STP – October 21st Submission

Footprint Name and Number: Staffordshire & Stoke-on-Trent (10)
Region: Midlands and East

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Key Footprint Information

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Region:	Midlands and East
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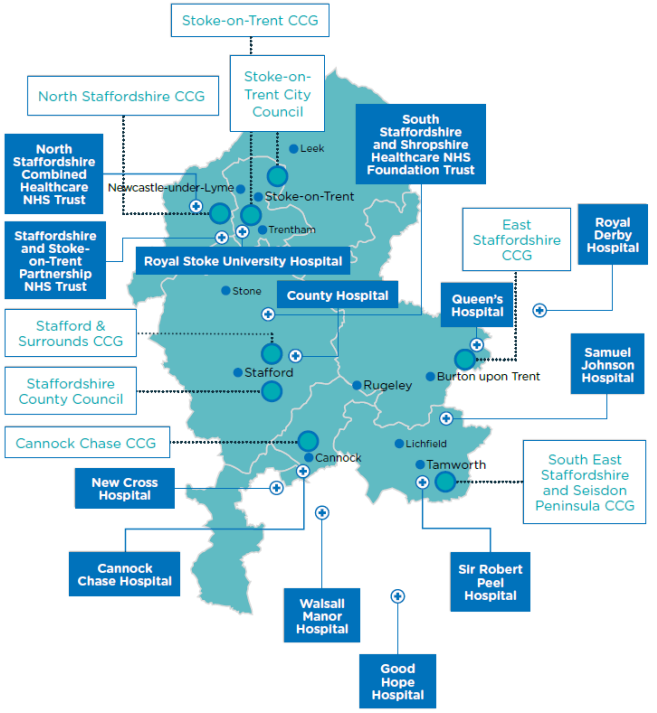


Our Strategic Objectives and Key Priorities

The Staffordshire & Stoke-on-Trent community faces some significant challenges which need to be addressed across health, social care, the voluntary sector, and with our communities if we are to make a difference to health outcomes. This STP plan has been developed as a collaboration between leaders of the health and care leadership in Staffordshire and Stoke-on-Trent and their organisations and is an iterative process. It outlines a range of potential opportunities for doing things differently, and recognises the need to bring our community on this journey with us through a robust and committed approach to engaging the public and workforce in the development and decisions we need to take as a system.

Our areas of focus haven't changed since the first draft submission.. Our priorities remain the same:

FOCUSED PREVENTION	Focus investment and prevention activities on tackling the top 3 issues e.g. obesity, smoking and diabetes along with addressing health inequalities.
ENHANCED PRIMARY & COMMUNITY CARE	Enhance and integrate primary and community care to enable frail elderly and those with long term conditions (LTCs) to live independent lives and avoid unnecessary, costly and upsetting emergency episodes.
EFFECTIVE & EFFICIENT PLANNED CARE	Reconfigure planned care services to meet patient needs, improve productivity and remove duplication and overcapacity.
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	Simplify emergency and urgent care services across the system to reduce avoidable A&E attendances and non-elective (NEL) admissions.
REDUCE COST OF SERVICES	Accelerate the delivery of productivity and efficiency plans. Reduce total bed capacity and rationalise estates. Increase provider collaboration to reduce management costs.

The STP will support an improvement in health outcomes across Staffordshire & Stoke-on-Trent, seeking to reduce health inequalities, delivering better outcomes for citizens, and reducing the impact of the wider determinants of health..

The plan is based on a new model of care where citizens are fully engaged and participate and take responsibility for the outcomes achieved. The bottom up development of integrated teams focused upon prevention and anticipatory care will improve both the experience and quality of care across the whole system and avoid unnecessary attendance at hospitals for planned care, urgent care, and non health related need.

The priority is to develop a completely different way of supporting the most vulnerable elderly. Primary care, social care and our skilled staff are key to the success of the new approach. We are supporting and encourage the bottom up, locality focussed development of new models of care in line with the Five Year Forward View and we already have some examples showing good progress, and an evolving plan to support further development across all 23 locality hub areas .

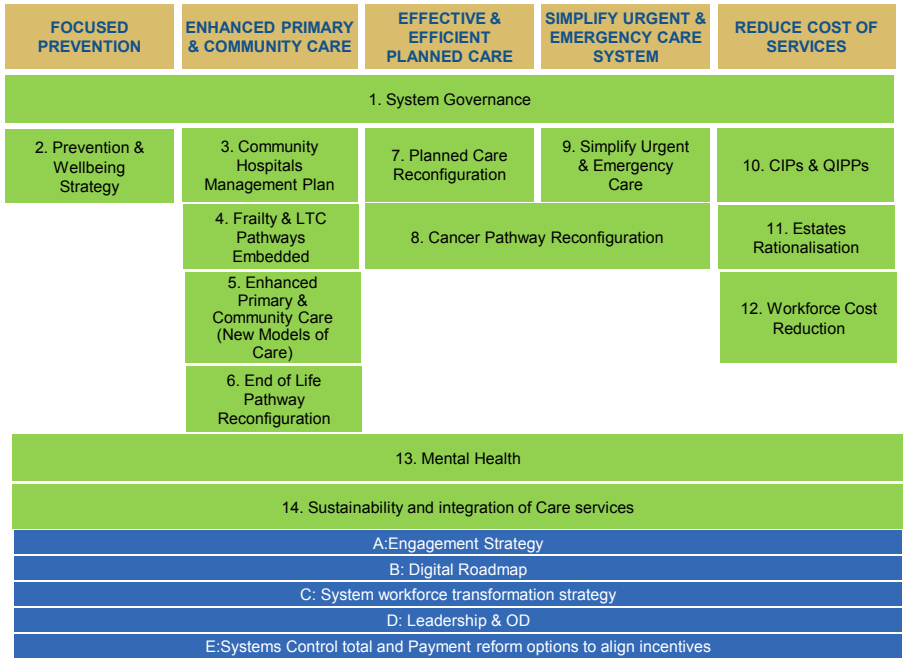
The model is based on health and care professionals working in multi-disciplinary teams, learning from each other working in a different manner with our citizens, working to 'do with' not to 'do to' each and every individual, focused upon prevention, self-care and empowering citizens themselves. This represents a significant culture change for clinicians and professionals and a change in approach for our population too.

The model of care will result in a service provision based on individuals needs, good quality provision, clinically led, responsibility , supporting the whole person and all their health and care needs (including mental health) together which allows the person to have the least intensive intervention and leads to financially sustainable services.

This will see a shift of services and resources away from the hospital and bed based traditional services towards a locality focussed model with a common standard of care across the whole of Staffordshire & Stoke-on-Trent.

Priority Programmes and Key Enablers

For each of these strategic objectives, we have agreed programmes and potential areas of opportunity to be developed in years 1 & 2. The system programmes (green) are grouped under the five strategic objectives (gold) and supported by key enablers (blue):



Executive Summary – Our Model of Care – Caring for You

	What We Aim To Do	How might we deliver this?
FOCUSED PREVENTION	We will work with you to stay healthier and independent by focusing on improving wellbeing and preventing illness, by involving you in all the decisions which affect you and by responding faster to you when problems arise.	• Work with the Staffordshire and Stoke-on-Trent communities to address the social, economic and environmental determinants of health • Focus on specific causes of illness – obesity, smoking and alcohol • Improve the speed with which we diagnose and treat cancer • Share with you the responsibility for staying well and managing your condition • Develop a care plan with you when you have a Long Term Condition so we can all respond faster and more appropriately when you are becoming ill • Create trusting relationships so you feel fully involved in all the decisions which affect you and the community you live in.
ENHANCED PRIMARY & COMMUNITY CARE	'We will deliver more **care in the community you live in** with less need for you to go to hospital.'	• Plan all our services around local communities of 30-70,000 people • Invest in the sustainability and transformation of general practice • Increase the capacity of primary and community care • Focus on the specific needs of people who are frail and elderly and people with long term conditions • Shift resources from hospitals to the community, including clinicians • Work with a wide range of partners in your community • Ensure that you are only admitted to hospital when it is really necessary
EFFECTIVE & EFFICIENT PLANNED CARE	'We will make our **services more joined up** so that everyone involved in your care knows about you and can work together with you.'	• Integrate the way we deliver our services and organise them around local communities • Develop and invest in community teams made up of people from a variety of professional and voluntary backgrounds with a wide range of skills • Re-design our care so it can 'follow you' across organisational boundaries • Integrate how we provide health and social care • Integrate how we provide mental health services into primary and community care • Create an electronic shared care record for you which everyone can see and use • Require organisations to work for the benefit of the whole system • Develop a collective responsibility for all of your care
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	'We will improve the **quality of care** you receive by simplifying and improving your access to it and by ensuring that the professional you contact is part of a motivated **team who have the time and skills to help you.'**	• Improve your access to primary care • Simplify the urgent and emergency care system in your community so you know where to get advice and help • Ensure you are cared for in a setting which is safe and appropriate for your needs • Develop and deliver a primary and community workforce plan • Put clinicians & professionals back in charge of developing the services they provide • Ensure equality of care by agreeing common service frameworks, standards and outcomes which apply wherever you live in Staffordshire or Stoke-on-Trent
EFFECTIVE & EFFICIENT PLANNED CARE	'When you do need to go to hospital, **we will treat you more efficiently and effectively and discharge you back home** as soon as soon as you are ready.''	• Assess you more quickly and ensure that the decision to admit you is the right one • Ensure that your mental health is taken as seriously as your physical health • Discharge you as soon as you are medically fit and help you to recover at home • Perform more operations and procedures as day cases • Perform more tests and follow ups in the community so you don't need to travel to hospital un-necessarily • Ensure that our hospitals work in collaboration with each other and with services in the community • As far as possible, separate the sites where planned and emergency care are given • Concentrate the experts in 'centres of excellence' to improve the quality and reduce the unwarranted variation and duplication of the hospital care we give you

Executive Summary

Understanding the Gap

We recognise the scale of the challenge faced by our health and social care system and the transformation required to address this. The leadership agreed that it will work together to address the gaps in health, care and affordability.

Staffordshire & Stoke-on-Trent's health and care economy has been under significant scrutiny from the public, regulators and press due to historical events. A number of health inequalities exist across the system, resulting in varying health and care outcomes across our population's communities, often below the performance of our peers.

The key areas to be addressed are highlighted below but there is also a need to focus on health inequalities especially in Stoke-on-Trent:

Population Health and Wellbeing

- **Cancer** is the primary reason for premature deaths for our population. This is exacerbated by poor performance in waiting times and diagnosis.
- **Mental Health (MH)** – The number of detentions under the MH Act across our population is significantly higher than our peers.
- **Complex frail elderly people** – our older population is growing faster than the national average, and we are an outlier on injuries from falls.
- **Smoking** – is an issue in pockets across the county. Stoke-on-Trent, Newcastle and Cannock have high rates of deaths due to smoking related illnesses in the 35+ population compared to the national average.
- **Obesity –** Around one in 10 children aged four to five is obese, rising to one in five by the age of 11. Two out of three adults have excess weight problems and one in four is obese. These are higher than the national average rates, however latest data shows that levels of obesity among year 6 pupils in Stoke-on-Trent has reduced.

Quality of Care

- **Access and waiting times** are major contributing factors for our service quality issues, including Referral To Treat (RTT), 62 day waiting times, MH assessment and psychosis referrals.
- **A&E** – our performance against the 4 hour A&E waiting times is a longstanding key issue, partly driven by the access to primary care and the risk averse culture and behaviour which exists across the system.
- **Readmissions** within 28 days of discharge from hospital is also one of our key focus areas to address, particularly in relation to frail elderly (FE) and mental health.

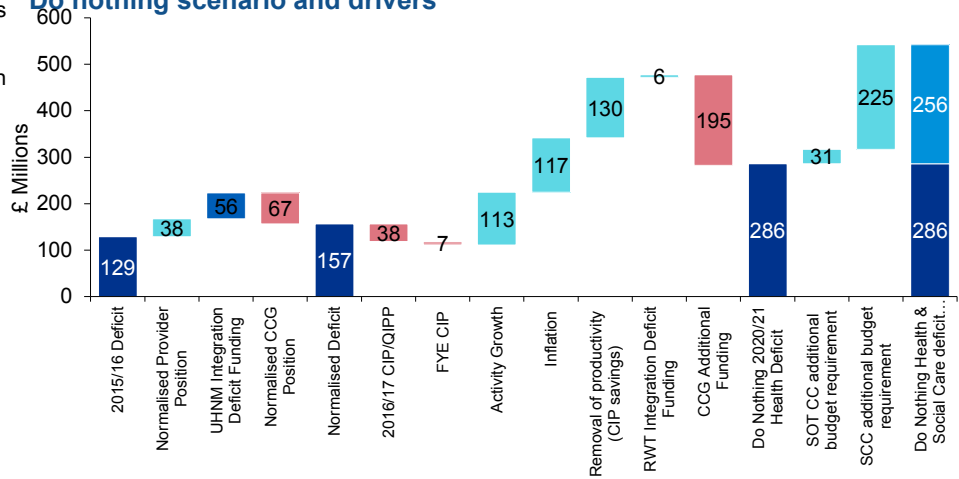
Finance and Efficiency

- **Financial position** – Our system's normalised health deficit amounts to **£157m** and increases further when the social care deficit is taken into account. The largest deficits lie in our acute hospital organisations (UHNM and BHFT), which combined account for £116m of the provider deficit.
- **Drivers** – high levels of avoidable admissions, high cost of urgent and emergency care, multiple access points, duplication of services and costs of planned care and too much estate and inpatient capacity in acute and community care are some of the key contributors to our current deficit position and unstainable model of care.

Financial Baseline

The final outturn position for 2015/16 shows a recurrent gap of £157m. Taking into account inflationary, population and non-demographic factors, the 'do-nothing' scenario forecasts a recurrent gap in 2020/21 of £286m for health. An additional £256m for social care cost pressures results in a total gap of £542m.

Do nothing scenario and drivers



The key drivers of this forecast do-nothing deficit are: no CIP or QIPP from 2017/18 onwards (as per national guidance), structural costs due to too much estate and inpatient capacity, the cost of duplication of services in planned and unplanned care, significant spend on agency staff (at least 3% higher than national average) and duplication of management costs due to the number of commissioners and providers.

In addition to a significant deficit, the do-nothing forecast predicts an additional acute inpatient activity of 27,906 cases (including day cases), requiring additional system wide workforce of 1302 WTE (of which 59 are consultants), and an additional 267 acute beds. Apart from being unaffordable, this is also not practical from a workforce and bed capacity perspective.

The potential solutions and opportunities for transformation and service redesign have not changed from our draft plan submission in June, however we have utilised the last 3 months to develop a level of specificity to our range of potential solutions, to explore in more detail the opportunities which will help to facilitate transformation, and achieve a system level view on our plan submission. We now have a well articulated model of care, which requires cultural change and modernisation along all elements of service delivery, and has been developed with leadership from clinicians and professionals from within the system.

Given the extent of the challenges, which are increasing, some of the potential solutions inevitably are radical but we are committed to work together to deliver them.
We do not underestimate that the Staffordshire & Stoke-on-Trent history makes this especially challenging. Engagement in the plan to date has been limited because of the need to test the model and to ensure we all really believe it will mean improvements whilst delivering the financial savings.

Our cross cutting Health and Care Collaboration is considering use of funding across the system and how it might be rebalanced in order to protect support adult social care. The STP will move from articulating the financial challenge facing adult social care to setting out how this might be addressed through a more sustainable configuration of funding.

Our local politicians do recognise the scale of the challenge and want to provide leadership in shaping and the delivery of the solutions but we will make limited progress without national support for the delivery of the changes. The preferred options within the plan do involve significant change and we need to engage fully with our population to explore whether these options will deliver the model of care and improve health outcome.

We want to explore:

- how to help individuals access urgent care in timely fashion close to home, this will have implications for the current pattern of provision across the county & Stoke-on-Trent
- how to improve and modernize the way we provide planned care and interactions with the health and care sector: if we were more efficient we would need less facilities
- whether we have too many organisations and we invest money too much money in our infrastructure (organisational costs)
- the improvement to be achieved by working together across the health and care sector and we want to support locality teams to work together and build on the expertise in primary care
- how the plan will achieve and deliver consistently the constitutional standards which the citizens of Staffordshire and Stoke-on-Trent should expect
- through this STP plan we will deliver a system wide approach to supporting individuals make the healthy choices

Only by being ambitious in our drive to improve services, care and health outcomes will we be able to attract and retain the skilled staff we need, and we will only achieve our ambitions if we work together as a system and are fully supported to make the real change

The time taken to develop the plan and the governance arrangements have supported the system wide working but we have unanimously agreed that we need to change the system architecture if we are to make the progress necessary. After a workshop with key leaders from across the system, the move towards a streamlined commissioning and provider landscape across the county whilst allowing the bottom up development of new models of care to support the 23 locality teams was proposed. Further work is needed to appraise the full benefits the potential solutions deliver and to outline the detail and implementation of this element of the plan. This process will involve all key stakeholders

Achieving Financial Sustainability

- Our first year was focussed on CIP and real cost out. Our target was £80m in STP. We are not confident we will make this in real terms as the challenges across the system are increasing but we are bringing forward our plans to pilot our new approaches through changes to the way in which services support the management of frail elderly patients. This will provide a test to the STP model of care, system leadership and collaborative working and provide evidence that the system can deliver significant outputs in partnership.
- The Staffordshire and Stoke-on-Trent STP delivers financial balance to the health system by the end of the five year delivery period if delivered in full. We recognise that the deficit funding requirement over the next five years may not be affordable and more radical action will be required.
- The challenge in social care is understood and the STP plans include provision for transitional funding and investment in primary, community and social care

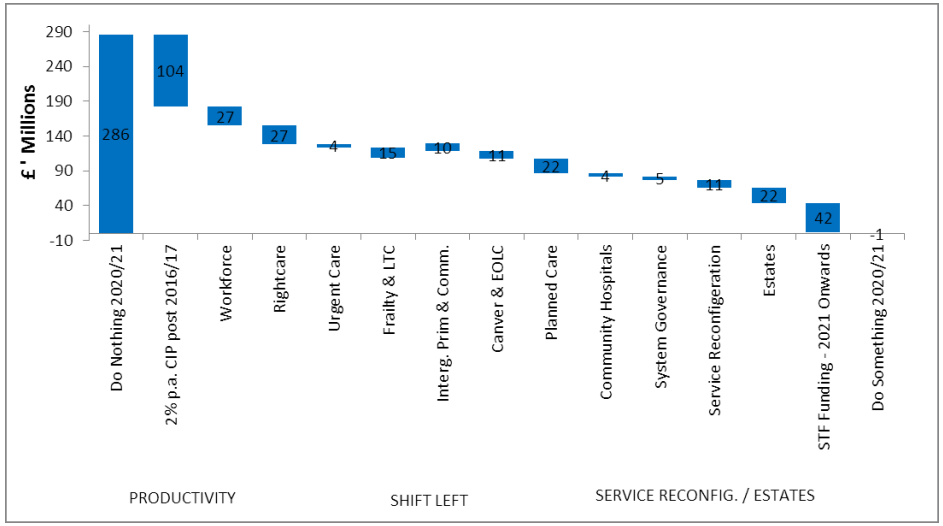
Financial Impact of 5 Year Plan

The following chart illustrates where the key net cost savings or cost avoidance programmes deliver savings by 2020/21. These are grouped into four areas which when taken together will transform the quality and cost of the system:

1. Productivity and efficiency
2. Transferring activity to lower acuity care settings where appropriate (“Shift Left”)
3. Reconfigure services and management to remove duplication
4. Take out fixed costs by reducing the estate footprint

All organisations within the system understand the need to accelerate their efficiency programmes alongside the key programmes of change.

In accordance with the guidance, the chart excludes the social care gap. However, as a system we recognise it as a system issue and will work together to bridge this, including initiatives around market management and domiciliary care.



Understanding the Gap

Key Issues and Drivers

The current configuration of the health and social care system results in an unsustainable and unaffordable model, which is not currently coping with demand and will certainly not cope in the future if nothing changes. The result is a gap against health, quality and affordability which must be addressed at speed to deliver a sustainable Staffordshire & Stoke-on-Trent health and care system. The below diagram highlights the specific issues within each domain of care.

Demand

Demand for, and hence cost of, health and social care is increasing due to the poor current health and wellbeing of the population (high prevalence of obesity and diabetes county wide and smoking in some areas). The ageing and growing population, with a forecast 16% growth rate in the 65+ population by 2021 (above the national average) leads to high levels of people living with more than one LTC and forecast high levels of dementia. Current culture and behaviours of citizens exacerbate demand as they attend A&E more frequently than peers, and the risk averse culture of staff does not counter this.

Primary Care

A workload and workforce crisis is fast rendering General Practice unsustainable in some parts of SSoT, especially for the high number of single handed practices. Whilst clustering, federating, implementing the GP5YFV, adopting the 10 high impact changes and engaging practices in the new models of care described in the STP are all underway, it still remains a huge challenge to stabilise General Practice so that it can form the nucleus of place based enhanced primary and community care

Community

Community services remain disjointed, overburdened and with many of the staff demoralised. There are 10 enhanced primary and community care (EPCC) initiatives underway across SSoT but, as yet, they only cover half the population. A system wide EPCC programme has brought them together to share learning, develop self improving skills and agree whole system strategic intentions, benchmarks, outcomes and impacts. This transformational change will take 3-5yrs to complete, a timescale which is at risk of being too slow to sufficiently increase community capacity, help to stabilise primary care or enable a major reduction in our dependence on bed based care.

Financial Position

The financial position is driven predominantly by the following areas:

- Limited achievement of efficiency and productivity, including CIPs
- High cost of urgent and emergency care due to multiple access points (3 A&Es, 5 MIUs)
- Higher than average A&E attendances
- High avoidable emergency admissions (13% higher in Stoke-on-Trent)
- Duplication of services and costs in planned care
- Large estate and infrastructure costs in acute and community, including beds

Social Care

Social Care are seeing increased demand and the need to work more closely with health to adjust care models to accommodate this increase whilst meeting budget constraints. The proportion of older people offered reablement on leaving an acute trust in this system is half the England average. The Local Authorities are under significant financial pressure, resulting in a decision to cut non-statutory spend which will have an impact on the health and care system.

Urgent Care

Urgent care activity at both acute trusts is higher than peers for A&E attendances, NEL admissions and readmission rates. The high demand is due to the poor primary and community infrastructure, the current system configuration (including multiple access points: 3 A&Es and 5 MIUs) and the culture and behaviours of citizens. Admitted patients (> 75 years) tend to stay longer in hospital due to delayed transfers of care (NHS and Social Services). Five of the six CCGs had fewer people dying in their usual place of residence than peers.

Mental Health

We have a 30% higher suicide rate than peers in Stoke-on-Trent for men aged 15-34 years and half the CCGs were above peer average for the number of people detained under the Mental Health Act 1983 per 100,000 population. Four out of six CCGs had a significant proportion of patients with common MH conditions waiting for assessment longer than 90 days. In addition four CCGs were worse than peers on readmissions to mental health services within 30 days of discharge.

Planned Care

Planned care is delivered from multiple sites across our large estate footprint, including three acute sites, one treatment centre and three community hospitals. This results in significant duplication, inefficiencies and unaffordable costs of planned care.
Patients wait longer than peers in many areas for treatment, especially for cancer and mental health services. There is significant variation in GP referrals across the system. First to follow up rates are higher than peers.

Overview of System Issues

In our STP return in April, we highlighted the need to improve the health and wellbeing of our population in Staffordshire & Stoke-on-Trent, which is below England averages in the areas described below.

We also recognised the health inequalities which exist across our system's footprint. These wide variances can often be linked to the deprivation found within the region's natural communities. For example, in Stoke-on-Trent, 52.6% of the population live in areas in the top 20% most deprived in England, and both life expectancy and healthy life expectancy lag behind the rest of Staffordshire and the West Midlands as illustrated in this table.

	Staffordshire		Stoke-on-Trent		West Midlands	
	M	F	M	F	M	F
Life Expectancy	79.7	83.1	76.5	80.6	78.8	82.8
Healthy Life Expectancy	62.8	63.4	60.9	58.9	62.4	62.8
% Life spent in good health	78.8	76.3	79.6	73.1	79.2	75.9

Since April, to enable us to better understand and quantify these issues and the underlying drivers which contribute to these, we conducted a detailed analysis and assessment of our system's performance. This covered performance in the areas of population health, quality, and productivity and efficiency, and included the aggregate financial position of our health and social care organisations. It also identified key drivers of the deficit and looked at future forecasts should the status quo continue. The findings are outlined below. Whilst we have presented issues and drivers, we are not suggesting specific cause and effect.

Population Health

Population Health Issues*

- **Obesity –** Obesity and excess weight was significantly worse than the England average in six of the nine District/Unitary Authorities across the region.
- **Complex frail older people –** Half the CCGs across the system exceeded their peer averages for injuries due to falls (ages 65+). Stoke-on-Trent was 30% above the national average.
- **Smoking –** Stoke-on-Trent, Newcastle and Cannock have high rates of deaths due to smoking related illnesses in the 35+ population compared to the national average.
- **Preventable Mortality – Cancer** was the primary reason for premature deaths for both Staffordshire and Stoke-on-Trent LAs between 2012-2014, approximately twice as high as the next largest contributors to premature deaths: heart disease and stroke.
- **LTCs – Diabetes and coronary heart disease** prevalence exceeded the England average in five of the six CCGs for 2014/15.
- **Alcohol –** Hospital stays for alcohol related harm were significantly higher than the England average for five of the six CCGs. This was highest in Stoke-on-Trent CCG – 52% higher than England average.
- **Mental Health** – The number of detentions under the MH Act (per 100,000 population) were above peer average for three of our CCGs in 2013/14. Additionally we have higher levels of emergency hospital admissions of those people who intentionally self harm in Staffordshire and Stoke-on-Trent.

Population Health Drivers*

Cancer Mortality

- **Waiting times –** Both acute Trusts (BHFT & UHNM) were the worst performing Trusts relative to peers in terms of cancer waiting standard from urgent GP referral to being seen in 2015/16 (79% and 75% of patients being seen within 62 days).
- **Diagnosis –** Five of the six CCGs across our system were in the bottom 30% against peers for cancer detection at stage 1 and 2 (based on latest Public Health England ('PHE') data).

Mental Health

- **Assessment –** Four CCGs reported a significant proportion of patients with common mental health conditions waiting for assessment longer than 90 days.
- **Psychosis referrals –** Stoke-on-Trent was the only CCG to report a rate of at least 50% of treatments commencing within 2 weeks.

LTCs

- **Diabetes (secondary prevention) –** The proportion of people with diabetes with good blood sugar control was worse than the England average in half the system's CCGs.
- **Obesity –** Obesity and excess weight was significantly worse than the England average in six of the nine District/Unitary Authorities across the region.

Complex Frail Elderly

- **Reablement –** The number of people who are offered reablement to allow discharge from hospital as a proportion of all discharges from hospital aged 65+ was 1.2% compared to the England average of 2.9%, almost 59% less than the national average. This is likely to have a significant impact on the number of non-elective admissions. This may also be a contributing factor towards the high number of injuries due to falls for those aged 65 and over.

*Whilst we have show both issues and drivers we are not suggesting specific cause and effect.

Understanding the Gap – Health, Quality and Finance 2015/16 (Drivers)

Quality

Quality Issues*

- **A&E -** Both UHNM and BHFT have consistently failed to meet the 4 hour wait target between 2012/13 and 2015/16. The combined average performance was 86% (9% below target).
- **RTT 18 week waiting times** – UHNM did not meet the 92% target in March 2016, although performed better than its peer average with a rate of 90.5%. BHFT met the target with a rate of 92.60% (March 2016).
- **Cancer waits –** Both Acute Trusts (BHFT and UHNM) were the worst performing Trusts relative to peers for cancer waiting standard from urgent GP referrals in 2015/16 (79% and 75% of patients being seen within 62 days).
- **Non elective admissions –** Two CCGs had significant non-elective admissions compared to peers: Stoke-on-Trent (13% higher) and Stafford and Surrounds CCG (11% higher) (2014/15).
- **% people dying in their own home –** Half of the six CCGs were below the 2015 England average (46%) for the percentage of patients dying in their usual place of residence defined as home, care homes (local authority and non-local authority) and religious establishments. Stoke-on-Trent CCG has the lowest percentage at 37%.
- **Emergency readmissions** – Half the CCGs were in the worst 30% performers against peers for emergency readmissions 30 days from discharge.
- **Reablement** - The number of people who are offered reablement to allow discharge from hospital as a proportion of all discharges from hospital aged 65+ was 1.2% compared to the England average of 2.9%, almost 59% less than the national average. However the percentage of older people who receive reablement on discharge from hospital who are still at home 91 days later: is 87.8% compared to the England average of 82.7%
- **Mental Health** – There is a lack of 24/7 mental health crisis response across the county.

Quality Drivers*

Non-Elective admissions (significantly higher than average for two CCGs)

- **End of Life Care** – The number of patients dying in their usual place of residence (set out on the previous page) highlights the absence of end of life planning in the last 18 months of life. Too many people are being admitted to hospital to receive end of life care rather than dying in their usual place of residence or place of choice. Advanced care planning for those on an end of life care pathway is currently limited across Staffordshire & Stoke-on-Trent.

Emergency Readmissions

Hip fractures and Mental Health were the key contributors for readmissions within the system:

- **Hip Fractures** - Patients admitted with a hip fracture and subsequently discharged in the North Staffordshire or Stafford and Surrounds areas are 35% and 33% more likely to be readmitted to hospital within 28 days respectively than their peer averages.
- **Mental Health** – Four of the CCGs performed poorly against their peers for unplanned readmissions to mental health service within 30 days of discharge. Of these four CCGs, East Staffordshire and Stafford and Surrounds were over 20% worse than peers.

A&E Waiting times

- **Access to primary care** – There are large variations in the number of GPs per head of population. Cannock Chase CCG ranked lowest within the region with 58 GPs per 100,000 population, 10 less than its peer average. It also has the highest percentage of GP practices with only one or two GPs, at 59.3%.
- **Culture and behaviour** – Both UHNM and BHFT had higher attendances at A&E than their peer average (UHNM 30% higher than peer average), arriving at multiple entry points across the system. This highlights the populations' dependency on A&E and leads to more patients being admitted into the acute system due to lack of integrated service models.

