# NHS Shropshire, Telford & Wrekin Clinical Commissioning Group

Clinical Commissioning strategy

# Version tracker



| Version Number | Date | Author | Details of Update |
|---|---|---|---|
| 0.1 | 1 October 2019 | Fran Beck | Early draft collating information to address KLOEs |
| 0.2 | 20 February 2020 | Sam Tilley | Updated with additional information following feedback |
| 0.3 | 13 March 2020 | Angela Parkes | Format changed following feedback<br>Restructured to provide an overarching narrative<br>Added Implementation and monitoring section<br>Redesigned Population health management section |
| 0.4 | 18 March 2020 | Angela Parkes | Updated vision and values section<br>Updated benefits realisation section<br>Added operating model as appendix<br>Added full benefits realisation document as appendix |
| 0.5 | 20 March 2020 | Angela Parkes | Updated contracts model section<br>Updated operating model appendix<br>Update Implementation and Monitoring impact graphs |
| 0.6 | April 2020 | Angela Parkes | Added Covid-19 impact statement<br>Added milestones appendix<br>Added organisational development section<br>Added future provider landscape section<br>Updated financial strategy section and impact graphs<br>Updated population health management section<br>Updated governance section |
| 0.7 | September 2020 | Sam Tilley | Update to slides to reflect development of system working and further impact of Covid-19<br>Updated System Governance<br>Updated (draft) finance section pending submission of finance Strategy on 5 October 20 |

# Version Tacker



| Version Number | Date | Author | Details of Update |
|---|---|---|---|
| 0.8 | 18 December 2020 | Sam Tilley | Full re-drafting of Strategy utilising NHSE/I feedback |
| 0.10 | January 2021 | Angela Parkes | Amendments to quality slide |
| 0.11 | March 2021 | Angela Parkes | Updated financial section to match financial strategy<br>Added Big Ticket items section including roadmap<br>Minor updates to Population Health Management section<br>Updated next steps section |
| 012 | March 2021 | Zena Young | Update to Quality section |

# Contents

# Foreword – Clinical Chair



## (Julian Povey , Joint Chair of Shropshire and Telford & Wrekin CCGs)

Our Clinical Commissioning strategy sets out how NHS Shropshire and Telford & Wrekin Clinical Commissioning Group aim to develop and improve health services for our population over the next three years. We want to ensure the right help is available to people when they need it, achieving the best health outcomes we can and making the best use of our resources, within a landscape of constrained financial resources, advances in medicine, and increasing life expectancy.

The future of both the commissioning and provision of healthcare is changing in a positive way. The development of integrated models of care through provider collaboratives, supported by strategic commissioning (working at a larger scale) has been identified as a future model for the NHS. This way of working means that a greater level of care will be provided to patients in their home or within their community, by a Place Based Multi-Disciplinary team of professionals. Our aim is to reduce reliance on hospital based care, but when patients do need hospital treatment they will receive the same seamless care delivered by an integrated community team. This strategy describes the aspirational journey we plan to take to improve the health and wellbeing of the local population.

Our strategy has been developed in alignment with national and local policy:

- The NHS Long Term Plan
- The Shropshire, Telford & Wrekin local Sustainability and Transformation Partnership and Long Term Plan
- Five Year Forward View
- General Practice Five Year Forward View
- Mental Health Forward View
- Transforming Care Programme
- National Cancer Strategy
- Shropshire Health and Wellbeing Strategy / Telford and Wrekin Health and Wellbeing Strategy
- STW System Improvement Plan

NHS Shropshire, Telford & Wrekin CCGs will endeavour to lead the local health and care system to ensure stronger strategic commissioning, a system approach where collaboration and partnerships underpin delivery as well as ensuring more personalised care, closer to patients homes with improved outcomes. Our strategy will align to these goals and is further informed by key health improvement areas identified by our quality and performance data.

Our effectiveness and success is dependent upon robust commissioning approaches, system collaboration, brave and resilient leadership, clinical engagement, drive, ambition and transformation, sound financial strategy and excellent transparent governance. We will be further developing and improving our approaches to these important underpinning characteristics over the next three years.
Our staff and membership are key to our success. Creating an environment that recognises good work, energy and effort will ensure that staff and our membership feel able and empowered to contribute to the transformation that is required to achieve our ambitions.

**National Context**

The NHS Long Term Plan (LTP) signalled the direction for health and social care services for the next 10 years. It aspires to provide everyone with the best start in life, deliver world-class care for major health problems, such as heart disease and cancer; and help people to age well with equal life expectancy regardless of social circumstances. The national LTP summarises the challenges faced by the NHS, such as growing demand and workforce shortages and sets out how these can be overcome by:-

1. Doing things differently: giving people more control over their own health and the care they receive
2. Taking more action on preventing illness and tacking health inequalities: increasing the focus on some of the most significant causes of ill health, smoking, alcohol and lifestyle changes to avoid Diabetes type 2
3. Improving care quality and outcomes for major conditions
4. Addressing workforce gaps by increasing the workforce, training and recruiting more professionals and redesigning roles
5. Making better use of data and digital technology
6. Getting the most out of taxpayers investment: reducing waste and duplication of delivery; improving efficiencies and transforming care, and doing things differently, for example, significantly changing Out Patient services.

Our system has prepared a local response to the LTP which provides the full detail of how we will deliver the ambition articulated in the national Long Term Plan. The new Strategic Commissioner will be a system leader to ensure we drive all of the changes planned, and at pace. This Clinical Commissioning Strategy attempts to provide a strategic overview of the plans of the Strategic Commissioner, supported by a set of very detailed programme plans.

**Covid-19 Impact**

The impact of Covid-19 for the NHS has been, and will continue to be, immense. Much of the planned transformation across the system has been paused or scaled back as the system responds specifically to the tasks of addressing patient need in relation to the pandemic.

Whilst the system addresses restoration and recovery from the impact of the pandemic alongside its ongoing management, the challenges this presents also brings opportunities.

The STW system has had to come together to collectively address a common goal in a way that it has not done so before. This has lead to the implementation of new collaborative structures for tasking as well as decision making and has been a catalyst for developing collaborative ways of working. Staff have stepped outside of their usual roles to deliver priority actions at pace, to develop solutions for wicked problems and to share ideas and innovation

The CCGs are leading the ongoing development of the systems collaborative approach by using the foundations laid during the height of the pandemic to support the building blocks for the future Integrated Care System and Strategic Commissioning. The learning from the pandemic is assisting in re-forming system structures, roles, responsibilities as well as its goals and ambitions

This process has accelerated the work that the system would have needed to undertake on its journey towards becoming an Integrated Care System and stands us in good stead to move forward with a new approach to commissioning, provider collaboratives and a more system focused philosophy for delivering the best patient care and outcomes

**Covid-19 Impact**

A set of principles to guide future working have been agreed

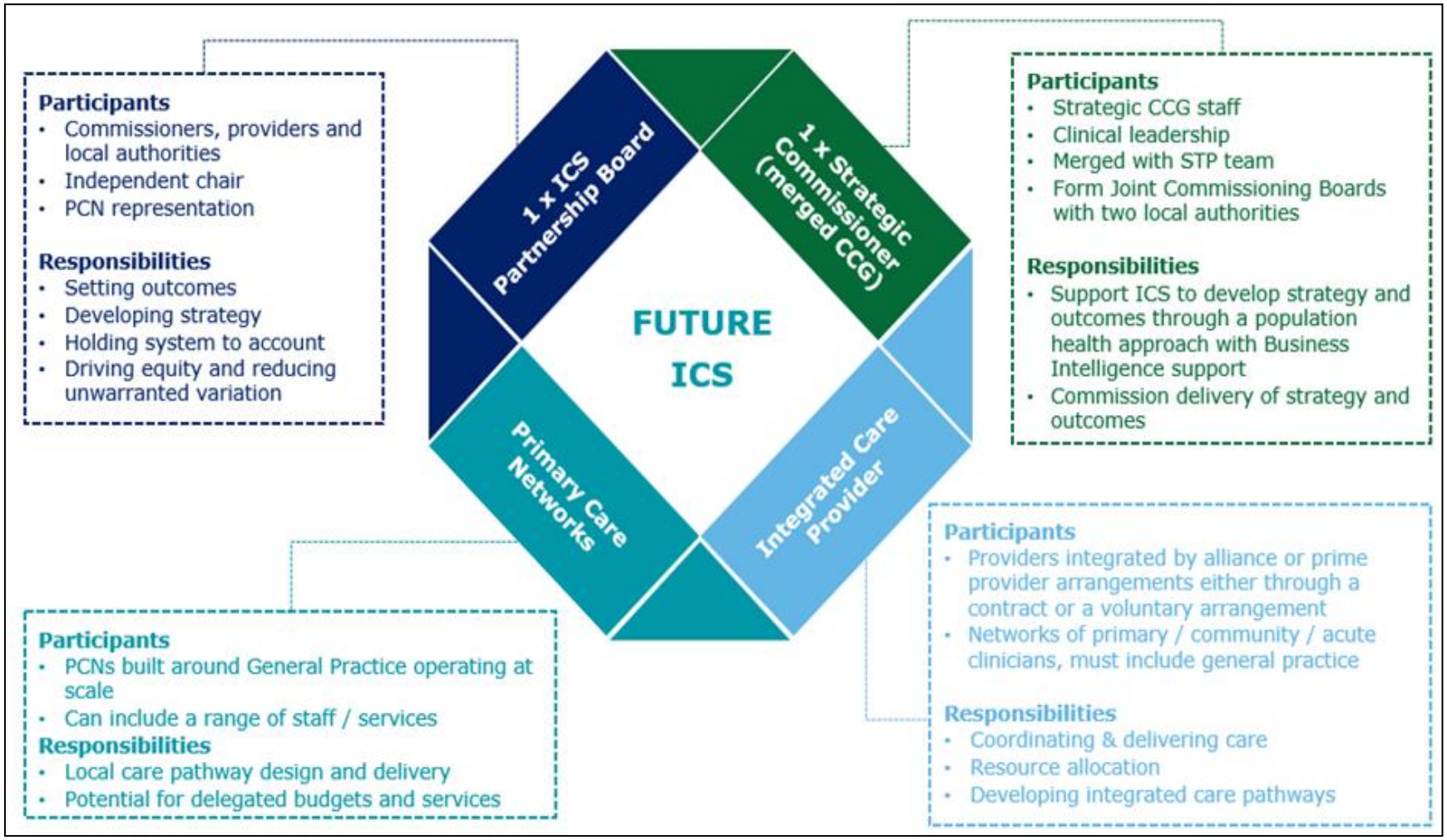
## System Principles

- System as default
- Re-organisation of the system around key priorities i.e. directing resource at delivering key priorities and stopping doing those things that do not deliver these priorities
- Maintain pan-organisational governance and ensure it continues to support solution focused, rapid decision making
- Deployment of staff to support priorities – matching skills with tasks and working across traditional boundaries
- Embrace change – the system cannot stay the same and nothing is off the table
- Combine efforts of system restore, prioritised services and winter plan response

These principles will underpin the strategic commissioners approach to its business and its focus on improving the health and care of its population

**Moving towards an integrated care model**

In implementing the sentiments of the NHS Long Term Plan the commissioner and provider landscape will change. Commissioning will take place at a number of levels; Regional and sub-regional, Sustainability and Transformation Partnership (STP) footprint or at Place level. We are clear that closer working between partners is a crucial ingredient for the delivery of our ambitious plans, we have tested this hypothesis during our Covid-19 response and we have some early indications of the benefits this can bring. For that reason we believe collaboration is better than competition and we want to cement our relationships by creating an Integrated Care System (ICS) by April 2021.



**Moving towards an Integrated Care model**

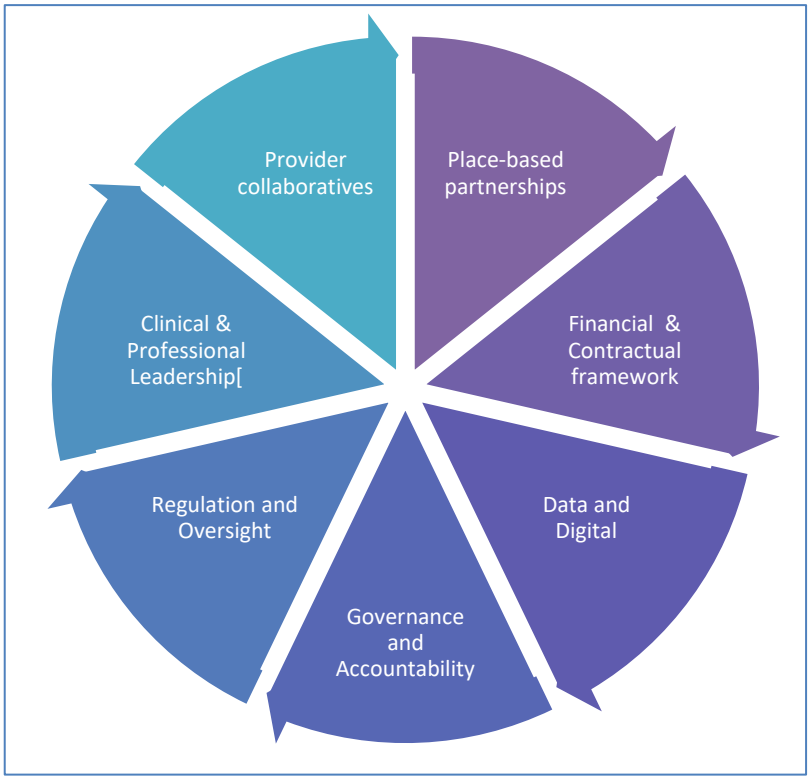
We will build our approach around the following NHSE/I principles:

Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;

**Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and

Developing strategic **commissioning** through systems with a focus on population health outcomes;

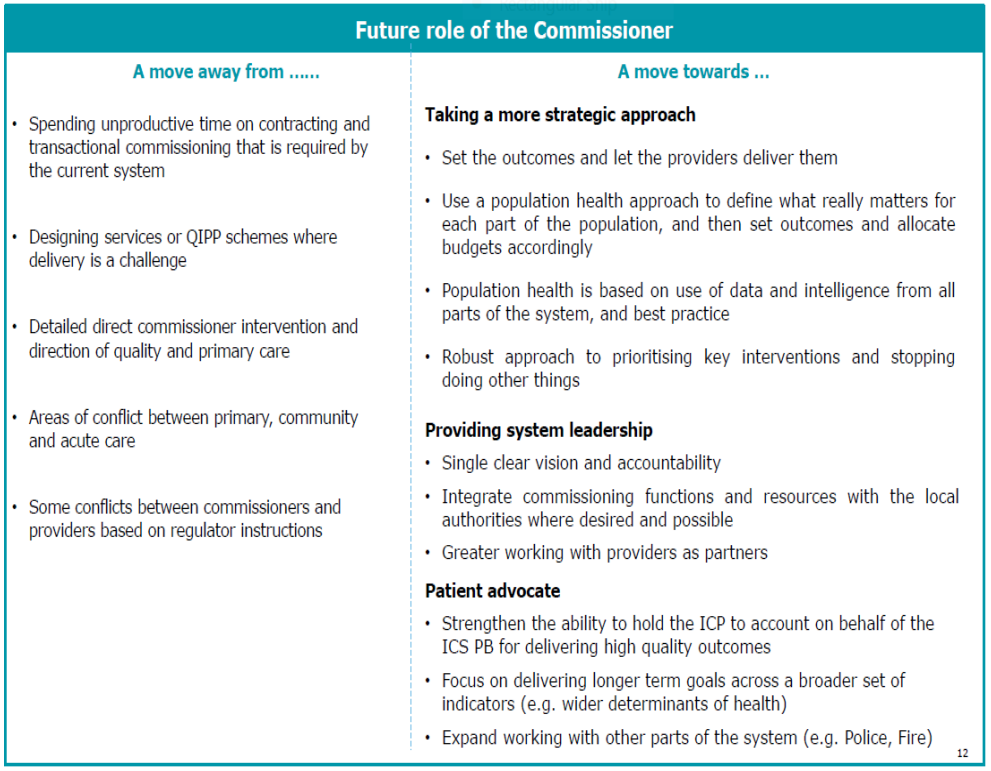
The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.



