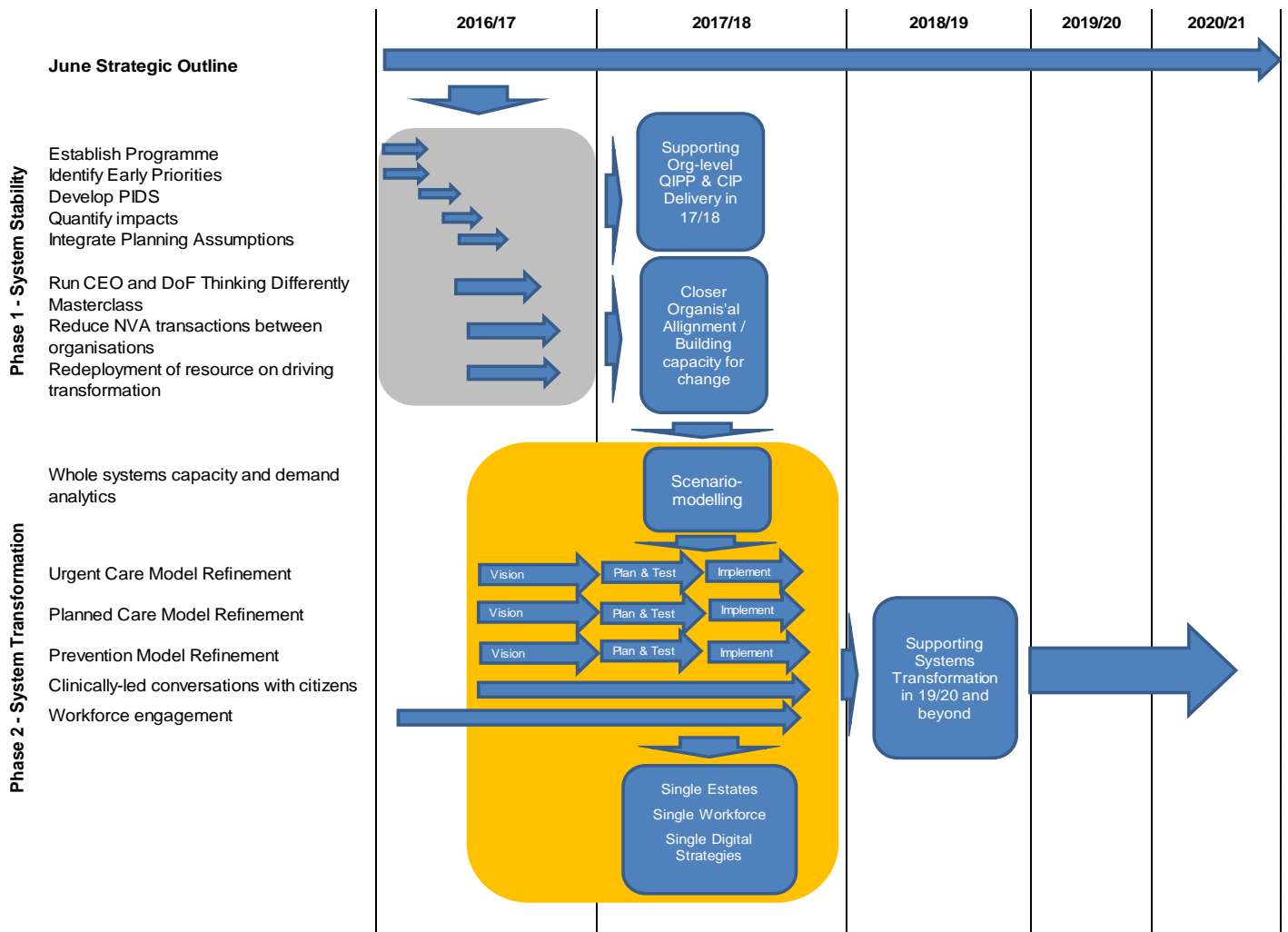
Recent additions include the establishment of:

- Clinical Board
- Mental Health Oversight Group
- BSW Cancer Forum

Delivery plan (high level)

We envisage the plan to be a live document that gets refreshed and refined through engagement and modelling. We will publish a revised version of our Plan in May 2017 following the next round of engagement design activities.

The programme plan below sets out the high level steps over the next 12 months that will enable us to complete this. In learning from other STPs we recognise the need to realign our resource to develop and deliver the STP. We do not have additional resource to complete this and therefore over the next three months we will set out what existing processes we will cease in order to redirect resource towards engagement and transformation.