Productivity and Finance

Productivity & Finance Issues

- **Financial position –** Staffordshire & Stoke-on-Trent's health deficit amounts to £157m (2015/16). This increases further when the social care deficit is taken into account (further detail on finance on page 11).
- **Where the provider deficits sit –** The system's provider financial position is largely driven by the £100m financial deficit at UHNM.
- **The CCG recurring deficit** in total is £29m. The accumulated CCG deficit at the end of 15/16 total £96m.
- **The Special Administrator (TSA) Funding –** The Staffordshire & Stoke-on-Trent Health System has significant non-recurrent funding due to the TSA legacy. The removal of the TSA support funding relating to MSFT amounts of £43m when this ceases at 31st March 2017.
- **CIP position –** 15% (£11.4m) of the providers' CIP target (£76.1m) in 2015/16 was not achieved. 23% (£14.7m) of CIPs delivered were non-recurrent.
- **Workforce –** Agency staffing costs reached £44m across health providers in 2015/16. Overall, this equates to 7% of total pay costs of £642.9m. This was particularly high at SSoTP (community hospitals) which amounted to 22%. Increased reliance on temporary staffing will impact on quality and continuity of care across organisations.

Productivity & Finance Drivers

Financial Deficit

- **Achievement of CIPs to date** - 15% (£11.4m) of the providers' CIP target (£76.1m) in 2015/16 was not achieved. 23% (£14.7m) of CIPs delivered were non-recurrent.
- **Community beds** – In 15/16 SSoTP had the largest number of community beds when compared to its peers. It also reported the highest occupancy rate of 96% (significantly above the peer average of 67% in Q3 2015).
- **Estate** – There are three connected issues related to estates. Firstly the overall size of the estate appears to be significantly greater on an acute floor space comparison. This gives rise, secondly, to the duplication of planned and unplanned services which are provided over three to four separate sites.
- **Workforce** – Agency costs are estimated to be at least 7% of total pay spend. National average is 4%.
- **Management costs** – Staffordshire & Stoke-on-Trent has six separate CCGs and five NHS providers which results in duplication of management costs and back office services.

*Whilst we have show both issues and drivers we are not suggesting specific cause and effect.

Understanding the Gap – Finance

- **The 2015/16 normalised position for the overall health economy is a £157m deficit.**
- **£127m relates to providers and in particular £100m relates to UHNM who received £56m of integration deficit funding in 2015/16.**
- **The health providers within Staffordshire & Stoke-on-Trent receive over £1.5bn of income.**

NHS Baseline position – 2015/16

As recognised in the Case for Change, health and care in Staffordshire & Stoke-on-Trent has been living beyond its financial means for a number of years and as stated in previous pages has not been able to demonstrate significant improvements in aspects of health and care outcomes. The normalised health system deficit for 15/16 was £157m. In addition, the health and care economy has already accumulated significant deficits that require repayment.

As demonstrated in the table to the right, both acute trusts (UHNM and BHFT) are in normalised financial deficit for 15/16. this means that, for example, UHNM services cost £100m more than the associated annual income. The challenge for social care is equally stark – Staffordshire County Council in its Integrated Business Plan ('IBP') in 15/16 presented an overspend on social care of £20m and Stoke-on-Trent City Council presented an IBP overspend of £4m on social care.

	15/16 Surplus/ Deficit (Providers)	15/16 Surplus/ Deficit (Commi-ssioners)	Net Non-Recurrent Income	Impairments	Normalised 15/16 Surplus/ Deficit
Providers					
UHNM	(26,936)		(72,923)		(99,859)
BHFT	(17,236)		0	1,230	(16,006)
SSoTP	603		(11,196)	(1,207)	(11,800)
SSSFT	9,350		(9,350)	0	0
NSCHT	790		(833)	43	0
Total Provider	(33,429)		(94,302)	**66**	(127,665)
CCGs					
NHS East Staffordshire		(7,115)	7,930		815
NHS North Staffordshire		(4,215)	1,215		(3,000)
NHS Stoke-on-Trent		503	(3,623)		(3,120)
NHS SESS		(34,675)	21,131		(13,544)
NHS Stafford and Surrounds		(25,957)	20,457		(5,500)
NHS Cannock Chase		(24,488)	19,744		(4,744)
Total CGG		(95,947)	66,854		(29,093)
Total	**(33,429)**	**(95,947)**	**(27,448)**	**66**	**(156,758)**

The figures presented exclude the income and expenditure of Royal Wolverhampton NHS FT. Significant activity for the population of Staffordshire & Stoke-on-Trent however is delivered by Cannock hospital (part of Royal Wolverhampton NHS FT) and is therefore included in our modelling.

It should be noted that whilst the system is in deficit overall, the normalised position for SSSFT and NSCHT shows balance.

The Staffordshire & Stoke-on-Trent health system has received significant non-recurrent funding as part of the TSA legacy. This accounts for £56m of the non-recurrent funding at UHNM and £6m at Royal Wolverhampton NHS FT. This will not be received after 16/17.

The bottom table provides a breakdown of expenditure in the provider organisations across the system. Staff costs represent over 43% of the cost to the healthcare system, with 35% in fixed costs. It is clear from this that to regain and maintain financial balance these are two key areas of focus. This should be achieved by using the workforce in different ways in order to address the increased demands on the system and utilising and rationalising fixed costs.

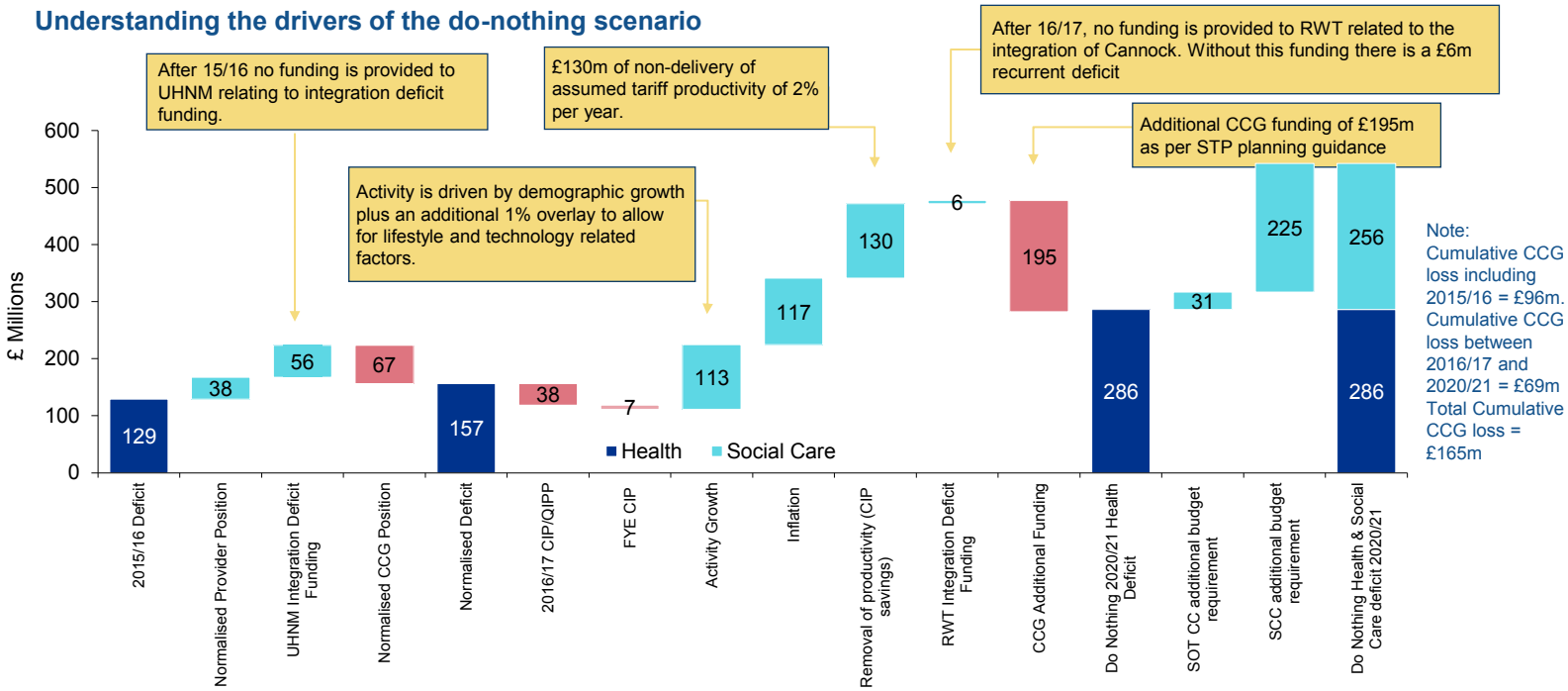
2015/16 Financial Outturn £'000

	BHFT	UHNM	NSCHT	SSSFT	SSoTP			Total
	Acute/ A&E	Acute/ A&E	Mental Health	Mental Health	Community Teams	Community Hospitals	Adult Social Care	
Income	184,282	702,917	78,587	177,342	153,509	67,441	151,603	1,515,681
Staff Costs	(107,417)	(244,598)	(56,069)	(102,291)	(94,443)	(38,113)	(27,487)	(670,418)
Variable Costs	(45,888)	(99,574)	(7,880)	(32,736)	(21,988)	(16,084)	(115,193)	(339,343)
Fixed Costs	(48,213)	(385,682)	(13,847)	(32,785)	(33,240)	(16,212)	(9,190)	(539,169)
Surplus/ Deficit	**(17,236)**	**(26,937)**	**790**	**9,350**	**3,839**	**(2,967)**	**(268)**	**(33,429)**

Understanding the Gap – Finance

- **By 2021 in a "do-nothing" scenario the overall health and social care economy will be in a £542m deficit, of which £286m relates to health care.**
- **This assumes non delivery of CIP of £130m over the 5 years (2% per annum)**
- **The Health Do Nothing deficit is increased by £42m since the original STP as a result of a deterioration in the 16/17 financial position.**

Understanding the drivers of the do-nothing scenario



Note: Cumulative CCG loss including 2015/16 = £96m. Cumulative CCG loss between 2016/17 and 2020/21 = £69m Total Cumulative CCG loss = £165m

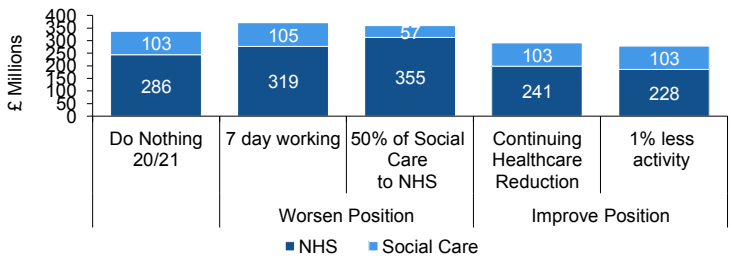
The health 'do-nothing' normalised recurring deficit in 2020/21 is forecast to be £286m. This deficit is calculated by the forecast income less the forecast expenditure. The Social Care 'do-nothing' commissioned by Staffordshire County Council and Stoke-on-Trent City Council in 2020/21 is forecast to cost £256m more to provide the same level of service. The Stoke-on-Trent City Council number has been amended (December 2016) to £38m to reflect the gross financial challenge. It should be noted that this will create cost pressures on the NHS if the local authorities cannot fund these increased costs or cut services.

The following sensitivities have been applied to the "do-nothing" scenario in order to understand the additional risks which are beyond the control of the system as a whole.

Sensitivity	Sensitised Impact	Description
7 Day Working	£33.3m additional cost to NHS £1.8m additional cost to Social Care	From 2019/20 onwards 2% of income as additional cost
50% of social care moved to NHS at double price	£69.2m additional cost to NHS £46.2 saving to Social Care	Half of social care to be provided by the NHS but this element to cost double the price of social care
Continuing Healthcare Reduction	£45.2m saving	Reduction in growth rates ranging from 5.5% to 6.6% from 12% per year
Activity reduction by 1%	£58.4m saving	1% less activity from 2016/17

The sensitivities have not been included in the 'do-nothing' forecast. These may result in changes to the overall deficit position, e.g. if there was a significant effort put into reducing the growth of Continuing Healthcare to the national forecast growth rates, the 2020/21 would be £45m lower than the current forecast gap.

Sensitivity Breakdown



In the original STP we aggregated the original organisational plans adjusted for CIPs having no specific plan and c.£30m of QIPP which was not a system wide saving. A detailed review of the consolidated 16/17 in-year financial positions across the system has revealed that a combination of additional cost pressures and CIP/QIPP plans that will not lead to system-wide savings totalling £41m. To be prudent we are treating this additional deficit as recurring.

Understanding the Gap –Social Care

The health and care system is inextricably interdependent: the sustainability of the NHS is critically dependent on public health and adult social care. Staffordshire County Council and Stoke City Council are under unprecedented financial pressure in the face of falling government funding, rising demand from an ageing population, and rising costs - in particular from the national living wage. The social care precept, which is being levied in full across both local authorities will only meet these in part, and there remains a substantial gap of £225m. The STP will seek transition funding for investment in prevention and adult social care to contribute to closing this and avoid these functions becoming progressively degraded and the system failing as a result.

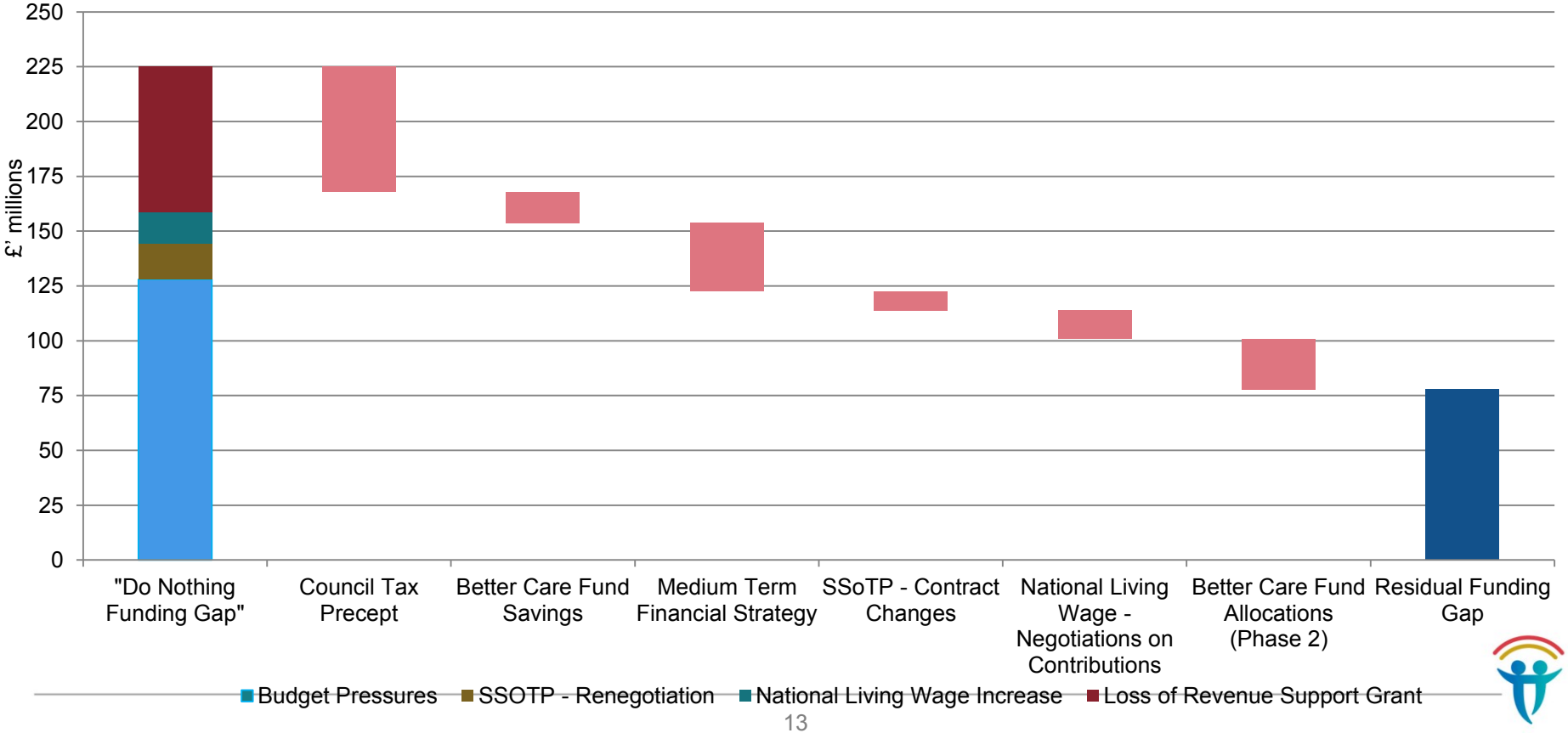
The Staffordshire County Council Social Care is bridge shown below. This shows the make up of the £225m do nothing position, and the various solution that reduce the residual gap to £78m by the end of 2020/21.

Stoke-on-Trent City Council Adult Social Care Services currently have a projected gap of £38m by the end of 2020/21, unless action is taken. In order to mitigate against this funding gap a number of potential proposals have been included within the City Council's Budget Consultation 2017/18 – 2019/20, which was publicly launched on 29 November 2016.

The proposals being consulted on include implementing the Adult Social Care Precept of 2% and a range of transformational and efficiency saving proposals from across the Better Care Fund, Adult Social Care, Public Health and other Council services.

In addition the medium term financial plan includes assumed additional Better Care Fund income allocations from Central Government. It should be noted that the delivery and achievement of savings proposals given continued demand upon services present a significant challenge and will require partners from across local government, the NHS and other sectors to work closely together to deliver an improved model of care.

Staffordshire County Council Social Care bridge



Priority Objectives Overview

Our Priority Objectives – direction of travel has not changed

Our 5 strategic objectives were set by the system after significant work in June and have not changed. The detail of our plans under each of the strategic objectives are set out below. These are also supported by system-wide programmes for mental health and health and social care collaboration. Details of these are discussed over the following pages. The strategic objectives, which will deliver the Five Year Forward View ('5YFV') , deliver constitutional targets and improve quality, care and outcomes, are summarised below and specific Staffordshire & Stoke-on-Trent challenges addressed by workstreams grouped under these objectives. Cumulatively these refined priorities will have a direct impact upon the way in which acute services are organised and from where.

Refined Objectives	
FOCUSED PREVENTION	Address the economic, social and environmental determinants of health. Focus current spend and prevention services on promoting healthy ageing and tackling health inequalities in Staffordshire & Stoke-on-Trent. Identify the top three industrial prevention actions (e.g. secondary prevention of diabetes, reducing the harm caused by smoking in pregnancy, obesity prevention in high risk individuals). Identify where upstream investment in prevention and early intervention services will have a positive impact on both the health of the population of Staffordshire & Stoke-on-Trent in the short, medium and long term and will have an upstream positive impact on the population of Staffordshire & Stoke-on-Trent and reduce high cost care.
ENHANCED PRIMARY & COMMUNITY CARE	Enhance primary and community care at pace to enable the frail elderly and those with long term conditions to live independent lives and avoid unnecessary, costly and upsetting emergency episodes. Best practice pathways for the frail elderly and those with long term conditions will be introduced. . Address the fragility within the domiciliary and home care sectors. Improve reablement and intermediate care collaboration with the local authorities. Across health and care, we will integrate community, mental health, primary, social care and the voluntary sector. This will be delivered through fully integrated locality hubs supporting populations of 30 – 70,000 citizens and form the foundation upon which we develop new models of care including MCPs and PACs.
EFFECTIVE & EFFICIENT PLANNED CARE	Develop options to re-configure services for planned care to deliver 'state of the art' highly efficient 7 day elective centres; keeping day case and outpatients local. Aims are to reduce duplication, deliver improved care at lower cost, and to include the release of estate. In parallel deliver productivity and efficiencies by specialty to reduce patient waiting time, improve referral processes, improve the quality of care and reduce costs. Improvements in productivity will further inform the re-configuration options as it will lead to a reduction in the required capacity to meet the Staffordshire & Stoke-on-Trent demand. This will lead to the potential for elective care being delivered across a reduced number of sites in Staffordshire and Stoke-on-Trent
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	Simplification of the urgent and emergency care pathway to ensure that people receive the right care, in the right place, at the right time, and with the right level of clinical expertise. Minimise the access points of emergency care – Urgent Care: Consolidate minor injuries, walk-in, GP urgent appointments, NHS 111, and other urgent and response services with access to diagnostics in community facing urgent care units. Implement alternative rapid response community facing services which support the ability of the system to avoid unnecessary hospital attendances and admissions, and where admission does occur, reduce length of stay and increase the number of people returning to their usual place of residence post discharge. A&E standards to be achieved consistently and maintained through alignment and engagement between the STP and A&E delivery boards. Consider a change of purpose on one site from A&E to Urgent Care Centre.
REDUCE COST OF SERVICES	Manage and deliver CIPs and QIPPs with a coordinated effort, ensuring that all providers and CCGs are in a strong position to deliver their in-year efficiencies through robust and forensic assessment of deliverability and the undertaking of significant mitigation actions where identified. Generating a long list of tactical savings outside of traditional QIPP/CIP. Develop a system-wide approach to the management and appointment of temporary staff, and sharing clinical capacity and expertise across the system irrespective of employer in order to reduce dependency upon agency workforce to lower cost. Rationalise estate and management costs to reduce fixed costs.

The delivery of our strategic objectives will mean the system looks and feels different for our citizens in 2020/21, a summary of which is in the following section.

Consolidated STP Programme Infrastructure

In the development of the programme since June 2016 the programme infrastructure has been consolidated across the STP footprint. Programme Directors at an Executive level have been released from within the health and care system to support this process.

- In order to maximise the resources available to the programme and also maximise the confirmed synergies that operate between the individual workstreams, the programme management and leadership of these are organised into 5 core programmes as outlined below.
- Each programme has a Senior Responsible Officer, a Programme Director, and a Clinical Lead who has oversight of the delivery of the overarching programme of work, ensuring clinical engagement and ownership, systemic and aligned planning and delivery profiles, alongside delivering the maximised synergies and benefits.
- Current SROs, and arrangements for individual workstreams have been retained.
- The programmes are also supported by resources from the CSU Strategy Unit in the development of options appraisals, and business cases, alongside undertaking data analytics to drive the opportunities for Planned Care, Urgent and Emergency Care and Enhanced Primary and Community Care.

BETTER HEALTH, BETTER CARE, AFFORDABLE SERVICES

Priority Programmes

FOCUSED PREVENTION	ENHANCED PRIMARY & COMMUNITY CARE	EFFECTIVE & EFFICIENT PLANNED CARE	SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	REDUCE COST OF SERVICES
Identify where upstream investment in prevention and early intervention will have a positive impact on both the health of the population and reduce high cost care.	Enhance and integrate primary and community care to enable frail elderly and those with LTCs to live independent lives and avoid unnecessary, costly and upsetting emergency episodes.	Reconfigure planned care services to meet patient needs, improve productivity and remove duplication and over capacity.	Simplify emergency and urgent care services across the system to reduce avoidable A&E attendances and NEL admissions.	Accelerate the delivery of productivity and efficiency plans. Reduce total bed capacity and rationalise estates. Provider collaboration to reduce management costs.

Workstreams

- 1. System Governance
- 2. Prevention & Wellbeing Strategy
- 3. Frailty & LTC Pathways Embedded
- 4. Community Hospitals Management Plan
- 5. Enhanced Primary & Community Care (New Models of Care)
- 6. End of Life Pathway Reconfiguration
- 7. Planned Care Reconfiguration
- 8. Cancer Pathway Reconfiguration
- 9. Simplify Urgent & Emergency Care
- 10. CIPs & QIPPs
- 11. Estates Rationalisation
- 12. Workforce Cost Reduction
- 13. Mental Health (representation in all core programmes)
- 14. Sustainability and Integration of Care Services

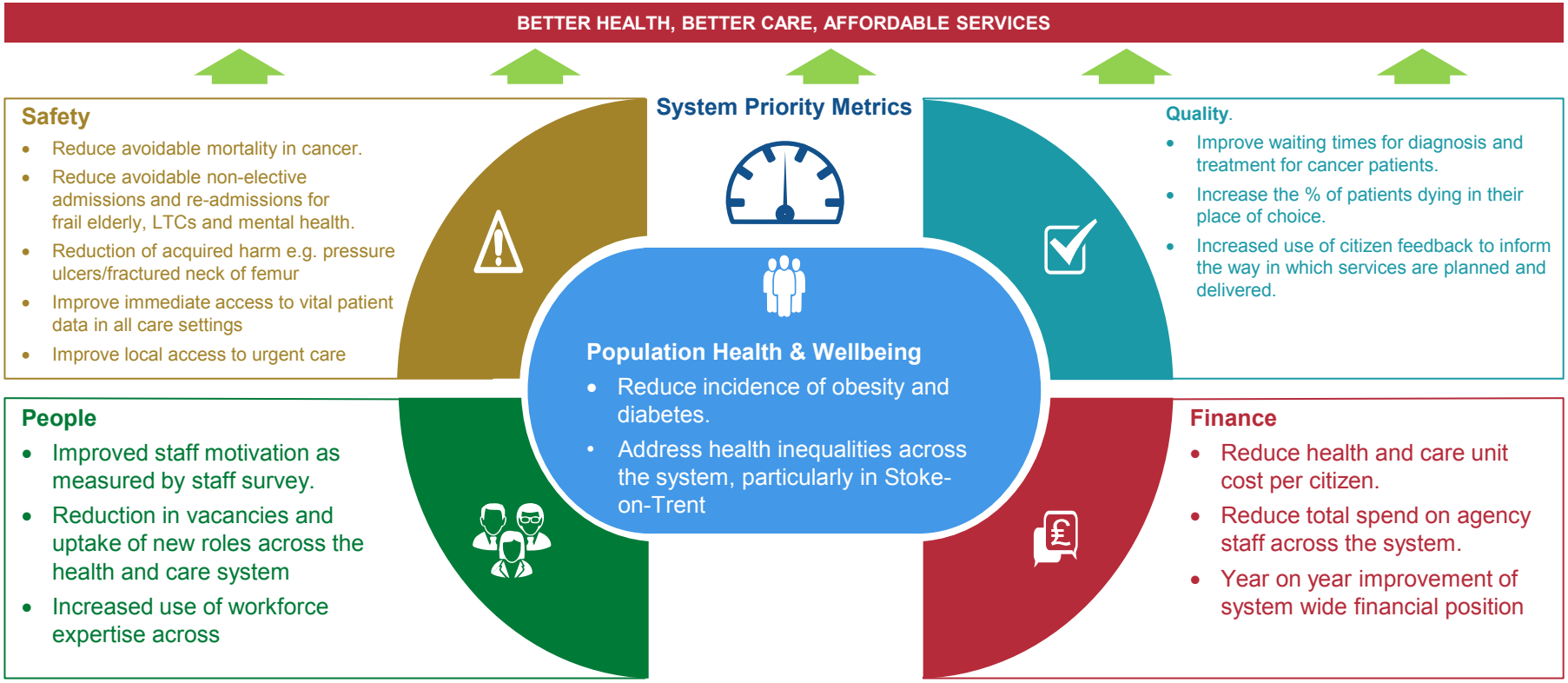
Enablers of Change

- A. Engagement Strategy
- B. Digital Roadmap
- C. System workforce transformation strategy
- D. Leadership & OD
- E. System Control Total and Payment reform options to align incentives

System Priorities – Measuring Progress

In order to "shift the dial" on current system performance, the following metrics have been agreed as the key measures against which the system will collaboratively drive performance improvement. Further work is required to agree the quantified performance improvement targets for each programme across each of the domains below for this year and how progress against these will be tracked. These metrics will be embedded into each workstream, and will act as key determinants of the progress against the STP as a whole. As well as the metrics, programmes will be measured also by individual critical success factors covering population health, quality and finance as appropriate – These are indicated on the Year 1-5 Summary Plans on the subsequent pages.

Whilst we recognise that there are constitutional targets that need to be met, those set out below are the system priority metrics.



Priority Objectives ‘On a Page’

Focused Prevention – Success in 2021

As part of the STP feedback it was clear that the system needed to set out what success would look like in 2020/21. For each of Staffordshire & Stoke-on-Trent's strategic objectives the system is clear on what success will look like in 2021 as set out below. An update on progress since June for each workstream within this priority programme is outlined in Appendix D.

	Success in 2021	Key measures
FOCUSED PREVENTION	• A healthy policy framework e.g. planning, licensing, housing, healthy work place is embedded within Staffordshire & Stoke-on-Trent • Community capacity to support health and well-being. • Information, advice and signposting resource is being accessed in support of self managed care. • Risk stratification to identify high risk communities & individuals is in place and is being used to reprioritise available investment to focus on these groups, to plan and deliver effective care. • NICE guidance to inform the type, level and funding of targeted prevention services to manage risks including lifestyles, falls and social isolation is used effectively. • Embedded preventive activities are delivered into existing services, including primary, community and secondary care services funded by the NHS. • Improvement of the health of the NHS and Care workforce in Staffordshire and Stoke-on-Trent. • Enhanced and proactive management of obesity and diabetes against all elements of the pathway is in place across health, care and self care	• Increased positive performance against workforce sickness targets • Increase in the appropriate use of bariatric surgery • Reduction in targeted levels of obesity • Reduction in the number of newly diagnosed diabetes • Targeted patient groups accessing health prevention services and self help

System Priorities: **(2) Prevention and Wellbeing**

Objective: Focused Prevention *Relevant key STP questions: 1, 2, 7, 8*	**SRO: Richard Harling** **Clinical Lead: Dr Lesley Mountford**	**Impact (£) by 2021: Neutral impact modelled as to avoid double count as actions taken in this workstream will provide savings across the system**

Description

This programme recognises that the greatest gains in health and well-being are achieved through influencing the environmental, economic and social determinants of health rather than individual interventions. Also that our populations need to take greater responsibility for their own health through their lifestyle choices. Where individuals are at risk of a reduced life expectancy or vulnerable, targeted interventions will be offered with increasing levels of intervention to groups with increasing risk of ill health or dependency. Key actions include;

- Develop a healthy policy framework e.g. planning, licensing, housing, healthy work places.
- Building community capacity to support health and well-being.
- Establish a low level information, advice and signposting resource.
- Apply a risk stratification approach to identify high risk communities and individuals and reprioritise available investment to focus on these groups.
- Utilise NICE guidance to inform the type, level and funding of targeted prevention services to manage risks including lifestyles, falls and social isolation.
- Where appropriate embed preventive activities into existing services, including primary, community and secondary care services funded by the NHS.
- Support improvement of the health of the NHS and Local Authorities workforce
- Enhance management of obesity and diabetes in the NHS including a review of the use of bariatric surgery.