**Future role of CCG**

As the ICS develops, we expect that a number of common functions will need to be established:

- Analytics and insight in support of Population Health Management and a wider system approach to Business Intelligence capabilities;
- Oversight and assurance of operational and financial performance and LTP implementation including workforce, estates and digital;
- Management of collective financial resources and identification and delivery of system-wide efficiencies;
- Co-ordination and delivery support for operational and strategic planning;
- Streamlined and robust system-wide decision-making and effective governance;
- Stakeholder engagement, clinical engagement, multi-professional leadership development and partnership working;
- Provider development across the system to support the development of provider collaboratives ,
- Focus on Place based approaches working in neighbourhoods and in particular supporting the development of PCNs ;
- Integration of health and care between NHS and local government at place and at neighbourhood; and
- Quality improvement and sharing best practice, involving all staff groups across the system.



**Future role of the Commissioner**

| A move away from ..... | A move towards ... |
|---|---|
| • Spending unproductive time on contracting and transactional commissioning that is required by the current system | **Taking a more strategic approach** |
| • Designing services or QIPP schemes where delivery is a challenge | • Set the outcomes and let the providers deliver them |
| • Detailed direct commissioner intervention and direction of quality and primary care | • Use a population health approach to define what really matters for each part of the population, and then set outcomes and allocate budgets accordingly |
| • Areas of conflict between primary, community and acute care | • Population health is based on use of data and intelligence from all parts of the system, and best practice |
| • Some conflicts between commissioners and providers based on regulator instructions | • Robust approach to prioritising key interventions and stopping doing other things |
| | **Providing system leadership** |
| | • Single clear vision and accountability |
| | • Integrate commissioning functions and resources with the local authorities where desired and possible |
| | • Greater working with providers as partners |
| | **Patient advocate** |
| | • Strengthen the ability to hold the ICP to account on behalf of the ICS PB for delivering high quality outcomes |
| | • Focus on delivering longer term goals across a broader set of indicators (e.g. wider determinants of health) |
| | • Expand working with other parts of the system (e.g. Police, Fire) |

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The future CCG role will include:

- Working Strategically with LA commissioners focusing more on population health need, whole system and population, community and individual patient outcomes
- Retaining statutory responsibilities but with some of these responsibilities to be discharged through working alongside system partners
- Aligning activities with local authorities, aiming to ensure effective integration of the approach
- Working with LAs and providers to shift some traditional commissioning activities (e.g. pathway redesign) to providers who may be better placed to undertake this work
- Increasingly directing CCG resources towards delivery of the necessary system-wide and place based functions.
- Working with neighbouring ICSs to take on greater responsibility in planning and managing specialised and direct commissioning services alongside budgetary accountability.

## Case for Change

The key challenges for the system can be broken into the following categories:

### Demographics and Geography

- Largely rural county with two main urban centres.
- An aging population
- Pockets of severe deprivation
- Lower wage economy
- Deprivation linked to education, access to employment and housing that need to be considered
- Lack of sound system level data and intelligence to inform delivery

### Operational Performance

- Local services struggling to meet demand
- Workforce constraints with NHS providers having high levels of staff vacancy
- Failing to deliver key targets e.g. A&E and cancer targets

### Quality

- CQC ratings are 'Inadequate' for care quality and leadership, notably within acute care and maternity services
- Pathways and facilities for Children and Young Persons in need of Mental Health assessment need reconsideration to meet national standards.
- Non delivery of some constitutional and service standards
- Shropshire Ofsted / CQC inspection - we are required to develop a Written Statement of Action (WSOA) for SEND improvements

### Workforce

- All providers in health and social care report difficulty in recruiting and retaining staff

### Reconfiguration

- The Hospital Transformation Programme (Future Fit) highlights key issues relating to outdated buildings, equipment and service models
- Focus on out of hospital care including prevention agendas
- Development of Primary Care Networks (PCNs)
- Community development

### Digital Infrastructure

- Differing levels of technology available to partners which limits the system moving forward towards a truly collaborative digital workspace

In the NHS Long Term Plan the ambition has been set for the NHS to adapt and improve to meet the challenges it faces. In order to fulfil its part in this ambition Shropshire CCG and Telford and Wrekin CCG have made a commitment to form a single strategic commissioning organisation. In doing this we believe that:

- A single set of commissioning and decision making processes will enable reduced variation in outcomes and access to services
- A single CCG will have greater influence with providers through one voice
- A single CCG will be more efficient with a better use of clinical and managerial time on the things that count, reducing duplication and running costs
- This supports the development of a robust Integrated Care System for the county of Shropshire

## CCG Mission / Vision

*To buy innovative, safe and high quality services that meet the current and future, rural and urban needs of the people of Shropshire, Telford and Wrekin*

**CCG Values**

Our vision and the way we deliver it clearly demonstrate our CCG values:


We recognise the level of transformation required across the system to enable us to deliver our vision. We will lead and drive this transformation through the clinical leadership model we are embedding into our CCG and through our new Strategic Commissioning Framework, using a PHM approach to commission services around patient and population characteristics, rather than providers. Our patients and communities will be better supported to keep themselves well at home, experience shorter waiting times, and receive more holistic patient centred care. We have commenced on this journey and have a collective aspiration to drive change and improvement.

We will have a stronger role as the patient's advocate to hold the ICP to account for delivering the high quality outcomes set, seek to deliver longer term goals for improvement in the local populations health, rather than the current transactional monitoring of sickness related activity. We will also broaden work with the system partners beyond health and social care e.g. police, fire service, schools, employers and housing providers.

# Section 2: Our vision and values – what can people expect from the CCG?



| Staff | Provider | Public |
|---|---|---|
| ▪ Always ask "What does this mean for the patient?" and prioritise this in all aspects of service design and improvement<br>▪ Display active listening, empathy, proactive rather than reactive behaviour<br>▪ Positive working environment where there is open regular communication, staff feel safe and supported, there is zero tolerance to bad behaviour, mistakes are used as learning opportunities and excellence is encouraged<br>▪ Clarity of expectations, roles, responsibility, accountability and priorities<br>▪ Individuals recognise own limitations, support each other, have the freedom to be brave and are motivated to make a difference<br>▪ Actively hold providers to account<br>▪ Empower staff with genuine autonomy and ability to develop creative solutions<br>▪ Be creative and innovative in use of resources<br>▪ Senior support to deliver schemes<br>▪ Personal integrity and transparency ensures organisational integrity and transparency<br>▪ Robust but fair challenge from both sides | ▪ Always asking "What does this mean for the patient?"<br>▪ Being open about challenges, financial constraints and the trade offs required, always seeking to put the patient first<br>▪ Organisation has empathy for pressures in providers, listens to providers concerns, provides support as well as challenge to enable them to fulfil their roles and sets outcomes but give providers flexibility on how to deliver them<br>▪ Collaborative approach where ideas for improvement are shared, change is embraced, providers are supported to make changes and continuous improvement is supported<br>▪ Mutual understanding of positions, shared risks and how these will be managed these together.<br>▪ Encourages feedback and responds to it<br>▪ Strive for good governance in all decision making with full transparency<br>▪ Open regular communications<br>▪ Set outcomes but hold providers to account for delivery of outcomes<br>▪ Sharing functions on a system footprint where possible | ▪ Open, honest and regular communication with a consistency of approach and language that is jargon and acronym free<br>▪ Ensure patients have a voice by creating a safe environment where everyone is free to speak, seek to build patient relationships and listen to patients and their families<br>▪ Consider patients as individuals, acknowledge diversity, understand each others perspective, have open and honest conversations about how the patient contributes to their own care<br>▪ Develop a more robust focus on equality, diversity and inclusion and utilise the learning from Covid-19 to develop our approaches to support our BAME communities<br>▪ Be clear on the consequences of decisions, show that acting in good faith, communicate that there are limited resources, acknowledge limitations and where the CCG gets it wrong.<br>▪ Have clear accountability, make evidence based decisions, provide assurance by seeking evidence of high quality care, continuous review of practice, focus on outcomes, transparency and openness around decisions and their implications.<br>▪ Be clear on the commissioner 's role in the allocation of the resources its receives<br>▪ Ensure the public is aware that the commissioner does not deliver services |

**Model for Executive Team**

The Executive Team will be utilising the ten behaviours expected from Governing Body members as outlined in the NHS Leadership Model.


**Delivery**

The key steps around delivery of the values and behaviours are outlined below:

- Communicate the vision and values at all levels within the CCG. Keep repeating it.
- Ensure senior managers and Governing Body are ready, willing and able to embrace the changes
- Encourage all levels of the organisation to embrace the change using change management ambassadors
- Change management ambassadors morph into staff engagement champions who track delivery of values and gather feedback
- Develop a plan of how the vision and values are going to be implemented, have deadlines and owners for all actions
- Staff survey and 360 degree feedback to gather information around delivery and morale
- Recommunicate the policy around whistleblowing
- Development of talent management approach including appraisals, PDPs, induction, shadowing and training
- Ensure the handover from past objectives / appraisals to future objectives / appraisals is smoothly handled
- Monitor how implementation of the plan and how the change is going on a regular basis
- If the plan isn't working don't be afraid to change it
- Promote flexible and agile working arragements to support staff wellbeing, efficiency and effectiveness

**Strategic objectives**

The new CCG will focus on 6 key strategic objectives (subject to ratification by the new Governing Body):

| No. | Objective | Link to STP |
|---|---|---|
| 1 | Lead the financial transformation needed to identify key shared priorities required to drive both clinical and financial sustainability and ensure these are delivered | Financial:<br>System deficit identified within plans as a priority for address.<br>Improvement to system deficit via transformation programmes, shared functions and system wide approaches. |
| 2 | Provide the strategic and clinical leadership in the planning and commissioning of care for the people of STW – this will include developing new transactional arrangements to incentivise providers to take lead responsibility for key cohorts of patients/populations | Financial:<br>Improvement to system deficit via transformation programmes<br>Transformation programmes are a key driver for STP plans and are being led by the CCG<br>Planning to incorporate development of shared functions where possible, based on principle of "System as Default" |
| 3 | Reduce health inequalities and demand by deploying a population health management approach to improve the physical and mental health of people living in Shropshire, Telford and Wrekin | Development of a system wide approach to Population Health Management and Business Intelligence. Development of shared resources and capabilities and expertise |
| 4 | Reduce variation in outcomes and quality of care | Quality planning underpins the STP governance and includes the requirement to reduce variation. Use system view to highlight areas that require addressing |
| 5 | Improve communication with an involvement of patients, public, clinicians and all stakeholders | Development of system wide comms approach, shared resources to support more effective and consistent communications and engagement<br>Co-production is a key feature of the Quality planning that underpins the STP governance. |
| 6 | Re-focus on prevention and anticipatory patient centred care | Further develop the STP workstream dedicated to prevention and place based care, driven by sound data and intelligence |

**Developing our priorities**

The commissioning priorities are directly linked to the system priorities that have been developed through system wide collaborative working as part of our Long Term Plan submission and more latterly the System Improvement Plan in the context of national and local policy.

Using a PHM approach we are developing a shared understanding of population need, drawing upon our two Local Authorities Joint Strategic Needs Assessments (JSNAs) and using intelligence and analysis of care needs, patient and population outcomes, patient experience, resource utilisation, analysis of variation and health inequalities.

We are using this intelligence to:

- Agree the **key system solutions** that will enable us to deliver our vision and the aims of the NHS LTP
- Agree the **critical path to delivery**, that will enable us to deliver those solutions
- Segment the resulting activities into clear programmes of work, and agreeing the key interventions and deliverables
- Agree **core priority areas** ( Prevention and Placed Based Care, Acute and Mental Health)
- Agree our underpinning **drivers of delivery**
- Understand the outcomes and benefits we expect, and develop our framework to monitor them

This approach is underpinned by clinical engagement, developed in partnership with our CCG clinical leaders and the work of our STP. It is also underpinned by an ongoing programme of patient and public engagement with support from Healthwatch Shropshire and Healthwatch Telford & Wrekin.

Our commissioning priorities reflect our need to develop new models and new pathways of care, underpinned by integrated workforce solutions across organisational boundaries. They also require us to address Clinical Sustainability across fragile services and develop networked solutions across providers both within and outside the STP footprint. In turn we anticipate that this will result in a more financially sustainable position for the system.

We will drive the delivery of our commissioning priorities through:

- Our Strategic Commissioning framework, setting out strategic direction and expected outcomes, with contractual frameworks that address barriers and incentivise delivery
- Supporting providers/place based alliances to respond with proposals to deliver new models of care and integrated pathways, clinically assuring pathway redesign, as well as supporting them to develop robust governance frameworks, for quality, clinical governance and resources/finance
- Developing our ICS operating model, to drive coordinated delivery across service transformation, quality, performance and finance functions

The headline impact of this is set out on the following three slides:

# Community and Place Based Care

| Community and Place Based Care | |
|---|---|
| Priority schemes ( subject to system wide ratification )<br><br>1. The completion and implementation of restoration and Recovery plans for primary care and community services<br>2. Roll out of case management services across Shropshire, Telford and Wrekin<br>3. Roll out of community Rapid Response / hospital at home services across Shropshire, Telford and Wrekin<br>4. Review of end of life care across Shropshire, Telford and Wrekin<br>5. Long Term Conditions – Pathway re-design<br>6. Personalised Care, social prescribing and community engagement<br>7. Review of wider community service model<br>8. Single Point of Access<br>9. Children's physical Health<br>10. Primary Care and PCN Development | Our STW LTP set out an ambition to achieve a 'left-shift' with a greater emphasis on citizens managing their own health, delivering more preventative care, treating people as close as possible to their homes. Reducing demands on acute services and maximising independence.<br><br>The priorities for Community and Place Based Care were reviewed in July 2020 in light of Covid-19 and are currently subject to ratification . |

The Key responsibility of the Community and Place Based Care Programme Board is to agree and oversee delivery of system defined priorities. System assurance will be sought from the STP system design, Prioritisation and Quality Assurance group who will review all implementation plans to ensure they are robust and that interdependencies are properly addressed.

The savings associated with the above priorities are currently being re-modelled. The table below provides an indication of cost reductions as previously submitted within the Long Term Plan, this excludes any investments that may be required.

| | | Value £000's | | |
|---|---|---|---|---|
| Community & Place Based Care | Efficiency Scheme Name | 2021/22 | 2022/23 | 2023/24 |
| System Priorities | Telford & Wrekin Integrated Place - integrated Teams | 637 | 850 | 0 |
| | Telford & Wrekin Proactive Admission Avoidance - Frailty | 1,064 | 1,419 | 0 |
| | Telford & Wrekin Integrated Place - Care Homes | 92 | 123 | 0 |
| | Telford & Wrekin - Healthy Hearts | 197 | 152 | 152 |
| | Shropshire Care Closer to Home - Case Management | 2,972 | 1,469 | 1,412 |
| | Shropshire Care Closer to Home - Winter Admission Avoidance Scheme | 2,175 | 2,032 | 0 |
| | Shropshire Care Closer to Home - Phase 3 Roll out of Sub Acute work | 1,000 | 1,407 | 0 |
| | Long Term Conditions ( Respiratory & Diabetes) | 521 | 150 | 550 |
| **Total** | | **8,658** | **7,602** | **2,114** |

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# Acute & Specialised Care

| Acute | |
|---|---|
| Priority schemes<br>1. Elective Care – MSK new model<br>2. Elective Care – Outpatient redesign<br>3. Hospital transformation – Future Fit<br>4. Maternity Care<br>5. USE (Flow)<br>6. Cancer Care | We will develop anticipatory care services and our out of hospital services to provide real alternatives to presentation to A and E, alongside improvements in flow through a shift to SDEC, early supported discharge and the delivery of care at home to reduce hospital acquired functional decline and reduced reliance on bedded care. We will implement the IUCS pathway, review our pathway against national standards of care for MIUs and UTCs and review our provision of A and E services across the three acute sites to ensure the optimal use of resources to drive improved delivery. |

The savings associated with the above priorities are currently being re-modelled. The table below provides an indication of cost reductions as previously submitted within the Long Term Plan.

The biggest STP scheme in this area is the hospital reconfiguration project- Future Fit, which focusses on the redesign of complex and emergency care

Specific plans are in place in relation to Musculoskeletal (MSK) services and Outpatient redesign. These key projects are being worked up within the system and are anticipated to provide streamlined services for patients in the right place at the right time. A new MSK alliance contract is being developed with system providers with a current 'go live' date of 1st December 2020.