Approach to integration of health and social care

As a system we are committed to the integration of health and social care wherever it makes sense to do so, we will:

- Adopt a system-wide methodology for quality improvement, working with the AHSN
- Recognise the need for a system-wide approach to health and wellbeing for our workforce
- Address mental and physical health and wellbeing in every pathway; and
- Appoint a champion for mental health on each workstream

For all STP workstreams, we will ask project leads to describe how their work will impact on the three elements of quality:

1. On the clinical effectiveness / clinical outcomes expected
2. On supporting a safe system of working and ensuring that the experience of the user / patient is considered alongside their engagement
3. On how choosing the right intervention (and the right time) benefits the individual as well as promoting better efficiencies within the system.

Each CCG has strong relationships across health and social care with their own approach to integration. We have developed a generic model for integrated working at STP level. Current and future plans for each population / CCG are set out below:

B&NES

- Long history of effective joint working and integration across local government and health resulting in a range of joint commissioning appointments e.g. Mental Health, LD, Children's Services, Older People and LTC's.
- Strong commitment to working in partnerships, good relationships and a clear understanding of the needs and issues of citizens. 5-year history of commissioning integrated health and social care community services, with an explicit commitment to explore further integration opportunities.
- The HWB is developing a proposal to move beyond integration of health and social care to take a much broader view of the role of housing, education, regeneration and economic development and perhaps most importantly, the assets of our people and communities.
- The commissioning landscape is changing. With 'Your Care, Your Way' there is a shared ambition to continue to commission integrated services in B&NES. We are responding to this by reviewing our functions, as some aspects of commissioning will be delegated to the Prime Provider, in order to consider the implications for future structures.

Swindon

- Long history of integrated commissioning and integrated service delivery for health and social care.
- Swindon Clinical Commissioning Group & Swindon Borough Council have aligned their resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations. This plan is also aligned with the work being progressed by the One Swindon Board as part of the Public Service Transformation network.
- We have engaged public, patients, GP practices, providers, voluntary sector, other stakeholders, providers, children and young people in the development of the Operational Plan. The Operational Plan links closely to the Better Care Fund Plan which is a summary of jointly agreed areas of priority.

Wiltshire

In Wiltshire, the well established Better Care Plan, led by a jointly appointed Director of Integration (between Council and CCG), already delivers good outcomes:

Patients being cared for in the right location

- Rate of avoidable admissions to hospital at its lowest for the last 2 years for frail and elderly people.
- 11% reduction in emergency admissions from care homes
- Reduction in the number of deaths in hospital which is currently 37.8% (lowest in region)

Longer term independence for our service users

- Volume of long term placements to nursing and residential care continue to fall and is below the BCF target
- More Wiltshire residents remain independent 91 days after discharge and performance through Integrated Teams is currently 87.5%
- Throughput and outputs in ICT remain strong

Higher level of patient and carer satisfaction

- Over 80% of Wiltshire residents surveyed said they were very satisfied with the service they have received.

Current strands of work (Better Care Fund enabled) are focusing on:

Intermediate Care	A new model of 70 cohorted intermediate care hospital beds has been launched and length of stay in these beds has been sustained which improves patient flow. A process of trusted assessment between providers has been initiated with dedicated community therapists working on an 'in reach basis' in the acute hospitals serving Wiltshire patients.
Admission avoidance	Focus has been maintained on the 'front doors' of acute hospitals by partner providers engaged in the BCF with the aim of preventing unnecessary admissions.
Step up care	A new model of step up beds has been introduced. The model provides an enhanced level of care to that delivered to patients in their own homes and prevents unnecessary admission to acute hospitals.
Urgent Care at Home	Through better adult community services and GP's out of hours service, more patients can access urgent care at home over a seven day period.
Community Geriatrics	Close working with consultants at the three acute hospitals serving Wiltshire has led to enhancements in the provision of geriatric care in the community.
Wiltshire Home First	A new service involving co-located health and social care providers and their partners in the voluntary sector is being piloted in the South of the county. Increased numbers of referrals of patients ready to leave Salisbury Foundation Trust are being received. The service has a number of key benefits including improved MDT working, changes to the existing culture of integrated working, reducing dependency, and increasing longer term independence of clients once discharged.
72-hour pathway for end of life patients	The GP out of hours provider continues to work in partnership with the hospices serving Wiltshire to provide an enhanced Urgent Care @ Home Service for patients at the end of their life. Initially Dorothy House and Prospect Hospice are providing an additional carer to the pool of staff available for the UC@H Service. They are available twenty four hours a day, seven days a week and are providing care for palliative patients (patients within the last year of life).