Key Assumptions

- To avoid double counting there are no immediate cost reductions modelled in the activity and financial cost saving bridge.
- The cost avoidance will come from a reduction in demand for health and social care in the longer term.
- Modelling this is complex because many of the benefits arise in the long term. However we know from evidence presented in reports such as Wanless and the Five Year Forward View (5YFV) that the NHS is only sustainable with a renewed emphasis on prevention.
- Efforts will continue to quantify short term savings for diabetes, bariatric surgery and falls prevention.

Enabling requirements

- Creation of a tier 1 digital platform.
- Identification of communities and individuals with risk factors for ill health and dependence and provide evidence based intervention.
- NHS premises adopt a smoke free/healthy workplace programme.
- Integrate prevention responsibilities within the prototype design of MCPs.
- Implementation of bariatric surgery policy and incentivisation.
- District council engagement to develop their role in the healthy policy framework and to support identification of target communities and delivering a response to the wider determinants of health.
- Third sector engagement to provide support to communities.
- Redefining role of Local Authority and NHS in prevention.

Key steps to delivery & milestones – 6, 12 and 18 months

- **6 months –** Healthy policy framework complete; community capacity building programme live; update of Staffordshire Carers website as primary access point and establishment of information, advice and signposting resource live; risk stratification complete; evidence base for targeted prevention services established; inclusion of workplace health in acute trust contracts; options appraisal for SCC National Workplace Health Charter; DFG pathway development; CBA for bariatric surgery; training of GP practice nurses to offer lifestyle advice
- **12 months –** Strategy to support recovery from mental ill health co-produced with provider; exit contract from universal lifestyle services by Staffordshire County Council and go-live of targeted prevention services; continued implementation of teenage pregnancy prevention and healthy lifestyles for Stoke-on-Trent; award contract for DFG; commissioning decision point on bariatric surgery
- **18 months –** Obesity prevention in high risk individuals; begin secondary prevention of diabetes by targeting those at risk;

Resource requirements (people and investment)

- Initially there would be no additional resource requirement beyond the PMO, and current local authority public health and CCG commissioning teams. Once specific schemes are decided then any resource requirement will be defined in line with the business cases. Of note in relation to investment is the responsibilities for prevention and well-being to be agreed and encapsulated in the role of the MCPs. Opportunities for investment in programmes that support prevention and wellbeing will be assessed as part of the Sustainability and Transformation fund apportionment.
- Moving forwards, it is proposed that we will establish a quarterly programme board which encompasses the two Councils and NHS organisations to manage delivery system-wide.

Enhanced Primary & Community Care – Success in 2021

As part of the STP feedback it was clear that the system needed to set out what success would look like in 2020/21. For each of Staffordshire & Stoke-on-Trent's Strategic objectives the system is clear on what success will look like in 2021 as set out below. An update on progress since June for each workstream within this priority programme is outlined in Appendix D.

	Success in 2021	Key measures
ENHANCED PRIMARY & COMMUNITY CARE	A shift left will have occurred delivering; • An increased in community and primary care interventions and opportunities to receive services • Effective management of patients with long term conditions as pivotal to supporting change in the system. • Community and primary care interfaces will have been reconfigured to reduce the number of community hospitals beds supporting people closer to their home. • Sustainable and empowered practice teams, integrated care teams, and GPs to provide services for patients whilst being at the heart of our communities. • New models of care will be delivered including, but not exclusively, MCPs and/or PACS • A new contracting framework, based on an outcomes delivery model	• Reduction in A&E attendances and NEL for Frail Elderly/LTC patients. • Reduced LoS in all areas of care delivery. • Reduction in emergency readmissions within 28 days. • Increased number of service users being discharged from acute hospital with re-ablement packages. • More patients returning to usual place of residence & treated closer to home. • Reduction in NEL by 23%. • Improved access to GP services. • Increased number of single integrated care plans digitally accessible. • .Number of patients requiring access to GPs decreases. • Number of patients accessing other appropriate clinicians (instead of GPs) increased • Increase in people reaching end of life in usual residence/place of choice. • Increased proportion of patients with end of life care plans in place which are updated and appropriate. • Reduced mortality – Improved 12 month survival. • Faster diagnosis – Improved urgent query cancer under 2 week wait referrals receiving diagnosis within 4 weeks. • Increased detection rates at stages 1 and 2. • Compliance with waiting time standards. • Improved sustainability of the health and care workforce.

System Priorities: **(3) Frailty and LTC Pathways**

Objective: Enhanced Primary & Community Care	SRO: Marcus Warnes Clinical Lead: Charles Pidsley, Bhushan Rao/Zafar Iqbal	Impact after removal of double count by 2021: £15.2m saving

Description

The implementation of these pathways will be a core requirement to the deliverables of the locality hubs. The programme will deliver integrated services for Frail Elderly (defined as over 75's with) and Long Term conditions (defined as over 65 with one or more LTC); diabetes, heart failure, stroke, respiratory conditions all with underlying hypertension; to allow for the management of the condition before their needs escalate. The programme will implement a Frail Elderly model of care across Staffordshire and Stoke-on-Trent and deliver a 30% reduction in non elective admissions of the FE/LTC cohort by 2021.

The programme will focus on:

- Prevention, care planning and early intervention – CCGs will build on existing practice to develop and implement a lifelong learning approach to patient education and carer resilience; to equip and empower patients and their carers with the tools to understand and manage their own long term conditions, delivered in collaboration and partnership with local authority public health approaches
- Admission avoidance (care closer to home) – Adoption of a universal frailty tool to support a consistent approach to case finding and to build our underpinning understanding of the incidence of frailty in our population. Step change in access to specialist support (Geriatrician in ED, GP Fellows, specialty nurses, social care, advice lines to specialties and integrated community health, care and voluntary sector support and TEC). Exemplar front door to be rolled our to 7 days per week/12 hours a day.
- Diverts from emergency portals – Frail Elderly Assessment Service providing a rapid response to care needs for anticipatory planning to redirect patients away from admission.
- Step down – Timely and responsive interventions by health and care professionals enabling a rapid response to their care needs, to support patients to step down to community based care or access to community based clinic support.

Key Assumptions

- Reduction achieved within current resources – No additional resource required. This is a change to ways of working and the introduction of new models which develop an integrated approach to complexity.
- Implementation of the four steps above would result in a 30% reduction in NEL ED admissions for Frail Elderly and LTCs (local point prevalence studies which have been undertaken within our large acute hospitals support this assumption).This is based on the proportion of people who are deemed not to require beds.
- 50% of all GP appointments and 70% of days spent in hospital beds are utilised by people with one or more long term condition.
- 30% of patients occupying a hospital bed who are frail elderly and/or have a long term condition do not need to be there.
- 68% of A&E attenders for this cohort of patients are admitted to a hospital bed.
- The current model of care provision is structured in a way that supports a maintenance model of monitoring conditions; not anticipatory care.
- There will need to be much speedier access to specialist geriatrician advice along the pathway.
- An enhanced model of primary care is needed to so that GPs can manage uncertainty in the community until patients become stable.

Enabling requirements

- IT workstream; single care records.
- Recruitment of GP Fellows.
- Enhanced Primary Care model in the community.
- Frailty Assessment Tool.
- Trusted Assessor.
- Consistent approach to risk stratification so that patient populations are understood.
- A new approach to multidisciplinary integrated team working (including mental health) with the GP at the core.

Resource requirements (people and investment)

- GP Fellows/ANPs/new roles.
- Low level investment for the implementation of frailty passport and frailty tool.
- Patient/Primary Care education.
- Intermediate Care; expanding the Primary Care offer including quicker access to diagnostics closer to patients homes.
- Investment to support exemplar front of house element of frail elderly assessment service.
- Enhanced skills in the management of frailties and LTCs

Key steps to delivery & milestones – 6, 12 and 18 months

- Completed actions: (Northern Staffordshire) Geriatrician Advice Line, Rapid Access Clinics (direct use by GP's); hot clinics (direct use by ED team), Exemplar Front of House operational 08.30 – 15.30 Monday – Friday to provide specialist advice in the portals to enable timely step down and admission avoidance. Frailty Tool implemented within general practice, paper version of frailty passport trailed high volume uses/frequent attenders. Recruitment of GP Fellows
- **6 months:** further roll out of Frailty Passport, additional recruitment to GP Fellows (potential to open to ANPs); expansion to exemplar front of house to 08.00-20.00 7 days per week. With a focus on the over 75's cohort.
- **12 months**: redesign of LTC services with a focus on community services
- **18 months:** Enhanced community model in place.

October Submission - System Priorities: (4) Community Hospitals Management Plan

Objective: Enhanced Primary & Community Care	SRO: Marcus Warnes Medical Director – Charles Pidsley, Bhushan Rao and Zafar Iqbal	Impact (£) by 2021 after removal of double count: potential £4.2m

Description

North Staffordshire currently has overprovision of community beds whereas the South operates a 'home first' model where appropriate which leads to spot purchasing of beds. Through a redesign of the community offer the focus will be a reduction in capacity of community bed based capacity. This will be achieved through growing community services to reduce the number of beds required - c40 complex patients per week will be discharged to non bed based community services. Assessment Centre within the community will support c4000 assessments per annum. An MCP model will be embedded (this is part of the enhanced primary and community care workstream and delivers new models of care into Staffordshire and Stoke-on-Trent wrapped around populations of 30-50,000 people), delivering care at a local level supporting local need. 40% fewer patients will be admitted through non-elective pathways. This is an ongoing initiative (commenced Oct 2014) and much data / modelling information already exists. In the South it has been recognised that many current services are not optimal and do not fit with the long term strategies and services and facilities will be reviewed to reduce expenditure.

Key Assumptions

- Temporary reduction in 68 community beds within year one.
- Potential to further reduce the community bed base by 99 beds within hospitals within year two (subject to formal consultation).
- Haywood bed provision as currently commissioned remains in place.
- Estates will potentially be rationalised through the outputs of the formal consultation process.
- Financial support will be made available for LAs and social and domiciliary care will be in place to address on-going demand
- Care will become integrated with barriers between services removed
- A number of beds will be procured based upon need and remaining community hospital capacity will be utilised in line with the service specification

Enabling requirements

- Defining the requirement for bed capacity,
    1. assessment (LOS up to 21 days);
    2. Intense rehab (LOS 10 days)
    3. Palliative Care
- Integrates with the Enhanced Primary and Community Care programme of work
- Change in behaviours (i.e. admission avoidance / discharge) and increased trust in community provision
- Robust consultation process with the public
- A community Urgent Care centre commissioned and in place
- UNHM decreasing dependence on beds as a discharge destination
- WMAS engagement utilising alternative pathways within community

Key steps to delivery & milestones – 6, 12 and 18 months

Activity Currently in progress: Haywood hospital bed base flexed to accept step down intermediate care and reablement patients, task force in place to tackle long acute and community bed LoS, investment made available to support the commissioning of a number of nursing home beds and to provide financial support to the LAs over winter to boost reablement services.

- 6 months - Increased Assessment Centre activity, Step down bed based reduced by a further 99 beds, HUB re-specified service implemented, Urgent Care Centre within Community launched, Integrated reablement/intermediate care service launched. Phased reduction of beds in parallel to public consultation
- 12 months – consultation completed on the future of the community hospitals
- 18 months – tender for final nursing home bed base undertaken

Resource requirements (people and investment)

- Specialist nursing in the community (respiratory, CV, geriatric physicians)
- Urgent care and assessment within the community
- Increased intermediate care capacity requires c£1.7m additional investment
- Medical governance model secured within intermediate care
- Resource plan including nursing home enhancement
- Training and education programme linked to enhanced primary care supporting the development of alternatives to admissions.
- Enhanced governance and stronger relationships with the voluntary sector supporting people in the community and at home.
- Building on current community care financial investment a continued review and investment profile for community services to deliver additional community and place based care

System Priorities: **(5) Enhanced Primary and Community Care**

Objective: Enhanced Primary & Community Care	SRO: Dr Andrew Bartlam Programme Director: Steve Grange Medical Director: Dr Bill Gowans	Impact by 2021 after removal of double count: £9.9m additional cost

Description

The EPCC programme will establish Integrated Care Hubs delivering integrated, place based care around groups of GP practices serving populations of 30,000-70,000 which will become the foundation for the new models of care. Building on work elsewhere, work is well advanced in defining these stages of development. Establishing an ongoing sustainable General Practice model working with integrated community teams, across organisational boundaries will provide pro-active care to people identified at highest risk of admission. Primary care 'at scale' will comprise of groups of GP practices working collaboratively with support from other community, social, voluntary and independent providers to provide new models of community-based urgent care, services for those with long term conditions and for people identified as complex or frail. Collaboration with 'non-health' partners will lead to holistic, early and preventative interventions which will address the needs of people with complex lives as well as those with complex needs.

Key Assumptions

The development of sustainable integrated care hubs is fundamental to the transformational change required for the STP and there will be a requirement to develop new models of enhanced primary & community care at scale and pace.

- robust financial, activity and workforce modelling will be undertaken to inform the development of the hubs as well as to understand current and future resource requirements
- Resources will transfer secondary care to the community to support the development of the hubs, and new investment in primary care will be delivered via CCGs to deliver the GPFV
- The cohort of patients at highest risk of admission to hospital (top 23%) have been identified and quantified.
- A needs assessment has been completed in conjunction with Public health to inform priority setting and service requirements.
- define and quantify resource requirements (financial and workforce) to deliver care at a care hub level
- The proposed model of care provision is structured in a way that supports a maintenance model of monitoring conditions; not anticipatory care.

Key steps to Delivery & Milestones – 6, 12 and 18 months

- **6 months** – Deploy plans to support general practice with a particular focus on workforce redesign and sustainability.
- Further build on the mapping work of the clusters and current patient flow to acute hospitals.
- Define integrated care hubs based on the clusters, identifying core activities/services and establish virtually integrated teams. Identify locality cluster specific health requirements to enable planning of extended services relevant to demographic needs. Continue and complete the logic modelling work to establish agreed outcomes.
- Share rapid learning from early implementers and agree strategic objectives to deliver place based care. Complete current and future capacity and demand modelling.
- Develop governance frameworks and pathway to development of new models of care
- **12 months** – Establish virtually integrated care hubs at scale. Complete workforce planning. Specify delivery at care hub level.
- **18 months** – 'sustainable' integrated care hubs developed and prototyped in preparation for roll out at scale in 2019/20.

Enabling requirements

- The establishment of place based care across all sectors aligned with efficiencies of scale (populations of 30,000-70,000). Work to establish natural communities has commenced and initial mapping has been completed.
- A focus on sustaining general practice which enables transformation and workforce redesign
- A sustainable, safe and effective model of primary care which enables MCP development.
- A transformational whole system workforce model.
- Equal partnerships with non health care providers.
- A new relationship with patients which resets the balance of rights v responsibilities and empowers them to self manage and share care.
- A shift from reactive to proactive care which moves away from an exclusively medical model and is then able to work with people who have complex lives as well as those with complex needs.
- A single electronic shared care record.
- Contracting and funding methods which follow the patient pathway.

Resource requirements (people and investment)

- Investment to delivery the GPFV
- Detailed modelling to support the transition from a 'standardised' to 'sustainable' model of care including development of governance frameworks that support service transition
- Funding to develop sustainable place based care.
- Resource to complete whole system workforce modelling which is translated to 'on the ground' changes in relationships, behaviour, education and training.
- Resource and expertise to embed rapid and shared learning as a default across the whole system.
- Resource to develop broad based clinical leadership and engagement.
- Resource to empower communities and the public to enable behavioural and social change.
- Investment to achieve single electronic shared care record across whole system.
- Investment to develop training, academic activity, research and skills development within Staffordshire and Stoke-on-Trent.

System Priorities: **(6) End of Life Pathway Reconfiguration**

Objective: Enhanced Primary & Community Care	**SRO: Andy Donald** **Charles Pidsley, Bhushan Rao/Zafar Iqbal**	**Impact by 2021 after removal of double count: £6.7m saving ***
Relevant key STP questions: 2, 4, 5, 6, 7		

Description

Creation of a fully integrated county wide end of life (EoL) service incorporating all NHS and non-NHS providers to improve outcomes. Increasing numbers of patients will be identified at the appropriate time as nearing end of life (proportion rising over 8 years towards an optimum 65 – 75% of all deaths). Through timely Identification, care co-ordination and planning a patient centered approach will be introduced to improve patient experience and quality of life for the dying, and loved ones. This will ensure equitable access to consistent clinically appropriate care and services built around the individual patients needs, leading to improved patient experience and an increasing proportion of patients being supported to live in the preferred pace of care for longer and dying at their preferred place of death. Anticipatory care plans and availability of 24/7 support for patients and carers with necessary medication and equipment in place will reduce A&E attendance and unnecessary acute admissions. Improvements will be incentivised by the use of an outcome based service specifications. Within the population at large, a gradual cultural shift in awareness and understanding of the natural process of death and dying will support “demedicalisation”, ensure carers have realistic expectations and provide a better outcomes for both people approaching end of life and their loved ones.

Key Assumptions

Procurement

- Process refined to reflect additional NHSE and local assurance requirements.
- Two phase approach with service transformation commencing Q4 2018/19.
- Collaborative working with SES CCG and East Staffs CCG to ensure alignment of the delivery of STP outcomes for EoL across STP footprint.
- Work through this programme will be incorporated into the enhanced primary and community care STP work stream, and be embedded into the development of MCPs and Integrated Care Teams for the whole of Staffordshire & Stoke-on-Trent .

Delivery

- Gain share with preferred bidder can be agreed which is aligned to and supports STP financial assumptions.
- Procurement and contract with Service Integrator will be compliant with NHSE assurance framework.

Enabling requirements

- Appointment of Service Integrator (SI)/agreement of contract.
- Service Integrator successfully meets all Phase 1 requirements.
- Digital design authority to agree fully functional integrated electronic patient records, care plans and care coordination systems available to all relevant end of life care professionals.
- Care co-ordination function to be established in a timely manner
- Collaboration and support of delivery partners outside the procurement process
- Services re-provision to support patients in primary and community setting to prevent clinically inappropriate/unnecessary A&E attendance or admission
- Development of end of life service “single virtual team” culture within providers and shift in culture and expectations across the wider community at large.
- Data/financial analysis to establish current allocated budgets and current actual service costs.
- Development of payment/contract model based on capitated/year of care funding structure for EoL services.

Key steps to delivery & milestones

- **6 months** – To note: Milestone shift due to NHSE procurement decision delay. Oct – Dec 16, Return to bidders and obtain further detail regarding response to STP process and MCP models. Oct-Dec 16 Contract negotiations and parallel assurance process begins,
- **12 months** – NHSE assurance process complete by end of June 17, Contract awarded and mobilization July – Dec 17.
- **18 months** – Jan 18 contract start date – Phase 1.
- (3 – 4 years) Jan 20 contract start date – Phase 2 (Services commissioned by SI).

Resource requirements (people and investment)

- Resource requirements will be largely met by Service Integrator or Macmillan Cancer Support. Existing commissioner input into programme to continue.
- The Transforming Cancer and EoL Programme will continue to work with patient champion networks and stakeholders. The programme objectives and Outcomes Framework are a result of extensive engagement and this will be extended to ensure pathway transformation benefits from meaningful co-design. Full engagement and consultation will be carried out in advance of decision re any proposed substantive changes to services.

* Figures in progress of being reviewed and revised

Effective & Efficient Planned Care – Success in 2021

As part of the STP feedback it was clear that the system needed to set out what success would look like in 2020/21. For each of Staffordshire & Stoke-on-Trent's Strategic objectives the system is clear on what success will look like in 2021 as set out below. An update on progress since June for each workstream within this priority programme is outlined in Appendix D.

	Success in 2021	Key measures
EFFECTIVE & EFFICIENT PLANNED CARE	Reduced pre-admission appointments and improved referral to treatment ratios. Reduced cost of staff undertaking appointments. Higher volume of appointments per staff member per clinic. Optimised scheduling and management. Extended clinical roles in theatre or outpatient procedure team. Proactive management of infections and readmissions. Use of alternative methods of follow up e.g. apps, videos, and Skype. Elective care centres delivering high quality and high volume interventions over a decreased estate footprint	• 10% reduction of existing orthopaedic and ophthalmology spend. • Inpatient access delivered from reduced number of high volume centres. • Increased day case rate. • Reduced LoS from elective care. • Reduced bed numbers. • Reduced delayed transfer of care (DTOCs). • Reduced POLCV. • Reduced follow-up ratio. • Increase number of patients treated in appropriate care settings, closer to home.

System Priorities: **(7) Planned Care Reconfiguration**

Objective: Effective & Efficient Planned Care	**SRO: Rob Courteney-Harris** **Clinical Lead: Steve Fawcett**	**Impact by 2021 after removal of double count:** **£15m saving (planned)** **£6.5m saving (prevention)**
Relevant key STP questions: 1, 2, 5, 6, 7, 8, 10		

Description

Demand for elective care is increasing; 14% growth over the last 4 years and is predicted to continue to grow at an increasing rate. In many specialties and in most providers, national standards are not being met. Benchmarking suggests there are longer than average patient waits, inappropriate and inconsistencies in referrals, inefficient pathways and longer than average length of stay. The provider landscape is complex and delivery is from multiple sites; this leads to duplication and inefficiencies and an unaffordable cost base, operating outside of the allocated cost envelope.

Areas of Focus

Configuration of services

- Review of current capacity, demand, patient flows and efficiencies of scale to deliver an appraisal of potential solutions. Options will include, centralisation of planned care delivery model and reduction of number of current planned care centres, performing some activity in a lower acuity setting, keeping day case and outpatients local, whilst looking at reducing the number of inpatient (28%) access points to deliver 'state of the art', highly efficient 7 day elective centres and where possible, a separation of planned and urgent care activity. This is a long term project and requires significant complex modelling and consultation.

Productivity and Efficiency

- Right Care, Carter, Monitor productivity report and the National Spinal pathway work have been instrumental in the prioritisation of specialties for focus:
  - Orthopaedics £69m spend 20% of total elective acute spend.
  - In depth for hips, knees and spinal.
  - Ophthalmology £22m 6% of total elective acute spend.
  - In depth for cataracts & wet injections.
  - Spinal Pathway £5m, represents 11% of years lived disabled, estimated £15-17bn indirect costs nationally.
- The review process runs from prevention, to diagnosis, through referral, to surgery and post-operative care.
- Clinical and patient involvement is essential to the successful delivery of this programme
- Research indicates the following specialties as the next priority areas:
  - Gastroenterology £17m acute spend.
  - Rheumatology £11m acute spend.
  - Cardiology £19m acute spend.

Diagnostics

- Initial focus on Endoscopy £9m spend, which is expected to grow by 44% by 2020.
- Options appraisal to
  - review benefits of consolidating expertise.
  - deliver a sustainable service against the anticipated demand projections.

Aims

- Reduce patient waiting time and improve healthy life expectancy.
- Improve productivity, streamline pathways and reduce costs by 10%.
- IMPROVE referral to treatment ratios, avoid inappropriate referrals.
- Reduce length of stay in hospital.
- Provide support for patient initiated follow up appointments.
- Improve patient, carer and staff satisfaction.
- Deliver high quality, efficient inpatient care with 7 day access.
- Remove duplication.
- Deliver a clinically and financially sustainable planned care service.

Key Assumptions

- Whole health economy thinking and buy in from all organisations
- Inter-dependencies outside of the county will be managed.
- Political pressures will be managed.
- Effects on financials/sustainability for the organisations will be dealt with.
- Primary and community care will deliver capacity to accommodate activity being performed in a lower acuity setting.
- Programme is underpinned by public, clinical and staff co-production.
- Workforce and skills required for redesigned services will be available.

Key steps to delivery & milestones – 6, 12, 18 months

6 months-16/17

- Configuration-deliver appraisal of potential solutions
- Orthopaedics, Ophthalmology & Spinal-implement productivity & efficiencies from workshops.
- Endoscopy-deliver options appraisal and begin pre-consultation.
- Commence preparatory work on further specialties.
- Review of Burton/Derby plans and out of county flows.
- Revisit TSA recommendation and clarify acute sector flows for Staffordshire & Stoke-on-Trent residents.

12 months-17/18

- Configuration-consultation & decision.
- Endoscopy-consultation & decision.
- Further specialties-implement productivity & efficiencies.
- Commence preparatory work on further specialties.

18 months-18/19, 19/20

- Configuration-Implementation & closure/rationalisation
- Endoscopy-implementation & closure/rationalisation

Enabling requirements

- In depth modelling of demand & capacity.
- Co-ordination and alignment with Urgent Care, Enhanced Primary & Community Care, Estates, Workforce and Digital.
- Providers working together to maximise the opportunities.
- Capacity for project management and implementation.

Resource requirements (people and investment)

- Core team, project management, sub-groups to implement.
- All providers.
- Communication and engagement fundamental.
- Clinical design authority/public user groups.
- Investment in technology, chosen centres of excellence and local delivery for outpatient, day case surgery, diagnostics.

System Priorities: **(8) Cancer Pathway Reconfiguration**

Objective: Effective & Efficient Planned Care/Simplify Urgent & Emergency Care System *Relevant key STP questions: 4, 5, 6, 7*	**SRO: Andy Donald** **Clinical Lead: Steve Fawcett**	**Impact by 2021 after removal of double count: £7.3m saving ***

Description

Creation of a fully integrated County wide cancer service incorporating all NHS and non-NHS providers. Improved awareness and early detection by increased uptake of screening and timely access to diagnostics will increase one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. Through care co-ordination and planning, a patient-centred approach will be introduced to improve patient experience and quality of life for patients and their loved ones. Development of consistent and evidence based "survivorship" services, encouraging supported self care but rapid seamless access to clinical services where cancer recurrence is suspected, ensuring stratified follow up pathways for breast cancer patients are rolled out and extended to other cancer types, all elements of the Recovery Package are commissioned, including holistic needs assessment and care plan at the point of diagnosis; treatment summaries sent to the patient's GP at the end of treatment and cancer care reviews completed by the GP within six months of a cancer diagnosis. Improvements will be incentivised by the use of an outcome based service specification.

The Programme will not deliver direct cost reduction but will support improved efficiency and allow incidence/prevalence growth up to 10% to be affordable within existing (as at Year 2) cost envelope by supporting 'left shift' i.e. More early interventions provided at home/in the community and less reliance on and time spent in hospital.

Key Assumptions

- Process refined to reflect additional assurance requirement.
- Two phase approach with service transformation to commence01/04/17.
- Collaborative working with SES CCG and East Staffordshire CCG to ensure alignment of the delivery of STP outcomes of Cancer.
- Work through this programme will be embedded within the planned care work stream and regional work streams of the Cancer Alliances and National Cancer Vanguards.

Delivery

- Procurement and contract with Service Integrator will be compliant with NHSE assurance framework.

Enabling requirements

- Appointment of Service Integrator (SI)/agreement of contract.
- Service Integrator successfully meets all Phase 1 requirements.
- Digital design authority to agree fully functional integrated electronic patient records, care plans and care coordination systems available to all relevant cancer care professionals.
- Care co-ordination function to be established in a timely manner.
- Collaboration and support of delivery partners outside the procurement process.
- Services re-provision to support patients in primary and community setting to prevent clinically inappropriate/unnecessary A&E attendance or admission.
- Data/financial analysis to establish current allocated budgets and current actual service costs.
- Development of cancer service "single virtual team" culture.

Key steps to delivery & milestones – 6, 12 and 18 months

- **6 months** – To note delay incurred for mobilization due to delay in final procurement process decision through NHSE .Final contract agreement with service integrator. Align plans of East and South East Staffs and include in STP scope. NHS assurance complete by end of Mar 17.
- **12 months** – Mobilisation Apr – Jun 17.
- **18 months** – Jul 17 contract start date – Phase 1.
- (3 – 4 years) Jul 19 contract start date – Phase 2 (Services commissioned by SI).

Resource requirements (people and investment)

- Resource requirements will be largely met by Service Integrator or Macmillan Cancer Support. Existing commissioner input into programme funded by Macmillan until 1/4/17.
- Contract management and mobilisation expertise will be integral to the programme delivery within the STP process.
- The Transforming Cancer and EoL Programme will continue to work with patient champion networks and stakeholders. The programme objectives and Outcomes Framework are a result of extensive engagement and this will be extended to ensure pathway transformation benefits from meaningful co-design. Full engagement and consultation will be carried out in advance of decision re any proposed substantive changes to services.

Note Cancer Pathway Reconfiguration spans both effective and efficient planned care and simplify urgent & emergency care system

* Figures in progress of being reviewed and revised.

Simplify Urgent & Emergency Care System – Success in 2021

As part of the STP feedback it was clear that the system needed to set out what success would look like in 2020/21. For each of Staffordshire & Stoke-on-Trent's Strategic objectives the system is clear on what success will look like in 2021 as set out below. An update on progress since June for each workstream within this priority programme is outlined in Appendix D.

