Herefordshire and Worcestershire
Draft proposals for discussion

GP Practices	92
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Well Being Boards	2

Population	780,000
Area	1,500sq miles

October 2016

Redditch and Bromsgrove CCG
South Worcestershire CCG
Wyre Forest CCG
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council

Herefordshire Council
Herefordshire CCG
Wye Valley NHS Trust
2gether NHS Foundation Trust
Taurus GP Federation (representing 26 practices)
Herefordshire Council

Our biggest challenges – care and quality & health and well being

Our starting point – our greatest risks and challenges

Health and Well Being	Care and Quality
• Children's health and well being outcomes, • Mental health outcomes and links to reduced life expectancy • Mental well being • Gap between life expectancy and healthy life expectancy) • Premature mortality rates • Health outcomes for specific conditions (Colorectal, lung and breast cancer, stroke, heart disease) • Health inequalities across specific groups (including rural and isolation issues) • The big four – diet, exercise, smoking, alcohol	• Capacity and resilience in primary care and general practice. • Two Trusts in special measures • Urgent Care performance, including stroke and responding to ECIP • Cancer waiting times – below national average • Social care provider capacity & quality (domiciliary and residential care are stretched) • Frailty and dementia • Workforce – retention, recruitment and capacity • End of life care • Unwarranted variation • Overarching messages around CQC inspections

Common themes running across both areas:

- Cancer, stroke, mental health and well-being, end of life, isolation/rurality.
- Clear focus on the importance of prevention.

Sept 2016 Highest risk areas for key NHS Constitutional standards

Urgent Care	Planned Care	Mental Health
• 4 hour A&E standards across all sites • Poor patient flow resulting in 12 Hour Trolley breaches (WAHT) • Stroke TIA (WVT) • Ambulance Handovers	• Referral to treatment 18 week (WVT & WAHT) • Cancer 62 day wait • Cancer all 2 week wait referrals • Cancer 2 week wait – Breast Symptomatic • Cancelled operations (WAHT)	• Dementia Diagnosis • IAPT Access • IAPT Recovery

**Across all sites unless stated*

What we need to change between now and 2020/21

- Emphasise the central role of individuals, families and communities in taking **responsibility for their own health and wellbeing**.
- At scale delivery of evidence based prevention across health and social care - **making prevention everybody's business**
- Deliver the **Five Year Forward View,** providing the resources and infrastructure for **primary care and community services** to provide more care at home and in the community reducing the need for admission to hospital. This will including redesigning our workforce to provide the skills and capacity, and specialist input where required.
- Ensure care is delivered of a standard and quality which is needed for our population and is on a trajectory to GOOD and aspires to be OUTSTANDING in terms of CQC ratings.
- **Improve clinical sustainability** through reducing unwarranted variation, ensuring our workforce culture & leadership, capacity and capability enable us to improve access and outcomes for communities. This will include new roles ad changing the way in which existing staff work across teams/disciplines and with patients in order to support self management by patients and their carers.