- In Wiltshire, the priority for 2017/18 and 18/19 is the delivery of even better integrated discharge, full development of our home first model, and augmentation of our step up/step down capability.

Modelling the financial resource of the STP

The scope of the financial totals does not include all contributors to the health and care economy

Our financial modelling seeks to draw together the income and expenditure and investments and savings plans from each of the organisations contributing to the STP. However, it is primarily a NHS funds financial model. Private and not-for-profit providers' figures are not included in the modelling, but they have been represented in planning the finances, savings priorities and discussions on collaborative transformation. Local government finances from the Better Care Fund are included, whilst the projected affordability gap reflects the wider range of social care services commissioned and provided through local government.

Financial performance requirements set by NHS England and NHS Improvement

Each STP has been given a two-tier, concurrent set of financial targets to achieve over the five year period. These are:

- Annual “Control Total” financial targets for NHS provider organisations to deliver in this year: 2016/17 and the years covered by the current 2 year planning process: 2017/18 and 2018/19. The award of Sustainability and Transformation funding from NHS Improvement is contingent on these control totals being accepted
- Annual financial performance requirements set for each CCG: specifically achieving a ½% retained surplus, as part of their formal regulatory framework
- STP wide control total, which we assume to be the sum of the individual organisation's financial targets, but which are expected to be delivered through collaboration and risk sharing across organisations

These financial expectations place increased pressure on our organisations and services to help to deliver the balanced position across the system, whilst delivering our individual financial objectives in line with our own regulatory and legislative obligations.

Addressing the financial gap

Above all, this financial modelling helps us to understand the scale of the financial challenge we face. These savings have to be delivered by service providers; and the solution will have to involve collaborative thinking and genuinely transformational change in all sectors in order for the financial gap to be closed. It is important to note that this transformation **cannot** be just about reducing expenditure in the system, it is also about managing demand and changing how our service users use our services. The financial gap will be met through the following key drivers:

Sustainability funding

Acceptance by NHS trusts of the financial control totals set will give us access to up to £65 million of sustainability funding over the three years 2016/17 to 2018/19. However, these funds will only be released if financial performance targets; and some key service targets are delivered.

Local savings targets

Local efficiency savings plans identified and managed by each of our organisations. NHS organisations have been delivering efficiency savings for many years now. NHS England and NHS Improvement expects that our organisations will continue to deliver these annual efficiency savings over the five year period. CCGs are expected to deliver savings of 1% of total income through quality and productivity improvements laid down in contracts with service providers. NHS trusts are expected to deliver 2% savings each year.

In recent years, our NHS trusts have had to set annual savings targets closer to 4% to achieve their annual financial targets.

Overall, our organisations have achieved around 70-80% of the value of the savings targeted in recent years. However, we all recognise that it is becoming increasingly difficult to find this scale of savings on our own.

In recognition of this, we have made a conservative assumption that we will deliver, across the STP around 50% of the local savings requirement identified over the five year plan.

Service transformation

The balance of the financial gap will have to be met through transformation of the way that we commission and provide care services. Over the five years to 2020/21, we expect this to be around £260 million. Some of this saving will be delivered through transforming the way that we administer our organisations: the so –called “back-office” costs. We are already making good progress with joining up the way that we buy supplies; and our payroll services. We are also challenging the way that other key support services (finance, workforce, estates and facilities etc) are provided. But, we are already efficient in these areas and although we expect to improve the quality of these services, the opportunity to save money is likely to be limited.

We expect that we will need to deliver over £200 million savings over the five year period, through transforming clinical services: through planned care, urgent and emergency care, as well as through preventative and proactive care approaches.

This transformational work is described in the rest of this plan.

Summary of our financial assumptions

The financial model is based on a number of assumptions. These are summarised in the following table:

Demand and activity growth and inflation projections over the five year period reflect the standard indexes issued by the Department of Health	It is recognised that there may be local variation in certain of these assumptions. These variances will be reflected as the financial planning becomes more detailed
The organisations will accept the financial control totals set for them for 2017/18 and 2018/19 (but this is not reflected fully in the model)	Each organisation has been set a proposed financial control total for 2017/18 and 2018/19. Organisations are required to notify acceptance of these targets by 24 November 2016. Organisations will have to deliver higher levels of savings in 2017/18 and 2018/19, to be sufficient for them to achieve the control totals set for them individually. Not all have projected that this will be achieved.
And associated S&T funding for providers will be achieved in full	Sustainability funding offers are attached to the control total offer. Receipt of funding in full is dependent on the providers delivering against key performance targets and is not guaranteed
CIP and QIPP savings for 2019/20 and 2020/21 are assumed at 2% and 1% respectively	The reflects the minimum annual organisational efficiency delivery targets expected by NHSE and NHSI
Carter (back-officer) review and an element of the clinical transformation savings projections are derived from relevant schemes within each organisation’s saving plans	Although transformation, the impact of the shortened time-frames to achieve balance is to increase the value of savings that need to be recognised at organisational, rather than STP level.
Transformation investment funding is held centrally. The model assumes that funding will be made available to support transformational investments	We do not know how funding for investing in transformation will be made available. Investment requirements have been identified, to support future bids for funding, but these are “memorandum” items in the model and do not impact on the overall financial projections
The financial impact of significant changes to the NHS contracting model have been assumed for the acute providers	HRG4+ impacts, where they are expected to have a positive consequence to acute providers. CCGs expect a nil net impact, with funding better reflecting where more complex procedures are carried out. MRET impacts, which are likely to have a positive consequence to acute providers are recognised where they have been identified.

The list below identifies the key financial risks facing the STP and the organisations within it.

- Significant savings to be delivered across a shortened timescale – on the 30th September 2016, NHS providers were notified of their financial control totals which highlighted the significant change to the timescale around a system wide in-year balance.
- Social care funding is reducing. This is not shown fully in the model, making the financial challenge greater
- Sustainability funding not guaranteed, but full receipt will be needed to deliver control total targets.
- Income assumptions will vary as the two year planning process and contract agreements with CCGs will not be finalised until late December 2016
- Impact on changes to the tariff (the price that is set nationally for many clinical treatments and services) will not be understood until after the tariff is published on 20 December 2016.
- STP transformation schemes are not fully developed so timescale of financial delivery may be delayed.
- STP transformation schemes are hampered by uncertainty over investment funding. Capital monies are particularly limited.
- The time-scales set for delivering both the STP plans and the two-year planning process, which is required by legislation and NHS regulation, are very challenging. This increases the reliance that we have to place on estimates, rather than confirmed figures. Much of the detail is still being worked through.
- The STP recognises it needs to close down the 2016/17 position as soon as possible, to remove uncertainty within individual organisations and to enable us to focus on the next years' planning.
- Organisational culture – the current regulatory structure does not allow for easy collaborative working, in particular within the finance environment. This could slow down decision making and therefore, have an impact on achieving financial improvements.



Roadmaps

Urgent and emergency care

	2016/17	2017/18	2018/19	2019/20
Ambulatory care: Define units consistently across the footprint	<ul style="list-style-type: none"> Design Geriatrician Model and recruit/align teams Develop Consistent Metrics which define access times for out of hospital alternatives Take stock of Urgent Care Review/Policy scheduled for publication by NHSE in June/July Scope what 2/3 of hospital/integrated models/pathways would deliver the biggest gain in supporting patients in the community – Frail Elderly Integrated Pathway, rapid response respiratory 	<ul style="list-style-type: none"> Develop clear estate plan for use of hospital campus to ensure well planned development of estates to accommodate alternative service solutions Establish Community Geriatrician Model as default for care of Frail and Elderly population Develop and establish single model of mental health liaison into acute hospital services Establish Single SRG 	<ul style="list-style-type: none"> Begin implementation of the chosen 2/3 integrated pathways which will deliver biggest gain in out of hospital resilience 	<ul style="list-style-type: none"> Begin implementation of the chosen 2/3 integrated pathways which will deliver biggest gain in out of hospital resilience Enable population to access primary care services in a timely way.
111/ OOH/ Ambulance Services: Opportunities for shared triage which gives consistency of response	<ul style="list-style-type: none"> Identify and commission appropriate technology to support self care and access to services e.g. apps Consider implications of Urgent Care Review/Policy from NHSE (June/July 2016) 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Re-procure 111/out of hours 	<ul style="list-style-type: none"> Include self-care/self-management enabling patients who pitch up at U&E to access this, when appropriate
Primary care model: urgent care and use of hubs	<ul style="list-style-type: none"> Stock take of current and already planned system model use. Agree principles of emergency model and design an agreed emergency model Understand 4 hour A&E Understand Domiciliary Care Plans Agree on common language for the system to help professionals and the Public to access the system Establish Mental Health Emergency “Fit” Understand estates and digital requirements 	<ul style="list-style-type: none"> signposting/behavioural change – social marketing Establish shared care record 		
Mental Health Models for Psych Liaison and Crisis Services	<ul style="list-style-type: none"> Need to establish links with Reference documents/policy document re CAMHS and C&YP services 			

Preventative and proactive care

The prevention and proactive care team has determined the vision and direction of travel. While the need for refinement with other workstreams and defining ways of working exists, the below timeline provides a high level of how we anticipate closing the gap.