Further details regarding release of net system cost in relation to specific disinvestment plans, commissioning plan changes, activity management changes and cost avoidance which will result in a forecast slow down in targeted spend in specific service areas can be found on slides 31-36 of the Finance Strategy

| | | Value £000's | | |
|---|---|---|---|---|
| **Acute & Specialised Care** | **Efficiency Scheme Name** | **2021/22** | **2022/23** | **2023/24** |
| System Priorities | MSK Alliance Model | 2,000 | 2,500 | 2,000 |
| | Outpatient Re-design | 1,201 | 1,281 | 1,281 |
| Other Opportunities and Transactional Efficiencies | Urgent Care Smaller Schemes - eg HISU, Big 6 | 584 | 143 | 138 |
| | Elective VBC | 150 | | 0 |
| | Urgent Care - Rightcare Opportunities HF | 500 | 500 | 500 |
| | Unwarranted Variation Elective & Daycase | 2,103 | 1,051 | 1,051 |
| | Unwarranted Variation Non Elective | 2,278 | 2,278 | 2,278 |
| **Total** | | **8,816** | **7,753** | **7,248** |

# Mental Health

| Mental Health | |
|---|---|
| Priority Schemes<br>1. All age Mental Health<br>2. Digital Workforce Integration<br>3. Parity of Esteem<br>4. Redesign Rehabilitation Pathways | We will deliver our system strategy for mental health during 2020-21. We will reduce inequality of access to appropriate support at the right time for people with mental health needs. Through our 'transforming community mental health care' test site status we will develop the primary care workforce to work alongside mental health specialists to ensure both physical and mental health needs are met for people with severe mental health illness. We will expand access to specialist community mental health services and through increased investment in urgent mental health pathways we will offer alternatives to A&E and early support including crisis cafes and community services. We will implement IAPT for people with long term conditions, and improve early identification and support for people with dementia. |

The Mental Health Investment Standard requires CCGs to increase Mental Health spend by at least the level of their overall allocation growth, plus an additional percentage to reflect any additional funding in CCG allocations. The current plan shown below achieves this through the areas of core Mental Health, Individual Commissioning and Mental Health prescribing expenditure shown in the various categories in this plan.

We plan to meet investment standards for Mental Health services in every year and will aim to do that by a) improving efficiencies* of existing services, plus b) reinvesting resources saved from other areas, e.g. unnecessary hospital attendances/ admissions for MH patients.

The Long Term Plan for Mental Health sets out the expectations for contemporary services to support recovery. As such there are specific requirements for investment, activity and workforce growth that the STP has submitted in its Long Term Plan. The investment required has been prioritised by commissioners to best meet the targets and achieve financial balance.

Further details regarding release of net system cost in relation to specific disinvestment plans, commissioning plan changes, activity management changes and cost avoidance which will result in a forecast slow down in targeted spend in specific service areas can be found on slides 31-36 of the Finance Strategy

| | 2020/21<br>£'000 | 2021/22<br>£'000 | 2022/23<br>£'000 | 2023/24<br>£'000 |
|---|---|---|---|---|
| **Total funding if LTP funding available** | **92,710** | **97,411** | **103,825** | **111,224** |
| Committed Expenditure | 92,710 | 90,668 | 93,483 | 96,553 |
| Investments | | 7,743 | 14,342 | 18,671 |
| QIPP | | -1,000 | -4,000 | -4,000 |
| **Total Expenditure** | **92,710** | **97,411** | **103,825** | **111,224** |

| Priorities for Investment |
|---|
| Crisis support for both adults and children |
| Childrens Mental Health (eg trail blazers, ASD, ED) |
| Severe Mental Illness (SMI) , including EIP |
| Recovery and Prevention (IPS, Perinatal, PCN/community support) |
| IAPT (Improving Access to Psychological Therapies) |
| Learning Disabilities and Autism |

* Some of the Mental Health Efficiency Programmes will impact on Acute Services and so the overall QIPP Benefit will be seen across different categories. Spend in the table above includes all Mental Health spend including that which is categorised in other areas eg acute/primary care etc.

# Individual Commissioning

| Individual Commissioning |
| --- |
| We will implement continuous review of individual commissioning decisions for both adults and children's to enable the system to react more effectively to changing needs of patients and ensure the best value for money with the packages of care implemented.<br><br>A robust process will be in place to ensure all decisions are fair and equitable.<br><br>We will continue our work to repatriate people with learning disabilities placed outside of the area.<br><br>We will implement a Hospice at home service to support our patients and their families towards the end of their life. |

Financially, this is an area of significant high risk for the new organisation with a material overspend seen across both CCGs in both 2019/20 and 2020/21. (Appendix 1 provides more information on this) .

We have set ourselves a challenging recovery programme for this area which generates around £10.8m savings across the four years of the strategy in an attempt to 'right size' our spend. However during 2020/21 a number of QIPP schemes had been delayed in the first part of the year due to the impact of the Covid-19 pandemic . Despite this, CCG projects are now starting to return to Business as usual and Bi- Weekly QIPP meetings have been re-established. Improved system partnerships have been formed though closer working with the Local Authority and this is seen as a real benefit in terms of progressing with scheme outcomes.

The Trusted assessor model was conceptualised by Telford and Shropshire CCG's during COVID and piloted during the lockdown, this has since been identified both locally and nationally as the preferred model for delivering CHC remotely. It means that the total time taken to complete a CHC assessment falls from 8 staff hours to 3 hours whilst remaining fully compliant with the NSF for CHC.

During 2019/20 The CCGs set up a programme of work to ensure that care packages are regularly reviewed and matched to the changing needs of patients whilst monitoring and controlling costs more robustly. an Action plan is in place to ensure the same level of scrutiny with regards to eligibility criteria and packages of care is applied across both CCGs. This has previously proved very successful in Telford and the process will continue into future years. A key benefit of creating the new organisation will be the consistent application of the frameworks for CHC and FNC across the county.

Similarly as the complexity of needs continues to grow we will be a stronger organisation to manage the market and ensure that current providers deliver care that will avoid the need for external placements. For example we will ensure that we commission robust assertive outreach for MH patients who otherwise need expensive out of area placements. We are also exploring market management opportunities with our two Local Authorities in order to further strengthen our position.

| | Value £000's | | | |
| --- | --- | --- | --- | --- |
| **Efficiency Scheme Name** | **2020/21** | **2021/22** | **2022/23** | **2023/24** |
| Hospice at Home | 125 | 0 | 0 | 0 |
| CHC Mental Health | 1,422 | | | |
| CHC - Review Programme | 377 | 3,821 | 2,542 | 2,525 |
| | **1,923** | **3,821** | **2,542** | **2,525** |

# Medicines Management

## Medicines Management

We will continue to improve management of high cost drugs to maximise value for money.

We will improve prescribing in respiratory disease, CVD, type 2 diabetes and pain management.

We continue to utilise prescription ordering direct to improve repeat prescribing.

We will continue to support care homes to improve residents care

We will improve appliance services and ordering focusing on wound management and stoma care.

The medicines management teams promote good prescribing practice across Shropshire and Telford through a number of interventions which also contribute to our QIPP plans.

Programmes of schemes are designed to optimise the use of medicines in the delivery of healthcare, for example implementing national guidance on items which should not routinely be prescribed in primary care.

Work continues through the Medicines Management team to contain spend and restrict growth in prescribing. This is linked into system work on Medicines Management across our main providers.

The current QIPP target for Medicines Management is £15.6m across the four years. However during 2020/21 a number of schemes had been delayed due to the Covid-19 pandemic . However, In recent months positive progress has been made as CCG projects are starting to return to Business as usual. Bi-Weekly meetings are now taking place in order to maintain a focus on delivery and the Joint QIPP Programme Board has been re-established. Processes across CCG's are being aligned which will help to harmonise schemes and support more efficient ways of working.

A number of schemes have already been identified for 20/21 and are shown in the table but there is still a significant amount of work being done to address the remaining target through the Medicines Management STP work stream.

| | Value £000's | | | |
|---|---|---|---|---|
| **Efficiency Scheme Name** | **2020/21** | **2021/22** | **2022/23** | **2023/24** |
| Meds Management - POD | 1,058 | | 0 | 0 |
| Meds Management - Drug Switches | 280 | 240 | 0 | 0 |
| Meds Management - Care home Prescribing | 483 | 0 | 0 | 0 |
| Meds Management - Scriptswitch / Optimise rx | 275 | 360 | 0 | 0 |
| Meds Management - Renal Unit Supplies | 185 | 0 | 0 | 0 |
| Meds Management - Diabetes | 130 | | 0 | 0 |
| Meds Management - DOLCV | 60 | | 0 | 0 |
| Meds Management - Appliances (Wound) | 50 | | 0 | 0 |
| Meds Management - Respiratory Rightcare | 50 | | 0 | 0 |
| Meds Management - DOLCV | 35 | 0 | 0 | 0 |
| Meds Management - Silver Dressings | 15 | | 0 | 0 |
| Meds Management - Ostomy (Continence) | 10 | 0 | 0 | 0 |
| Meds Management - Self-Care | 5 | 0 | 0 | 0 |
| Meds Management - Rightcare Opportunities | 0 | 0 | 350 | 350 |
| Meds Management - Future plans | 0 | 2,378 | 4,339 | 4,914 |
| **Grand Total** | **2,636** | **2,978** | **4,689** | **5,264** |

# Redesign of community services

| Redesign of community services |
| --- |
| We will review our community services provisions and redesign to meet the needs of the population and to ensure future services are sustainable and affordable.<br><br>We will look at new contracting models to support these newly designed services to ensure the whole system benefits from the changes. |

Significant community investment is shown throughout the plan and in the table below . This investment will be used to commission integrated care delivery models and pathways through Care Closer to Home and the Telford Integrated Place Partnership. The investment plus the integration of existing hospital, community and primary care teams will base care around delivery of long term conditions and urgent care.

| Community Investment | 2021/22 | 2022/23 | 2023/24 |
| --- | --- | --- | --- |
| Shropshire | -2,423 | -2,755 | -1,129 |
| Telford | -1,237 | -1,776 | 0 |
| **Total** | **-3,660** | **-4,531** | **-1,129** |

Resources will be allocated based on new models of care and through contract redesign in order to follow the patient. All investments will be subject to system governance and NHSEI approval.

National investment is also being used to invest in the primary care network infrastructure as primary care networks will be key in delivery of the transformational changes being implemented.

**Link to Health and Wellbeing Board Priorities**

| Telford and Wrekin Health and Wellbeing board priorities | Workstreams |
|---|---|
| Encourage healthier lifestyles | Acute: Maternity, MSK transformation, Cancer<br>Prevention: Alcohol management, weight management<br>Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways |
| Improve mental health and wellbeing | Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways<br>Prevention: Alcohol management |
| Strengthen communities and community based support | Acute: Cancer redesign<br>Prevention: TW Integrated place, Shropshire CCTH, primary care resilience<br>Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways |

| Shropshire Health and Wellbeing board priorities | Workstreams |
|---|---|
| Prevention: Health promotion and resilience | Acute: MSK redesign, outpatients redesign, cancer redesign<br>Prevention: Alcohol management, weight management, TW Integrated place, Shropshire CCTH, primary care resilience<br>Mental Health: All age mental health, parity of esteem, redesign of rehabilitation pathways |
| Sustainability: Promoting independence at home | Acute: MSK redesign, outpatients redesign, cancer redesign<br>Prevention: TW Integrated place, Shropshire CCTH, primary care resilience |
| Sustainability: Promoting easy access to joined up care | Acute: MSK redesign, outpatients redesign, cancer redesign<br>Prevention: TW Integrated place, Shropshire CCTH, primary care resilience<br>Mental health: All age mental health, parity of esteem, redesign of rehabilitation pathways |

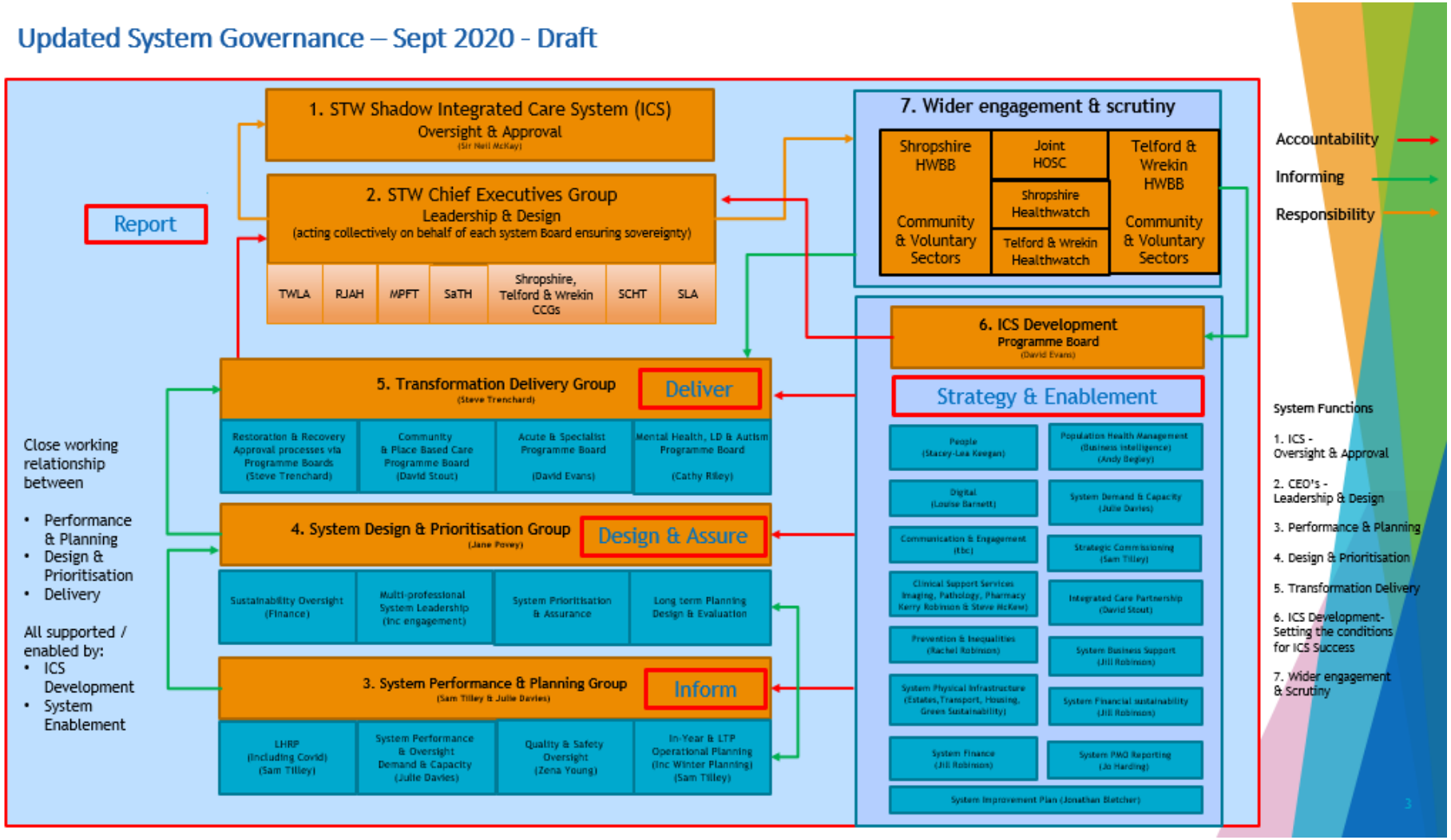
- As the System evolves, its structure has been redefined to take into account:
  - The ongoing shift towards strategic commissioning and ICP working,
  - Covid-19 restore and recover work,
  - Development, management and delivery of transformation programmes,
  - Development and delivery of system long term plan priorities,
  - Winter planning, performance and business as usual,
  - Planned service development projects
  - System Improvement plans
  - Alignment of system finance plan and workforce strategy
  - Surge Planning
  - The requirement to move towards greater financial sustainability

- The commissioning intentions and planned work have been consolidated and apportioned to the STP Programme Boards:
  - Acute & Specialist Care
  - Community & Place Based Care
  - Mental Health, Autism and Learning Disabilities

- The current governance structure and whole system delivery approach is set out below