	Success in 2021	Key measures
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	• Better support will be in place for self-care. • People with urgent care needs get the right advice in the right place, first time. • Highly responsive urgent care services outside of hospital will be delivered so people no longer choose to queue. • Those people with serious or life-threatening emergency care needs will receive treatment in emergency centres with the right facilities and expertise, to maximise chances of survival and a good recovery. • All urgent and emergency care services will be connected together, so the overall system becomes more than just the sum of its parts. • Staffordshire & Stoke-on-Trent will have a simplified urgent and emergency care system which is clinically, operationally and financially sustainable for the future. • A reduced use of agency staff in urgent and emergency care due to flexible workforce options being implemented • People will not attend emergency departments who require no treatment, as alternatives will be in place, and pathways will not facilitate this. Figures for those who attend the ED and receive no treatment, leave prior to treatment and attend with no follow up will be significantly reduced	: • A reduction of attendances in the A&E departments by 30%. • A 23% reduction in Non Elective admissions to acute hospital. • Consistently achieve 4 hour A & E Wait target. • A reduction in delayed transfers of care to 2.5%. • Improved LoS • Patient satisfaction improvements

System Priorities: **(9) Simplify Urgent & Emergency Care**

Objective: Simplify Urgent & Emergency Care *Relevant key STP questions: 1, 4, 5, 6, 7, 10*	**SRO: Helen Scott-South** **Clinical Lead: Mark Williams**	**Impact by 2021 after removal of double count: £4.3m saving**

Description

Following the Keogh and 5YFV recommendations, we aim to simplify urgent and emergency care access and services in order to deliver the provision of the right care at the right time in the right place. We will know that we are achieving this by using national and regional benchmarking/indicators to measure outputs and inform service model performance.

Core areas of focus

- The patients and the general public feel confident and knowledgeable in accessing the appropriate level of urgent and emergency care services for their condition and are able to receive prompt and appropriate treatment to meet their needs.
- Patients receive the treatment they need in their local community and at A & E only when appropriate.
- Ensuring that patients are treated in their optimal setting to deliver the best outcome for them. This will include the patient's clinical and social needs, care management plan, acuity, specialist requirements and their geographical location.
- Patients are only admitted for true urgent and emergency care needs and that following admission they are discharged in a timely and efficient manner to the most appropriate setting.
- To reduce the number of ongoing care needs assessments being undertaken in an acute hospital setting.

Key options being explored and analysed are

1. Redesign of urgent and emergency care pathways including access route to A&E, discharge to assess model and exemplar front door.
2. Integrated Urgent Care model which incorporates minor injury, walk-in, GP Urgent appointment, Pharmacy, Dental, MH crisis and other urgent non emergency functions into a single model.
3. Move from to 3 to 2 A&E sites and 1 Urgent Care center and an exploration of the potential options.
4. Development of integrated clinical capacity across the urgent and emergency care system where a specialist work force can work across organisational boundaries in the best interest of patient care.
5. Providing adequate resources in the community to ensure patients are discharged from an Acute setting when clinically ready to do so. These include exploring discharge to access models and step down facilities.

Delivery Targets

- A reduction of attendances in the A&E departments by 30% – A 23% reduction in Non Elective admissions to acute hospital – Achieve 4 hour A & E Wait target – A reduction in delayed transfers of care to 2.5%.

Objectives

1. To provide better support for self-care.
2. To help people with urgent care needs get the right advice in the right place, first time.
3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue.
4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise, to maximise chances of survival and a good recovery.
5. To connect all urgent and emergency care services together, so the overall system becomes more than just the sum of its parts.
6. To deliver a simplified urgent and emergency care system which is clinically, operationally and financially sustainable into the future.

Key Assumptions

- Primary and community care will deliver capacity to accommodate 'left shift' so that activity is performed in a lower acuity environment.
- Plans will be aligned and approved by all organisations, A & E Delivery Boards, STP, Urgent and Emergency Care Network, and out of area collaborations.
- Public and clinical engagement and co-production will ensure greater understanding and ownership of challenges and proposals for services changes.
- All partners will engage fully regardless of organisational boundaries
- Workforce skills and expertise available for redesigned services.

Key steps to delivery & milestones

16/17

- Q2 Creation of A&E delivery boards
- Q2 Identification of services model potential solutions which need further review and discussion with broader audience
- Q3 Delivery of Discharge to Assess project (under A&E delivery boards)
- Q3 Baseline analysis of current service provision produced.
- Q3 Joint workshop with aligned work streams undertaken to further develop service model
- Q3 Design service model solutions for urgent and emergency care in primary, community and acute services, social care, voluntary sector and other providers.
- Q3 Gap analysis to map options for delivery of the new service model.
- Q3/Q4 Pre-consultation process.
- Q4/Q1 (17/18) Shortlisted potential solutions to be constructed to include activity flows, workforce, finances and facility assumptions.

17/18

- Q2 Commence Consultation process.
- Q4 Commence service transformation programme.

Enabling requirements

- System leadership and governance.
- Unanimity across clinical and operational teams to deliver the clinical model.
- Primary and community care capacity.
- Integrated governance and system-wide full engagement.
- Digital shared clinical record in place.

Resource requirements (people and investment)

- SRO and Programme Director supported by a team of commissioners and operational managers with PMO function.
- Clinical Leadership to drive clinical engagement and ownership.
- A range of CSU support including data analysis, business intelligence, finance.
- Communication and engagement support.
- Expertise in workforce engagement and development.
- Clinical reference groups.
- Resource will be needed for the consultation process.

Reduced Cost of Services – Success in 2021

As part of the STP feedback it was clear that the system needed to set out what success would look like in 2020/21. For each of Staffordshire & Stoke-on-Trent's Strategic objectives the system is clear on what success will look like in 2021 as set out below. An update on progress since June for each workstream within this priority programme is outlined in Appendix D.

	Success in 2021	Key measures
REDUCE COST OF SERVICES	• Realisation of cost savings from major estate closures post reconfiguration activities. • CIP achievement across the system . • A financially balanced health and care system • Embedded system wide working pan organisation • A developed collaborative bank system established and embedded utilising peripatetic expertise to reduce bank and agency usage. • Joined up estates plan across the public sector with investment in multi use capacity • Delivery of care village concept linked to community hospitals/hubs and integrated teams (including voluntary sector)	• 2%+ per year delivery of CIP and QIPP: • Reduced cost per citizen. • Estate increase income per sq. ft. • Improved facilities for patients. • 25% agency to bank ratio achieved within two years. • Reduction in spend on temporary staff. • Reduction in vacancies. • Improved staff morale as measured by Staff Survey. • Estate running costs to be reduced across the public sector. • Non-clinical space (%) reduction to 35% by April 2020. • Unoccupied floor space (%) reuction to 2.5% by April 2020. • Functional suitability of 90%.. • System wide deficit brought into balance • Increased investment in social care

System Priorities: **(10) Delivery of CIPs and QIPPs**

Objective: Reduce Cost of Services *Relevant key STP question: 10*	**SRO: All organisations** **Clinical Lead: Dr Bill Gowans**	**Impact by 2021 after removal of double count: £104.5m saving**

Description

The achievement of the cost reductions is key to the successful closure of the financial gap. The system recognises the need to accelerate the pace and delivery of productivity and efficiency initiatives across all organisations within the footprint. In the 30th June STP we included an £80m CIP/QIPP plan for 16/17. This has been subsequently downgraded to £38m, recognizing that the commissioner QIPP plans were not system wide savings. The £38m provider savings are being monitored monthly. The £38m represents a 3% in-year saving. As such, there is confidence that an expectation that the £104 million target (after other programmes which would be traditional CIP programmes) for efficiency over and above the system priorities should be achievable if the organisations maintain the pace of their CIP programmes. £104 million equates to 8% of the 2020/21 cost base of the providers. This 2% per annum efficiency target is lower than the quantum being achieved in 2016/17 . Additionally no modelling of the effect of the digital roadmap has been taken into account. This is key in driving workforce productivity and will in later years provide significant efficiency savings, however it is too early to be precise about the scale and nature of these savings.

We have implemented a system-wide financial monitoring template. For 2016/17 each organisation is submitting a key data set on the 12th working day following each month-end. This enables the system to evaluate progress in the delivery of CIPs against a phased plan. Each organisation is committed to open book accounting. The system is providing external resources to organisations that are struggling with the efficiency agenda. For 2017/18, we are putting in place an assurance system to ensure that each provider organisation identifies 2% of efficiency savings as part of the annual planning process, and subsequently delivers on the schemes. The 2% annual CIP requirement is a key element of each organisation's financial plan. The 2017/18 CIP plans will need to be a part of the first draft operational plans in December.

Key Assumptions

- UHNM appointed PwC as a strategic transformation partner with a focus of the work on cost reduction and efficiency, and are remunerated on a risk sharing model.
- An efficiency and productivity review being undertaken by Meridian Productivity Ltd at NSCHT will support delivery of their CIP programme.
- Providers sharing a common and continued commitment to the targets and milestones within the plan.

Enabling requirements

- Organisations continue to take individual accountability for their respective CIP targets and drive delivery accordingly.
- There is continued investment from organisations in CIP programme and PMO infrastructure to both upscale capability and quality of cost reduction planning and de-risk ongoing implementation and monitoring of delivery.
- A dedicated work programme for taking the Carter recommendations forward within the system.
- A forum for sharing cost reduction initiatives and workstreams to facilitate best practice sharing across the footprint.

Key steps to delivery & milestones – 6, 12 and 18 months

- 6 months – Fully implement 2016/17 cost reduction initiatives and quantify full year effect. Evaluate financial model for 2017/18 and begin cost reduction planning.
- 12/18 months – Closer integration and best practice sharing between cost reduction programmes and workstreams.

Resource requirements (people and investment)

- The cost improvement planning and delivery cycle will continue to be the independent responsibility of organisations within the footprint. The success of this workstream depends on sufficient resources, being committed by the respective trusts.

System Priority Programmes: **(11) Estates Rationalisation**

Objective: Reduce Cost of Services	**SRO: Tony Bruce**	**Impact by 2021 after removal of double count: £22.0m**
Relevant key STP question: 10		

Description

- The Estates programme is an underpinning enabler which will enable real system change to be delivered through influencing on a whole STP footprint wide basis. Through identifying the 'art of the possible', the estates workstream can help shape the STP outcomes by identifying community need and providing solutions to enable community self sufficient. In doing so the rationalisation of the estate can take place, together with increased utilisation of premises. Thus delivering associated specific estate savings across the footprint, as well as enabling service delivery savings to be made.
- The health care village concept delivered across. Staffordshire & Stoke-on-Trent. These villages will be outcomes driven based on community need and will have links to voluntary sector and to housing for preventative measures and service investment.
- Developing proof of concept programmes specific to estate expenditure ie: development of single energy provider concept across Staffordshire and Stoke-on-Trent

Key Assumptions

- Work to be developed in partnership with local authorities with a view to maximising benefit across the partners and the system.
- All workstreams where demand reduction or redeployment is an outcome will release estate capacity into the system.
- Staffordshire & Stoke-on-Trent has an oversupply of building which are not maximised in terms of utilization.
- Mothballing, partnership, or ales will be an option for he system for excess estate
- Benefit will be incremental and is likely to accelerate in later years of the programme.

Enabling requirements

- Baseline of current estates information including.
  - Floor space.
  - Utilisation.
  - Soft/Hard FM costs.
  - Contracted out estates services and spend.
  - Understanding of ownership of estates.
  - Valuation of estates.
- Link to all other workstreams to further develop estates implication of opportunities.

Key steps to delivery & milestones – 6, 12 and 18 months

- **6 months** – Baseline mapping to be carried out to identify current picture of estate. MoU produced for all STP partners to agree to working for system benefit. Potential sites for community focused development to be delivered.
- **12 months** – MoU signed and supported, full business cases develop for agreed opportunities and identification of associated savings. Agreement of estates savings. Agree opportunities and associated savings identified and full business case to be developed for the health villages by September 2017.
- **18 Months** – Commencement of building of approved development and rationalisation of estates commencing.

Resource requirements (people and investment)

- Estates mapping and financial modelling expertise.
- Community Housing Partnership (CHP) support.
- Local Estates Forum (LEF) to provide governance and support.
- CHP support
- Specific resource for professional fess to deliver the 5 business cases to OBC approval - £2.5m.

System Priority Programmes: **(12) Workforce strategy**

Objective: Reduce Cost of Services *Relevant key STP questions: 3, 9, 10*	**SRO: Neil Carr** **Clinical Lead: Dr John Oxtoby**	**Impact by 2021 after removal of double count: £27.0m**

Description

The workforce enabler is focused on the sustainability, innovation and collaboration of our staff cross the Health and Care system in Staffordshire & Stoke-on-Trent. Our work is channelled through our vibrant Staffordshire and Stoke-on-Trent 'workforce taskforce' , which is focused on 7 principle objectives as far ranging as: improved inter organisational vacancy advertising; to new role development in primary care; to developing curricula to reflect new models of care, through to ensuring our staff embrace the changes proposed by the digital enabler. Our priority initiative at this time aims to reduce the spend on workforce, particularly focusing on temporary staffing costs. During the life cycle of this STP we wish to establish Staffordshire & Stoke-on-Trent as being renowned as a flexible and attractive employer, agile in both creating portfolio careers and cross boundary working across Health and Care.

Key Assumptions

Progress is currently being made across our 3 priority objectives

1. **Reduction in temporary staff spend** through exploration of bank efficiency and agency usage. A scoping study will conclude in November exploring the value of a collaborative bank across Staffordshire & Stoke-on-Trent. In order to scope the optimal footprint for collaboration we are currently seeking inclusion from GP federations, councils and neighbouring STPs with shared intent. Our saving impact links to this project.
2. **Enhanced entry level recruitment** and innovation, e.g. in domiciliary care and healthcare navigation. The city council is currently leading on a project to identify best practice for retaining domiciliary care staff across Staffordshire and Stoke-on-Trent.
3. **Sustainable workforce**. Our sustainability strategy will initially focus on primary care. It will then proceed to ensure mental health, social care and community workforce planning aids efficient development of EPCC & Urgent care pathways. Key milestones for the primary care work are now agreed.

We are in the planning and data gathering stage for objectives 4-7

4. **Development of training new roles** within academic centres across the county in order to develop a sustainable pipeline of new roles.
5. **New skills Development**. Shift of focus and development to navigation/signposting, prevention, parity of esteem and well-being. Aiding reduction in demand for urgent care and increase in citizen self-care, community capacity and empowerment.
6. **Linking workforce to IT developments**, allowing improved communication and reduced duplication between organisations.
7. **Staffordshire and Stoke-on-Trent recruitment campaign** to make health and social care more attractive and lower vacancy rates. Our campaigns we draw on our universal selling point of flexibility which we hope we attract a net increase in applications to the system. PR to compliment STP communication initiatives.

These assumptions are being tested locally during a workshop in November.

Enabling requirements

- Continued support from the LWAB, HEWM and NHS England
- Identification of best practice
- Understanding benchmarks by organisational type
- Work will be needed to review existing temporary staffing initiatives within the individual organisation and where additional savings from a system wide approach will be achieved to avoid duplication
- Continue to enhance primary care workforce planning with LMC & GP Federations
- Establish a Memorandum of Understanding between organisations on operating model for a system wide regional bank.

Resource requirements (people and investment)

- This will be determined once the full scale of the issue has been scoped and we have a measure of what best practice looks like.

This may include:

- IT system which allows all Trusts to view each other's rostering systems so that the bank shifts can be offered up to all the staff
- Capacity to support implementation of schemes and projects at pace required

Key steps to Delivery & Milestones – 6, 12 and 18 months

6 months

- Detailed plan to support the initiative agreed by organisations with team mobilised to implement actions
- Enact Quick wins from the Primary care workforce plan.
- Spread learning from Domiciliary care independent review.
- Update and communicate organisational policies on temporary staff accordingly to reduce usage of temporary staff

12 months

- MoU established between organisations on regional bank
- Technology specifications identified and agreed on system level

18 months

- Initial savings realised on an incremental basis based on baseline through to 25%

System Priority Programmes: **(13) Mental Health**

Objective: All *Relevant key STP questions: 3, 4, 5, 6, 7*	**SRO: Caroline Donovan** **Clinical Lead: Dr Avid Khan**	**Impact by 2021 after removal of double count: £0** **All savings realised by Mental Health workstream are currently assumed to be used to fund mental health initiatives**

Description

Mental health will be embedded as part of comprehensive holistic care pathways integrated with physical health services in primary care, community services, for long term conditions, the frail elderly and in urgent care. The Transformation Programme for Mental Health will focus on two programme priorities: 1) Mental Health integration within the STP footprint 2) Specialist MH services an expectation that a collaborative approach to commissioning with specialised services will align resources/pathways and investments going forward to take a place based approach.

Key Assumptions

Mental Health integration driven through actions across the STP priority work streams.

Urgent and Emergency Care

- Emergency attendances with primary diagnosis a mental health condition will reduce; through enhancing provision of community treatments as an alternative to emergency admissions (e.g. RAID)
- There will be enhanced capacity for provision of Place of Safety
- Crisis Home Treatment 24/7

Planned Care

- Developing a dual care function and therefore minimising the impact of MH complications on planned episodes of care

Enhanced Primary and Community Care

- Community MH teams will be integrated within locality hubs
- Earlier access and intervention will be achieved as a result of developing enhanced mental health skills in primary care reducing barriers and stigma
- Capacity for delivery of IAPT services will need to be enhanced, particularly for LTCs.

Prevention

- New models of care with enhanced mental health skills within the community and focusing on prevention and earlier intervention.
- A truly integrated health and social care system to support physical and mental health needs will work with employment services, housing, schools and the voluntary sector to provide a holistic approach to prevention and wellbeing.

Specialist Mental Health

Areas of focus:-

1) Out of Area Placements – Out of area placements will be reduced for acute mental health care for adults.

A. This will be achieved through developing a service that maximises the access to specialist services within Staffordshire and Stoke-on-Trent through repatriation of care packages currently provided outside of area.
B. To minimise the flow of patients going out of area for specialist MH interventions we will maximise the skills, expertise and facilities within Staffordshire and Stoke-on-Trent.

2) CAMHS - In line with the FYFV expand the capacity of CAMHS specialist services to meet the growing portion of diagnosable mental health conditions. Set up community eating disorder services to ensure urgent access in one week or routine access within 4 weeks. Devolved specialist arrangements with regional provider strategic intentions for CAMHS Tier 4, low secure services and 24/7 crisis home treatment.

3) Learning Disabilities -Delivery of the Transforming Care for People with Learning Disabilities .

4) Early Intervention Psychosis

5) Secure Care – Delivering specialised localised services closer to home.

6) Quality Improvement – we have identified 3 key areas:

A. Reducing re-admissions
B. Reducing Detentions under the Mental Health Act
C. Reduction of suicide rates in Staffordshire and Stoke-on-Trent to below national average, on a targeted basis, through development of a Public and Third sector strategy

Key steps to Delivery & Milestones – 6, 12 and 18 months

- Agree the integrated work programme with a particular emphasis on supporting the “left shift” and prevention pathways.
- Develop and agree a Transformation Plan for Adult MH Out of area placements
- Agree Transformation Plan which will align to the priorities of the 5YFV, CAMHS and LD Transformation Plans for all age mental health provision 24/7.
- Review of specialised commissioning services to develop services which place people closer to home with access to the right care at the right time

Resource requirements (people and investment)

- Transition funding for delivery of community based enhanced and integrated alternatives, and delivery of the MHFV.
- Ensure Staffordshire & Stoke-on-Trent wide approach
- Programme management approach

Enabling requirements

- Mental Health specialists will continue to be an integral part of all workstreams ensuring specialist clinics and parity of esteem remain a priority in development of clinical pathways, and key focus is on skills development within the community facing provision
- Engagement with all sectors who provide care - to understand the impacts and consequences of planned and unplanned change
- Greater modelling needed on the early input of MH and LD services to the acute and primary care pathways supporting the “left shift” model

Objective: Cross cutting	**SRO:**	**No specific impact has been modelled as this is an underpinning workstream to support the shift left in a methodology which works for the health and care system**
Relevant key STP questions: [1,4,7,8,9,10]		

Description

We recognise that the health and care system is inextricably interdependent: the sustainability of the NHS is critically dependent on public health and adult social care. Staffordshire County Council and Stoke-on-Trent City Council, who are responsible for these functions, are under unprecedented financial pressure in the face of falling government funding, rising demand from an ageing population, and rising costs – In particular from the national living wage. Significant challenges include the fragility of the care home market causing real system pressure, developing a firm alignment between the priorities of the STP and those being developed under the BCF, an under developed level of integrated service delivery models, and the way in which the system develops its approach to using the voluntary sector as part of its core approach to delivering solutions to challenges in the market. Key areas of priority therefore for this enabling workstream include;

- Addressing the fragility of care home and domiciliary market, through a range of integrated approaches including market development and collaboration with new models of care development.
- Establishing a development plan for a thriving voluntary sector as part of the solution to challenges in the market (links to Prevention and Enhanced Primary & Community).
- Review and align BCF programme to the STP and transitional funding.
- Establish an opportunity pipeline for review of CHC and reablement
- Maximise opportunities for health and care integration at a service delivery at a local level

Key Assumptions

- Estates workstream will continue is whole partnership approach to exploring the role of current buildings and potential future development opportunities across the health and care system building on current examples of collocating extra care and nursing homes alongside enhanced primary care and volunteer run community services that we are keen to build on.
- Whole system engagement with the LGA facilitated workshop for self assessment on integrated care, to develop baseline and additional plans
- System leaders continue to support this opportunity and commitment to integrated delivery models
- The approach will extend to housing, employment and reducing social isolation initiatives over the course of the 5 year programme

Enabling requirements

- Whole system engagement in facilitated self assessment
- Commitment for integrated approach development wherever possible
- Working group established
- Finance and budget input to workstream

Key Milestones:

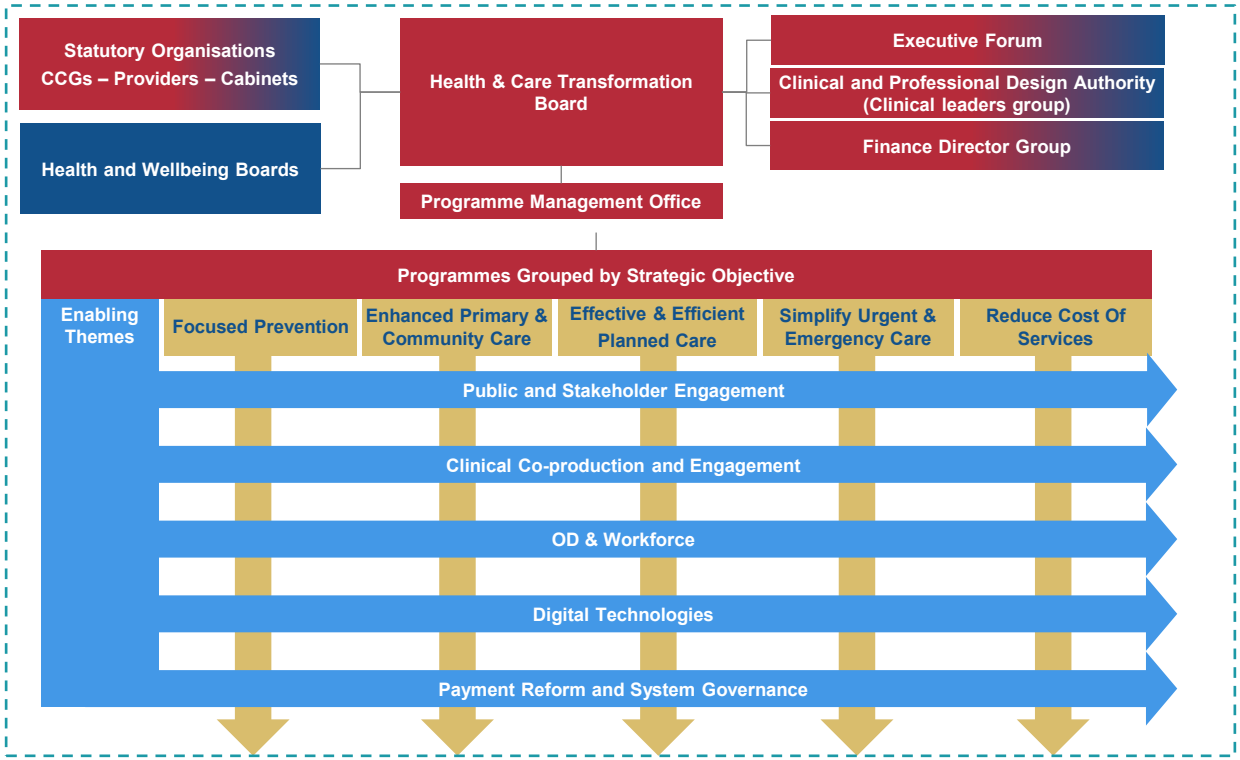
- Establish core work programme and delivery plan: Nov 2016
- Review and embed BCF work programme into current STP programmes and deploy relevant resource to support: Dec 2016
- Develop mapping of care home capacity across system, and identify priorities: Dec 2016
- Establish care homes plan including benefit realisation: Jan 2017
- Undertake CHC opportunity review: Feb 2017
- Review all programmes for approach to health and care integration: Dec 2016
- Undertake facilitated integration self assessment across the system with LGA: Dec 2016

System Enablers

System Priority 1: **Enhanced System Governance**

Progress in the Mobilisation for Phase 2

Key changes have been implemented which will enable us to mobilise as we move as a system from planning to more detailed delivery phasing, which include specifically a revision of the programme infrastructure and consolidation of the programme governance response.



NHSE, NHSI and LGA Regulation and Oversight

Out of Footprint Collaborations

Oversight | Advisory | Executory

Board Membership

H&C Transformation Board

- Independent Chair
- Chief Officers (LAs, CCGs, NHS providers)
- Transformation Programme, Medical and Finance Directors
- HealthWatch
- NHSE and NHSI
- Primary Care Providers
- LMC

Executive Forum

- Chief Officers from CCGs, providers and local authorities
- Transformation Programme Director

Clinical and Professional Design Authority (Clinical leaders group)

- Medical Director
- Clinical and Professional Leaders

Programme Leadership

Each programme has a Senior Responsible Officer ('SRO'), Clinical Lead & Programme Director.

Governance Principles

- Patients and public will play a central role
- Support integrated health and care
- System risks are owned at system level
- System wide metrics focus common purpose
- Accountability at system level
- Clearly defined roles and responsibilities

Key Priorities and Highlights

- It is recognised that effective inter-organisational working is leading to the development of integrated solutions. These will be delivered at pace via programmes grouped along the five strategic objectives, supported by the enabling work.
- There has been systematic engagement from all system leaders – With a direction of travel toward a collaborative health and social care system, this will be continued by the ongoing development of the now established Staffordshire & Stoke-on-Trent Executive Forum.
- The Health and Care Transformation Board will continue to be the fulcrum of the transformation programme – co-ordinating interactions across the system,. A decision making process is under discussion.
- We recognise that an effective assurance framework is a fundamental cornerstone for the success of the TWB Transformation Programme as it will deliver an efficient approach to the management of the programme by providing oversight and assurance at the level of granularity required by the Health and Care Transformation Board. Monthly assurance meetings with the SRO, Programme Director, Clinical Lead and Programme Manager are the cornerstone of this approach.
- Next Steps: We recognise that enhancing the system governance is an iterative process and the need to continuously strengthen our approach. As such we will revisit our system governance framework to ensure that we have the correct representation from Non Executive Directors and to deliver external assurance, alongside reviewing the way in which we are able to decision make regarding the implementation and ongoing development of the STP with systematic processes, agreed mandate, and governance.

Although we have built on previous engagement within this health economy, engagement on the detail of our plan to date has been limited because of the need to test the model and to ensure we all really believe it will mean improvements whilst delivering the financial savings. Our proposals are necessarily ambitious and we do not underestimate that the Staffordshire & Stoke-on-Trent history makes this specially challenging.

Our local politicians recognize the scale of the challenge and want to provide leadership in shaping and the delivery of the solution but we will make limited progress without national support for the delivery of the changes

We are now in a position to have more meaningful dialogue about the direction of travel of our proposals and the benefits that a new model of care could bring to our communities .Current and planned activity is as follows:

Communications and engagement workstream

- Communications leads are assigned to each of the workstreams to facilitate two-way communication, to advise on best practice, legal and assurance processes and to record all engagement so that we properly capture feedback from stakeholders and use this to inform the development of our plans.
- A series of communications and engagement workshops has been devised for dissemination of key information to SROs and operational leads on all workstreams. The first took place in September and was supported by the Consultation Institute.
- A series of 10 events will take place across Staffordshire and Stoke-on-Trent with members of the public throughout November and December. These are being hosted by the Staffordshire and Stoke-on-Trent Healthwatch teams with the aim of highlighting the key issues arising from the STP proposals and providing the opportunity for communities to ask questions and provide feedback . Our public facing STP will be published 31 October and will form part of the presentation materials. A panel of senior executives, clinicians and frontline staff have been identified and a 'marketplace' involving the leads from the enabling workstream has been convened. Our aim is to highlight both the challenges we face and the opportunities that a new model of care could bring in terms of improving health and well-being, quality and affordability of services. A detailed Q&A will be produced so that the programme has consistent answers to any questions raised, and media enquiries will be co-ordinated via the CSU.
- An Engagement sub-group now meets regularly. Partners have agreed an Engagement Toolkit incorporating engagement methodology, engagement and consultation guide and co-production approach, to ensure consistency across all our activity

  The Ambassadors programme is now underway. Partner organisations have identified staff and public individuals to train as ambassadors to disseminate key messages to stakeholders. Healthwatch Staffordshire and Healthwatch Stoke-on-Trent have delivered a series of pilot training sessions and provided ambassador packs. Feedback is leading to a revised on-going programme of training.

Programme-wide communications support

- Engagement with councillors, MPs, ministers and scrutiny committees continues to be coordinated across all partner organisations, with the Programme Director and Chair taking the lead with regular briefings. A Health and Care Collaboration Group has been established to ensure that those elected by local people to deliver democratic leadership are and will continue to be fully involved. Feedback is provided to the Communications and Engagement workstream to allow for regular updates to the stakeholder narrative and presentations updated monthly.
- The STP has received some interest from the media, MPs and online. A social media and media relations plan is being developed incorporating positive case studies or vignettes and press releases. The existing transformation programme website will be refreshed following the publication of the public facing STP on 31st October.
- NHS England communications and engagement guidance and assurance information continues to be disseminated to the programme team and communications leads and attendance at regional and national meetings and on conference calls remains a priority.
- Briefings by the Programme Director and Chair are scheduled for governing body, cabinet and trust board meetings as per guidance for November and December. A series of briefings to borough councils is scheduled for delivery by the Deputy Programme Director.