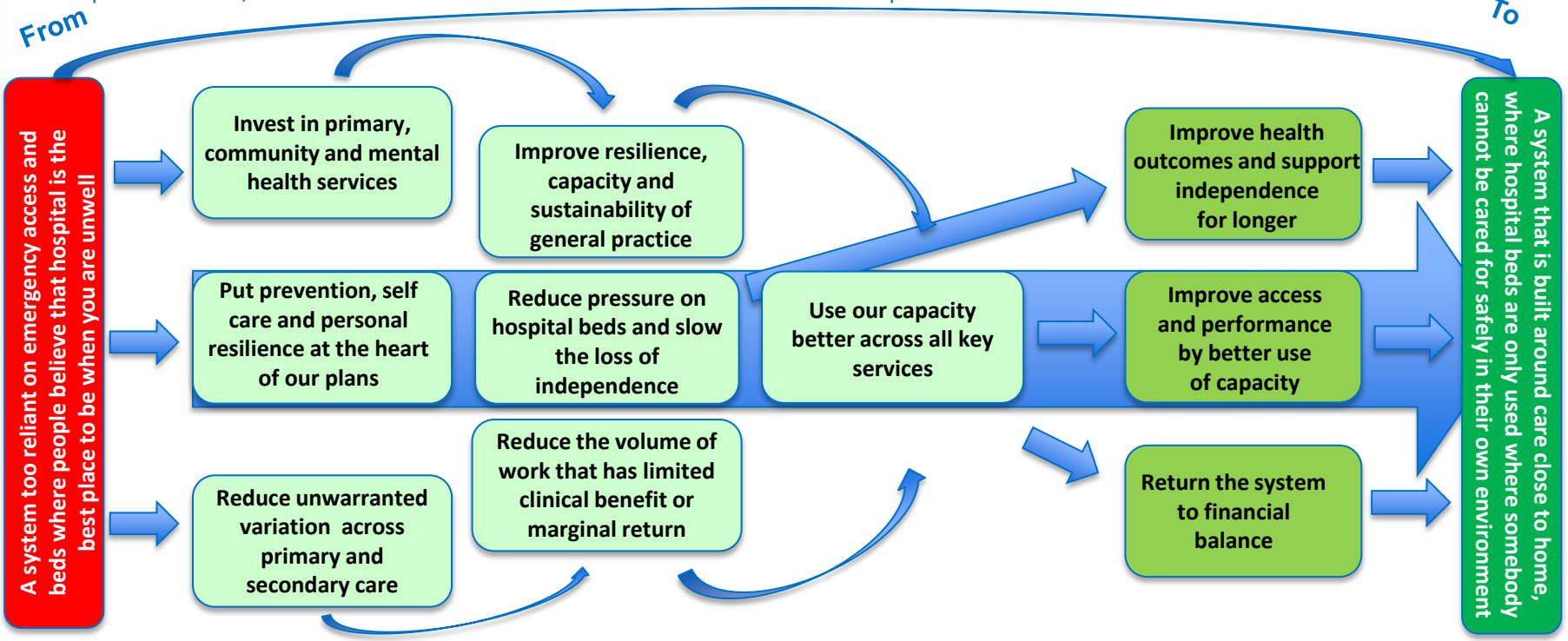
Our vision for 2020/21

"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people".

What we mean	
Live well in a supportive community…	There is collective agreement across the wider public and voluntary/community sector that one of the most effective ways to improve health is for people to live well within supportive resilient communities taking ownership of their own health and well-being. We will be better at helping residents to draw on the support available from their local communities and voluntary groups, and we will help those communities and groups develop the capacity to meet these needs.. We will use social impact bonds and social prescribing to support this. This will apply across all age groups.
…with joined up care…	Where individuals have a health or care need this will be delivered in an integrated way, with a single plan developed with and owned by the individual in true partnership and available wherever people access the system. Local integrated delivery teams will be in place which recognise the central role of the GP and reflect a broad range of skills and expertise from across the organisations. We will make care boundaries invisible to people using our services by removing operational boundaries between organisations and we will ensure that co-production is embedded in everything we do.
…underpinned by specialists…	Specialist care will always be needed, but there are times when care could be safely provided under the remote supervision of a specialist across a digital solution. For example, by developing better digital links between practices and hospitals we believe that more care can be provided locally by GPs and other health or social care staff based in the community. This is particularly important given our rurality challenge. Our workforce, organisational development and recruitment plans will focus on making sure that we make Herefordshire and Worcestershire an attractive place to work so we have a stable and committed workforce, with much less reliance on agency employment.