**Governance for interim period**

The Local system Governance arrangements are evolving. Below is the most current iteration to put forward for approval

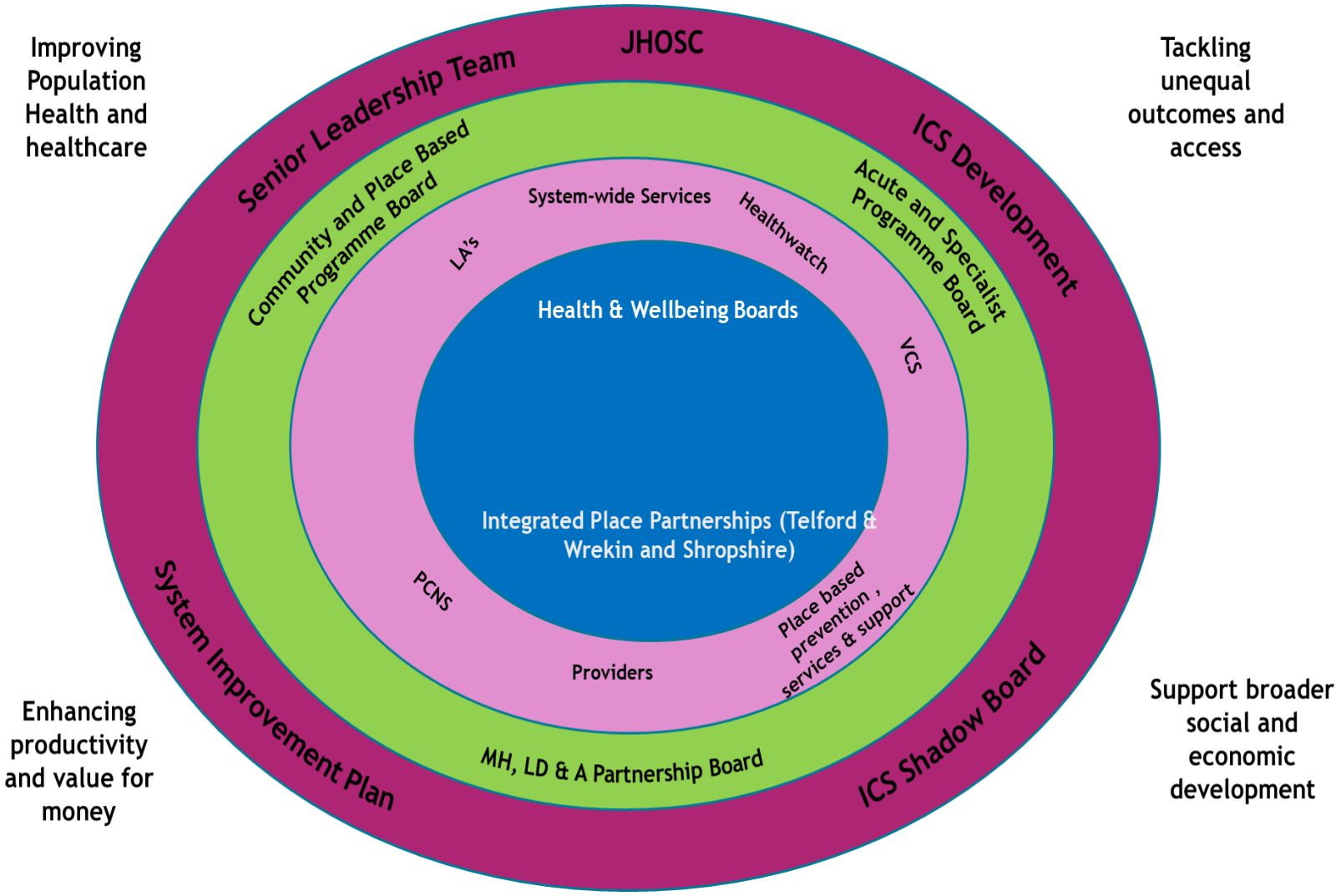


**Partnership Working**

The CCG will continue to work in conjunction with a wide range of partners to ensure we effectively meet our statutory obligations.

| Primary Care Networks | Local Authorities | Integrated Care Providers | Commissioning Support Unit | Regional Partners | Other partners |
|---|---|---|---|---|---|
| •7 PCNs across footprint<br>•Focus on Place at heart of approach<br>•Building blocks of new care models<br>•Key partner in transformation<br>•Part of Integrated Care System<br>•Driving redesign of services in neighbourhoods | •Proactive and valued partners<br>•Heavily engaged in designing and delivering approaches to Population Health Management, Place and Locality MDT working<br>•CCG committed to ensuring capacity and structure to deliver integrated health and social care<br>•Review BCF to clarify how to maximise use of shared resources to better meet the needs of the population<br>•Health and well being boards to take on increase responsibility for place based working | •Alliances of providers working together to deliver care (Health, social care, independent and third sector)<br>•All Primary Care Networks will be integral to the ICP | •Review all support services to develop proposals on “do”, “buy” or “share” functions.<br>•Move to more operational and transactional tasks being completed outside of the CCG | •Services outside STP boundaries work with other ICSs and NHS England to ensure effective pathways and services<br>•Working with commissioners within Wales to manage cross border flows and cross charging mechanisms<br>•Work with partners for integrated commissioning frameworks for regional and specialised commissioning.<br>•Work with clinical networks<br>•Work with the cancer alliance<br>•Work with regional specialist working groups | •Work with community and voluntary sector to build on current arrangements and utilise expertise and capacity<br>•Work with care homes to build on current arrangements and utilise expertise and capacity<br>•Work with Healthwatches to ensure we continue to effectively engage with patients and the public |

**Whole system approach:**

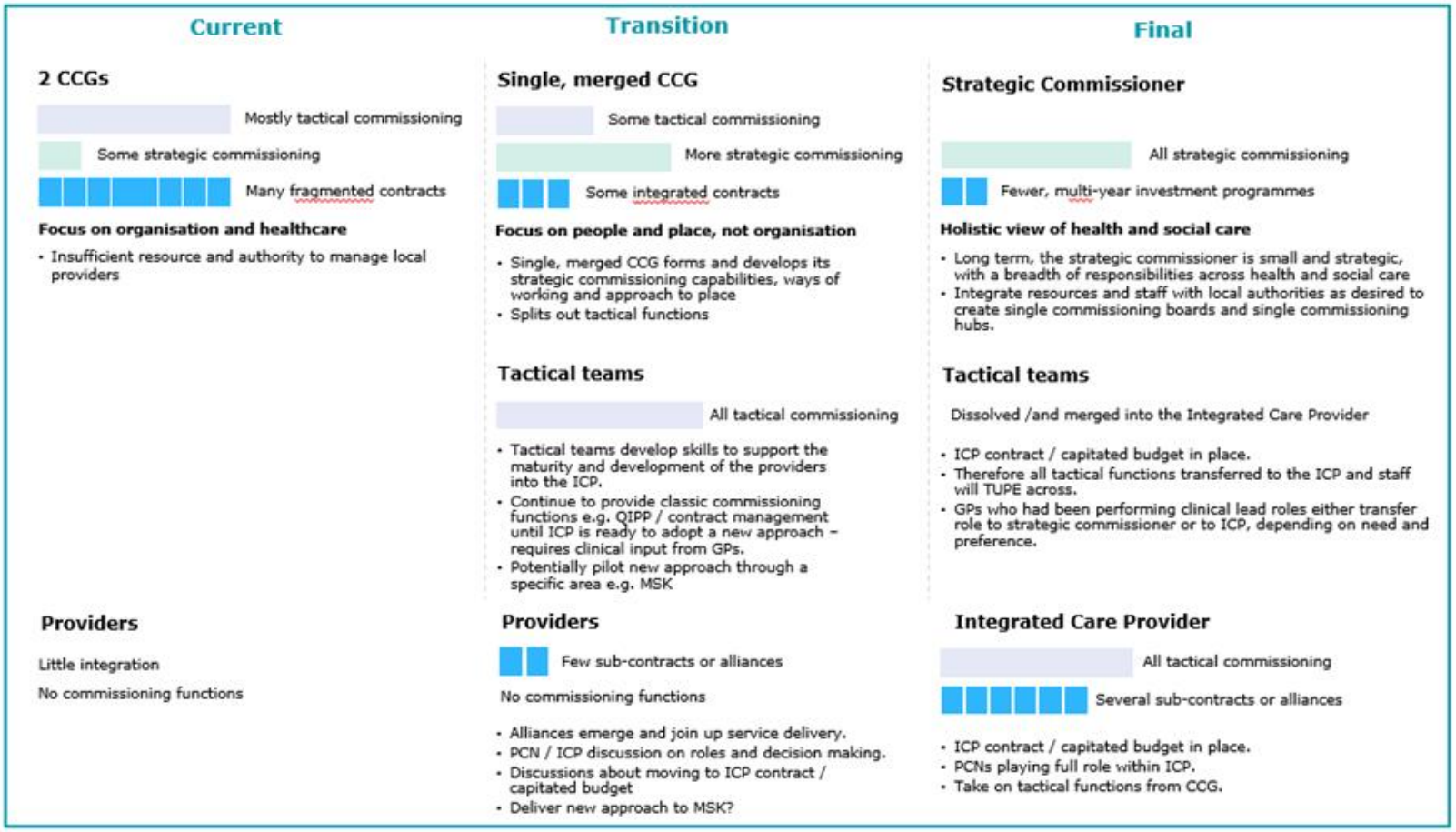



**Key:** JHOSC =Joint Health Overview and Scrutiny Committee; ICS=Integrated Care System; VCS =Voluntary and Community Sector; PCN=Primary Care Networks; LA=Local Authority

**Becoming a strategic commissioner**

We recognise that we are on a journey to becoming a strategic commissioner and we have a clear vision for how the new organisation will evolve over time. The NHS Long Term Plan indicates that there should be a single CCG for each ICS, unless there is clear rationale for departing from this model. There is a clear agreement to establish a single CCG to act as a strategic commissioner as part of the wider roadmap towards establishing the ICS across Shropshire, Telford and Wrekin.

The strategic commissioner will assume a leadership role in driving the change required to become an ICS and ensure the maintenance of pace. Below is the current position, the proposed transition including a single merged CCG and the final position of an ICS.



**Organisational Development**

An organisational development strategy and plan has been written as part of the development of a single CCG. Our aim is to take a planned, whole system approach to building a new organisation with the highest levels of effectiveness and efficiency in meeting the health needs of the Shropshire, Telford and Wrekin population.

**Our OD priorities:**


**Who will we focus on:**

**Staff:** The OD plan commits to providing support to staff to go through the design and restructuring process that lies ahead, while developing skills, personal support and environmental factors required for them to do their jobs effectively both now and in the new organisation.

**GP members:** The OD plan will outline how GP members will be involved in the design process of building a new organisation, as well as committing to exploring some key issues that will affect GPs such as the development of ICPs and PCNs.

**Leaders and Governing Body members:** This is a complicated and ambiguous process in some ways and leaders will require support to understand their role, provide support to their staff and GP members, and function as a corporate leadership team throughout the transition process.

**Partner organisations:** The CCGs cannot deliver transformation by themselves. They need to work with their partners across the Integrated Care System to deliver change. The OD plan provides ways for the CCGs to embrace and engage with partners in a collaborative way to support delivery in the future.

The following slide sets out the timetable and key steps in taking this work forwards. More detail can be found within the CCG's OD Strategy document.

## Organisational Development

### Key Milestones

| Area | Action | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | Ma-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Commissioner | Establish shadow Governing Body | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Deliver shared constitution | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Undertake OD sessions | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Create one senior management team | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Develop staffing structure | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Develop OD programme relating to being a single commissioner and team development | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Review CCG business processes | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Set up task and finish groups for population health management, finance, contracting, role of general practice and Quality | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Undertake OD session for CCG and ICP | | | | | | | | | | | | | | | | | | | |
| Strategic Commissioner | Design and launch communications and engagement process with the public | | | | | | | | | | | | | | | | | | | |
| People Development | Develop work programme to support staff | | | | | | | | | | | | | | | | | | | |
| People Development | Hold resillience sessions for staff | | | | | | | | | | | | | | | | | | | |
| People Development | Hold CV and interview skills sessions for staff | | | | | | | | | | | | | | | | | | | |
| People Development | Develop staff survey | | | | | | | | | | | | | | | | | | | |
| People Development | Develop staff engagement group | | | | | | | | | | | | | | | | | | | |
| People Development | Review HR policies | | | | | | | | | | | | | | | | | | | |
| People Development | Develop coaching and mentoring programme | | | | | | | | | | | | | | | | | | | |
| People Development | Develop talent management approach | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Review clinical leadership arrangements | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Develop process for determining mentoring/coahing support required for directors | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Review, update and deliver senior leadership development programme | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Review, update and deliver Governing Body development programme | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Hold facilitated development sessions for Governing Body members, executive team and lay members | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Develop and implement programme of support for managers | | | | | | | | | | | | | | | | | | | |
| Leadership Development | Develop and implement leadership development programme for aspiring managers and leaders | | | | | | | | | | | | | | | | | | | |

**Organisational Development**

Our aim will be to create leaders with the capability and confidence to find solutions to new challenges, and develop our individuals to thrive. The kinds of behaviours that may be required are summarised in the diagram to the right

**System Development: Future Provider Configuration**

Development of the future provider landscape is still under development across the system. The aim is to have Integrated Care Provider arrangements across the system to drive integration and co-ordinated delivery of care for our population. The priority for the ICP will be improving long term health and care outcomes for the population.

The advancements in our system working brought about by the development of a system wide response and associated structure to address the Covid-19 pandemic has provided the opportunity to move more rapidly forwards with the reconfiguration of our system into and ICS and IPC arrangement. However, there continues to be some key elements of work to complete over the next 6 months to finalise these arrangements as set out below. The new collaborative structures we have established will better enable us to do this.

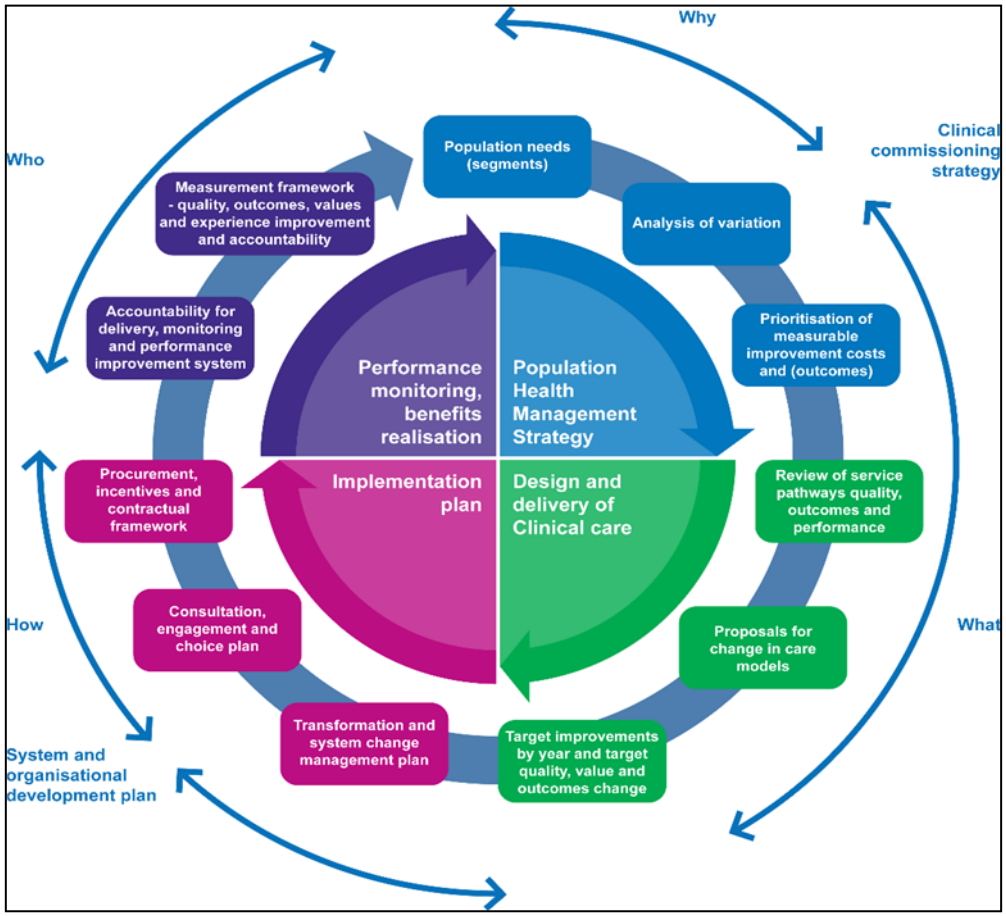
Plans for development:

- Agree which providers are part of the ICP
- Agree lead provider of ICP
- Develop service delivery model for the ICP
- Develop financial arrangements for the ICP
- Develop contractual arrangements for the ICP
- Develop outcomes framework for the ICP
- Develop implementation plan for ICP “go live”
- Implement plan

The recent NHS England/ Improvement publication of ‘Integrating Care – Next Steps for Integrated Care Systems’ builds on the route map set out in the Long Term Plan and details how constituent organisations will accelerate collaborative ways or working. Whilst the document and its contents are still consultative it sets out some principle considerations and will further assist in accelerating STW system discussions and plans in moving towards a fully functioning ICS, building further on the progress and approach set out in the documents

## Strategic Commissioning Cycle

Commissioning has traditionally been delivered through detailed contract specification, negotiation and monitoring utilising tendering processes. National payment regimes have not always supported cost reduction or innovation. Strategic commissioning moves towards focussing on outcomes, collaboration, differing financial and contractual models that incentivise providers to deliver benefits for the whole system. The traditional commissioning cycle will be adapted to support our new strategic position.