Clinical engagement

- Since the draft STP June submission, the Clinical Leaders Group (CLG) has revised its terms of reference to adopt a more formal responsibility for the clinical assurance of new models of care being developed through the STP, and to act as a Clinical Design Authority.
- As part of this, the membership of the group has been expanded to include all the workstream clinical leads and a GP Federation representative. This has strengthened the clinical engagement in the workstreams and enhanced the contribution that the group is able to give to each stream as they develop their plans.
- The Manchester Transformation Unit has been engaged to work with the CLG to develop a leadership and engagement programme which will initially concentrate on the members of the CLG but will quickly expand to focus on the critical need to engage with front line clinicians and grow the leadership across the system.
- The CLG recognises that clinicians will not engage unless the issues they face on a daily basis are addressed as an integral part of the larger scale change programme. Chief amongst these is the primary care crisis and the sustainability of general practice which must be addressed by implementing the GP5YFV and the 10 high impact actions.
- The STP programme is working with NHSE at local, regional and national level and the Midlands and Lancashire CSU Strategy Unit to develop and deliver a comprehensive package of support and development for practices at three levels:
  - To address the immediate issues of 'at risk' practices who would benefit from support to address demand, workforce capacity, business capability, the management of change and premises
  - To support practices in 'clustering' to form locality hubs through informal and formal networking arrangements enabling them to benefit in the short term from the economies of scale and improved productivity which these arrangements offer, such as back office functions and community based urgent care
  - To enable clinicians to shape and improve the services they provide in the medium and long term by developing the skills and capacities to become self improving teams.
- Strong clinical leadership at team and local level is required to achieve these objectives and this in turn requires an enabling style of systems leadership at board and system level. The CLG is championing this 'inversion' of traditional leadership across the system.
- As well as their responsibilities to lead clinical and professional engagement, the members of the CLG also recognise their role in leading discussions with the public and other stakeholders, including the media.

Activity to date	Future activity
• Set-up and preparation of case for change End Dec 2015 • Production of Sustainability and Transformation Plans (STP) to end Oct 2016 • Set up and deliver pilot training sessions for ambassadors programme • Develop communications and engagement workshop series and provide training for law and process for consultation • Engage stakeholders in the development of the STP	• Continue to raise programme awareness and enhancing public involvement with detail from each of the workstreams to March 2017 • Pre-consultation and consultation March 2017 onwards • Post-consultation feedback and communicating decisions 2017 / 18 • Programme implementation to end 2021

The Digital roadmap for Staffordshire and Stoke-on-Trent has been produced , and the plan will be submitted through an aligned approach with the STP submission timescales.

As the 2016 Staffordshire and Stoke-on-Trent Local Digital Roadmap (LDR) demonstrates, there is a strong commitment to deliver Digital solutions which enable system-wide Health and Social care Transformation. The Digital Workstream has established an exciting portfolio of Digital Programmes which will support the transformation described in the STP and focus on four themes of Share, Engage, Understand and Connect.

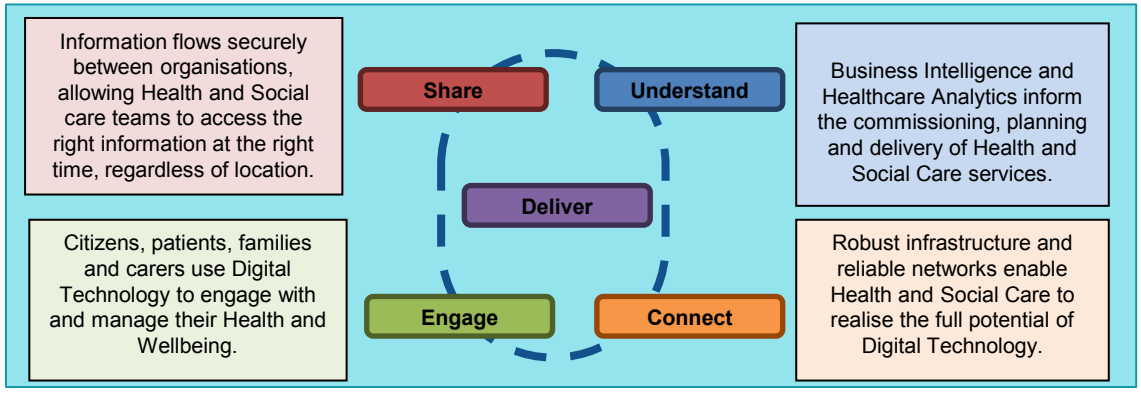
The Staffordshire and Stoke-on-Trent Local Digital Roadmap (LDR) sets out the aspirations of the Local Health and Social Care Economy (LHSE) to harness the potential of Digital Technology and Health & Care data to enable system-wide transformation. The development of the first LDR in Staffordshire and Stoke-on-Trent has been carried out across organisational boundaries, and will accompany the STP submission to NHS England.

The inclusion of a Digital Workstream in the STP programme structure has ensured that local Health and Social Care priorities are at the heart of the LDR. Formal alignment with the STP has been achieved by the appointment of a Digital Lead (CIO or equivalent) to each clinical workstream, which has helped to ensure that both clinical requirements and digital capabilities are aligned and understood by all. The Staffordshire and Stoke-on-Trent LDR identifies the significant variation in baseline digital maturity and recognises that different organisations will be at different stages when it comes to digital capability. It is widely anticipated that one of the on-going challenges for the Digital Workstream will be managing the migration paths for each organisation (each with a different starting point) onto a common digital architecture that enables personal information to be shared safely, securely and appropriately.

The collective digital strength that exists across Staffordshire and Stoke-on-Trent is clear for all to see in the founding principle of “Working Together by Agreement”, to which all organisations have signed up. There is a strong ambition to exploit the collaborative approach which has been created during the production of this LDR to deliver digitally-enabled transformation of the Health and Social Care system. Evidence of putting this collective commitment into practice is reflected in the agreement to cede some local digital decision-making responsibility for the ‘greater good’ to the newly-formed Staffordshire and Stoke-on-Trent Digital Design Authority.

The incremental approach to delivering Digital Technologies described in this LDR ensures that operational and business change can be embedded across the local Health and Social Care systems. It is anticipated that STP alignment will be the initial vehicle for delivering this change at the scale and pace required, but CCGs also have a pivotal role in scaling up and increasing coverage and usage of digital solutions across the LHSE by collectively commissioning digital solutions which embed the transformation in services and deliver benefits to staff and patients. This will be another example of the principle “Working Together by Agreement” in action, and the Digital Workstream will build the Strategic Outline Business Case for the overall programme to inform the commissioning strategy for investment in Digital Technology.

When it comes to deploying Digital Technology, the prioritisation of professional groups and organisations will be informed by STP priorities and clinical/patient engagement, alongside the evaluation of benefits, safety and value for money. The contribution of organisations such as hospices, charities and private providers will be of great significance and they will have a key role to play in the delivery of the LDR, however digitally-enabled transformation needs to start somewhere. In order to deliver the system-wide transformation outlined in the STP, the LDR will focus on a core group of organisations and practitioners before undertaking the extensive and cross-economy delivery. In addition, with large numbers of individuals choosing to access Health and Social Care services in neighbouring regions such as Birmingham, Wolverhampton and Derbyshire, a commitment has also been made to ensure that all Staffordshire and Stoke-on-Trent residents benefit from Digital Initiatives regardless of their postcode or choice of provider.



There are a number of risks, constraints and dependencies which will all have an impact on the ability of the LHSE partner organisations to deliver the Staffordshire and Stoke-on-Trent LDR, but there are a significant number of opportunities too. Successful delivery will only be assured if organisations can continue to live up to the professionalism, maturity and collaboration that they have shown in the production of this LDR.

It will be the role of every member of the Digital Workstream Programme Board to hold themselves and each other to account to make sure that the founding principle of “Working Together by Agreement” is upheld and translated into practical behaviours that put improving services to patients and citizens above organisational protectionism and personal self-interest.

System Enabler C & D: **Workforce and Organisational Development**

Workforce

The workforce workstream has identified the following as its top priorities and outcomes to achieve a sustainable and efficient workforce delivering.

This work is occurring in conjunction with workforce leads assigned to each clinical pathway, challenging workforce assumptions and highlighting best practice. Workforce scenario modelling workshops will be held in Q4 based on the STP future vision:

7. Staffordshire and Stoke-on-Trent recruitment campaign to make health and social care more attractive and lower vacancy rates. PR to compliment STP comms.

6. Linking workforce to IT developments, allowing improved communication and reduced duplication between organisations.

5. Shift of focus and development to navigation/signposting, prevention, parity of esteem and well-being. Aiding reduction in demand for urgent care and increase in citizen self-care, community capacity and empowerment.

1. Reduction in temporary staff spend through exploration of bank efficiency and agency usage.

2. Enhanced entry level recruitment and innovation, e.g. in domiciliary care and healthcare navigation. Leading to reduced pressure on patient flow and professional workloads through smarter take-up and development roles.

3. Sustainable workforce. This sustainability plan will initially focus on primary care. It will then proceed to ensure mental health, social care and community workforce planning aids efficient development of EPCC and Urgent care pathways.

4. Development of training new roles within academic centres across the county in order to develop a sustainable pipeline of new roles.

Organisational Development and System Leadership

The OD workstream aims to achieve its outcome objectives through 3 themes:

Outcomes

- Generating greater system leadership capacity (On-Going)
- Supporting engagement of clinicians into the STP. Ensuring our approach adopts engaging systems behaviours. (From Oct 2016)
- System wide transformation plan (2017+)

1. Transformation Q1 2017

- Progressing talks with SSSFT to develop learning from the Virginia Mason model into STP

2. Engagement Q3 2016 +

- Critical Friend supporting the transformation board and SRO's. Revision of behavioural concordat.
- Staff Engagement activity in conjunction with Communications and Engagement enabler
- Cultural systems diagnostic and responsive OD plans led by the data. Quarterly pulse check.
- Cultural alignment & OD consequences of system architecture
- Central induction for all work stream newcomers on Together we're better programme in place once STP made public

3. Leadership Q2 2016 +

- System leadership faculty and associated masterclass series for education and greater engagement. Association with Harvard
- Advancing talent programme (30 places) including stretch projects for aspirant director talent into programme work streams AfC 8C+ and equivalent. Stretch projects identified across STP pathways
- Primary care leadership programme (40 places) Linked to care hub and MCP development
- Coaching and career planning for SRO community. Coaching pool being developed to support project managers in implementation

System Enabler: E – Payment reform options to Align Incentives (How we contract)

Meeting the Vision of the Five Year Forward View (5YFV)

The 5YFV sets out a clear vision for future services to be both integrated across health and social care and built around the patient. This will be achieved by dissolving traditional care boundaries and new models of care including MCPs, PACs, ACO's and Urgent Care Networks to name a few possibilities. The move to a system-based approach to commissioning acts as a catalyst to new and innovative models of contracting. **Core areas of focus** with the 5YFV in mind are:

- Oversight of the implementation of the **2017/18 & 2018/19 NHS planning round**
- Building the **case for change**
- Connectivity with STP **workstreams to align interdependencies**
- Identification and evaluation of **new models of contracting** to enable a system-based approach.

There are three key **delivery targets and milestones** to show progress towards these areas of focus:

1. **2 year contracts** by 3rd December 2016 (as per NHS planning guidance)
2. A **case for change** away from the status quo by March 2017
3. Provision of **evidence based strategic** advice to STP workstreams

Key steps to delivery & milestones

16/17

- Q3 Mapping of existing contracts and build case for change.
- Q3 Deliver NHS planning round 2017/18 & 2018/19.
- Q4 Mop up residual issues arising from NHS Planning round.
- Q4 Establish evidence bank and gather intelligence through site visits.

17/18

- Q1 Provision of specialist advice and guidance to STP workstreams on design features of new contracting forms.

The following **objectives** allow us to achieve these delivery targets:

1. To build a **case for change** away from the status quo.
2. To map existing contracts and contractual form to **define the system starting point.**
3. To provide oversight to the **delegation and/or transfer of primary care commissioning** into clinical commissioning groups.
4. To be a tangible presence in the STP and a **central point of coordination and communication** in relation to relevant material.
5. To assess the **short term implications** for contracting and maintain oversight of the need for procurement and termination advice.
6. To identify and evaluate **alternative contractual forms** aligned to STP workstreams.
7. To build an **evidence bank of intelligence** linked to new contractual forms and ensure this is considered in the design and development of new models of care developed by STP workstreams.

Achievement of these objectives will be dependent on the below **enablers**:

Requirements	Resource requirements	Key Assumptions
• Contract information from partner organisations. • Published research. • Development of emergent themes from STP workstreams. • System leadership support.	Core programme team including PMO function (funding and resource-in-kind dependent), • Clinical input (predominantly Primary Care re delegated commissioning). • Initially resourced by partner organisations for resource and expertise. • The programme may need specialist expertise and/or knowledge not routinely available in partner organisations and this will be identified on an 'as and when' basis.	• Organisations will work in best interest of system not individual organisation. • Organisations will work on an 'open book' basis in relation to sharing financial information and the practical implications of PBR. • Options to move away from PBR will be acceptable to NHS Improvement and NHS England. • Published research into new contractual forms is sufficiently broad to enable reliance on findings. • STP workstreams are sufficiently advanced to enable translation of new model of care into new model of contracting.

Key options being explored and analysed are:

1. Mapping of existing contracts and contractual form to build a case for change away from the status quo
2. New models of contracting including Prime Commissioner, Prime Provider, Alliance and/or Joint Ventures
3. Funding models best aligned to contractual form
4. There are links between payment reform and the setting of system control totals

Detailed work on the option analysis will be fully aligned to the emergent thinking arising from the individual STP workstreams to ensure program synergy.

Reflection of the STP in the Operating plans

In line to the NHSE guidance regarding the 2018/17 - 2018/19 operating plan submission we have agreed on a system wide basis to adopt the following approach to aligning the operating plan with the STP:

The Executive Forum have agreed a approach to the development of the operating plan which enables a system wide plan and all staff involved in the Operational Planning and Contracting round setting the Boards expectation of the way are cogniscent of the change in approach.

The Executive Forum is clear that the Operational Planning and Contracting round is to design to deliver the STP in 17/18 and 18/19 not individual organisational aspirations and this includes an open book. It will fundamentally require a change in control totals for certain organisations.

A key element to the successful delivery of operational planning and the contracts that flow from this is that all organisations provide their own planning assumptions but then come to the table in a pragmatic manner to agree activity levels which reflect the joint plans that have been agreed by all the organisations in the STP. This is critical because previous experience has shown that although there was a robust methodology for the calculation of activity linked to growth, organisations have ignored this information and continued to submit plans which were the opposite to what the agreed methodology was highlighting.

The Executive Forum has confirmed their support for an open book approach and that all organisations agree to adhere to this along with the following methodology and approach to activity planning, as follows:

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- The last two contracting rounds the Staffordshire & Stoke-on-Trent system has been characterised as a system of high risk because a number contractual disagreements have gone to escalation and ultimately to arbitration. It is clear from the guidance that there will be very little tolerance of this for 17/18 and 18/19 with intervention from the Chief Executives of NHS England and NHS Improvement.
- As system leaders there is awareness that arbitration is something that is not helpful, It is therefore critical that the STP leaders demonstrate problems can be resolved locally without recourse to national intervention. With this in mind the Executive Forum support the development of an internal escalation panel across Commissioners and Providers that is enable the system to address issues as they arise across a range of contracts, this will include developing a process for managing difficult issues. In essence this would be an internal mediation system and it is proposed that the STP Programme Director is part of that process.
- Commissioning intentions have been aligned to the STP, however there is a disconnect between the timelines advised in the programme critical paths for activity reductions and system redesign implementation and the requirement to have granularity at a HRG level prior to the first cut contract proposals in early November. This is proving a challenge however the approach to mitigating the risk is outlined above, and we are reviewing accelerated plans for inclusion in the operating plan aligned to the STP.
- Each organisation has been issued with an Individual Control Total (ICT) for 17/18 and 18/19. These ICT's have been set with the aim of bringing the system back into financial balance well in advance of the five year STP trajectory. To the extent that operating plans include greater savings in a faster timescale, then these will be incorporated in a revised STP.
- The expected trajectories for performance on A&E, RTT and GP access performance trajectories will be in the operational plans submitted by CCGs and providers in December and will be consistent with the STP.
- The 2017/18 Operational Planning Guidance Annex 6 identifies a number of funding streams to support the delivery of the GPFV. We have identified the GPFV requirements and also the anticipated funding streams over the three year period 2016/17-2018/9. The funding includes support for GPIT, extended access, new workforce models/training, primary care at scale, resilience and sustainability. CCGs are required to outline their plans to deliver the GPFV in the 2017/18 Operational Plans by 23rd December 2017/18. Primary care leads across Staffordshire are working collaboratively to agree plans that reflect local need but are consistent with the ambitions of the STP and EPCC programme. The STP will monitor the investment profile into primary care through its assurance processes to ensure it adequately meets the nation commitment of the GPFV.

Areas of Opportunity

Transforming Care – Areas of Opportunity to be Developed

The below sets out the areas of opportunity to be developed the system is working towards. All of these decisions need to be sense check against ongoing engagement and eventual consultation. The decisions were reviewed and refined based on the following high impact areas. We recognise that the critical decisions are interrelated and that the exact timing and sequencing will be set out within the detailed programme plan.

Priority Objectives	Workstream	SYSTEM CONSIDERATIONS	FURTHER CONSIDERATIONS	DUE DATE
ENHANCED PRIMARY & COMMUNITY CARE	5. Enhanced Primary and Community Care	The scale and pace at which we can invest and deliver the integrated community model (MCP) across Staffordshire & Stoke-on-Trent to enable integration of community care, mental health and end of life care with a sustainable primary care structure.	• The scale and pace at which we can invest and deliver the integrated community model • The steps to develop the new models of care (MCP) • Agree the pathway which provides assurance through the pathway of change but supports primary care innovation	Mar' 17
	4. Community Hospitals Management Plan	Consider solutions to reconfigure, reuse or reposition community hospitals and/or enhance estate utilisation in line with the development of new MCPs.	• Determine the future role and function of every community hospital in Staffordshire & Stoke-on-Trent (linked to the development of the community hubs).	Oct' 17
EFFECTIVE & EFFICIENT PLANNED CARE	7. Planned Care Reconfiguration	The initial focus on productivity alongside options appraisal for the reconfiguration of elective care to maximise estate utilisation.	• Agree the centralisation of UHNM planned care services. • Determine the scale of reduction in the number of planned care centres. • Determine the future of the network of the provider relationships across Staffordshire & Stoke-on-Trent (this affects all acute sites).	Oct' 17
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	9. Simplify Urgent & Emergency Care	Whether to move from three to two A&E sites and one Urgent Care Centre.	• What is the sustainable future for the Acute Care in Staffordshire and Stoke-on-Trent • Revisit the TSA recommendations. • Determine the level of estate rationalisation at Royal Stoke as a result of planned and urgent care changes	Oct'17
REDUCE COST OF SERVICES	1. System Governance	A strategy to move to a single shadow financial control total for the system and agree the preferred enabling system governance model to integrate all CCGs. Options to include e.g. ACOs, chains, but change without benefit will be avoided.	• Decision on the future configuration on the CCGs • Decisions on the future configuration of the community and mental health providers (which will enable devolution to new models of care) . • Agree the decision making process for the implementation of the STP	May '17

Quantified Solutions: Financial Impact

Solutions and Impact – Summary of financial solutions

- **To reduce the deficit by 2020/21, a number of solutions have to be produced:**
- **£130m relates to CIP savings (£27m from workforce).**
- **£22m from estates through better utilisation of current estates within the Staffordshire & Stoke-on-Trent region.**
- **Planned and urgent care are areas which have been targeted as they are care settings with high levels of costs.**

Based on analysis and workstream activities as indicated in this report, a golden thread has emerged on the overall sustainability solution for Staffordshire & Stoke-on-Trent. The themes emerging are demonstrated across four key areas;

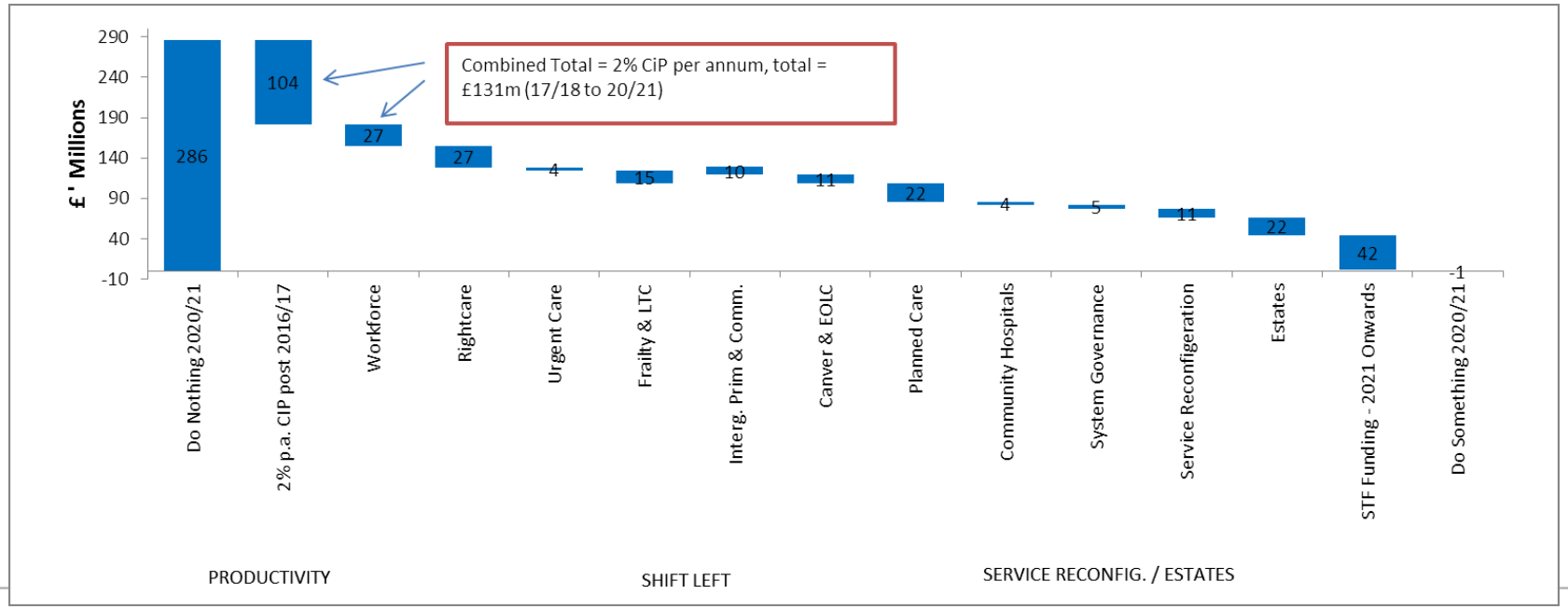
1. Accelerate the pace and delivery of productivity and efficiency improvements across all organisations;
2. Transferring activity to lower acuity care settings where appropriate ("Shift Left").
3. Reconfigure elective inpatient services & Urgent Care services to meet patient needs, improve productivity and remove duplication and capacity; and
4. Reduce total bed capacity, estates and management overheads to take out fixed costs.

A guiding principle will be the redeployment of clinical staff from the elective and urgent care reconfiguration into substantive posts to reduce cost and reliance on temporary staff.

The bridge below demonstrates the key areas (as outlined above) where cost reduction will be achieved in order to achieve financial balance whilst enhancing care. Each of the system priorities is modelled and the effect is shown below. The assumptions used in order to model the financial effect are highlighted on the next two pages. . The clinical workstreams are at various stages of developing detailed transformation plans. There is nothing in the work to date that suggests that the modelling shown below is unrealistic. The planned changes to community hospitals are most advanced and confirm the original estimated savings.

In order to achieve these system cost savings there will be an adverse effect on organisations within the system. In order to ensure that the system is incentivised to achieve the savings required we suggest that a system control total should be implemented.

The original STP aggregated the original organisational plans adjusted for CIPs having no specific plan and c.£30m of QIPP which was not a system wide saving. A detailed review of the consolidated 16/17 in-year financial positions across the system has revealed that a combination of additional cost pressures and CIP/QIPP plans that will not lead to system-wide savings totalling £41m. To be prudent this additional deficit is being treated as recurring. The £76m of recurring STF Allocation in 20/21 is being used to cover this additional financial challenge, with the balance being held as a contingency against this and other risks.



The assumptions made and the details of each of the cost reduction schemes are summarised below. The detailed plans are at various stages of development as highlighted on pages 16-19 and appendix A. The direction of travel has been agreed by the system, and the system as a whole is committed to deliver the objectives collaboratively. The below describes what would be needed in order to deliver the savings identified. The previous pages identify the actions and decisions needed to give the required results. All solutions have been calculated fully and any double counting from other solutions has been removed.

	Assumptions and target	Impact after removal of double count	STP forecast 17/18 delivery	STP forecast 18/19 cumulative saving
QIPPs and CIPs	**CIPs** • 2% efficiency saving from total provider expenditure from 2017/18 onwards.	£130.5m saving	£31.4m	£63.4m
Workforce Cost Reduction	**Reduction in agency spend** • Savings are from the agency premium. • Agency staff to be replaced by substantive staffing in all providers and staffing categories. • Assumed agency premium of 50%.	£27.0m saving Included in the Above	Included in above	Included in above
Right Care	• To estimate the impact of delivering the right care initiative we have assumed that the top six opportunity areas for Staffordshire & Stoke-on-Trent would be implemented. This is a total opportunity of £55m. To be prudent we have assumed that only 50% of this benefit will be realised.	£27.0m saving	£6.8m	£13.5m
Simplify Urgent and Emergency Care	**Rescope MIUs** • 75% of activity transferred to the community. • 25% of activity transferred to the most local A&E. • Assumed staff would be redeployed at A&E, reducing the need for agency staff.	£4.3m saving	£2.6m	£3.0m
	Reduction in A&E and non-elective spells • 30% reduction in A&E non-admitted. • 20% reduction in A&E admitted. • 8% reduction in non-elective spells. **30% reduction in A&E and non-elective spells** The total saving has been reduced to take into account double counting from other schemes. *Note: only saving for the under 65 cohort is included to avoid double counting with the Frailty and LTC option..			
Frailty and LTC Pathways Embedded	**Improved care for frailty and LTC resulting in lower admissions** • Population drawn from ONS population data. • 20% NEL EM admission for LTC and Frail Elderly can be reduced from 16/17. • No additional resources are anticipated to be required to deliver this. • Note: some activity to support this has been contracted with UHNM from April.	£15.2m saving	£1.4m	£5.9m
Enhanced Primary and Community Care	• Establishing MCP to provide community support for patients that have been shifted left. • MCP team including: – GPs, Nurses, Specialist Nurses, Occupational therapists, Physiotherapists, Mental Health Workers, Social Care, Domiciliary Care and voluntary services.	(£9.9m) Additional Cost	(£2m) Additional Cost	(£4.5m) Additional cost
Cancer Pathway Reconfiguration*	**Improved Cancer Care** • Total cancer care spend of 4 CCGs of £46.5m. • Increased spend over 5 years expected to be £10.4m, to be saved from initiatives. • Saving realised from 2019/20 onwards. • 70% cost response and saving from 2019/20 onwards.	£7.3m Saving	-	-
End of Life Care Pathway*	**Improved End of Life Care** • EOLC of 4 CCGs of £40.5m. • Increased spend over 5 years expected to be £8.5m, which will be saved from initiatives. • 70% cost response and saving from 2019/20 onwards.	£6.7m saving	-	-

Note: the assumptions totalled have had areas that double count removed. This has reduced the impact of certain schemes

** Figures to be reviewed and refreshed*

Solutions and Impact (cont.)

	Assumptions and target	Impact after removal of double count	STP forecast 17/18 saving	STP forecast 18/19 cumulative saving
Planned Care Reconfiguration	**UHNM and Burton planned care** • Inpatient spells: - 20% of orthopaedics inpatients converted to daycase. - 1% of all other inpatient spells converted to daycase. - Improved LOS by 5%. • Follow-up reduction/improvement: - 30% of follow-up attendances are reduced due to efficiencies or use of new technologies. - 50% reduction in the cost of follow up appointments. • Additional saving from procedures of limited/no benefit. Need to be 'harsher' with implementation. • A saving of £6.5m has been included based on analysis from reducing GP referrals. There is further evidence that this order of magnitude saving can be delivered from analysis of the level of variation in spend per GP across the footprint.	£15.0m saving £6.5m	£2m - 	£6.7m £1.5
Prevention and Wellbeing Strategy	• No financial saving has been included from this working group. However it is anticipated that this workstream will seek to prevent future demand.	-	-	-
Community Hospitals Management Plan	**Community Hospital Management Plan** • Closure of 105 community beds: - 85 at Longton and Cheadle Hospitals. - 20 at Haywood Hospital. Further identified community beds will be closed during 16/17, the financial impact of which will be modelled. • 11% of staffing and variable costs saved at Haywood Hospital in line with the numbers of beds reduced at the hospital.	£4.2m saving	£4.0m	£4.0m
System Governance	• Removal of CCG overheads and 15% of back office staff Removal of 10% of providers' back office (finance, HR, procurement, communications) – Excluded as assumed to double count with CIP.	£5.2m saving	£2.6m	£5.2m
System reconfiguration	• One A&E changed to a UCC. Non-elective admissions connected to A&E change to UCC transferred to other hospital within Staffordshire and out of area Transfer Stoke-on-Trent orthopaedics to County Hospital. • No fixed cost saving is assumed. This is assumed to enable the saving estimated in the estates rationalisation option to be delivered. • Assumed that the average length of stay at County Hospital can be improved to Stoke-on-Trent hospital average length of stay. An additional 5% length of stay improvement in unplanned care is also assumed.	£11.2m saving	-	-
Mental Health Integration	• No modelling assumptions have been provided to model the impact of mental health integration.		-	
Estates	• Rationalisation of hospital estate – Yet to be identified.	£22.0m Saving	£1.0m	£2.0m
Health and Social Care Collaboration	• No modelling assumptions have been provided to model the impact of health and social care collaboration.			
Total		**£245.2m saving**	**£49.7m**	**£100.7m**

Note: the assumptions totalled have had areas that double count removed. This has reduced the impact of certain schemes.