	2016/17	2017/18	2018/19	2019/20
Ageing Well	<ul style="list-style-type: none"> Commence dialogue with voluntary sector and other statutory organisations e.g. fire services Develop service specification for assessment of Safe and Independent Living in B&NES to match provision across STP footprint Agree Frailty Tool Evaluate SFT / national evidence for fracture liaison pathway 	<ul style="list-style-type: none"> Develop Safe and Independent Living Services within each CCG area Roll out use of the common frailty tool Dependent on outcome of evaluation of fracture liaison service, seek funding to roll out to other acute trusts using a common service specification 	<ul style="list-style-type: none"> Evaluate pilots Evaluate the effectiveness of the frailty tool 	<ul style="list-style-type: none"> Amend approaches based on evaluations and roll out
Tackling Obesity	<ul style="list-style-type: none"> Share current practice and experience across the STP area Review evidence base for effective weight management services Set up workshops for organisations to support understanding of requirements of Workforce Wellbeing Charter 	<ul style="list-style-type: none"> Review current thresholds for access to services Agree common approach to commissioning tier 4 weight management services and implement Identify organisations who will spearhead the implementation of the Workforce Wellbeing Charter and consider how we will evaluate the impact 	<ul style="list-style-type: none"> Agree common approach to commissioning tier 2 and 3 weight management services and implement Evaluate the effectiveness of tier 4 services and adjust approach as appropriate Roll out implementation of the Workforce Wellbeing Charter to other health and care partners 	<ul style="list-style-type: none"> Evaluate effectiveness of approach to weight management and adjust as appropriate Evaluate the impact of the implementation of the Workforce Wellbeing Charter

	2016/17	2017/18	2018/19	2019/20
Proactive Management of LTCs	<ul style="list-style-type: none"> Undertake readiness assessment to implement the Diabetes Prevention Programme Develop bids to National Diabetes fund to target CCG specific areas of variation Agree LTC for priority focus (in consultation with planned care and urgent and emergency care work streams) Plan messaging campaigns to influence vaccinations behaviour in winter 2016 	<ul style="list-style-type: none"> Develop an agreed integrated care pathway with education and support included for priority LTC Commence discussions with expert voluntary sector regarding their potential role in delivery Implement Diabetes Prevention Programme across STP 	<ul style="list-style-type: none"> Evaluate impact of new care pathway and adjust as appropriate Agree second LTC for focus Evaluate the effectiveness of the vaccination campaign Agree integrated care pathway for second LTC and implement across STP If cost benefit analysis demonstrates VFM, implement Diabetes Prevention Programme 	<ul style="list-style-type: none"> Evaluate effectiveness and agree roll out plans

Planned care

The planned care team has determined the vision and direction of travel. While the need for refinement with other workstreams and defining ways of working exists, the below timeline provides a high level of how we anticipate closing the gap.

	2016/17	2017/18	2018/19	2019/20
Demand management in line with prevention and enabled through a shared referral management system	<ul style="list-style-type: none"> Combined capacity and demand baseline and projection. Design of referral management service methodology and consistency Evaluation of 1st pathways before planned roll out. Create transparency of data to reduce clinical variation Design consistency of thresholds, ceiling of care and clinical priorities 	<ul style="list-style-type: none"> Prevention at start of pathway phase 1. Roll out and implementation of phase 1 incl. interim system wide RMS approach. Phase 1 evaluation. 	<ul style="list-style-type: none"> Full establishment of system wide RMS for all referrals. Phase 2 roll out based on evaluation of phase 1. 	<ul style="list-style-type: none"> Every pathway starts with prevention (formal inclusion)
Sustainability of provision	<ul style="list-style-type: none"> Establish mechanism for planned care capacity planning Agree to Phase 1 rollout, evaluation and 	<ul style="list-style-type: none"> Phase 2 roll out 	<ul style="list-style-type: none"> Standardise protocols and ways of working 	<ul style="list-style-type: none"> All services have sustainable provision in place.