As a strategic commissioner we will focus on:

- Strategy and planning for the system linking finance, governance and accountability
- Establishing an outcomes framework and monitoring impact against this
- Identifying opportunities for improvements in outcomes, quality and value
- Evolving the focus on prevention and addressing health inequalities utilising Population Health Management methodology
- Utilisation of robust system wide Business Intelligence to drive the agenda for service improvement and transformation and to support sound decision making
- Setting priorities for the system supported by funding agreements
- Planning and programme management and facilitation across the system
- Supporting and facilitating clinical leadership and engagement
- Development of appropriate accountability system that accommodate whole system and place based commissioning and delivery

The new CCG will adopt a number of specific principles, set within the context of the wider system principles set out earlier in this document, to support its approach to commissioning:

- A locality based approach, focused around PCN geographies and local authority boundaries, working at system level where scale matters
- A lean management structure focused in delivery of a key set of priorities.
- Data and intelligence led, value based approaches to commissioning.
- Prevention first, sustainability over the long term.
- Co-designed and delivered across the system (recognising the locality based approach) with genuine patient and citizen involvement throughout the commissioning process
- System thinking to commissioning to produce improvement with a targeted Transformation Programme focusing on the issues that matter most.
- A genuine partnership approach - building bridges not protecting our borders. Organisational boundaries will be more permeable with people at the centre of our approach.

We will be working with these principles as we continue work on the design of the new organisation. We will continue to work closely with our membership, our staff, local authority, PCN and others to finalise our operating model and design our organisational structure.

Shropshire, Telford and Wrekin has a diverse population with areas of deprivation across the whole of the county and therefore differing needs. The new organisation will commission services sensitively to meet these needs, with a strategic focus on reducing health inequalities. The new organisation will have to be flexible and innovative to do this successfully. It will work with its partners and local people to commission services in different ways and at different levels, wherever it makes most sense to do so to ensure that we most effectively meet the needs of our citizens.

This flexible approach will be necessary to ensure local need is reflected in services, as long as a standard set of outcomes are being achieved across the county. We will work with our partners to develop a robust approach to population health and business intelligence to support more informed and effective priority setting and service design based on a sophisticated understanding of needs across the county.

We will ensure that there is genuine patient and citizen involvement throughout our commission processes to ensure that what we do is genuinely co-produced.

The new organisation will have to collaborate at a local level alongside local authority staff and also with other strategic commissioners across a larger footprint

**Agreed system priorities** will be delivered through System Programme Boards, each led by a CEO SRO
Each Programme Board has agreed priorities, of which the principle priorities are set out here:

- **Community & Place Based Programme Board**
  - Focused on delivery of place based care in Primary and Community Care Settings to support reduced demand on acute

- **Acute & Specialist Programme Board**
  - Focused on reducing out-patient new and follow-up appointments
  - Transformation of areas requiring improvements (Maternity, Cancer)

- **Mental Health, LD& Autism Programme Board**
  - Focused on crisis care (all ages)

**All enabled by**

**System Enablement Programmes**
Focus on Digital, Estates & People

**ICS Development Programmes**
Focus on system capability to strategically design and deliver at scale. Ensuring sound link to financial strategy

SROs have been established for all ICS development work streams and a governance system is in place as set out on slide 24

| ICS Development<br>**Setting the conditions for ICS success** | |
|---|---|
| Population Health Management (Business intelligence) | Andy Begley |
| Demand & Capacity Modelling | Julie Davies |
| Strategic Commissioning | Sam Tilley |
| Integrated Care Partnership | David Stout |
| System Business Support | Jill Robinson |
| System Financial sustainability | Jill Robinson |
| System PMO Reporting | Jo Harding |

Additionally, this approach sits within an philosophy of working towards addressing the system's financial challenges to bring the system back into financial balance

**System Improvement Plan (SIP)**

The SIP provides an opportunity to accelerate many key programmes described in the system LTP and outlines both the immediate priorities and programmes of work for the next 6 months as well as setting out medium and longer term priorities. The SIP will be intrinsic to the systems approach to the commissioning of services over this period, aligned with the system Programme Board Structure and their identified priority areas, as described on the previous slide. The SIP in its entirety is appended to this document.

The SIP specifically sets out a set of zero to six month priorities in relation to Urgent and Emergency Care and Elective Care with longer term priorities building from this. In addition it proposed a number of additional areas of focus for the six to twenty four months period

Outcomes Framework – the SIP articulates the approach to incentivising providers to deliver against 'best practice' services through an outcomes based approach by means of Aligned Incentive Contracts (further details are set out on slide 36). A system of agreed outcome measure, distinct from performance measures, will be supported by a sound evidence base and reflective of the complete cycle of healthcare.

Additional work will be undertaken to develop our outcomes framework further - clustered around the following categories:

**Patient Outcomes** – those relating directly to patients, for example Patient Reported Outcome Measures (PROM) or the experience of the service provided

**Operational Outcomes** – those relating to changes in the way providers of services operate. For example, moving to system and population-based monitoring using health improvement measures, working collaboratively to ensure consistent delivery of service models and measuring their outcomes, measuring movements in capacity and demand across the system.

**Sustainability outcomes** - outcomes that support the sustainability of the system in particularly progressing a sustainable workforce including, delivering better value, sustainable services move to integrated financial approach.

**Cultural Outcomes** – outcomes that will support cultural changes required across the system. For example, increase clinical engagement in innovation and programme design, improved use of information and evidence-based practice (PHM). Progressing a culture of collaboration and service integration between providers to improve quality and safety and collaborative approach and co-design of clinical pathways

# Contracts Incentive Strategy

We have recognised for some time as a system that we need to step away from our transactional relationships and focus instead on collective achievement of patient outcomes and financial balance. As part of this we are working to establish relationships, governance and tools that will enable us to do this.

We have developed our thinking about how we can best use contracts to drive results in the system. A working group has been set up as a sub group of the system DOFs. In this group CCG staff are actively working with key providers to transform current contracting arrangements with a view to implementing our new approach for 1 April 2021:

There is an increasing requirement to contain the cost of the rising demand for healthcare through redesign of services and integration. The CCG is aware that the way that the majority of healthcare is paid for can hinder the transformation needed.

To support system transformation, a new contract and payment approach is being developed which recognises the need for expenditure to be contained within the resources available to the system and focuses on cost avoidance and reduction. Our aim is to create a contract form that minimises contract management bureaucracy and gives a clear framework of expected outcomes alongside associated performance management data.

NHS organisations are working together, in an open and transparent way to deliver improvements to care, population health and use of resources. In recognition of this a contract approach is being developed, taking a collaborative and system-wide approach to agree:

- A system methodology for developing and agreeing the activity and financial baselines, ensuring consistency across contracts;
- A proposition for a type of aligned incentive contract with/without a variable element for some deliverables within the contract. Looking to build on the successes and address any challenges identified from implementation in other NHS systems;
- The principles, terms and condition and governance require to ensure the new contractual form delivers the intended system outcomes;
- A risk-share/incentive mechanism that wraps around different types of activity and also aligns across contracts to drive the behaviours and changes required within the system;
- The use of a risk pool/fund, available for all parties to jointly manage the cost impact of unforeseen challenges/circumstances;

Development and agreement of the aligned incentive type of contract and payment approach requires commissioners and providers to acknowledge that there is a finite sum of money and that decisions on how it should be spent are best taken collectively with risks shared.

One size does not fit all across the healthcare system so it is likely different models will be applied in different situations and consideration is being given to how this would be written into the methodology, mechanisms and incentive models within the aligned incentive approach.

**Quality Approach**

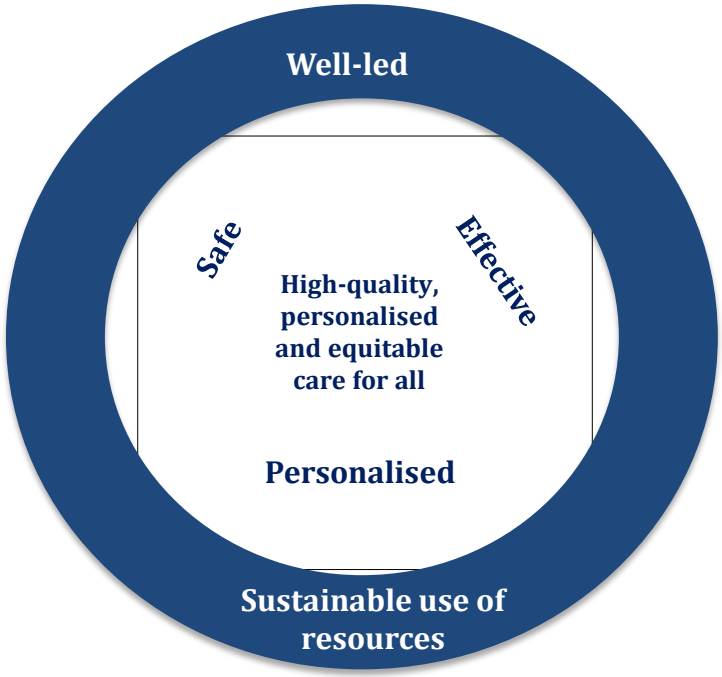
The CCG approach to quality is set out in detail in the Quality Strategy, revised in November 2020 to take account of: feedback from NHSEI Single Strategic Commissioner application panel; issue of phase 3 Covid-19 pandemic response and anticipated revised NQB publication – A Shared Commitment to Quality. The Lead for this Strategy is the Executive Director of Quality. The Quality Strategy is owned and monitored by the CCG's Quality and Performance Committees in Common, chaired by a lay member Non-Executive Director. The Strategy is underpinned by a detailed Operational Delivery Plan and will be delivered in two phases:

- **Phase 1:** 2020/21 will see us setting out the key quality governance framework and developing standard approaches to quality assure the services we commission.

- **Phase 2:** during 2021/2022 we will mature our approach to actively promote and encourage the sharing of best practice and resources across our providers, with the aim of continually raising standards across the system.

A range of associated outcome measures are used to determine quality of services.

We use the Darzi definition and dimensions of quality (patient safety, clinical effectiveness and patient experience) along with organisations ability to effectively lead and manage services in accordance with the CQC Well Led framework and NHSI sustainable Use of Resources assessments.



**Quality of care and outcomes**

We expect our PHM approach to deliver significant improvements in both quality and outcomes. The benefits to patients will be:-

- Greater ownership of their own health, moving away from the paternalistic model to an NHS that empowers and supports people to look after their health
- The focus on commissioning to meet needs will ensure more timely, tailored services
- There is a wealth of evidence that risk stratification and proactive case management approaches prevent deterioration and/or improve co-ordination of care so patients don't experience duplication, fragmentation and inconsistency
- We will identify which clinical interventions need to be performed in a single way to reduce unwanted variation by adopting a single approach across the system; while encouraging local variation when that is the best way of meeting the diverse needs of different populations/geographical areas
- The Quality Strategy describes how, by working as one organisation, we will apply consistent quality standards and expectations across the system and will be in a stronger position to ensure compliance.

The improved patient outcomes will be:-

- Greater engagement from individuals and each community/cohort of patients at all stages of our new clinical pathways
- Improvement in immediate and future health status at both individual and community /cohort levels. This will include, for example, reductions in adverse outcomes for Diabetic patients at an individual ,community and therefore system level.
- As more patients feel confident and empowered to self-care, capacity in primary care will be released to focus on higher risk patients
- Improved mental and physical health as improvements in one will be linked to improvements in the other e.g. links between anxiety/depression and many MSK conditions; and better physical and mental health outcomes for people with SMI
- Fewer hospital admissions
- Reduction in variation of outcomes between affluent and less affluent areas
- Reduced health inequalities with fewer deaths from cancers and CVD in our disadvantaged communities, particularly the urban hot spots.

Ultimately we aim to improve the health and wellbeing of the populations we serve

## ICS Development

Shropshire & Telford & Wrekin STP (STW STP) is currently undergoing NHSEI assurance to achieve designation as an ICS by April 2021

Achievements to date on the path to becoming an ICS:

System Principles agreed:

- **System First** - A recognition that all work programmes cross all system partners
- **Distributed Leadership** is key, SRO roles will be System not Organisational
- All partners will require an **agile approach** to plans as we transition from Restoration to Recovery,
- a philosophy of shared understanding & learning, **effective communication**, transparency of progress and risk will be required.
- The recognition that as a system all programmes of work are **multi-professionally led** through the SDPG
- **Ability to evolve** and make **rapid decisions** as we transition from Restoration to Recovery, we will review Governance arrangements 3 monthly at System CEO Meetings
- All Programmes of work are expected to be **co-produced** with relevant partners, users and stakeholders their implementation plans
- All Programmes are required to **build upon accelerated transformation** as a result of Covid-19 response, particularly digital acceleration **(Digital where possible & appropriate)** and voluntary and community sector partnerships
- Clear SRO responsibilities, with **aligned leadership and programme support**
- All programmes required to work in a system manner with regard **to monitoring & reporting** & will be available to all system partners
- **System Risks will be addressed collectively** through Programmes SRO's in the first instance and escalated to CEO's only if not able to mitigate

## ICS Development

**ICS Operating Standards: Collaborative Leadership Arrangements**

- agreed by all partners – support for joint working and quick, effective decision-making. including;
- a single STP/ICS leader and a non-executive chair,
- clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

**Leadership model established**

Part-time independent non-executive chair in place and a lead interim CEO with dedicated time

CEO Group, which includes all NHS and LA chief executives, overseeing performance of the system and developing the long term plan

Sub-structure in place with CEOs / senior Executive Directors as Senior Responsible Officers for each area (Programme Boards / Enabling Groups)

Substantive ICS Independent Chair in post since Nov 2018

ICS Lead CEO/Programme Director Post in place (interim)

**ICS Shadow Board meeting monthly; ToR established and a workplan has been agreed**

Membership includes voluntary and community representatives

Shadow Board oversees system Finance and Performance

**Integrated Care Partnership defined with 2 "Place" requirements supported by 7 PCNs**

System Operating Model in development to support the system to make decisions and local choices on how we deliver

## ICS Development

**Organisations within the system coming together to serve communities through a Partnership Board,**
underpinned by;

- agreed governance and decision making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on coproduction, engagement and evidence.