Solution and Impact

- **The phasing of the cost savings has been profiled in accordance with the plans as they are currently developed.**
- **•There are clear interdependencies and risks to the timing of the phasing and the detailed plans will be developed further in the next months.**
- **•The total deficit funding requirement post legacy funding for 2016/17 to 2020/21 is £361m.**

The solutions have been modelled over the next 5 years. They have been phased at a high level and detailed business cases will be developed to provide a "bottom up" plan. Until we have developed these business plans there remains considerable risk.

The table opposite summarises the financial implications of the proposed solutions and the anticipated phasing. The position as presented is on a net basis.

By 2020/21, the Healthcare system will be in balance, if the proposed solutions are delivered. Nonetheless, between 2016/17 and 2019/20, the system will continue to be in overall deficit, which will need to be bridged. Any opportunities to accelerate the cost savings, to alleviate this scenario, will clearly be rigorously pursued and may require more radical options. Further work is needed to develop the next stage of the modelling.

There are also a number of interdependencies and risks to achieving the delivery (and phasing) of the proposed solutions. For example, in relation to the requisite primary and community care capacity that will facilitate the release of the acute care savings.

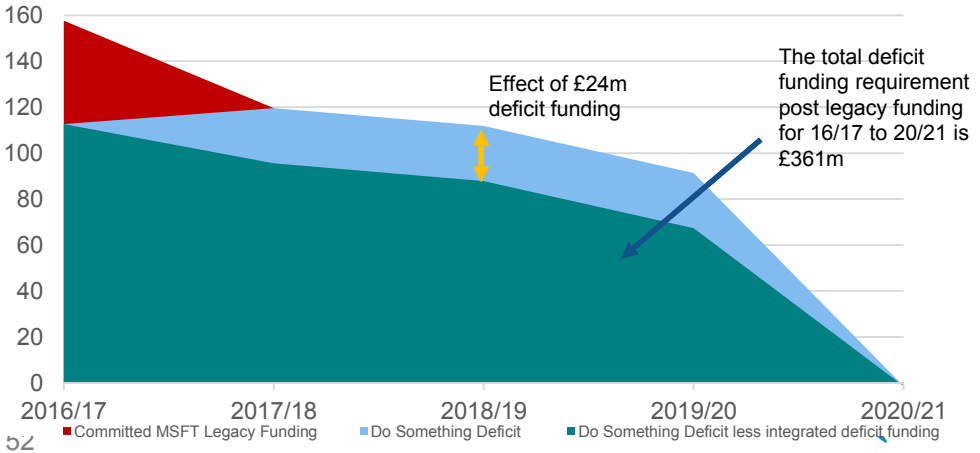
That said, the assumptions that have been applied in preparing this plan are deemed to be appropriate and reasonable by the System Finance Directors. They will need to be further substantiated by further detailed work. The forecast position includes the £6m recurrent deficit due to the integration of Cannock Hospital at Royal Wolverhampton NHS FT. Whilst the financial template does not include it in the position of the SSoT Health system, we have included it within the number presented as we believe there is a requirement to solve this problem as part of the SSoT system transformation changes. The graphic opposite sets out the in-year year deficit for the SSoT system and the cumulative deficit by 2020/21. Key points to note are:

- The total deficit funding requirement between 2016/17 and 2020/21 is £361m. This has increased by £168m as a result of the increased deficit in 16/17. It is recognised that we need to look at more significant options to cut this requirement in 17/18 and 18/19.
- The deficit funding requirement is in addition to the non-recurrent integration deficit funding of c.£24m (£15m from NHS-E to Stafford and Surrounds CCG and £9m from the Department of Health to UHNM) from 2017/18 to 2021/22 which has been committed to the SSoT system.
- It does not include the repayment of any historic deficits.
- This plan does not currently include the costs of investment, capital or revenue for transformation.
- It should be noted that whilst the "do-something" has a significant cumulative deficit of £361m, this compares to a "do-nothing" cumulative deficit of £1,080m.

The Staffordshire County Council Social Care bridge shows the make up of the £225m do nothing position, and the various solution that reduce the residual gap to £78m by the end of 2020/21. In light of this residual gap the system has allocated £5m per year for each of the next 4 years to facilitate transformation. In addition, the system has set aside £34m of recurring STF funds to cover further investment in primary, community and social care to enable the shift left.

Do Something: Whole System Within Year Deficit (£ ' 000) – Phased NSH Financial Bridge

		2016/17	2017/18	2018/19	2019/20	2020/21
		£ ' 000	£ ' 000	£ ' 000	£ ' 000	£ ' 000
Do Nothing Healthcare Deficit		**(159,546)**	**(169,268)**	**(212,666)**	**(252,888)**	**(285,402)**
(exc Specialised, WMA inc RW Rec Int £6m)						
Solution Number per Template	**Solution Name**					
Solution 2	CIP/Workforce	0	31,397	63,444	96,479	130,447
Solution 3	Right Care	0	6,750	13,500	20,250	27,000
Solution 4	Urgent Care	0	2,560	3,042	3,529	4,252
Solution 5	Frailty & LTC	0	1,426	5,937	11,521	15,235
Solution 6	Integrated Primary & Community	0	(1,990)	(4,476)	(7,117)	(9,853)
Solution 7	Cancer & EOLC	0	0	0	5,737	14,047
Solution 8	Planned Care	0	2,000	6,677	10,266	14,944
Solution 9	Prevention (in Planned care)	0	0	1,500	4,000	6,500
Solution 10	Community Hospitals	1,940	3,956	4,021	4,087	4,202
Solution 11	System Governance	0	2,611	5,222	5,222	5,222
Solution 12	System Reconfiguration	0	0	0	5,613	11,225
Solution 12	Estates Strategy	0	1,000	2,000	2,000	22,000
STF Funding Applied in Year to Meet 16/17 Recurrent Pressures						41,600
Total Solution Value		1,940	49,711	100,868	161,588	286,822
Do Something Healthcare Deficit (exc Specialised, WMA)		**(157,606)**	**(119,557)**	**(111,798)**	**(91,300)**	**1,420**



Sustainability and Transformation Fund (STF)

We have calculated that the Staffordshire & Stoke-on-Trent health and social care organisations need £120m of one-off revenue in the 4 years 2017-21 to transform services in order to deliver £286m of recurring savings by the end of 2020/21. The funding request is £30m per annum. We assume that the 16/17 level of STF funding currently available to the Staffordshire & Stoke-on-Trent providers will continue in each of the next four years. It is recognised that this means that the STF funding will not be available to offset deficits as assumed in the recently issued 17/18 and 18/19 Individual Control Totals (ICTs). This will lead to a difference between the STP and the aggregate of the ICTs in each of the next four years.
Details of the transformation costs are shown in the following table. It is recognised that at this stage these are estimated numbers. The costs will be firmed up as the clinical workstreams develop detailed transition plans.

STP Transformation Costs 2017/18 to 2020/21 Cumulative	2017/18	2018/19	2019/20	2020/21
	£ '000	£ '000	£ '000	£ '000
Programme / Change Management Costs	1,212	2,319	3,967	6,724
Cost of Staff Change	2,500	5,000	7,500	10,000
Double Running Staff Costs	8,507	14,902	24,976	35,695
Costs of Enhanced Primary Care (23 Hubs)	2,000	4,000	6,000	8,000
Communications and Engagement	750	1,500	2,250	3,000
Social Care Transformation Costs	5,000	10,000	15,000	20,000
IM & T Revenue (inc. Digital)	9,631	21,079	28,307	33,781
Dep. Est Associated with Capital	400	1,200	2,000	2,800
TOTAL	**30,000**	**60,000**	**90,000**	**120,000**

Capital

Given the extremely constrained capital environment, we have limited our capital requirements to £20m. This is to fund two £10m schemes over 17/18 and 18/19 described as follows:

- To create a GP front of house facility at RSUH
- To consolidate inpatient capacity re: the transfer of elective activity.

Although small in value, both schemes are pivotal to the delivery of high value savings:

- Urgent care (£4.5m)
- Planned care (£15m)

Delivering our Plan: Key Risks and Assurance Process

Delivering Our Plan – Key Risks

Key Risks	Mitigating Actions	External Dependencies
Workforce capacity and/or skill set insufficient to deliver quality service during transformation Recruitment and retention of expert clinical staff through a period of significant change, particularly in primary care and while reducing agency spend.	Engagement and co-production with staff via Clinical and Professional Design Authority. Guarantee regarding staff redeployment in case of service redesign. Dedicated workforce workstream, with priority reduction of agency spend via dedicated system workforce bank. Workforce elements of primary care strategy. On-going engagement with Health Education England.	National messages regarding new roles and engagement with key leadership e.g. LMC.
External Governance: accountable organisations are constrained by governance and regulation and cannot drive the change required Specifically between local authority and NHS organisations, and between different NHS organisations. Regulation not supporting collaborative working.	All members of the transformation board have agreed to the principle that collaborative working is fundamental to the success of any significant transformation. System leaders have made progress in demonstrating co-operative working behaviours.	Regulator permission for individual organisations to have short term flexibility on financial or performance targets. Potential for system wide targets (financial and clinical).
Political and Public: Insufficient scale of transformation Inadequate political engagement and support leading to risk averse behaviour and lowering of ambition.	Early engagement with local politicians in STP process. Meeting with minister and MPs planned. Chair of the Board setting up local advisory groups. Workstream established and developing plan for engagement and communications processes.	Regulatory support for consultation and engagement on difficult decisions. National engagement re. level of change required across systems and sharing of level of ambition alongside key messages to provide context for local challenges.
Political and Public: Public objections to the plans developed impact timeline or scale of transformation	Key role of patients and public in co-production and the training of workstream leaders on co-production principles. All workstreams to develop proactive patient and public engagement via the engagement workstream, development of champions and effective media strategy.	NHSE and NHSI support on consistent messaging and that the options on the table need to be resolved. Clear expectations around engagement and consultation processes within defined timetables for transformation. Expert input may be required at key points.
Culture and Alignment: Organisational culture and direction not aligned with system wide goals Achieving and maintaining a common purpose and alignment across system and organisations at every level is key	Effective leadership from programme board ensuring full organisational involvement. OD and leadership development enabling work to invite and capture energy and innovation of frontline staff. System leadership coaching programmes for aspiring directors and senior clinicians. To include stretch project, buddying and peer mentoring initiatives.	Regulatory support to develop a system wide culture and approach which may move from collaboration to a more formal structure based upon system value-add. Support drive and ambition to develop internally rather than through external regulation and pressure.
Operating Plan, and STP not aligned leading to failure to secure 2 x year contract agreement	Agreed approach to alignment through Executive Forum Coordinated approach across CCG with one CCG leading on behalf of all to deliver consistency Internal arbitration approach implemented by Executive Forum. STP led mediation	Regulatory support to facilitate agreed position
Capacity for Change: Inadequate capacity and capability to deliver required change at pace due to lack of resource, time, or leadership capability	Create leadership capacity and capability through senior leadership OD tier's development of leadership culture, behaviour and director development (appendix D) for all workstream SROs and Programme Directors. Embedding leadership in workstreams via tier 2 of leadership development, using independent feedback and challenge to develop well-defined roles and coaching programmes. Adequate resourcing of the programme with time and resource from partner organisations. PWC partnership with UHNM to deliver CIPs and QIPPs. Transition investment plans supports whole system change (including primary and social care)	Access to vanguard outputs and lessons. Access via national team to specialist expertise in health and care transformation, particularly in relation to new models of care. Regulatory support for changes and recognition of pressures on individual organisations and leaders from the change process.
Aligning Financial Incentives: **Transformation priorities are hindered by the incentives alignment or by perverse financial incentives.** Failure to agree system wide control total prevents organisations from supporting change which might negatively affect their organisation.	Staffordshire & Stoke-on-Trent system seeking authority to shadow a system control total in 16/17 at national discussions. Contracting workstream actively investigating the best methods of contracting and incentives to support the functional change required.	Support and information to drive a review of the current financial incentives programme and to introduce a system wide control total ahead of current planning timelines.

Progress in the Mobilisation for Phase 2

Key changes have been implemented which will enable us to mobilise as we move as a system from planning to more detailed delivery phasing, which include specifically a revision of the programme infrastructure and consolidation of the programme governance response.

Monitoring of forward progress – We recognise that an effective assurance framework is a fundamental cornerstone for the success of the TWB Transformation Programme as it will deliver an efficient approach to the management of the programme by providing oversight and assurance at the level of granularity required by the Health and Care Transformation Board. Monthly assurance meetings with the SRO, Programme Director, Clinical Lead and Programme Manager are the cornerstone of this approach. The system benefits are the introduced enterprise level PMO function are below:

- Effective oversight and clarity at each level and phase,
- A real time process of risk escalation,
- A culture of recovery and mitigation planning,
- Enhanced project and programme management discipline,
- Effective governance and assurance delivered and owned at each level of responsibility and accountability,
- A shared view of what success looks like,
- The maximisation of synergies and reduction in duplicated effort,
- The ability of the programme and system leaders to heighten their level of responsiveness to changes,
- Confidence in the programmes ability to achieve its targets.

The Health & Care Transformation Board has strengthen its **assurance and governance function** alongside its roles as the system leadership team. The H&CTBs membership has been revised to take into account primary care provider representation. Key areas of responsibility are below:

- Provide a point of escalation for the PMO.
- Review and agree recovery and mitigation plans for major and catastrophic risk.
- Act as the final approval for all new projects/programmes & phase throughout the TWB Programme.
- Receive, scrutinise and approve the monthly Programme Oversight Report (the report which is an accumulation of the individual programme reviews undertaken by the PMO in a comply or explain style).
- Agree external reporting position.
- Review and agree any proposed programme/project re-profiling.
- Review and approve programme changes that will affect the performance of the overall Programme plan.
- Maintaining a strategic overview and implementation of the strategy; this includes setting out explicitly the common purpose for the work;
- Agreeing the system wide priorities for the programme;
- Defining the programme boundaries in terms of time, cost, scope and quality;
- Providing programme leadership including the responsibility for setting the culture across the system;
- Setting out the planning, governance and decision making processes for the programme;
- Securing the necessary resources for the programme (including access to support external to the system) and monitoring the use of these resources;
- Establish the principles and processes for engaging and communicating with key stakeholder groups including patients, public and staff
- As the programme moves to the implementation stage ensuring that transitional arrangements are in place to incentivise decisions that are in interest of the system and public rather than in the interest of individual organisations;
- Recommending strategic decisions as appropriate to NHS England (NHSE), NHS Improvement (NHSI).

The nest steps will be to develop the detail of the decision making processes which enable appropriate steps to allow delegation to a joint committee

The gateway assurance process is delivered through the STP Programme Management Office. It utilises standardised project scrutiny processes in order to have oversight on a monthly basis of the programmes status. Further details of what we have done since June to enhance the system governance and assurance processes and deliver the STP enterprise programme management function are in [Appendix A]. Central to the process are the monthly gateway assurance meetings. These provide a forum to undertake the following key functions:

- Review of workstream progress against plan.
- Identifying risk/issues both workstream specific and those that emerge as consistent across more than one workstream.
- Supporting the delivery of the programme through the identification of resources and resolution of issues required to progress.
- Establishing an agreed monthly status in 3 key areas – Progress against plan, delivery confidence, programme assurance level.
- As an agreed point of escalation.

Key elements of the gateway assurance process include;

- Scrutiny of individual project performance and delivery against plan – Early warning system for barriers, risks, and delivery challenge.
- To determine project status in month.
- To ensure enhanced mitigation plans for underperforming and failing projects are robust and are identified and delivered in real time.
- To agree mitigation and recovery plans.
- Lead by Deputy Programme Director.
- To undertake a comprehensive review on a monthly basis to provide corporate assurance against plan.
- To ensure accountabilities and responsibilities for the delivery of plan are understood and delivered.
- To provide assurance to the H&CTB Chair, Programme Director & H&C Transformation Board.
- PSR1 Completion by Programme Manager 2 days prior to review.
- Attendance of SRO/Clinical Lead/Programme Delivery Director and PM.

In the first months programmes have engaged with the process well and a summary of the outputs from each review is outlined in a monthly report to the H&CTB. Key additional actions have been agreed with a number of workstreams in order to maintain momentum. Key areas of focus for forthcoming assurance meetings include;

- Effectively moving from planning to delivery.
- Workstream position within the 5 programmes and synergies.
- PID updates.
- Risks and mitigation.
- Acceleration of pace where appropriate.
- Amends to the critical path.
- Interdependencies.
- Current challenges and solution focussed thinking.

Appendix A: Addressing June Feedback

Appendix A - Addressing the June STP feedback

The Staffordshire and Stoke-on-Trent 30th June STP Submission was reviewed by the regional and national STP teams and received much positive feedback. The system recognises that this was a good start, and that this must be used as a platform to drive the change. The work has continued since June and the feedback areas for improvement have been specifically targeted and the progress in the key areas has been set out below.

STP June Submission Feedback	Update to date	Next Steps
Workstreams to have greater depth and specificity, with clear and realistic actions, timelines, benefits (financial and non-financial outcomes), resources and owners. (template for finance and workforce will be provided by NHSE).	The workstreams have been actively refining their plans since June and have progressed to more granular plans with committed timescales. Crucially resource has been seconded from each of the Staffordshire & Stoke-on-Trent organisations in order to keep the pace A programme management approach as been deployed, and each programme has a core PMO, and detailed delivery plan/critical path. A set of clinical indicators has been developed including outcomes and strategic benefits to change. Further development of the range of potential solutions is in progress with detailed analysis of impact and outcomes highlighting the most favourable solutions for the system. All programme assumptions have been reviewed by the Directors of Finance Group.	Each programme has a timeline for the completion of the appraisal of potential solutions all of which will be delivered before the end of March 2017. Priorities will include the development of the case for consultation, consolidating and aligning the outputs into the operating plan and contracts, and confirming the critical path for engagement, consultation and impact delivery.
Include stronger plans for primary care and wider community services that reflect the General Practice Forward View, drawing on the advice of the RCGP ambassadors and engaging with Local Medical Committees.	The STP is built around the delivery of place based care delivered to local populations of 30-70,000. These 'local units of planning' are being formed through the 'clustering' of local practices to create 23 locality hubs across SSoT. The STP therefore depends on thriving and stable General Practice s who are able to develop in this way, but many of whom are currently in the throes of a workload and workforce crisis. This will be urgently addressed by implementing the GP5YFV and 10 high impact actions in partnership with NHSE, the 6 CCGs and 2 LMCs. The general practice stabilization and development programme will be tiered to address: 1) immediate problems in individual practices – business capability, workforce and demand management, 2) promoting collaboration with neighbouring practices to 'cluster' and benefit from economies of scale, and 3) to develop larger scale MCPs. Funding for this will be sourced locally, regionally and nationally through NHSE monies, combined with STP transitional funding. The STP of Staffordshire & Stoke-on-Trent has identified reinvestment of a number of efficiencies identified into primary and community services @ 50%. Funding streams for primary care are; • CCG allocation • GPFV monies • STP new investment • Transformation reinvestment Locality mapping is completed and 23 locality hubs are either active or proposed and agreed. Royal College of General Practitioners (RCGP) ambassador, and LMC representation is now part of the core membership of the Health and Care Transformation Board and engaged in planning and system discussions.	Agree the costed model linking key KPIs and assumptions to be completed. Confirm across each locality the steps being taken to address the immediate sustainability gap within GP practices. Review the existing, and proposed clustering of GP practices in order to agree how these new clusters will work to deliver against the 10 high impact changes.

STP June Submission Feedback	Update to date	Next Steps
Include stronger plans for mental health drawing on the recent publication of the Forward View for Mental Health.	The mental health programme has redefined programme priorities since June as MH Integration and Specialist Mental Health. In addition its has undertaken and achieved completed the following; • Reviewed the key objectives through the recent Planning Guidance. • Embedded mental health leads in the core programmes and ensured STP workstreams are identifying mental health needs as part of their plans. • CCGs have been awarded pilot status for Early Implementer LTC IAPT and IAPT services in SE Staffs, Seisdon and East Staffs have been aligned to the same model of delivery. • Strengthened reference to the delivery of the Transforming Care Partnership Plan. Key revised delivery timeline, realigned and set clear service targets and critical path to those in The Mental Health Five Year Forward View. Agreed expanded engagement to include: • Providers and commissioners, health and care representation through Steering Group. • 3rd sector represented. • Engagement with service user groups underway	Ensure mental health is fully embedded in each workstream. Agree and deliver links with early intervention models within LTC and prevention pathways supporting admission avoidance and links with preventative mental health and public health. Develop and agree a Transformation Plan for Adult MH Out of area placements. To work with other work streams (Urgent Care, EPCC and LTC) to identify new models and skills required (e.g. crisis, 7 day working, liaison services). Embed the Forward View for Mental Health local critical path into all service delivery workstreams.
System control totals: Set system control totals that enable STP partners to propose changes to individual control totals for CCGs and NHS providers, provided they are consistent with the overall system control total. The CCGs and NHS providers involved will remain accountable for their individual control totals, but the system control total will allow STPs to recognise the additional financial pressures that some parts of the system may face in helping to improve overall financial performance at a system level.	The new guidance that allows STPs to recognise the additional financial pressures that some part of the system may face in helping to improve overall financial performance at a system level, is most welcome. As part of completing the STP Financial Template we are working out the impact that both the financial challenge and the solutions will have on individual organisations. The aim is to have discussions with the regulators immediately following the 21st October submission to agree the necessary changes to Individual Control Totals (ICTs) to facilitate all organisations acting in the interest of Staffordshire & Stoke-on-Trent as a whole.	Complete the calculation of the impact of the financial solutions on each organisation and agree these within the system. Use this agreement for a discussion with the regulators about changes to ICTs, in order to better align incentives.
Continue to build on existing work and strengthen plans to deliver the ambitious CIP requirements aligned with clinical improvements.	There is now a system-wide financial monitoring system in place for 16/17. Each organisation currently submits a key data set on the 12th working day following the month end. This enables the system to evaluate delivery against phased financial plans, including CIPs.	For 17/18 we are putting in place an assurance system to ensure that each organisation identifies at least 2% of efficiency savings as part of the annual planning process, and then delivers on those schemes. The assurance system is being designed by an expert third party provider.

The Staffordshire and Stoke-on-Trent 30th June STP Submission had a clear road map to follow in order to progress the transformation required. Significant progress has been made in a relatively short timescale, and whilst the detail is set out in this document the key highlights are:

	STP June position	Update to date	Next Steps
Working as a system	Estates Mapping and Shared approach	One Public Estate funding and membership awarded and confirmed for ongoing collaboration with local authorities across Staffordshire. And Stoke-on-Trent Significant progress has been made by the Estates programme since June including the following; Whole Staffordshire & Stoke-on-Trent, community centric concept approach agreed by STP. Workstream team established, continuing from work previously carried out for the Strategic Estates Planning work. Integration with the STP and the Local Estates Forum (LEF). Integration with the STP, LEF and OPE. Resources secured for the workstream team. Estates template produced by workstream team and approved. Initial links made with priority STP programme workstreams and work to integrate with them to influence critical decision making is commencing. Initial baseline nearly completed. Strong links with other public sector organisations and discussions about how to work together to deliver the concept developments has begun. Baseline mapping completed in order to understand the estates across the NHS and LAs.	Deploy estates expertise to the planned care programme for estates reconfiguration proposal based upon activity shifts and realisation of best estate. Granular plan development. Deploy estates expertise to the urgent and emergency care programme to ensure estates benefit realisations are aligned between programmes and offer maximum scale and pace. Granular plan development. Review and revise overarching estate plan. Continue detailed analysis and plan development support to the Primary and Community Care programme. Confirm estate disposal opportunities. Confirm estate maximisation opportunities. Develop Cheadle Hospital proposal. Opportunity development for Tamworth multipurpose primary and community estate.
	BCF Review	Programmes impact reviewed as part of understanding the social care challenge work and embedded within that.	Align BCF programme with STP priorities.

Appendix A - Progress since June highlights (cont.)

The Staffordshire and Stoke-on-Trent 30th June STP Submission had a clear road map to follow in order to progress the transformation required. Significant progress has been made in a relatively short timescale, and whilst the detail is set out in this document the key highlights are:

	STP June position	Update to date	Next Steps
Working as system	Collaboration and integration across Health and Social Care	Health and social care have made significant progress towards working in an integrated and structured way through the Health and Care Transformation Board. Health and care are working together across the programme with an emphasis on prevention and reducing cost of services by integrated working (e.g. Public Estate). Adult social care is now embedded in the Urgent and Emergency Care and Primary and Community Care workstreams. The local authorities have commenced working closely with the NHS to develop discharge to assess pathways which should improve patient flow through urgent care and allow acute trust capacity to be closed in favour of investment in home based services. It is now a shared expectationthat social work teams will be aligned with Multi-Speciality Community Providers and Locality Hubs as these are developed. The local authorities are also involved in our Estates work, which is exploring the role of current buildings and potential future developments across the health and care system – We have examples of collocating extra care and nursing homes alongside enhanced primary care and volunteer run community services that we are keen to build on. Alongside this the STP will be engaged in the One Public Estate award and investment through the Estates programme which has been confirmed. Our cross cutting Health and Care Collaboration has been actively considering use of funding across the system and how it might be rebalanced in order to protect and support adult social care.	Move from articulating the financial challenge facing adult social care to setting out how this might be addressed through a more sustainable configuration of funding. Building on the willingness and ability of local politicians to lead and support difficult decisions if these are necessary in order to create an reconfigure health and care services we will continue to develop our partnership in this area. Continue to share with the LGA learning from the STP process. Undertake a LGA developed and facilitated self assessment of integration. Continue to develop system architecture discussions alongside the development of new models of care (MCP's), to develop end state and staging post discussions across the system underpinned by the delivery of integrated primary and community care locality hubs and new models of care.
	Scale of Care Financial Challenge	The scale of the Social Care financial challenge over the next 5 years has been reviewed and slightly increased since June. Stoke-on-Trent City Council and Staffordshire County Council are planning to produce a financial bridge, including potential solutions, in a time frame that fits their 17/18 planning cycle ie January 2017.	Our cross cutting Health and Care Collaboration will be considering use of funding across the system and how it might be rebalanced in order to protect support adult social care.

Appendix A - Progress since June highlights (cont.)

The Staffordshire and Stoke-on-Trent 30th June STP Submission had a clear road map to follow in order to progress the transformation required. Significant progress has been made in a relatively short timescale, and whilst the detail is set out in this document the key highlights are:

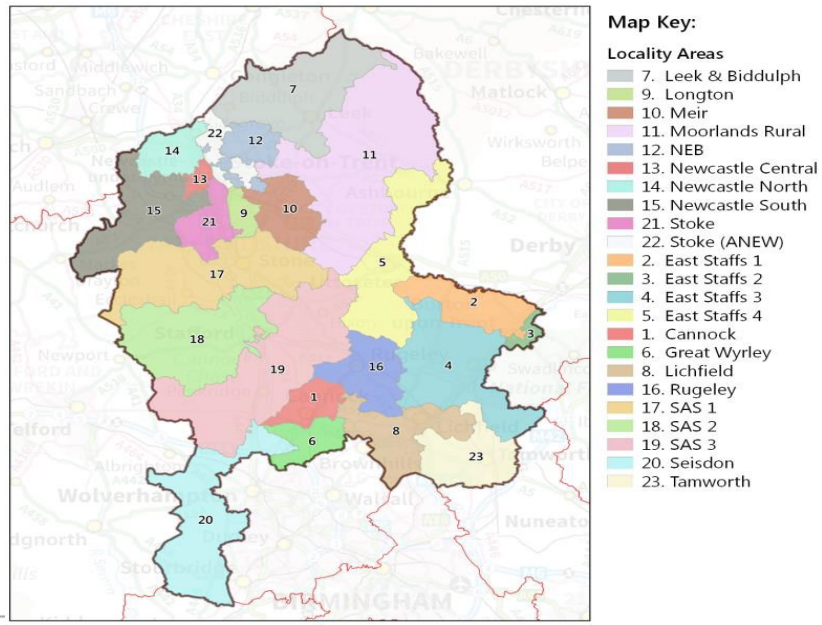
	STP June position	Update to date	Next Steps
Engagement	Political liaison and engagement	We acknowledge that the key to effective delivery of the STP is to bring the citizens of Staffordshire and Stoke-on-Trent with us on this journey – Getting out of theory and into practice. Over the last 3 months we have actively engaged in discussion regarding the case for change and implications of our developing plan with; • the Leader and Cabinet of Staffordshire County Council, • Leaders and Chief Executives from Borough and District Councils. • Elected representatives from Stoke on Trent City Council • Chief Officers of Staffordshire County Council and Stoke-on-Trent City Council are full members of the Executive Forum Follow up engagements at a local level are currently in progress, and presentations have been delivered at Health and Wellbeing Boards, Staffordshire 100 and a number of other politically engaged forums. Staffordshire County Council and Stoke on Trent City Council have had political engagement in key workshops and decision making forums.	Not least among those considerations we will be developing over the next months is how we can capitalise on a streamlined commissioning and provider landscape in the County and City, supporting the system architecture discussions and planning. Additionally we will be engaged in meetings with MPs and local leaders to align the ongoing political support to the emerging potential system solutions. Continue dialogue with district and borough councils.
	Voluntary Sector engagement	Engagement with the Voluntary, Community and Social Enterprise (VCSE) group to commence initial discussions about the alignment of STP potential solutions and the contribution of the voluntary sector. Engagement of the voluntary sector with lead programmes across the system. Individual discussions with voluntary sector groups regarding learning form other areas and enhanced engagement in the process.	System wide mapping of voluntary sector opportunity within the redesign plans.
	Public engagement	Communications leads are assigned to each of the workstreams to facilitate two-way communication, to advise on best practice, legal and assurance processes and identify resources to deliver the activity that will be needed to involve local people through engagement and where necessary consultation. A series of communications and engagement workshops has been devised for dissemination of key information to SROs and operational leads on all workstreams. The first took place in September and was supported by the Consultation Institute. An Engagement sub-group now meets regularly recognising different organisational structures. This task and finish group was established bringing together partners with a specific role in delivering Patient and Public involvement (PPI). Activity delivered includes: Engagement Toolkit: incorporates engagement methodology, engagement and consultation guide and co-production approach. Ambassadors programme: partner organisations have identified staff and public individuals to train as ambassadors to disseminate key messages to stakeholders. Healthwatch Staffordshire and Healthwatch Stoke-on-Trent have delivered a series of pilot training sessions and provided ambassador packs. Feedback is leading to a revised ongoing programme of training.	A series of 10 events is planned to take place across Staffordshire and Stoke-on-Trent with members of the public throughout November and December. A panel of senior executives, clinicians and frontline staff have been identified and a 'marketplace' involving the leads from the enabling workstream has been convened. These events are being facilitated by Health Watch Staffordshire and Health Watch Stoke-on-Trent.