	2016/17	2017/18	2018/19	2019/20
	monitoring process (i.e.. dermatology, radiology, chronic pain management, ophthalmology, cancer 2 week wait, pathology lab)		(referrals, theatres)	
Commissioning for outcomes & standardisation of care	<ul style="list-style-type: none"> • Identification of opportunities to remove transactional activity and develop collaborative commissioning • Define pathways to prioritise standardisation and outcome based measurement 	<ul style="list-style-type: none"> • System wide approach to collaborative commissioning function (potential rationalising). • Outcome based specifications phase 1 	<ul style="list-style-type: none"> • Outcome based specifications phase 2 • System wide approach to provider side procurements 	
Alternative contracting	<ul style="list-style-type: none"> • Perform options appraisal around lead provider/ supply control for each pathway • Define incentives or risk share 	<ul style="list-style-type: none"> • Define budget/ programme budgets to reflect option chose • Begin implementation phase 		<ul style="list-style-type: none"> • End to end ACO / Incentivised programme budget and supply control

Workforce

	2016/17	2017/18	2018/19
Shared and aligned training Including skills passport	<ul style="list-style-type: none"> • Map existing training provision and opportunities for sharing and identify key players • Agree a vision for shared and aligned training • Identify and implement any 'quick wins' • Decision: do we share provider training delivery? • Develop a priority list for next steps • Define scope of skills passport and identify key players. • Pilot implementation of skills passport for 3 statutory/mandatory training courses 	<ul style="list-style-type: none"> • Implementation of priorities for developing further shared and aligned learning • Implement passport for 3 further subjects • Implement passport for DBS checks. • Define any new skills competencies and order of development from emerging new models of care • 	
Employment offer (attraction of people into the system)	<ul style="list-style-type: none"> • address any critical workforce gaps eg GPs in Swindon • Define shared 'bank' service, rules for employees and governance arrangements • Develop more student placements in non-acute settings • Increase the number of inter organisational rotations available for newly qualified staff • Investigate the opportunity of health and social care apprentices. 	<ul style="list-style-type: none"> • Implement shared bank • Develop consistent promotional offer for health and social care workforce in BSW • Implement a number of pilot health and social care apprentices. 	<ul style="list-style-type: none"> • Evaluate if gaps defined are alleviated. • Implement changes required to respond to the new models of care including development of new skills and working in new settings

	2016/17	2017/18	2018/19
	<ul style="list-style-type: none"> Define and influence level of engagement needed (i.e. social care). 		
Joint workforce planning	<ul style="list-style-type: none"> Establish shared workforce planning resource. Map baseline data and ensure comprehensive intelligence Understand the needs of other workstreams and model changes to workforce required as a result Define ways of working together with other workstreams i.e. back office. Model workforce to new models of care requirements, get other workstream info by Christmas. Inclusion of mental health and primary care workforce, and an idea about a system to enable e-rostering 	<ul style="list-style-type: none"> Influence and engage with universities and colleges on need. 	

Infrastructure

	2016/17	2017/18	2018/19	2019/20
Support Services	<ul style="list-style-type: none"> Procurement collaborative across acutes – already underway Scope non-clinical services provision Shared MOU outlining approach and principles Host shared support services workshop(s) 	<ul style="list-style-type: none"> Develop business case setting out options, benefits and risks assessed against clear criteria Implementation starts Regular review against criteria to ensure identified benefits are realised 	<ul style="list-style-type: none"> Implementation starts Regular review against criteria to ensure identified benefits are realised 	<ul style="list-style-type: none"> Implementation starts Regular review against criteria to ensure identified benefits are realised
Estates	<ul style="list-style-type: none"> Understand all estates, including primary care and future requirement. Develop estates strategy Conduct workshop of all estates leads Establish principles for the estates plan. Identify quick wins in the form of upcoming lease breaks. Draft estate strategy. Finalise FM working arrangements. 	<ul style="list-style-type: none"> Business cases for PFI put to NHSI Wiltshire community estate to NHSPS Align plans with model of care requirements. Identify solution to Wiltshire estate. Support services estate 		<ul style="list-style-type: none"> Fit for purpose estate with high utilisation

Digital	<ul style="list-style-type: none"> • Continue collaborative working to begin immediately – terms of reference being developed • Develop informatics strategy • Collaborative working on key projects • Extending access to primary care data • Improved capabilities in secondary care 	<ul style="list-style-type: none"> • Common interoperability standards established • OD work starts 		<ul style="list-style-type: none"> • System wide data analytics in place • Integrated patient record established • Patient portal • Paper free at point of care
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