**Agreed system Priorities**

- To develop programmes of work that address the financial challenges of the system
- Delivered through System Programme Boards, each led by CEO SRO
- Each Programme Board has agreed priorities, for the purpose of ICS development, core priorities only are
- highlighted here ie – those programmes of work that will have the biggest system impact

**Plans to streamline commissioning through a single ICS/STP approach.**

- Establishing a single CCG and strategic commissioning arrangements

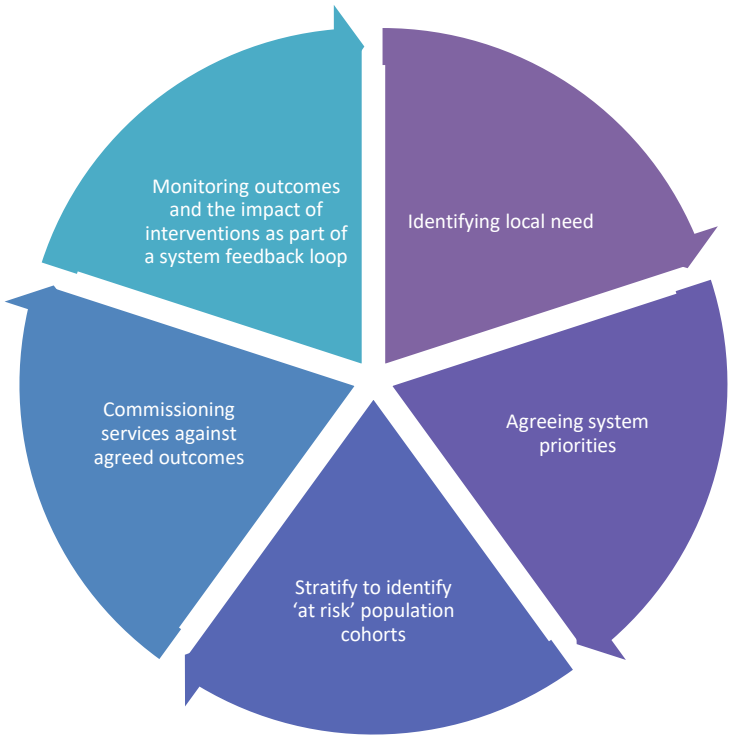
**A plan for developing and implementing a full shared care record**

- allowing the safe flow of patient data between care settings,
- Development of capacity and capability to embed population health

The STW draft Operating model is attached as an appendices to this Commissioning Strategy. However, as the system further enhances its collaborative working and works towards defining the next steps it will take on this journey, it is currently consulting on the final form of the Operating Model

**Population Health Management Approach**

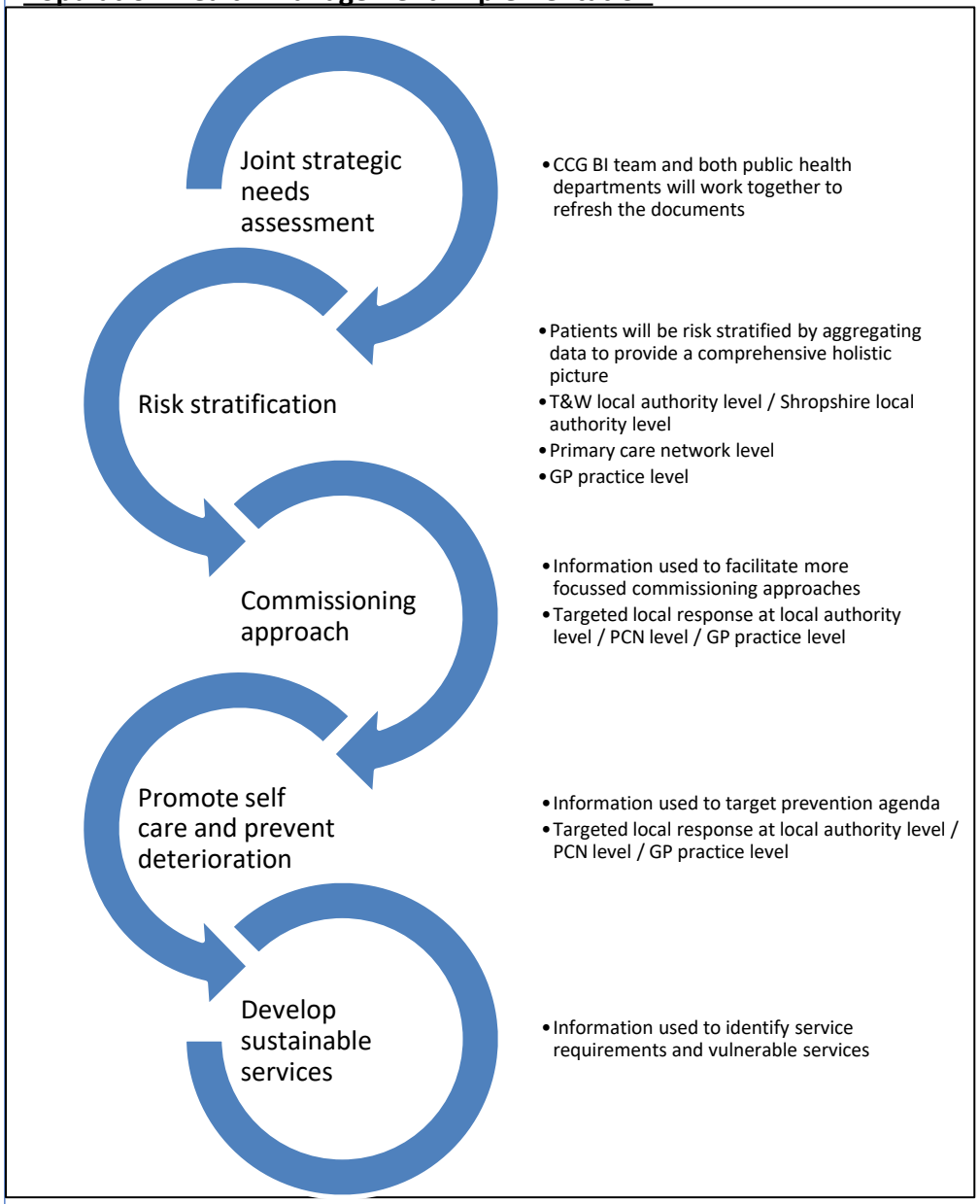
The CCG recognises the importance of Population Health Management (PHM) in delivering effective strategic commissioning including identifying clear priorities, target interventions and monitor the effectiveness of the interventions. PHM is based on a partnership approach across the NHS, local authorities, schools, police, fire service, housing associations, voluntary sector and the public. All have a role to play in addressing the interdependent issues that affect peoples health and well being.




PHM Approach will encompass:

1. Needs assessment to analyse all data to differentiate needs at each level of commissioning (whole system, Local Authority, PCN, practice, specific disease, complex individuals), compare with known prevalence data, gather intelligence about demand and capacity and seek sustainable solutions where gaps are identified
2. Creating a rich picture of the needs of our population and how it is configured across our geography to inform service development, priorities and allocation of resources to affect the biggest improvements and best outcomes
3. Creating the right environment for individuals, families and communities to self care and enable organisations to support self care within both urban and rural systems
4. Work at all commissioning levels to ensure priority is given to both Primary and Secondary prevention. PCNs will be supported to deliver integrated proactive care to prevent medium and high risk patients deteriorating.
5. Place based partners including PCNs will use risk stratification tools to anticipate deteriorating patients to minimise fragmentation and maximise patient experience. Multidisciplinary working will be promoted including outreach from secondary care for physical and mental health
6. Prioritise reaching agreement on lead provider and alliance arrangements
7. Complete demand and capacity planning in collaboration with other commissioners

**Population Health Management Implementation**




The population health management approach will be utilised to develop a rich source of information at system, local authority, PCN and practice level. This information will be utilised to drive plans including commissioning and contracting approaches.

Traditional commissioning based on cost and volume focuses on individual organisations working separately to treat patients. This can lead to a fragmented approach to care deliver with no overall responsibility for patient outcomes. Through the population health management approach our ambition is to agree not only new clinical models of care but also new transactional models. This ambition relies on providers in the ICS engaging in this new model of delivery and the CCG recognises the facilitation role they will need to play to ensure this is successful across the system.

To enable the CCG to effectively implement services where providers are rewarded for working together to deliver the best outcomes for populations an understanding of the current patient population is required. This can be obtained through population profiling and risk stratifying as part of the population health management approach. Equitable outcomes, targets and budgets can then be set using this information.

As the CCG moves towards models of care that incentivise collaboration, while targeting outcomes for health that matter to the local population, we need to ensure mechanisms are in place to allow data sharing across the system to support a successful population management strategy.

To ensure an effective implementation of a population health management approach in the CCG two joint Population Health Lead posts have been developed in conjunction with the Local Authorities. These posts are integral in ensuring Population Health Management is at the centre of all plans.

**Population Health Management Implementation – taking forward our approach**

A system SRO has been appointed and work is ongoing to develop a shared staffing resource to support an effective PHM approach.

To deliver our ambitions, to put in place a whole system population health model, there are a number of key deliverables on this work stream. Currently the Local Authorities provide the Joint Strategic Needs Analysis (JSNA) using teams of analysts, and analysts also exist within the CCGs, the Commissioning Support Unit (CSU) and in many of our provider organisations. We will improve our PHM approach by developing a **Decision Support Unit** that will:

- Bring intelligence and business intelligence (BI) teams together to enhance our ability to provide high quality and timely population health and BI to inform change and impact across our entire system and its two places Shropshire, Telford & Wrekin – **Summer 2021**
- Develop a community of practice. Already, our STP governance has allowed us to bring analysts together from across the system for the first time. Creating an analyst network, for sharing, learning and to test out this new way of working across a system through learning on a priority area – **started as part of the PHM regional programme but has been on pause through Covid – will begin again Spring 2021**
- Workforce development – ensuring that PHM skills are embedded through all organisations and at all appropriate levels from leadership through analyst and BI functions. We will work develop skills working with Local Workforce Action Boards (LWABs) to influence spend on leadership and analyst development. This will also consider career progression pathways as part of team structures There is a need to increase capacity and capability to deliver this population health management approach across the system – **ongoing since 2019**
- Jointly fund and recruit 2 x joint PHM officer posts (1 for each council) – **January 2020**

We have already taken steps as a system to test a PHM approach, identifying diabetes as a prototype for this approach. To date we have used this approach to build a population profile, identify barriers and resolve them and build an infrastructure based on positive partner relationships.

The project aim is to: Improve the health outcomes of people newly diagnosed with type 2 diabetes.' The population subgroup is people across Shropshire, Telford & Wrekin who were diagnosed with diabetes between April 2017 and April 2019.' Increasing knowledge and understanding of type 2 diabetes for both practitioners and the public will improve decision making, self-care, take up of screening and structured education resulting in:

- Structured education - increase access and awareness
- Weight management - increase awareness of weight as a risk factor, and access to support
- Attendance at screening and support programmes - increase awareness and access • Population - general knowledge and understanding

This prototype will be used to develop further programmes of work based on PHM principles and for the CCG will be lead by the Director of Planning

- Prevention, self help and wider community wellbeing

- Case identification of individuals and cohorts amenable to interventions

- Population profiling
- Understanding inequalities and variation
- Cohorts and individuals amenable to interventions
- Application and evaluation of effective interventions

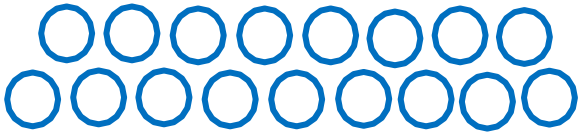
- Whole population profiling and person level analysis for pathway and service planning
- Understanding inequalities and variation
- Cost, activity and outcomes analysis
- Modelling areas of identified need
- Application and evaluation of interventions

- Robust PHM needs assessment to agree system priorities, support resource allocation and set outcomes for contracts and assurance
- Monitoring framework
- Profiling of future population trends
- Population profiling for regional services e.g. specialised services and prevention at scale

**Individuals – community, friends, family & carers**

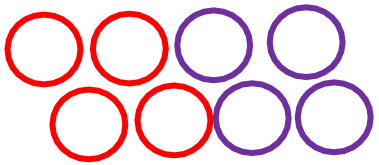
Individuals & community networks

**Individual GP Practices**



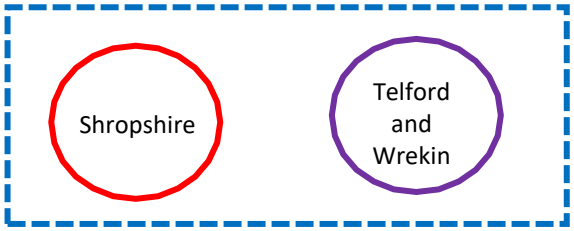
Population c 1,000 – 10,000

**PCNs**



Population c 30,000 – 50,000

**Place Based Alliances**
**Linked to Health and Wellbeing Board**



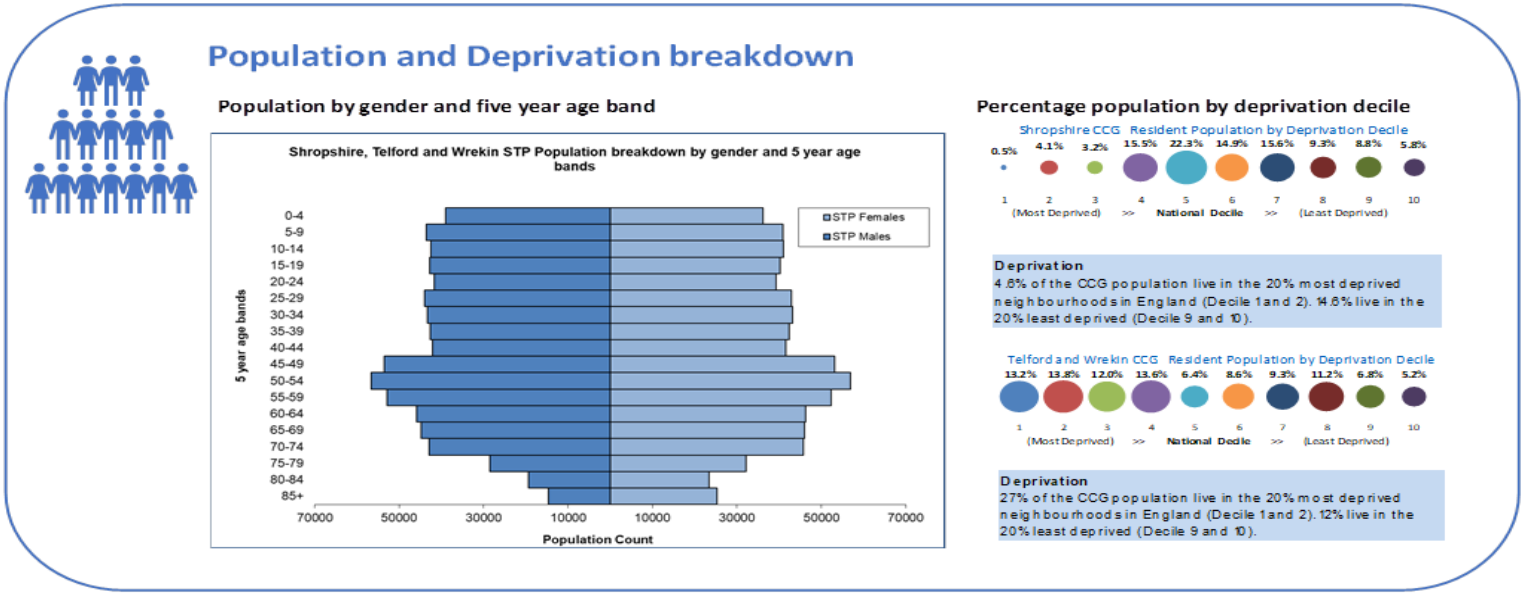

Population c 100,000 – 300,000


Population c 500,000

**Alliances with other ICS's and Regional Commissioners**

## Understanding our population

Population of 481k dispersed over 14th largest geographical area in England and categorised by significant variation in social, health and deprivation profiles. Rural and large urban centres experiencing deprivation and difficulty maintaining sustainable services.




Areas of the county have a large percentage of over 65s and it is expected that 3% will have severe frailty, 12% will have moderate frailty and 35% will have mild frailty. The CCG will need to factor the increase in frail patients into the service models. Key priorities need to be implemented looking at preventing or delaying the onset of frailty and transforming care for this cohort.

| Category | 2016 Total | 2026 Predicted | 2036 Predicted |
|---|---|---|---|
| Severe | 3,088 | 3,803 | 4,789 |
| Moderate | 12,350 | 15,209 | 19,161 |
| Mild | 36,020 | 44,358 | 55,885 |

**Health summary**

## Life expectancy

Life expectancy within Shropshire is higher than the England average while within Telford and Wrekin life expectancy is lower than the England average. Across both areas there is a significant difference between life expectancy in the most deprived areas compared to the least.