Progress since June highlights (cont.)

The Staffordshire and Stoke-on-Trent 30th June STP Submission had a clear road map to follow in order to progress the transformation required. Significant progress has been made in a relatively short timescale, and whilst the detail is set out in this document the key highlights are:

STP	June position	Update to date	Next Steps
System Structure	System leadership	The new governance arrangements in place since the June submission have strengthened the system wide ownership of the STP plan with The introduction of the Health and Care Collaboration to ensure the social care impacts and challenges are addressed within the plan and that the plan addresses the Health and Care system-wide Staffordshire and Stoke-on-Trent requirements. Membership includes representation from Staffordshire County Council and Stoke-on-Trent City Council The introduction of a formal meeting of the Health and Care chief officers, to ensure continued system-wide working together in support of the STP. The introduction of a Clinical Design Authority, to ensure any planned changes accord with best practice and are clinically and/or professionally deliverable. This group is also be responsible for assuring themselves that there has been adequate clinical and professional engagement in the detail of the elements of the plan has taken place. The development of an engagement plan at system level, but also explicit requirement for each SRO to ensure there is full engagement in detailed design work with key stakeholders across the system.	The City & County council leadership wishes to explore the development of closer working across the council politicians and NHS leadership and these opportunities need to be explored in full as local ownership of the agenda is key to delivery across the whole county and city. In addition, the formal decision making process is being developed along with the governance for the management of the system control total and delivery of the two year operating plan (in line with STP) These will both requirement amendments to the current governance of Together We're Better programme and proposals will be finalized in January 2017 Any changes to the system architecture as a result of proposals being put together will be reflected as these are implemented
	System Architecture	Since April 2016 Staffordshire & Stoke-on-Trent health and social care partners have been working together as system leaders to better understand the key challenges and opportunities across Staffordshire & Stoke-on-Trent and to develop an agreed view of actions required to transform the services across Staffordshire and Stoke-on-Trent such that they are financially sustainable in future years, improve the quality of care and enhance population health and well being. Since June it was agreed that the current system architecture may be part of the change required to become sustainable and to address some of the system wide issues driving the current poor performance and budget overspends. The case for change was made through a series of independent interviews with key stakeholders (44 principals) across the system. The response was unanimous in supporting the view that a new system architecture would better deliver the strategic goals and the system leaders and stakeholders who met together on 28th September 2016 to consider what the options might be in both the long and short term. The outcome was that those present determined that: • A change in the current NHS organisational form is required but this must be in response to a system wide commitment to developing high quality place based care supporting primary care as the core of locality based health and care teams for populations of 30-70k (23 localities) sympathetic to, and accommodating of, natural communities. • That whatever the NHS arrangements, there was a commitment to supporting bottom up, primary care development of MCPs or PACs as the basic building blocks for the new models of care. The form of such developments needed to develop overtime. • Both the commissioner and provider landscape needed to change. • The core objectives for revision to the system architecture were agreed. • We have progressed our understanding of the requirements of our future system architecture and have defined a short list of options for both the future state and the stepping stones to achieve this state.	A considerable amount of further work will need to be undertaken to develop the preferred system architecture option(s). This will involve: • Detailed work on the granular definition of options including comprehensive supporting analysis. • Understanding the full implications of each option. • Wider engagement and consultation with boards, governing bodies, the Local Authority democratic process ,regulators and staff to help inform how these options could be taken forward – But with a clear steer about the preferred option and the timetable. • Development of a navigation path We would anticipate that this work will be completed by April 2017 .. As one of the core drivers is to develop a sustainable workforce there is also a commitment to develop a formal management of change policy across the STP footprint to support any staff effected by change resulting from these proposals.

The Staffordshire and Stoke-on-Trent 30th June STP Submission had a clear road map to follow in order to progress the transformation required. Significant progress has been made in a relatively short timescale, and whilst the detail is set out in this document the key highlights are:

	STP June position	Update	Next Steps
Place based integrated Care	Place based Integrated Care	To develop the system and as part of the system's roadmap, we have produced a manifesto for place based integrated care. In order to do this we have completed the following actions: 1. Place mapping via the enhanced Primary and Community Care Workstream 2. Model MCP has been developed 3. System level logic modelling completed 4. Current delivery models are being mapped into the system 5. Workshops established to progress. 6. Outcomes framework drafted 7. Detailed delivery plan in development 8. Locality Cluster Statement of Purpose drafted 9. GP practices have been mapped against the locality areas they operate within. This mapping has provided a baseline position showing where clusters currently exist, where proposed clusters will form and where risk of sustainability is present. Each are being evaluated against the 10 high impact changes. The clustering of practice lists to form hubs of 30-70,000 population will form the local unit of planning for the entire STP programme. This allows a balance between true localism and a provision of effective layered governance and architecture.  Map Key: Locality Areas 7. Leek & Biddulph 9. Longton 10. Meir 11. Moorlands Rural 12. NEB 13. Newcastle Central 14. Newcastle North 15. Newcastle South 21. Stoke 22. Stoke (ANEW) 2. East Staffs 1 3. East Staffs 2 4. East Staffs 3 5. East Staffs 4 1. Cannock 6. Great Wyrley 8. Lichfield 16. Rugeley 17. SAS 1 18. SAS 2 19. SAS 3 20. Seisdon 23. Tamworth	This mapping will support our system in establishing the baseline against the MCP models in order to deliver our primary care strategy. The 23 clusters will form the basis of logical modelling that will inform our plans for sustainability. This work has commenced. This will also identify areas of concern such as independent practices and areas of specialist clinical expertise.

Our system governance ensured that we delivered a robust STP in June. As a system we recognise that this needs to be enhanced now we are moving into the delivery stage. The steps we have taken are set out below.

Governance Change	Update to date	Completion Date
The membership of the Health and Care Transformation Board has been reviewed in light of the need to develop a broader inclusion of other system partners, specifically primary care delivery partners, in order to consolidate the delivery of core assurance, decision making and integrated governance.	H&CTB Terms of Reference reviewed and updated. H&CTB membership reviewed and updated. HCTB approved recommendations and changes.	14.07.2016 14.07.2016 21.07.2016
The Clinical & Professional Design Authority has evolved from the Clinical Leaders Group, with a defined reference frame, and a proactive approach to delivering greater clinical engagement and ownership within workstreams and into the individual organisations.	Proposal for the Clinical and Professional Design Authority developed. Draft terms of reference agreed. HCTB approved recommendations and changes.	11.08.2016 11.08.2016 18.08.2016
An Executive Forum has been established in order to provide a forum for the operational oversight group for the delivery of the STP, deliver decision making at a system wide level, explore complex system wide issues and potential solutions and approaches.	Terms of reference drafted. Mandate established. Approval and agreement at HCTB.	04.08.2016 04.08.2016 18.08.2016
Individual workstreams are now hosted under 5 overarching system programmes which reflect the core priorities of the STP, and support the maximising of synergies and avoidance of duplication. System programmes are; • Prevention and Wellbeing • Enhanced Primary and Community Care • Efficient and Effective Planned Care • Simplified Urgent and Emergency Care • Reducing Costs	Programme leadership inc. Programme Director & Senior Responsible Officer (SRO) has been confirmed. Agreed resource requirement to deliver the programme. Agreed programme of work for the next 2 x quarters with the Srategy Unit. Work commenced.	04.08.2016 18.08.2016 15.09.2016
Implementation of the Standard Operating Procedures for enterprise programme management.	Approved by the HCTB	21.07.2016

Appendix B:
Programme Infrastructure

Appendix B: Programme plan resourcing

The programme is now resourced with resources and expertise from across the system and each of the system priorities has embedded governance and structure in order to move from the planning to implementation phase. Specialist support will be accessed where necessary from either within the system, from the CSU or externally.

	FOCUSED PREVENTION	ENHANCED PRIMARY & COMMUNITY CARE	EFFECTIVE & EFFICIENT PLANNED CARE	SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	REDUCE COST OF SERVICES
Strategic Objectives	Identify where upstream investment in prevention and early intervention will have a positive impact on both the health of the population and reduce high cost care.	Enhance and integrate primary and community care to enable frail elderly and those with LTCs to live independent lives and avoid unnecessary, costly and upsetting emergency episodes.	Reconfigure planned care services to meet patient needs, improve productivity and remove duplication and over capacity.	Simplify emergency and urgent care services across the system to reduce avoidable A&E attendances and NEL admissions.	Accelerate the delivery of productivity and efficiency plans. Reduce total bed capacity and rationalise estates. Provider collaboration to reduce management costs.
Current Programme Delivery Resource	• Programme SRO – R Harling • Programme Clinical Lead – Dr Lesley Mountford • Programme Director – Jonathon Bletcher • Finance & Risk Lead – Jonathon Tringham • Communications and Engagement Lead – Cristian Marcucci • Programme Manager – Amanda Stringer • Project Support Officer	• Programme SRO – Andrew Bartlam/Marcus Warnes • Programme Clinical Lead – Dr(s) Charles Pidsley.Bhushan Rao/Zafar Iqbal • Programme Director – Steve Grange • Finance & Risk Lead – Iain Stoddard, Jonathon Tringham • Communications and Engagement Lead – Martin Evans • Programme Manager – Helen Aribi • Project Support Officer – Gordon Macharenas	• Programme SRO – Rob Courtney Harris • Programme Clinical Lead – Steve Fawcett • Programme Director- Mark Seaton • Finance & Risk Lead – Sarah Preston/Wendy Kerr • Communications and Engagement Lead – Naomi Duggan • Programme Manager – Debbie Thwaites • Project Support Officer	• Programme SRO – Helen Scott South • Programme Clinical Lead – Mark Williams • Programme Director – Rob Lusuardi • Finance & Risk Lead – John Sargeant/Wendy Kerr • Communications and Engagement Lead – Louise Thompson • Programme Manager – TBC • Project Support Officer – Gordon Macharenas	• Programme SRO :TBC • Programme Clinical & Quality Lead – Bill Gowans • Programme Director (Finance) - Neil Chapman • Communications and Engagement Lead – Pam Schrier • Programme Manager (Risk Lead) – Steve Smith • Project Support Officer • Oversight Group: Directors of Finance
System Programmes	**13. Mental Health Steering Group (representation in all core programmes for mental health and dementia)**				
	14. Sustainability and Integration of Care Services				

Appendix C: System Plan: Progress Update and Next Steps

Appendix C: System Plan – Summary of progress to date

A summary of the system plan over the next 5 years is presented in our June submission. Our progress in each programme since June is summarised below.

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
FOCUSED PREVENTION	2. Prevention & Wellbeing Strategy	• Completion of Healthy policy framework and risk stratification. Establishment of evidence base for targeted prevention support. • Commencement of the community capacity building programme and information, advice and signposting resource. • Exit contract from universal lifestyle services by Staffordshire County Council. • Go-live of targeted prevention support; continued implementation of teenage pregnancy prevention & healthy lifestyles in Stoke-on-Trent. • Complete the review of bariatric surgery impact and confirm recommendations.	• Focused on establishing system wide programme from multiple prevention initiatives across CCGs, Stoke-on-Trent City Council and Staffordshire County Council. • Specifically added the prevention action "Support improvement of the health of the NHS and Local Authority workforces" in recognition that prevention can be completed by our own organisations. **Key revised delivery timeline:** • Healthy policy framework complete; • community capacity building programme live; • update of Staffordshire Carers website as primary access point and establishment of information, advice and signposting resource live; • risk stratification complete; • evidence base for targeted prevention services established; • inclusion of workplace health in acute trust contracts; • options appraisal for National Workplace Health Charter; • DFG pathway development; CBA for bariatric surgery; training of GP practice nurses to offer lifestyle advice	• **6 months** – Healthy policy framework complete; community capacity building programme live; update of Staffordshire Carers website as primary access point and establishment of information, advice and signposting resource live; risk stratification complete; evidence base for targeted prevention services established; inclusion of workplace health in acute trust contracts; options appraisal for National Workplace Health Charter; DFG pathway development; CBA for bariatric surgery; training of GP practice nurses to offer lifestyle advice. • **12 months** – Strategy to support recovery from mental ill health co-produced with provider; exit contract from universal lifestyle services in Staffordshire and go-live of targeted prevention services; continued implementation of teenage pregnancy prevention and healthy lifestyles for Stoke-on-Trent; award contract for DFG; commissioning decision point on bariatric surgery. • **18 months** – Obesity prevention in high risk individuals; begin secondary prevention of diabetes by targeting those at risk;
ENHANCED PRIMARY & COMMUNITY CARE	3. Frailty & LTC Pathways	• Rapid Access clinics implemented for direct use by GPs in some areas of Staffordshire & Stoke-on-Trent. • Hot Clinics introduced for direct access by ED team. • Partnership working with Acute Care specialists to the portals to enable timely step down of patients and avoidance of admission. • Introduction of LTC portal pull, Geriatric advice line, frailty tool and frailty passport.	• Implementation of Frail Elderly Assessment Service at Royal Stoke Hospital; aligned to Exemplar Front of House principles (supported by Emergency Care Intensive Support Team(ECIST)) diverting ED patients. • Paper version of Frailly Passport implemented. • Frailty Tool within General Practice embedded in clinical systems. • Geriatrician Advice line in place offering support to General Practice and intermediate care teams. • Implementation of rapid access clinics for general practice, supporting admission avoidance. • Re-design of long term condition services for the community and acute; focussing on outcomes with a move away from a case management approach. This incorporates patient/primary care education. • Implementation of GP Fellowship scheme. • Pan Staffs approach to enhanced intermediate care offering support to care homes to prevent unnecessary admissions.	• Effective risk stratification of patient cohorts linked to the Electronic Frailty Index (eFI). • Electronic Version of Passport implemented and rolled out Pan Staffs. • Advice Line rolled out Pan Staffordshire. • Implementation of revised LTC service across Community and Acute services. • Standardised approach to frailty assessment across all health sectors.

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
ENHANCED PRIMARY & COMMUNITY CARE	4. Community Hospitals Management Plan	• Haywood hospital bed base dedicated to step up activity. • Rollout of Nursing Home Direct Access initiative. • Task force in place to tackle long community bed length of stay (LoS). • Escalation capacity closed through: • 30 bed reduction, IV antibiotic provision within Step up Intermediate Care, CIP Intensive Support week, Increased Assessment Centre activity, Step down bed based reduced by 46 beds, HUB re-specified service implemented, Urgent Care Centre within Community launched, Integrated re-ablement/intermediate care service launched.	• Community Hospitals have commenced delivery of the plan. Immediate impacts have included a bed reduction in Jackfield and Cheadle hospital of 68 since June.	• Pilot an integrated model of working commencing in October 2016 where no assessment of long term care needs is undertaken on an acute ward and patients once MFFD are discharged home for rehabilitation prior to assessment and rehabilitation, rather than waiting in a bed for a home based service. • Develop robust potential range of solutions, proposal and plan for South Staffordshire Community Hospital beds, deploying learning from North County • The EMI Stay at Home service requires a full review and specification • Deliver further 4 week consultation period (North County) – outcomes by Jan 2017
	5. Enhanced Primary, Community Care	• Share rapid learning from early implementers and agree strategic objectives to deliver place based care to populations of 30,000-70,000. • Identify and define the 30,000-70,000 populations, taking into account natural communities. • Define future structure of primary and community care and degree of integration with social care, mental health and acute hospitals. • Increase Voluntary care sector involvement and engagement.	• A programme management approach has been deployed. • Standardisation of governance, terms of reference, clear focus on priorities and full alignment to the local issues. • An EPCC PMO has been established. • Localities have been mapped and identified. • An MCP operating model has been agreed. • A core offer is in the early stages of development. • A logic model has been developed and is in the process of being road tested. • A primary care manifesto is in the early stages of development • A clinical vision has been developed. • A set of clinical indicators has been developed including outcomes and strategic benefits to change. • A cost model has been developed and is being logic modelled. • A set of case studies and vignettes have been developed demonstrating success to date.	• Share the completed work across the Staffordshire & Stoke-on-Trent footprint which defines the c30,000-70,000 cluster populations, which have naturally formed relative to established communities. • Further build on the mapping work of the clusters and current patient flow to acute hospitals. • Define integrated care hubs based on the clusters, identifying core activities/services and establish virtually integrated teams. • Identify locality cluster specific health requirements to enable planning of extended services relevant to demographic needs. • Complete current and future capacity and demand modelling by March '17. • Define steps being taken on a locality basis to sustain general practice

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
ENHANCED PRIMARY & COMMUNITY CARE	6. End of Life	• Return to bidders & obtain detail regarding response to STP process & MCP models. • Agree investment profile & focus with chosen partner, • Inclusion of East and South East and Seisdon CCG into the programme. • Contract negotiations and parallel assurance process with NHSE complete.	• This workstream has been on hold since June awaiting NHSE decision to progress. This has now been received and the pause to the programme removed, therefore programme will proceed albeit with a 5 month delay to the timeline	• **6 months** – Oct – Dec 16, Return to bidders and obtain further detail regarding response to STP process and MCP models. Oct-Dec 16 Contract negotiations and parallel assurance process begins, • **12 months** – NHSE assurance process complete by end of June 17, Contract awarded and mobilization July – Dec 17. • **18 months** – Jan 18 contract start date – Phase 1. • **(3 – 4 years)** Jan 20 contract start date – Phase 2 (Services commissioned by SI).
EFFECTIVE & EFFICIENT PLANNED CARE	7. Planned Care Recon-figuration	• Continued reduction of Procedures of Limited Clinical Value (POLCV). • Implement organisational quick wins e.g. proposed move of UHNM orthopaedics to County. Assess demand including activity impact of providers outside the footprint (RWT, DHFT) and consider interventions. Calculate excess capacity remaining. • Pilot referral reduction, outpatient follow-up reduction and alternative delivery settings. • Align with Prevention workstream.	• Fully established core team, including additional clinical support. **Productivity and efficiency** • Initial workshops for: Orthopaedics, Ophthalmology & Spinal, follow up workshops organized. • Agreed action areas and focus. • Detailed data collection underway. • Process mapping underway. • Engagement with national digital outpatients team. • Commenced procurement programme-initially prosthetics. • Endoscopy & Gastroenterology agreed work programme. **Re-configuration** • Agreed work plan with CSU Strategy Unit re reconfiguration to: – Baseline activity and project growth – Model productivity gains – Collect capacity including outpatients – Deliver options appraisal by March 2017	**6 months-16/17** • Configuration-deliver options appraisal. • Orthopaedics, Ophthalmology & Spinal-implement productivity & efficiencies. • Endoscopy-deliver options appraisal and begin pre-consultation. • Commence preparatory work on further specialties. **Some key system issues to understand and progress** • Further detail required around Burton/Derby partnership. • Clarity required around Wolverhampton intentions for Cannock. • Understanding of any re-configuration outside of our STP, e.g. Leighton. • Further detail of delivery expectations around locality hubs. Planned care reconfiguration could offer challenge and this should e carefully explored and where possible mitigated with good citizen and stakeholder engagement

Appendix C: System Plan – Summary of progress to date

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
Effective & Efficient Planned Care	8. Cancer	• Seek NHSE approval and agree final contract with Service Integrator. • Beginning of contract implementation from July 2017.	• This workstream has been on hold since June awaiting NHSE decision to progress. This has now been received and the pause to the programme removed, therefore programme will proceed albeit with a 5 month delay to the timeline	• **6 months** – Final contract agreement with service integrator. Align plans of East and South East Staffs and include in STP scope. NHS assurance complete by end of Mar 17. • **12 months** – Mobilisation Apr-Jun 17. • **18 months** – Jul 17 contract start date – Phase 1. • **(3 – 4 years)** Jul 19 contract start date – Phase 2 (Services commissioned by SI).
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	9. Simplify Urgent & Emergency Care	• Mapping and gap analysis completed to identify reconfiguration options. • Run joint workshop with aligned workstreams to develop detailed delivery plan, funding proposals and initiate mobilisation. • Develop full proposal and start consultation on major service changes including the rationalisation of A&Es and MIUs and establishment of virtual wards.	• Two exploratory clinical work shops to start ascertaining what the challenges and issues are, what we want to address and what processes and service model options there are for taking the work programme forward • Identification of service model potential solutions which need further review and discussion with broader audience:- – clinical Hubs – System wide – clinical defining of urgent and emergency care to support pathway development, right care in the right place, at the right time which is safe, improves quality and outcomes – identification of the support urgent care will need to support the left shift working with the enhanced primary and community care work stream – reduction in access points • Creation of A & E Delivery Boards – Aligning A & E Improvement Plans with STP • Third workshop held 11th October identifying parameters within which we will design future urgent and emergency care service models for local delivery and to help define requirements for A & E services across Staffordshire and Stoke-on-Trent • Timeline has been revised to meet consultation process but requires further realignment with EPCC priorities and enabling work streams. Implementation of redesign service model to commence Spring 2018. • System wide engagement at managerial and clinical level. Better engagement required with WMAS, Social Care and Local Authorities.	Next step engagement with enabling work streams to map implications of new service models, in particular work force, digital and estates. Timeline has been revised to meet consultation process but requires further realignment with EPCC priorities and enabling work streams. Implementation of redesign service model to commence Spring 2018. **16/17** • Q3 Baseline analysis of current service provision being produced. • Q3 Joint workshop with aligned work streams undertaken to further develop service model. • Q3 Design service model for urgent and emergency care in primary, community and acute services, social care, voluntary sector and other providers. • Q3 Gap analysis to map options for delivery of the new service model. • Q3/Q4 Pre-consultation process. • Q4/Q1 (17/18) Shortlisted solutions to be constructed to include activity flows, workforce, finances and facility assumptions. **17/18** • Q2 Commence Consultation process. • Q4 Commence service transformation programme. Likelihood of challenge • Whilst at a health commissioner and provider level there is unanimity for the type and level of change required the anticipated new service models which may challenge public preconceptions around the type of facilities and access to urgent care services such that there may be a degree of perceived loss and therefore challenge to the proposals.

Appendix C: System Plan – Summary of progress to date (cont.)

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
REDUCE COST OF SERVICES	10. CIPs & QIPPs	• Deliver QIPPs and CIPs with co-ordinated effort across the system. • Develop system assurance process for CIP and QIPP delivery. • Evaluate system wide financial model for 2017/18 and address as a system. • Closer integration and best practice sharing between cost reduction programmes and workstreams.	• We have implemented a system-wide financial monitoring system. • For 2016/17 each organisation is submitting a key data set on the 12th working day following each month-end. This enables the system to evaluate progress in the delivery of CIPs against a phased plan. • The system is providing external resources to organisations that are struggling with the efficiency agenda.	• For 2017/18, we need to put in place an assurance system to ensure that each provider organisation identifies 2% of efficiency savings as part of the annual planning process, and subsequently delivers on the schemes. This assurance system is in design by a third party and then will be reviewed by the system. • The 2% annual CIP requirement is a key element of each organisation's financial plan. The 2017/18 CIP plans will need to be a part of the first draft operational plans in early November.
	11. Estates Rationalisation	• Estates mapping completed with clear identification of current excess estate. • Staffordshire & Stoke-on-Trent-wide health and care estates strategy completed including key areas of benefit identified (One Public Estate). • Collaboration with local authorities to commence and be in progress regarding the development of a shared approach to estate utilisation (potentially a special purpose vehicle). • Outline proposal to be reviewed and approved by Health and Care Transformation Board (H&CTB).	• Whole Staffordshire & Stoke-on-Trent, community centric concept approach agreed by STP. • Workstream team put in place and resources secured. • Integration with the STP, LEF and OPE. • Estates template produced and approved. • Initial links made with priority STP programme workstreams and work to integrate with them to influence critical decision making is commencing. • Initial baseline nearly completed. • Strong links with other public sector organisations and discussions about how to work together to deliver the concept developments has begun. • Wide engagement including Estates workstream, local Council's – Boroughs, Districts, County and City, CCGs, Trusts, NHSE.	• Utilisation of the opportunities being awarded One Public Estate funding gives the system. • Agree opportunities and associated savings identified and full business case to be developed for the health villages by September 2017. • Each organisation involved in each of the proposed developments will need to support it. This will need to be backed up by support from the STP Board for this approach. • There will also need to be support from each of the relevant STP programme groups (EPCC, CHMP and SUEC initially) to work with the estates workstream when formulating their key decisions • The specific proposals have not yet been identified, as we need to progress the meetings with each relevant workstream first to identify the possibilities. Each proposal will need support and agreement from a number of organisations to make the vision a reality but the engagement with each of these organisations has already begun and so support for them is likely to be positive.

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
REDUCE COST OF SERVICES	12. Workforce	• Develop and agree a detailed plan to support the initiative with a team mobilised to implement actions. • Develop and implement a system approach to managing workforce requirements to reduce need for temporary staff and high cost agency/locums via a system bank. • Update and communicate organisational policies on temporary staff accordingly to reduce usage.	Work has progressed since June. The greatest progress has been made is systematising the actions stemming from the workforce taskforce through robust project management and timeline breakdown of our priority objectives.. Through the Staffordshire and Shropshire LWAB we have shared common themes for collaboration across our respective STP workforce priorities. There is great commonality in our objectives linked to temporary staffing, skill development and exploration of new roles. Linked to the temporary staffing objective a full scoping study has been designed and implemented with the all 5 provider organisations completing comprehensive data sets for analysis. The data is currently being tested against the key assumptions originally outlined. KPMG continue to identify best practice and understand benchmark data by organisational type so we can create appropriate stretch assumptions linked to the back work. The scoping study is currently reviewing existing temporary staffing practice and initiatives within the individual organisations. Whilst a collaborative bank is actively being discussed it may prove to be just one of many solutions to curb agency reliance. The workshop in November will draw out a full range of solutions to assist a reduction in expenditure. The independent domiciliary care report will feedback in November with the results shared county wide. Implementing the changes from this study will hopefully lead to reduced pressure on patient flow. Our major acute provider and GP federation are in talks to create portfolio job roles to attract the next generation of medics to stay and be attracted to the county, picking on feedback from local trainees that a career straddling a variety of interests is highly desirable.	**6 months** • Detailed plan to support the initiative agreed by organisations with team mobilised to implement actions • Enact Quick wins from the Primary care workforce plan. • Spread learning from Domiciliary care independent review. • Update and communicate organisational policies on temporary staff accordingly to reduce usage of temporary staff **12 months** • MoU established between organisations on regional bank • Technology specifications identified and agreed on system level **18 months** • Initial savings realised on an incremental basis based on baseline through to 25%

Objective	Programme	Year 1 (to March '17)	Progress since June	Next Steps
ALL	13. Mental Health	• Develop and agree the integrated work programme to support the MH input into the System Priority Programmes with a particular emphasis on supporting the "left shift". • Agree and deliver links with early intervention models within LTC and prevention pathways supporting admission avoidance and links with preventative mental health and public health. • Develop and agree a Transformation Plan for Adult MH Out of area placements. • To work with other work streams (Urgent Care, EPCC and LTC) to identify new models and skills required (e.g. crisis, 7 day working, liaison services).	• Redefined programme priorities: MH Integration and Specialist Mental Health. • Further clarity on key objectives through the recent Planning Guidance. • STP workstreams identifying mental health needs as part of their plans. • North Staffs and Stoke-on-Trent CCG have been awarded pilot status for Early Implementer LTC IAPT and IAPT services in SE Staffs, Seisdon and East Staffs have been aligned to the same model of delivery. • The workstream covers mental health and learning disabilities – Strengthened reference to the delivery of the Transforming Care Partnership Plan. • Engagement to date has included: Providers and commissioners, health and care representation through Steering Group, 3rd sector and engagement with service user groups underway	• Develop and agree the integrated work programme to support the MH input into the System Priority Programmes with a particular emphasis on supporting the "left shift". • Agree and deliver links with early intervention models within LTC and prevention pathways supporting admission avoidance and links with preventative mental health and public health. • Develop and agree a Transformation Plan for Adult MH Out of area placements. • To work with other work streams (Urgent Care, EPCC and LTC) to identify new models and skills required (e.g. crisis, 7 day working, liaison services). • The commissioning and provider infrastructure to support consistent and efficient service delivery across the STP footprint needs to be explored further as integrated working with physical care and new pathways for identified mental health services are developed.
	14. Sustainability and Integration of Care Services	• Address fragility of care home and domiciliary market. • Develop incentives and potential for combining health and social care budgets with commissioning. • Develop plan for thriving voluntary sector as part of the solution to challenges in the market (links to Prevention and Enhanced Primary & Community). • Review and align BCF programme. • Investigate NHS and social care reviews of CHC and reablement.	• New ToR, meeting established with officer engagement from both Councils • Recognition that STP sets the frame for future joint working • Three year contract agreed for social care with Staffordshire County Council • Stoke-on-Trent City Council underwritten potential budget shortfall in 16/17	• Develop and sign off the engagement plan jointly, LA and NHS attendance at all meetings • Joint leadership of discharge to assess project as pilot for the new approach set out in STP • Agreement on decision making process for STP recommendations • Agree extent of cabinet and leaders engagement in driving the delivery of the STP
	15. System Governance	• Agreed system governance including options for an Accountable Care Organisation or alternative (e.g. chains). • A conflict resolution mechanism for the system. • Shadow single control finance total. • Options for moving to aligned financial models. • System transformation capacity and capability diagnostics. • Leadership and operational development.	• System Architecture – Workshop delivered across system leaders • Shortlist of provider and commissioner potential solutions developed from initial long list • Work has been performed over a 10 week period to engage across the system, including more than 44 key stakeholders representing providers, commissioners and citizens	• Wider engagement and consultation with boards, governing bodies, democratic processes and staff to help inform how these will be taken forward • Detailed development work on the granular definition of options including comprehensive supporting analysis. • Developed understanding the full implications of each option. • Development of a navigation path from the stepping stone options through to achievement of the long term vision.