What we mean	
…delivered in the best place…	We will have completely adopted and embraced the principle of "home first" and will deliver as many services as possible close to home. We will carefully balance the need and benefit of local access against that of service consolidation for quality, safety and cost effectiveness. We will reduce as far as possible the need for people to travel out of their area to access most services. Some services will be brought out into communities and delivered in GP surgeries, community hospitals or other local premises. Equally some services will be consolidated where clinical sustainability or quality of care is significantly improved by doing so. Joined up transport planning will enable us to support people in planning their travel arrangements where this is the case. We will involve the public in any decisions and provide the information needed to understand how and why things need to change.
…by the most appropriate person.	We need to create the capacity and resilience to enable GPs to be clinical navigators and senior clinical decision makers in the out of hospital care setting. This will be with a particular emphasis on people who are frail and those at risk of emergency admission. We will develop extended roles such as physician assistants and advanced practitioners in areas such as physiotherapy, dermatology and pharmacy and review the skill mix to free up the GP time needed to focus on patients with the most complex needs. Equally there are times when the demarcations in roles are too prohibitive and result in the need for additional roles that add more cost than value. This will change with alignment of pathways of care. Over time we have introduced a degree of complexity and cost that is not sustainable. The work we do to implement this plan will mean that people will be seen by the right person in the right place at the right time. This will mean change to the way in which services are delivered.

Our health and care economy has become too dependent on reactive bed based care that results in reduced wellbeing, a poor patient experience and higher cost of services. There remains a public perception that being in hospital is the best place to be when people are unwell. This is despite there being considerable evidence to the contrary, particularly for people who are frail. The essence of our vision is to change this by keeping people well and enabling them to remain in their own homes. We will achieve this by focusing our efforts more on what happens in our communities, not just in hospitals. We will build our system around resilient and properly resourced general practice, that has community services wrapped around them. This will relieve pressure on our hospitals, which will be freed up to focus on efficiently dealing with complex elective and emergency care. Waiting times and outcomes for patients will be better. For the system it will enable us to live within the financial means available by the end of the 5 year period. To achieve this change we will require all partners to commit to this approach and to deliver this through their operational planning and delivery work. It will also require change from the population. We will need local residents and citizens to take more control of their own health and well being, to take more responsibility for supporting others in their communities. Building strong and resilient communities, through wider work around employment, housing and education, will be an essential foundation for this. As a result, people will no longer need the historic range and level of public services, and will be sensible consumers of the services we do need to provide.



Our priorities for transformation

Transformation Priorities	Delivery Programmes	Enablers
1 Maximise **efficiency and effectiveness** across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes.	• Maximising efficiency in Infrastructure and back office services • Transforming diagnostics and clinical support services • Medicines optimisation and eradicating waste	Develop **the right workforce and Organisational Development** within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face. Invest in **digital and new technologies** to support self care and independence and to enable our workforce to provide, and patients to access, care in the most efficient and effective way, delivering the best outcomes. Engage with the **voluntary and community sector** to build vibrant and sustainable partnerships that harness innovation, further strengthen community resilience and place based solutions. Develop a **clear communications and engagement plan** to set out our strong commitment to involving key stakeholders in the shaping of our plan and describe the process and potential timelines associated with this.
2 Reshape our **approach to prevention**, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.	• Embedding prevention in everything we do and investing in 4 key at scale prevention programmes • Supporting resilient communities and promoting self care and patient activation	
3 Develop an improved **out of hospital care** model, by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising "own bed instead".	• Investing in primary care to develop the infrastructure, IG requirements and a new workforce model that has capacity and capability as well as resilience • Redesigning and Investing in community based physical and mental health services to support care closer to home • Redefining the role for community hospitals (a	
4 Establish **sustainable services** through development of the right networks and collaborations across and beyond the STP footprint to improve urgent care, cancer care, elective care, maternity services, specialist mental health and learning disability services.	• Transforming urgent Care Delivering improved maternity care • Investing in mental health and learning disability services • Improving elective care and reducing variation	

A single page summary of the big priorities

Sustainable General Practice

- Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health/mental health services.
- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.
- Share information across practices and other providers to enable seamless care.
- Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.