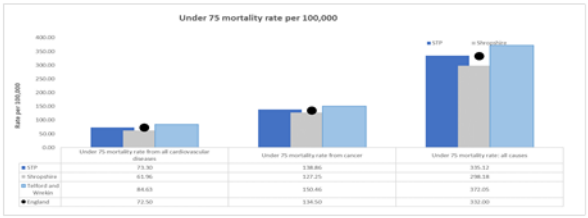
### Life expectancy and mortality

**Mortality Rate**

The rate of mortality for all causes within the STP footprint was **335** per 100,000

With Telford being worse than England at **372** per 100,000

And Shropshire being better than England at **298** per 100,000




**Life Expectancy at Birth**

**79.4** years of age was the life expectancy of Males within the STP, which is in line with the national average age of **79.6**. Telford CCG was lower than the national at **78**, with Shropshire having a male life expectancy of **80** years old

**82.6** years of age was the life expectanct of Females within the STP, which is in less than the national average age of **83.2**. Telford CCG was lower than the national at **81.9**, with Shropshire having a female life expectancy of **83.4** years old

**Infant Mortality**

**4.45** per 1,000 is the infant mortality rate

For Shropshire, Telford and Wrekin STP

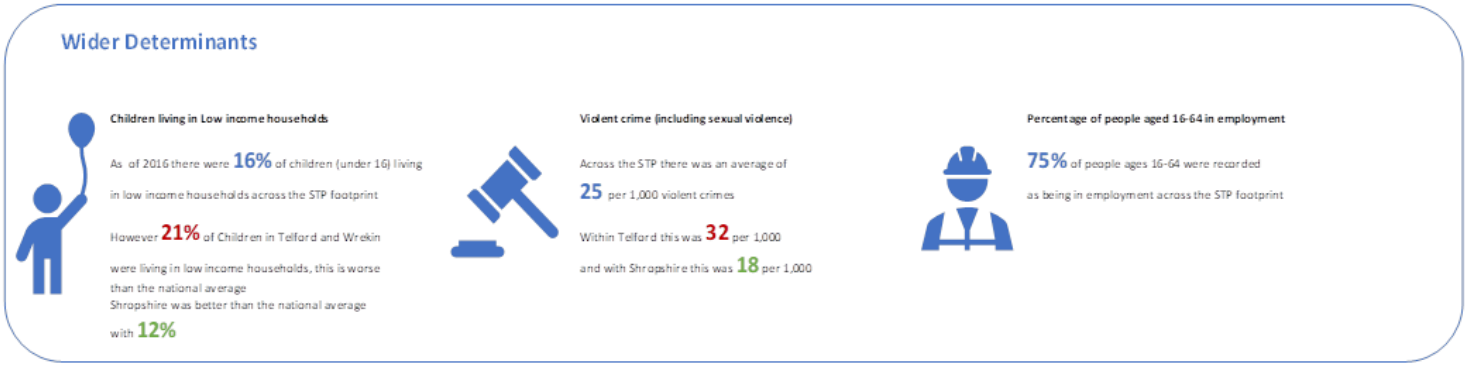
This is simliar to the National rate of **3.90**

**Excess Winter Deaths**

**21%** of deaths as a ratio of excess winter deaths to the average of non- winter deaths

This is the same as the Percentage of excess winter deaths nationally

## Health summary




### Child Health

In year 6 16.9% of children in Shropshire classed as obese whereas in Telford the level is 20.8% of children
Both areas have issues with the rate of alcohol specific hospital stays for those under 18 (27 per 100k in Shropshire and 26 per 100k in Telford)
In both areas smoking at time of delivery is worse than the England average
In Shropshire levels of breastfeeding are better than the England average while in Telford they are worse
Levels of GCSE attainment is worse than the England average in Telford

### Adult Health

Both areas have issues with alcohol related harm hospital stays (656 per 100k in Shropshire and 673 per 100k in Telford)
The rate of self harm hospital stays in Shropshire is better than the England average while Telford is worse
Shropshire are worse than the England average for estimated levels of adult excess weight
Telford are worse than the England average for estimated levels of adult physical activity
In Shropshire the rate of people killed or seriously injured on roads is worse than the England average
Rates of sexually transmitted infections are better than average in both areas
Rates of TB are better than the England average in both areas
The rates of hip fractures are worse than the England average in Telford and Wrekin
Rates of violent crime is better than average in Shropshire and worse than average in Telford
Rates of early deaths from cancer and CVD are both better than average in Shropshire and worse than average in Telford

**Health summary**

## Severe and enduring mental health

Significantly higher rates of women with non-psychotic but severe and complex mental health illness, particularly aged 15 to 24 years
Similar rates for males and females for ongoing psychotic episodes, with highest female rate aged 45 to 64 years and highest male rate aged 15 to 44 years
Higher rate of psychotic crisis in males with similar rates between age bands 0.36% (n=1,409): estimated prevalence of psychotic disorder in people over 16 years in Shropshire
Rate of GP prescriptions for psychoses and related disorders is lower in Shropshire compared to England average between 2014/15 and 2107/18
Across Shropshire and Telford & Wrekin there were 95 suicide deaths between 2014 and 2016 (69 men, 27 women)
The local suicide rate (9.7 per 100,000 in 2013-15) has been statistically similar to the England average rate since 2010/12 and the rate has been reducing in recent years.
Suicidal thoughts are the predominant reason why people in Shropshire are admitted to a Section 136 Suite (police based place of safety) or access the Shropshire Sanctuary and Telford & Wrekin Branches (out of hours care suites set up by CCG and voluntary organisations as an alternative to a Section 136)
A&E attendance for deliberate self-harm is strongly associated with those from most deprived parts of Shropshire

## Summary

It can be seen from the health summary that there are significant differences in performance against the England average for key indicators. Telford and Wrekin appears to perform worse in areas that are linked to low income and deprivation. The CCG will investigate these areas to determine if these are the determining factors or if there are lessons to be learnt from the Shropshire area to improve performance in Telford and Wrekin. Similarly, learning from improvements implemented in Telford and Wrekin will be considered for the Shropshire area.

It is clear that due to fundamental differences in demographics and rurality that one size will not fit all. The CCG is committed to commissioning at place level to mitigate these differences where appropriate.

Areas of work identified linked to health summary; Weight management, alcohol misuse, frailty, mental health services

**Emerging operating model**

The new organisation will not continue to work as the current CCGs do now in having very operational functions and micro-managing our providers. Through the Population Health Management Approach our ambition is to agree not only new clinical models of care but new transactional models. This ambition relies on continuing to evolve our system working arrangements where providers in the ICS engaging in new model of deliver and the CCG playing a key facilitation role in this.

The CCG plans to move away from transactional payments and agree capitated budgets that encourage system working across providers delivering co-ordinated support for the physical, mental and social care needs of the population. Care will be provided in line with agreed quality and outcomes standards that have been developed with patient involvement. Commissioners will agree contract values that will include whole system savings (including QIPP) but also risk and gain share agreements to allow providers to benefit from driving service improvements.

As commissioners we will scrutinise the delivery of contracts and will retain a portion of the budget until the lead provider has evidenced that it has fulfilled its responsibilities (including using performance measures). Given our financial position and the need to rapidly transform care in our key priority areas we aim to establish a lead provider for the following:

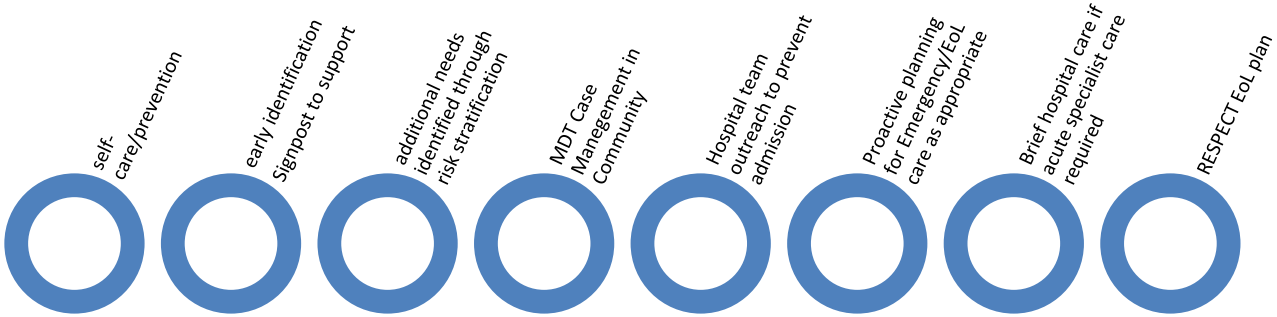
- All patients aged over 65
- MSK patients
- Planned care patients

Other areas will be identified as the operating model develops across the system. Each lead provider will be incentivised to develop clinical networks/sub-contracts with partners to agree integrated arrangements and to manage demand and deliver care in the most effective and efficient way which will in turn deliver efficiency savings for the system.

This move will be as part of a stepped process. Commissioning intentions for 2020/21 have stated that we will be increasing the use of block contract arrangements that include outcomes and intend to further develop a phased approach toward capitated budgets for key priority areas for 2021/22.

**Model of service review**

The CCG will facilitate the review of existing care pathways and services involving clinicians from all relevant providers to map what is provided at each level. The population health management and other needs analysis will be used to identify gaps in provision, duplication, areas for improvement and good practice. The aim is to implement more effective system working and improve system ownership. A high level example can be seen below:




The new Commissioner will facilitate the development of ***Implementation Plans*** which will have clear ***Transformation and System Change Management Plans*** elements, each with:-

- A clearly defined Service Model
- A clearly defined procurement proposal or Alliance proposal for the ICP
- Financial evaluation of investment/savings
- Proposal for optimal transaction/contractual arrangements
- Actions required for implementation
- Timescales/milestones for key deliverables
- Framework for quality, outcomes and performance monitoring with effective measures/metrics
- Quality and Equality Impact Assessments
- Investment/Savings required
- Communication plans (including engagement/consultation as required)

**The CCG, working with system partners has identified a number of priority areas of work. These are set out as follows:**

| Acute & Specialist Care |
|---|
| Breast Cancer (Cancer transformation) |
| Outpatients ( Elective Care Transformation) |
| MSK Alliance |
| Saving Babies Lives Initiative |
| NHS 111 First |
| Urgent Care Improvement Plan (SaTH UEC Improvement plan, Discharge and winter) |
| HTP |
| Respiratory Pathways - Post Covid |

| Community & Place Based Care |
|---|
| System Phlebotomy Service |
| Review of Adult Community Services |
| Frailty Front Door/ Model |
| Children's SALT and SEND |
| CYP Physical Health Pathways |
| Case Management |
| Rapid Response |
| Review of EOL services |
| Respiratory Pathways Redesign |
| Primary Care Digital First |

| Mental Health, Learning Disabilities & Autism |
|---|
| Community Mental Health Transformation |
| Crisis 24/7 including CYP crisis expansion * |
| ASD pathways |
| CYP place of Safety |
| Perinatal Mental Health (includes Ockenden) |
| Children & Young People Long Term Plan |
| Rehabilitation pathway |
| LD Strategy and Transformation |
| Autism Strategy and Transformation * |
| Improvement in IAPT |
| Suicide Prevention |
| Trauma Informed Care |

These programmes of work, which are also linked to the System Improvement Plan described on slide 36, will be managed via the system governance structure set out on slide 25. This structure will ensure the appropriate clinical engagement as well as input and oversight from all partner organisations.

The Finance Strategy Section is under development as part of the current system sustainability and recovery planning

## Outcome and Performance Monitoring Framework

The CCG will be utilising a Performance Monitoring Framework as part of its approach to Benefits Realisation
The Performance Monitoring framework sits within the Governance structure set out on slide 26 and slide 64

All performance framework metrics stratified into:-

- Red, performance deteriorating
- Red, performance improving
- Green, performance deteriorating
- Green, performance stable/improving

- Improvement plans required for all Red metrics and for those that are Green but have deteriorating trend for >3months. These plans will have named senior management leads and executive sponsors
- Detailed exception reporting for improvement plans to the groups identified under the programme boards to focus on delivery of continuous improvement and to manage issues/barriers to that improvement. High level summary exception reporting will then be reported to the programme boards with items for escalation.

A summary of all the performance outcome measures are reported monthly to the CCG's Quality & Performance Committee (Q&P).

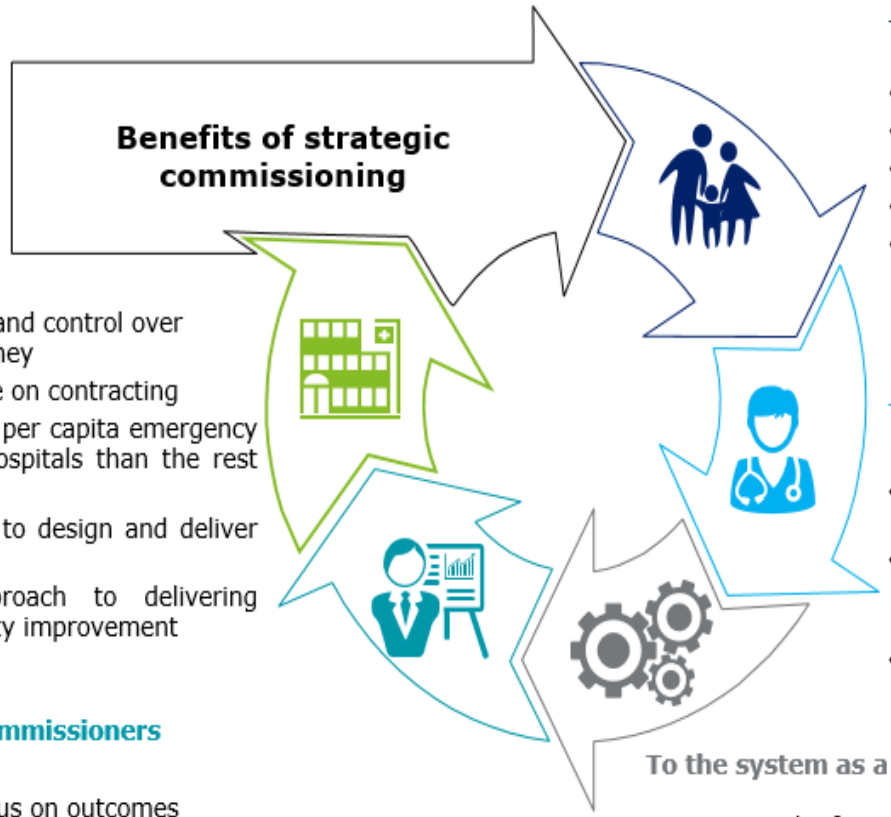
During the next 6 months improvement plans are being refreshed based on the prioritisation outlined above. These plans will be taken through the Q&P committee for sign off in advance of the specific programme boards to maintain the performance oversight function of the new CCG.

New role of performance assurance managers will focus on the delivery of key actions for improvement, help to quantify expected impact of those actions and hold the ring on the individual improvement plans for the CCG and the wider system going forwards. They will provide the updates to the programme boards and narrative for CCG and System performance reporting.

The Q&P committee will also have a performance programme of work for the year that will allow a focus on a particular area e.g. January – Cancer, February – Elective Recovery, March – SEND etc.

This performance monitoring Framework will allow us to monitor the impact of work streams, understand the benefits released as a result and to highlight where changes are still required.