Appendix C: Immediate Next Steps - Update

In addition to the critical decisions there are a number of immediate next steps which we agreed as a system. This was in order to accelerate the programme into the delivery phase and to ensure the momentum that we have achieved is maintained. We set out on the following pages an update against the key next steps we set out in June.

PROGRAMME MANAGEMENT

Review and strengthen the delivery skill base including the clinical and professional and analytical support.

- Resource secured via CSU Strategy Unit to support analytics, option appraisal and business case development within workstreams. Programme of work has commenced.
- Clinical Leaders Group have developed the Clinical and Professional Design Authority and have reviewed the development updates from each of the core workstreams on 2 x occasions.

Identify Programme Directors for the 5 programmes from within the system.

- Programme Directors confirmed in all programmes.

Refine the programme plan to include timing and sequencing of the key decision points.

- Programme Critical Path submitted to Board on 21 July 2016

Implement the standard operating procedures which have been developed for the whole programme.

- Standard Operating Procedures (Programme Management) approved and implemented from 21.07.2016. Assurance meetings commenced and aggregate report considered by Board on a monthly basis.

Establish the Sustainability and Integration of Care Services workstream.

- Priorities established.
- Leadership confirmed.

STAKEHOLDER MANAGEMENT

Incorporate feedback from the national conversation.

- Next steps and key priorities were identified following the national conversation and feedback. These were included in the programme plans and critical path, and are all monitored through the assurance process.

Develop primary care engagement and involvement in the programme.

- Clinical engagement principles incorporated into the Engagement Discussion Report and considered at the Health and Care Transformation Board 21.07.2016.
- Clinical Leaders Group are in the process of revewing the current primary care engagement and make individual workstream/programme recommendations.
- Primary Care Provider representation has been included as core membership at the Health & Care Transformation Board at a LMC and Federation level.

Identify further key stakeholders and define engagement strategy.

- Engagement Discussion Report was considered at the Health and Care Transformation Board 21.07.2016.
- Communications and Engagement Workstream collaboration established with the Workforce and Organisational Development Workstream.
- Integrated plan is included in the October submission.
- Workstreams have identified key stakeholders and initial engagement requirements:
  - Communications leads identified for each workstream.

Develop MP and political engagement strategy and roll out.

- Engagement has been led John MacDonald (STP Chair).
- Staffordshire 100 meeting presentation completed.
- Individual meetings held with a number of local politicians.
- All Leaders and Chief Executives across Staffordshire and Stoke-on-Trent have been engaged via the CEO and Leaders Group, and this has been followed up by planned individual Borough or District meetings which have now commenced..

Agree and plan for the organisation messages to statutory bodies and key stakeholders.

- Communications and Engagement Workstream progressing.
- Private and Public Board briefings developed and took place in July.
- Workforce and OD Workstream collaboration with the Communications and Engagement Workstream established.

Develop media and communications strategy across the programme.

- In progress via the Communications and Engagement Workstream.

Appendix C: Immediate Next Steps – Update

FINANCE

Further refine the option analysis for all programmes

- Finance leads confirmed for all workstreams and the 5 programmes.
- Potential solutions are reviewed and assessed as they develop.

Build the finance task force to support the development of the programme plans.

- As above.

Formalise the finance director group's role in the oversight and assurance of system wide CIP achievement.

- Finance Directors Group developed and agreed the oversight proposal for system wide CIP achievement and assurance.
- Template design completed.
- Monitoring commenced from Aug **2016.**
- **Monitoring commenced from Aug 2016.**

Define and agree the shadow resource control total and options for future management arrangements to align financial incentives in a system financial strategy.

- **Individual organisation's financial positions (ie challenges and solutions) will be calculated for each of the 5 years of the STP period. (by the end of October).**
- **Discussions will be held with the regulators about using the revised financial projections to flex ICTs within the aggregate STP position. This will give us the chance to align incentives.**

Quantify transformation investment requirements, impact assessment and sensitivity analysis for all programmes.

- **In progress –** Workstreams have identified a number of key areas of transitional funding requirements**.**

GOVERNANCE

Key partners to meet and formalise the governance arrangements

- CEOs and Accountable Officers have met to review the proposed governance arrangements and to establish the Executive Forum.
- Governance arrangements reviewed and supported via the extraordinary H&CTB on 29.07.2016.
- Governance highlighted changes incorporated into this update.
- TOR and mandates submitted to H&CTB in August as per previous slide.

Governance arrangements to be agreed at the Health and Care Transformation Board.

- Detailed as above. Agreed and complete.

Agree system wide delivery and oversight of CIP, likely to be bi-monthly through the finance and/or executive forum.

- Finance Directors Group developed oversight proposal for system wide CIP achievement.
- Template design completed and implemented.
- Monitoring commenced from Aug 2016.

Define role and function of the Clinical and Professional Design Authority.

- ToR agreed by Clinical Leaders Group and HCTB.
- Led by Bill Gowans.
- Submitted for approval by the H&CTB in August. Agreed.

Gateway review of progress against year one plans to commence.

- Gateway assurance meetings have been undertaken with core workstreams and a forward planned into next year.
- Workstream assurance updates to H&CTB are delivered monthly.
- Monthly meetings established.

Appendix D:
Areas of Opportunity update since June 2016

Appendix D: Transforming Care – Areas of Opportunity (update since June 2016)

OBJECTIVE	SYSTEM PRIORITY	System Considerations	System Opportunity Enablers
ENHANCED PRIMARY & COMMUNITY CARE	5. Enhanced Primary and Community Care	The scale and pace at which we can invest and deliver the integrated community model (MCP) across Staffordshire & Stoke-on-Trent to enable integration of community care, mental health and end of life care with a sustainable primary care structure.	• Primary care ownership of plans. • local medical committee ('LMC') engagement and support at national level. • Sharing of learning from national models and vanguards.

Our vision for Staffordshire and Stoke-on-Trent is to provide affordable care built and given locally around communities of 30-70,000 people. By doing this, services will be tailored to local need and, supported by less complicated locality and county wide arrangements, will allow us to give joined up care to people close to or in their own homes, with less need to go to hospital. We recognise that GPs and practice teams provide vital services for patients. They are at the heart of our communities, the foundation of the NHS and internationally renowned. Their services are now under unprecedented pressure and, as set out in the NHS Five Year Forward View and in guidance issued by the Royal Colleague of General Practitioners; it has become clear that action is needed so we have a responsive NHS, fit for the future.

As such this programme is supported by clear links to the local medical committees and a system wide clinical leaders group.

Actions to address these issues include approaches to sustain general practice including the formation of PACS and the development of new models of care and the deployment of the multispecialty community provider (MCP) emerging care models and new contracting frameworks.

Each CCG, in partnership with NHS England, is developing local implementation plans to support the delivery of the vision, with clear outcomes and timescales. CCGs are working collaboratively across the whole of Staffordshire & Stoke-on-Trent where there is mutual benefit and economies of scale. This will include the development of a primary care manifesto that is clinically led and integrated within plans to deliver the NHS GP Five Year Forward View and integral to defining future workforce needs.

The STP Medical Director and Clinical Leaders' group have started early thoughts on the development of this approach which includes:

A compelling, owned and agreed vision for the future of the primary can community care model for Staffordshire & Stoke-on-Trent 2016-2021.	Steps being taken to address the immediate sustainability gap within GP practices.	The steps being taken to align the national work programmes including the modernisation of the workforce, developing new roles within the practices and the deployment of new models of care including MCPs, ACOs and PACS.	Review the existing, and proposed clustering of GP practices in order to facilitate how these new clusters will work to deliver against the 10 high impact changes.	The development of local programmes that build on and provide focus on the delivery of the changes at a local level based around the practices and the unique needs of their local population.	The complete alignment to local drivers within the practices, health economy drivers within our STP and national drivers as prescribed by the NHS GP Five Year Forward View and the NHS Five year Forward View.	A model to encourage and facilitate clusters to use their capability and capacity to support their own sustainability and promote a culture of continual professional development.	Work is underway to ensure complete alignment between all stakeholders, both commissioner and provider, in regard to delivering these objectives.

Many of the areas above are interdependent and inextricably linked in terms of drivers and outcome dependencies. In recognition of this, the priorities of transforming primary care (including new models of care and MCP), sustaining general practice and redesigning our approach to supporting patients with long term conditions and the community hospital programme have been aligned into a single STP portfolio now named Enhanced Primary and Community Care (EPCC).The vision in the GP five year forward view been tested with our Local Medical Committees and a system wide clinical leaders group leading to the development of an outline of an operating model for the Multi-Specialist Community Provider (MCP) 'new model of care'. This co-produced with public health, primary care, community, mental health, third sector and social care partners (the MCP Partnership) across the geography of. Staffordshire & Stoke-on-Trent

As noted in the EPCC plan on a page GP practices have been mapped against the locality areas they operate within. This mapping has provided a baseline position showing where clusters currently exist, where proposed clusters will form and where risk of sustainability risk and are being evaluated against the 10 high impact changes.

The clustering of practice lists to form hubs of 30-70,000 population will form the local unit of planning for the entire STP programme. This allows a balance between true localism and a provision of effective layered governance and architecture. This mapping will support our system in establishing the baseline against the MCP models in order to deliver our primary care strategy. The 23 clusters will form the basis of logical modelling that will inform our plans for sustainability, and this work has already begun. This will also identify areas of concern such as independent practices and areas of specialist clinical expertise.

OBJECTIVE	SYSTEM PRIORITY	System Considerations	System Opportunity Enablers
ENHANCED PRIMARY & COMMUNITY CARE	3. Community Hospitals Management Plan	Reconfigure, reuse or reposition community hospitals and/or enhance estate utilisation in line with the development of new models of care.	• Detailed option appraisal including forecast savings and use of facilities by other sectors. • Detailed engagement plan. • National support to manage political ramifications.

Work has been progressing to ensure that the reconfiguration of community hospitals is carried out to provide better support for patients closer to home and reduce the Systems reliance on bed based care, which has been demonstrated to be less beneficial to patients than quality provision in or close to place of normal residence. Additionally the estimated savings and subsequent required reinvestment for 2016/17 and 2017/18 to support both health and social care services have been modelled.

As the plans on the closure to new admissions to the Cheadle and Bradwell bed bases has been brought forward, the CCGs have sought legal advice on the requirement for further consultation on the bed base only. As a result, there will be a further four week consultation period in line with the following timescales:

Date	Action
• 24 October 2016	Launch of Case for Change and on-line survey supported by communications through local media, patient and public groups, social media and partners.
• 25 October 2016	Local Equality Advisory Forum
• TBC	Public meeting to be held at Leek Council Building, Public meeting to be held at Cheadle Guild Hall, Public meeting to be held at Stoke Jubilee Hall 3.30pm – 8pm Public meeting to be held at Newcastle Red Street Community Centre 4.30 – 7.30pm
• 25 Nov 2016	Consultation Closes
• 15 Dec 2017	Results to be considered by Joint Patient Congress
• Jan 2017	Publication of Results

Following on from the consultation of the closure of the bed base to new admissions, the CCGs in the North will be consulting on the future use of the hospital sites at Longton, Leek, and Cheadle with alternative uses proposed in line with the MCP model of care and primary care hubs in addition to other viable alternatives through discussions with the Local Authorities. The proposed timescales for this process are outlined below and are subject to NHS England assurance and sign off.

Date	Action
• 1 February 2017	Launch of Case for Change and on-line survey supported by communications through local media, patient and public groups, social media and partners.
• February 2017	Local Equality Advisory Forum
• Feb/March 2017	Public meeting to be held at Leek Council Building, Public meeting to be held at Cheadle Guild Hall, Public meeting to be held at Stoke Jubilee Hall Public meeting to be held at Newcastle Red Street Community Centre
• March and April 2017	Various stalls at markets across Stoke-on-Trent and North Staffordshire
• 26 April 2017	Consultation Closes
• May 2017	Results to be considered by Joint Patient Congress
• 31 May 2017	Publication of Results

OBJECTIVE	SYSTEM PRIORITY	System Considerations	System Opportunity Enablers
EFFECTIVE & EFFICIENT PLANNED CARE	7. Planned Care Reconfiguration	How to remove duplication and for the reconfiguration of elective care to maximise estate utilisation.	• Detailed demand & capacity model. • Detailed option appraisal. • Detailed engagement plan. • National support to manage political ramifications. • Collaboration with neighbouring STP footprints.

Project Focus & Context

Re-Configuration of Elective Care

There are indications of over/under capacity and inefficiencies:

1. RTT- The national target is to have 92% of patients wait no more than 18 weeks after Referral to Treatment (RTT). University Hospitals of North Midlands NHS Trust did not meet this target in March 2016, although it did perform better than its peer average with a rate of 90.51%. Burton Hospitals NHS Foundation Trust exceeds this national target, but has reported figures that lie just below its peer average at 92.60%. Burton are consistently higher than the 92% target, UHNM have been below 92% since Q4 2014/15. If we look at the target by specialty some are failing consistently whereas others are exceeding the target consistently.

2. General and acute bed occupancy rates were 92% in 13/14, 93% in 14/15 and 89% Q2 15/16, but there is a high proportion of beds blocked.

3. In Burton social care is by far the largest contributor to delays. In January 2016, the Trust experienced a total of 444 delayed days. Of these, 356 (80 %) were due to social care and the remaining 88 days due to NHS delays. There has, however, been a consistent improvement in delays due to Social Care since August 2015, where the total number of delayed days was 934. Burton does, however, have fewer total delayed days than its peer average. The two primary reasons for these delays within Social Care are patients awaiting completion of an assessment of their future care needs and an identification of an appropriate care setting, and patients whose assessment is complete but transfer is delayed due to awaiting a package of care in their own home. If Burton were able to reduce DTOC to the peer group average level, it would save approximately 5,674 bed days per year (13 beds in total based on 85% bed utilization)

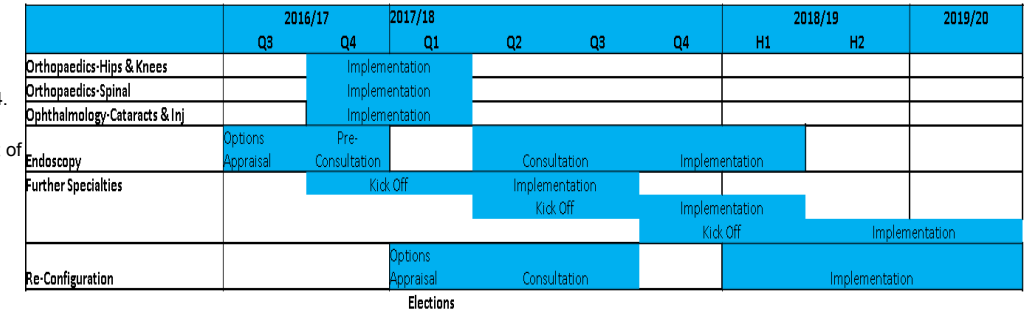
4. University Hospitals of North Midlands it appears that NHS is by far the primary contributor to delays, and the trend has been worsening on average since April 2015–total days delayed due to the NHS in March 2015 were 435, and by January 2016 this had worsened to 1,140. However further work is underway with the trust around the reason codes as it is the Trusts understanding the primary reason is social care. UHNM does, however, have fewer total delayed days than its peer average.

5. Theater Utilisation - There are indications of low utilization rates in the theatres, at UHNM the overall average for in-session utilisation is 67% and in Burton 77%; target utilization is 85%.This highlights an opportunity related to booking, scheduling and improving the flow of patients

6. through theatres on the day of surgery. There are small amounts of theatre usage on Saturday and Sunday linked to waiting list initiatives.

7. Landscape - We have a complex provider landscape where we have providers on our borders who deliver quite significant volumes of service. We also know we have duplication, inefficiency in theatre utilization, inefficient pathways, do not operate fully 24/7 and we know that efficiencies can be achieved at scale. Some of our providers are already working together in a network to deliver efficiencies. We need to model the changes in demand in order to assess the capacity required

Primary milestones for the delivery of a reconfigured system based upon the maximization of the opportunities outlined above are:



Appendix D: Transforming Care – Areas of Opportunity (update since June 2016)

OBJECTIVE	SYSTEM PRIORITY	System Considerations	System Opportunity Enablers
SIMPLIFY URGENT & EMERGENCY CARE SYSTEM	9. Simplify Urgent & Emergency Care	Whether to move from three to two A&E sites and one Urgent Care Centre, identify which A&E site should be downgraded or ultimately to agree whether to close an Acute hospital site.	• Detailed option appraisal including forecast savings. • Detailed engagement and consultation plan. • Early national support regarding direction of travel, engagement and to manage political ramifications. • Rationalisation of plans with financial and service delivery requirements e.g. departure from TSA recommendations. • Test models for Keogh implementation including interaction and shared learning with neighbouring STP footprints.

Action taken by the workstream includes;

- Two exploratory clinical work shops to start ascertaining what the challenges and issues are, what we want to address and what processes and service model options there are for taking the work programme forward
- Identification of service potential solutions which will be further reviewed and developed in collaboration with a broader audience include:-
  - Clinical Hubs – system wide
  - Clinical defining of urgent and emergency care to support pathway development, right care in the right place, at the right time which is safe, improves quality and outcomes
  - Identification of the support urgent care will need to support the left shift working with the enhanced primary and community care work stream
  - Reduction in access points
- Creation of A & E Delivery Boards – these are now chaired by the CEOs of each system acute hospital Trust, and have representation from the Urgent and Emergency Programme

- **Summary of any changes to the plan and why**
  - Third workshop held 11th October identified parameters within which we will design future urgent and emergency care service models for local delivery and to help define requirements for A & E services across Staffordshire and Stoke-on-Trent
  - Next step engagement with enabling work streams to map implications of new service models, in particular work force, digital and estates, and broader engagement in the conversation with public and other stakeholders
- **Key revised delivery timeline**
  - Timeline has been revised to meet consultation process but requires further realignment with EPCC priorities and enabling work streams. Implementation of redesign service model to commence Spring 2018.
- **Summary of who has been involved/engaged to date**
  - System wide engagement at managerial and clinical level. Next steps include the development of better engagement with WMAS, Social Care and Local Authorities, alongside the commencement of the implementation of the U&EC programme engagement plan with the public
- **The programme has a clear and credible delivery plan, including milestones, outcomes, resources, owners, risks and mitigations.** Timeline has been revised to meet consultation process but requires further realignment with EPCC priorities and enabling work streams. Implementation of redesign service model to commence Spring 2018.
- **The programme has effective leadership, capacity and capability with dedicated resources of SRO, Programme Director, Programme Manager, Project Support assistant, Communications and Engagement specialist, Finance Director lead, and Workforce lead,. Additionally the programme has engaged clinical leadership across the system and is comprehensively supported at both a primary care and emergency physician level**
- **Do we expect a level of challenge for any of the proposals?** At a health commissioner and provider level there is unanimity for the type and level of change required. The anticipated proposed solutions will challenge public preconceptions around the type of facilities and access to urgent care services such that there may be a degree of perceived loss and therefore challenge to the proposals.
- **What support or decisions are required by whom to deliver the plan?**
  - Agreement on cross acute and primary care service model parameters – Health and Care Transformation Board
  - Working with MCPs/locality hubs to define what services will look like in those localities integral with other EPCC service delivery models
  - Acute provision of urgent care (Access to real emergency care).
- **The principal strategic/system wide issue /challenge will be the delivery of a proposal that makes a compelling care to the public for change, underpinned by evidence and improvement, which is supported at a regulatory, political, and system leadership**

Appendix D: Transforming Care – Areas of Opportunity (update since June 2016)

OBJECTIVE	SYSTEM PRIORITY	System Considerations	System Opportunity Enablers
REDUCE COST OF SERVICES	1. System Governance (Organisational Forms)	Strategy to move to a single shadow financial control total for the system and agree the preferred enabling system governance model to deliver a more integrated approach to strategic commissioning, supporting & enabling the STP transformation plan and provision of services across health and care	• Early agreement of financial and regulatory arrangements across Staffordshire & Stoke-on-Trent to ensure focus on cost reduction for system wide benefit.

A summary of the outcome of the system architecture workshop

The system has approached the future form by addressing the architecture of Staffordshire & Stoke-on-Trent. Work has been performed over a 10 week period to engage across the system, including more than 44 key stakeholders representing providers, commissioners and citizens. It was agreed that the following were the key objectives of a system architecture:

1. Positively enable a focus on significantly improved safety and quality of care
2. Clear leadership and Governance.
3. Joint accountability for delivery of robust and credible system plans.
4. Incentives aligned to deliver system aims.
5. Enables responses to the needs of different places across Staffordshire and Stoke-on-Trent – Enables a local approach.

A long list of 25 potential solutions were drawn from both national (albeit early stage) and international case studies and were considered by the stakeholders. Whilst there was not a single vision for the future system architecture agreed at this point there is consensus that the number of commissioner and provider organisations needs to be reduced and that the key steps towards the locality hubs and new models of care should be implemented at an accelerated pace. The short listed opportunities as documented by GEHCF from the workshop are set out below:

	Option	Description
Commissioner	Option 3.1	2 health and care commissioning organisations – North, and South plus East
	Option 3.2	2 health and care commissioning organisations – Staffordshire and Stoke-on-Trent
	Option 4	1 commissioning organisation + social care
	Option 5	1 combined commissioner and provider organisation
Provider	Option 2b	1 fully integrated out of hospital provider (including community and mental health) plus 23 locality care hubs
	Option 4.1d	1 Multispecialty Community Provider across Staffordshire and Stoke-on-Trent plus 23 locality care hubs
	Option 6a	1 ACO across Staffordshire and Stoke-on-Trent plus 23 locality care hubs
	Option 6b	2 ACOs across Staffordshire and Stoke-on-Trent plus 23 locality care hubs
	Option 6c	3 ACOs across Staffordshire and Stoke-on-Trent plus 23 locality care hubs
	Option 7	1 Fully integrated health and care commissioning and delivery model across Staffordshire and Stoke-on-Trent

The stakeholders have agreed that the roadmap to the future state will include "stepping stones" to take the system to its final form. Enabling the development and delivery of Locality Hubs and New Models of Care is a priority for this piece of work, and this will now move forward at pace.

Next Steps

In order to progress the work that the initial workshop provided a springboard for in relation to the STP System Architecture , a number of focussed and analytical pieces of work must be undertaken. The proposed actions in the table below are not exhaustive and is designed to prompt discussion and debate and ascertain agreement about next steps. The approach that has been taken is to develop next steps actions in 4 areas; STP Programme Enabling, Commissioning, Out of Hospital Provision, & Acute Provision., and are outline below:

System Architecture
STP Programme Enabling
System Architecture: Outline process for development of system architecture options
Review output options from system architecture workshop and confirm shortlist of options to be appraised
Develop and confirm TOR and MOU between all stakeholder organisations , establishing an outline scheme of delegation for, risk share & decisions to be taken collectively, and the duration of MOU whilst system architecture elements are developed
Commissioning Organisations
Agree Approach to engagement across commissioning organisations and process for and active collaborative approach to co production
CCGs /LAs– develop a co- produced case for change proposal for movement to a more integrated commissioning function across Staffordshire and Stoke-on-Trent inc. social care
Community Provider Organisations
Establish integration development group, membership to include representatives from all providers including GP's and Local Authorities.
Review current plans and timetable for delivery of Locality Hubs and NMCs from EPCC programme
Assess residual impact of Locality Hub and NMC delivery against community provision in partnership with EPCC programme
Explore opportunities for more integrated strategic and managerial working to support the delivery of Locality Hub delivery plans in partnership with EPCC programme
Explore opportunities for realising back office function benefits from more integrated working
Review outputs from the SA workshop and undertake full options appraisal on options 2b, 4.1d, 6a, 6b, 6c and 7 leading to a strategic options proposal: - Detailed work on the granular definition of options including comprehensive supporting analysis. - Understanding the full implications of each option.
Undertake wider engagement and consultation with boards, regulators, governing bodies and staff to help inform how these will be taken forward.

OBJECTIVE	SYSTEM PRIORITY	System Considerations	System Opportunity Enablers
REDUCE COST OF SERVICES	1. System Governance (System Control Total)	Strategy to move to a single shadow financial control total for the health system and agree the preferred enabling system governance model to integrate all CCGs.	• Early agreement of financial and regulatory arrangements across Staffordshire & Stoke-on-Trent to ensure focus on cost reduction for system wide benefit.

Shadow control total

The new guidance that allows STPs to recognise the additional financial pressures that some part of the system may face in helping to improve overall financial performance at a system level, is most welcome. As part of completing the STP Financial Template we are working out the impact that both the financial challenge and the solutions will have on individual organisations. The aim is to have discussions with the regulators immediately following the 21st October submission to agree the necessary changes to Individual Control Totals (ICTs) to facilitate all organisations acting in the interest of Staffordshire & Stoke-on-Trent as a whole.

We understand the rules to achieve this for those systems wishing to apply for flexibility in operating their operational control totals for 2017/18 should submit a proposal covering the following:

- *A description of how the control total will operate, including the planned footprint, any initial flexibility proposals and the likely further flexibility required during the financial year,*
- *The accountability proposals*
- *The oversight and monitoring arrangement for the operation of the control total*
- *The additional reporting arrangement that will be required*
- *An explanation of the expected benefits, including how these will be measured, and*
- *Any consideration for specialised services commissioning or provision, and any other cross border issues relevant to the application."*

Practical first steps we are taking to understand our position are:

1. Model the impact of the future financial challenge and solutions as shown in the STP on individual organisations by mid November
2. Compare this modelling with individual control totals for 17/18 and 18/19 by the end of November
3. Open discussion with regulators as soon as step 1 and 2 have been completed

Our understanding is that in order to present a strong application to NHS England we will work as a system produce the following content:

A. A clear statement of why having a control total for Staffordshire & Stoke-on-Trent is beneficial to the system (both STP and wider system)
B. A description of how the control total could operate in practice
C. A conceptual financial model demonstrating how the control total could be structured
D. A governance and accountability framework
E. The oversight and monitoring arrangements for the operation of the control total
F. The additional reporting arrangements that will be required and value tracking of the stated benefits for the system
G. A description of how Staffordshire & Stoke-on-Trent will co-ordinate with specialised services commissioning

Appendix E: How our solutions address the STP 10 questions

Appendix: How our priorities address the 10 STP questions

The following demonstrate where in our STP we address the 10 key STP questions. We have developed our STP to show how we are going to progress rapidly as a system. In doing this we will address the key questions as set out in the FYFV. The below is a summary of which of the system priorities will do this. For more detail please see the body of the document.

	Appendix Letter/ Workstream number
1. How are you going to prevent ill health and moderate demand for healthcare? Including: • A reduction in childhood obesity • Enrolling people at risk in the Diabetes Prevention Programme • Do more to tackle smoking, alcohol and physical inactivity • A reduction in avoidable admissions	**2**, 4, 5, 7, 9
2. How are you engaging patients, communities and NHS staff? Including: • A step-change in patient activation and self-care • Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care • Improve the health of NHS employees and reduce sickness rates	2, 4, 6 Enablers B,C,D
3. How will you support, invest in and improve general practice? Including: • Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff • Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package • Support primary care redesign, workload management, improved access, more shared working across practices	4, **5**, 12, 13 Enablers B,C,D
4. How will you implement new care models that address local challenges? Including: • Integrated 111/out-of-hours services available everywhere with a single point of contact • A simplified UEC system with fewer, less confusing points of entry • New whole population models of care • Hospitals networks, groups or franchises to share expertise and reduce avoidable variations in cost and quality of care • Health and social care integration with a reduction in delayed transfers of care • A reduction in emergency admission and inpatient bed-day rates	3, **5**, 6, 8, **9**, **13** Appendix C
5. How will you achieve and maintain performance against core standards? Including: • A&E and ambulance waits; referral-to-treatment times	3, 5, 6, 7, 8, 9, 13
6. How will you achieve our 2020 ambitions on key clinical priorities? Including: • Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks • Implement two new mental heath waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity • Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries • Maintain a minimum of two-thirds diagnosis rate for people with dementia	4, 5, 6, 7, 8, 9, 13

How our priorities address the 10 STP questions cont.

	Appendix A Number
7. How will you improve quality and safety? Including: • Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions • Achieving a significant reduction in avoidable deaths • Ensuring most providers are rated outstanding or good– and none are in special measures • Improved antimicrobial prescribing and resistance rates	2, 3, 4, 5, 6, 7, 8, 9, 13
8. How will you deploy technology to accelerate change? Including: • Full interoperability by 2020 and paper-free at the point of use • Every patient has access to digital health records that they can share with their families, carers and clinical teams • Offering all GP patients e-consultations and other digital services	2, 5 Enabler B
9. How will you develop the workforce you need to deliver? Including: • Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values • Integrated multidisciplinary teams to underpin new care models • New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice	4, 5, 12 Enabler C,D
10. How will you achieve and maintain financial balance? Including: • A local financial sustainability plan • Credible plans for moderating activity growth by c.1% pa • Improved provider efficiency of at least 2% p.a. including through delivery of Carter Review recommendations	3, 5, 7, 9, 10, 11, 12

The below table demonstrate the coverage of the 10 key STP questions across our programmes and enabling work.

		Key Question Number									
Appendix	**Programme**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
A	2	■	■					■	■		
	3				■	■		■			■
	4	■	■	■			■	■		■	
	5	■		■	■	■	■	■	■	■	■
	6		■		■	■	■	■			
	7	■				■	■	■			■
	8				■	■	■	■			
	9	■			■	■	■	■			■
	10										■
	11										■
	12			■						■	■
	13			■	■	■	■	■			
B			■	■							
C			■	■					■		
D			■	■	■					■	