## Benefits Realisation – Strategic Commissioning




### To providers

- More autonomy and control over services and money
- Less wasted time on contracting
- Lower growth in per capita emergency admissions to hospitals than the rest of England
- The opportunity to design and deliver local services
- Joined up approach to delivering continuous quality improvement

### To patients

- Better services and better outcomes
- More joined up services
- More local services
- Improved access to services
- Focus on driving equity to improve services and health for those in the most deprived areas

### To Primary and Secondary Care Clinicians

- A central leadership role in setting the vision and outcomes
- Greater autonomy and determination of how services are shaped for their local populations and how money is spent
- More joined up working across professional groups

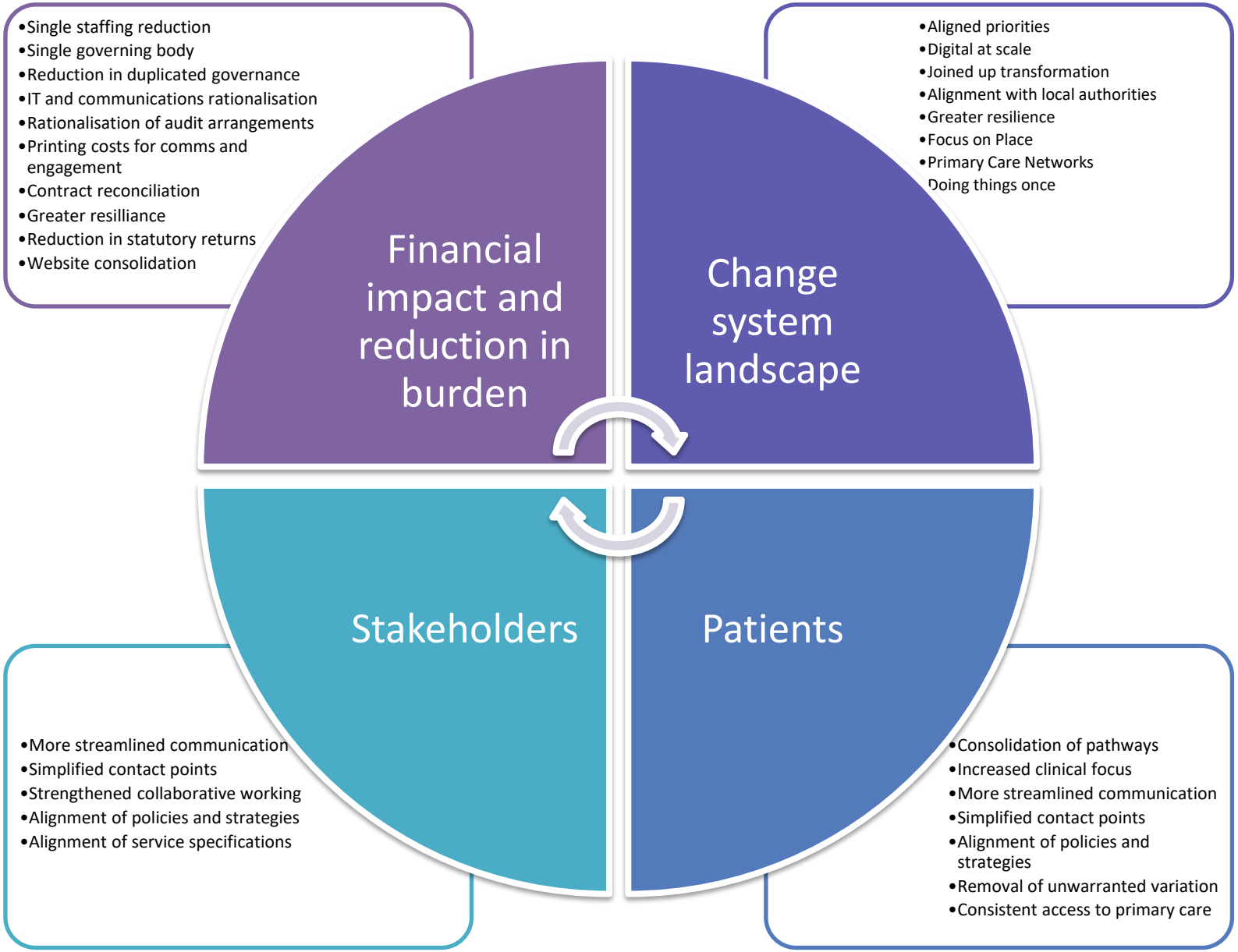
### To commissioners

- Focus on outcomes
- Higher quality strategy based on BI and population health
- Stop wasting time on contracting and QIPP
- More chance of delivery given relationships with providers
- Transfer of financial risk to those who hold the vast majority of budget and spending power

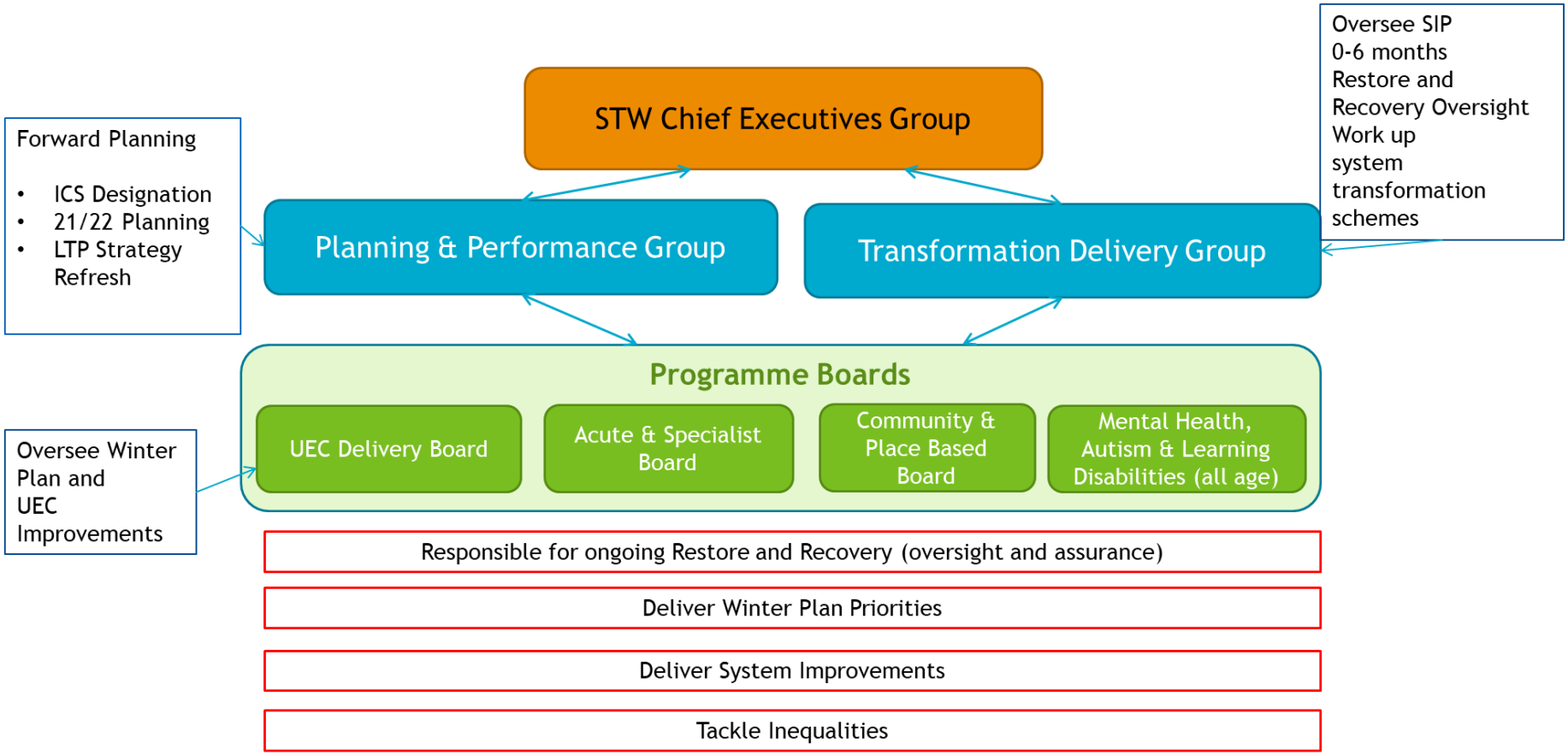
### To the system as a whole

- Focus on the financial performance of the system as a whole rather than deficit in individual areas.
- Greater emphasis on prevention and population health
- Opportunity to re-designate and reconfigure acute services
- Opportunity to shift resources into primary care
- Two Local Authorities now working with a single commissioner and set of priorities.

## Benefits Realisation – Single Commissioner



**Governance for Management of System Priorities and Workstreams**



**Prevention and place based care**

Key changes:

- Joint health and social care rapid response team responding to patients within 2 hours within Telford and Wrekin
- Community based acute and semi-acute responsive services that provide higher level support within Shropshire
- Proactive management of patients at risk of unplanned acute admissions by MDTs across Telford and Shropshire
- Rollout of PCNs to increase primary care resilience and improve access
- Improved alcohol care teams delivering support to patients
- Blue light approach for alcohol targeting high end users
- Improved care pathways for weight management including access to weight management support through social prescribing

Task and finish groups as required

| Improved outcomes | Activity impact | Quality impact |
|---|---|---|
| • Patients responded to within two hours<br>• Default to community first<br>• Improved access to primary care<br>• Improved alcohol support teams to support patients and prevent future attendances/admissions<br>• Blue light approach for alcohol to support high end users<br>• Patients accessing social prescribing for weight management | • Reduction in ambulance conveyances, A&E attendances and hospital admissions for targeted groups<br>• Reduction in number of people falling<br>• Reduction in average LOS for patients 65+<br>• Reduction in childhood obesity<br>• Reduction in adult obesity | • Improved patient experience<br>• People feel supported to manage their own conditions<br>• Increase in ANPs in community<br>• Increase retention and recruitment of GPs |

**Acute and Specialist Care**

Key changes:

- More responsive advice and guidance
- Improved ENT, gynaecology and cardiology pathways
- Increase in digital technology to reduce outpatient activity
- System wider clinical strategy developed to deliver Hospital Transformation Programme
- UTC in place on both hospital sites
- SDEC in place 12 hours per day 7 days per week
- Acute frailty in place for 70 hours per week
- Improved flow within wards
- Fully compliant with Saving Babies Lives Care bundle
- County wide smoking cessation service and weight management service for pregnant women
- Maternity hubs model
- Best practice pathways in place for Lung, Prostate, Upper GI and Colorectal
- Rapid Diagnosis Centres established for cancer pathways

Task and finish groups as required

| Improved outcomes | Activity impact | Quality impact |
|---|---|---|
| • Clinical strategy in place<br>• Reduction in admission conversion rates for over 75s<br>• Increased access to acute frailty support<br>• Reduction in still birth rates<br>• Increase in early diagnosis for cancer<br>• Increase in survival rate of cancer<br>• New MSK model in place<br>• Improved access to alternatives to face to face appointments | • Increase in UTC activity by source<br>• Reduction in 12 hour waits<br>• Increase in 4 hour target<br>• Increase in SDEC activity<br>• Reduction in smoking at time of delivery<br>• Reduction in GP appointments (cancer)<br>• Reduction in MSK surgery / increase in conservative management<br>• Increase in A&G<br>• Reduction in OPA / Increase in non face to face OPA | • Increase in emergency and urgent care workforce<br>• Improved continuity of carer for women during pregnancy<br>• Cancer waiting times targets met<br>• Patient experience improved<br>• Consistency across pathways improved<br>• Increased access to specialist advice for GPs<br>• Reduction in unnecessary appointments for patients |

**Mental Health, Learning Disabilities and Autism**

Key changes:

- Calm cafes in place
- Improved children and young people crisis offer
- Support for people with emotional distress aligned to PCNs
- SIM model in place
- New clinical model for rehab beds in place
- Out of area patients repatriated
- Strategy developed for learning disability
- Strategy developed for autism
- Post diagnostic ASD support in place
- Trauma informed working embedded across the system
- Digital solution in place to ensure professionals can communicate effectively

Task and finish groups as required

| Improved outcomes | Activity impact | Quality impact |
|---|---|---|
| • Improved self management<br>• People seen earlier<br>• Improved access for people with LD or autism<br>• Reduction in CYP on SEN/EHC plans excluded<br>• Patients to do not to repeat their stories<br>• Reduced duplication<br>• Improved recovery outcomes | • Reduction in A&E attendances<br>• Reduction in s136<br>• Reduction in demand for GP attendances<br>• Reduction in referrals to BeeU<br>• Reduced LOS in rehab<br>• Increased number of people with LD or autism accessing services<br>• Reduced spend on care packages for complex/challenging behaviours | • Improvement in satisfaction rates<br>• Reduced relapse rate<br>• Reduction in suicide rates<br>• Increases in numbers of people receiving health checks<br>• Reduction in inappropriate prescribing |

# Section 11: System Big Ticket items



Since the last version of the CCG Commissioning Strategy was developed work has continued to refine the system wide priorities. The Shropshire, Telford and Wrekin system is required to establish robust and credible delivery plans for restoring sustainability across the system over the medium term. The system has agreed that the formulation of these plans needs to be on a finite number of clearly prioritised 'Big Ticket items'.

The six identified Big Ticket items are outlined below:

- MSK Transformation
- Outpatient Transformation
- Alternatives to hospital admission
- Commissioning and procurement
- Workforce
- Hospital Transformation Programme

It can clearly be seen that these Big Ticket items overlap with the priorities identified across the Commissioning Strategy and these will be combined into single workstreams to ensure there is no duplication of effort and maximum impact is achieved.

There are three main components to how the Big-Ticket items contribute towards financial sustainability:

- Removing unsustainable levels of excess cost from expenditure across all system partners
- Preventing further reactive expenditure growth to ensure a portion of the systems growth allocation each year can be set aside to support continuing existing costs which have been incurred in excess of the systems population funding share.
- Leveraging productivity improvements which enable recovery of services (most likely in planned care pathways) with only incremental draw on any new inflows of external funding for recovery.

The initial draft roadmap for the Big Ticket items is shown on the following two slides.

## Draft Roadmap (page one of two)

| Programme | Action | 2020/21 | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| MSK Transformation | Implementation and consolidation of community MSK provision | | | | | | | | | |
| | Implementation and strenthening of rheumatology | | | | | | | | | |
| | Design and agree implementation of Midlands Elective Programme | | | | | | | | | |
| | Implementation of Midlands Elective Programme | | | | | | | | | |
| | Orthopaedics optimisation clinical case and feasibility study | | | | | | | | | |
| | Benefits realisation | | | | | | | | | |
| Outpatients Transformation | Validate long term plan assumptions | | | | | | | | | |
| | Identify priority specialties | | | | | | | | | |
| | Develop plan for demand management | | | | | | | | | |
| | Develop plan for alternatives to face to face appointments | | | | | | | | | |
| Alternatives to hospital admissions | Design Home First (Rapid response / single access point / case management) | | | | | | | | | |
| | Implementation of home first | | | | | | | | | |

## Draft Roadmap (page two of two)

| Programme | Action | 2020/21 | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Commissioning and procurement | Recruit to invest to save joint posts with the local authority | | | | | | | | | |
| | Develop plans for place based commissioning | | | | | | | | | |
| Workforce | Develop system level plan to grow our substantive workforce | | | | | | | | | |
| | Develop system level plan to manage temporary staff (including one bank) | | | | | | | | | |
| Hospital Transformation Programme | Complete clinical review of opportunities to identify early adoption schemes | | | | | | | | | |
| | Develop potential design solutions to reflect a continuum of opportunities | | | | | | | | | |
| | Develop outline business case (including revenue and capital costs impact of options) | | | | | | | | | |
| | Complete system wider benefits assessment of options | | | | | | | | | |
| | Preferred option identified | | | | | | | | | |
| | Detailed business case developed for implementation | | | | | | | | | |

**Next steps:**

- Review all plans and deadlines to understand the impact of Covid-19
- Continue to drive forwards the collaborative system approach that has been consolidated during the Covid-19 response phase
- Develop full implementation plan for Population Health Management approach, building on the commitment to develop a shared system resource
- Work with system to develop future provider collaborative model
- Continue to support ICS development programme
- Implement Financial model
- Implement Contractual Incentives Scheme
- Implement and Monitor the System Improvement Plan
- Develop full delivery plan for Big Ticket items by end of March outlining the requirements for delivering the programme including:
    - Programme support
    - Capacity support to SROs
    - Modelling for activity, finance and workforce
    - Next steps including timeline
- Finalise roadmap
- Develop a modelled financial strategy for the Big Ticket items

Commissioning and implementing the key commissioning priorities/ changes will come through :

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

Additionally we will facilitate the development of Implementation Plans with clear Transformation and System Change Management Plans elements to include:

- A clearly defined Service Model
- A clearly defined procurement proposal or Alliance proposal for the ICP
- Financial evaluation of investment/savings
- Proposal for optimal transaction/contractual arrangements
- Actions required for implementation
- Timescales/milestones for key deliverables
- Framework for quality, outcomes and performance monitoring with effective measures/metrics
- Quality and Equality Impact Assessments
- Investment/Savings required
- Communication plans (including engagement/consultation as required)