Primary & Community Services

- Through the One Herefordshire Alliance and the Worcs Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.
- Commission services from between 1 and 4 locality based Multi-Speciality Community Providers or similarly formed new model of care alliances..
- Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness.
- Develop integrated frailty pathways in both counties, focused on real alternatives to hospital admission. For Herefordshire the appropriate frailty pathways will be put in place between home, community hospitals and the County Hospital and the development of two specialist frailty units in Worcestershire for Worcestershire residents.

MH & LD

- Work with NHS specialised services to Increase local child mental health services to reduce demand for complex out of county services and enable repatriation of complex cases back to the local footprint.
- With local authorities, develop joint outcomes and shared care for people with learning disabilities.
- Deliver the requirements of the national taskforce.

Urgent Care

- Review and potentially reduce the number of individual physical access points to urgent care services across the footprint by 2020/21.
- Retain 3 units with an A&E function, but explore reductions to the number of MIUs and the Walk in Centre in Herefordshire and standardised opening hours for MIUs in Worcestershire.
- Shift to home based care – reduce the number of community based beds across the system and shift resources to primary and community services.

Maternity

- Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.
- Develop a jointly commissioned, jointly provided maternity service across the whole footprint.
- Establish a single service with specialist teams working under a common management structure, delivered locally.

Elective Care

- Develop 4 key at scale prevention programmes to reduce demand for surgery and improve the likelihood of positive clinical outcomes following surgery.
- Undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes.
- Develop strategic partnerships with external partners to secure organised access to elective surge capacity in a planned and managed way.
- Expand pan STP working on cancer services and deliver the requirements of the national taskforce.

Infrastructure

- Explore the benefits from integration in pathology, radiology and pharmacy services across the footprint.
- Develop robotic pharmacy functions and maximise the use of technology.
- Develop a single strategy and implementation plan for a joined up place based back office across all local government and NHS partners.
- Develop a place based estates strategy and a place based transport strategy.

Nine Must Dos for 2017-18 and 2018

9 Must Dos	Delivery Programme
1. STP's • Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.	We have a significant challenge in achieving the system and provider control totals for 2017/18 and 2018/19. Through delivering our programmes of work we will; • Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market". • Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions • Reduce variation in prescribing patterns and increase adherence to approved use of medicines, allowing allocation of additional resource available for new and proven treatments to support prevention and demand control • To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.
2. Finance • Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector and CCG Sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.	
3. Primary Care • Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support and the 10 high impact changes. • Ensure local investment meets or exceeds minimum required levels. • Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors, pharmacists working in general practice by 2020,the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.	• Delivery of improved access to routine and urgent primary care appointments across 7 days a week through roll out of Prime Minister's Access Fund initiatives. • Local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with community pharmacy, third sector and public sector services as well as community and mental health services. • We will implement the "10 high impact areas for General Practice" within and across practices. • With increased capacity within primary care we will adopt new ways of working: Moving to a proactive model of care, identifying and case managing through an MDT approach adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access.

Nine Must Dos for 2017-18 and 2018

	9 Must Dos	Delivery Programme
4. Urgent & Emergency Care	• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.	• Improve urgent care pathways to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements • Deliver the four priority standards for seven-day hospital services for all urgent network specialist services • Access will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Implement the crisis concordat action plan
5. RRTT and elective care	Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, Better Births, through local maternity systems.	• More planned care will be available closer to home e.g. outpatients and day case, reducing the need to travel for regular appointments • Citizens will have access to high quality, safe and sustainable, acute, women and neonatal and mental health services, localised where possible and centralised where necessary • Two aspects to improving elective care: 1. Effective commissioning policies and stricter treatment thresholds 2. Efficient organisation of services to meet demand, undertake more routine elective activity on a reduced number of "cold" sites
6. Cancer	• Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report. • Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards. • Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. • Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types. • Ensure all elements of the Recovery Package are commissioned	• The system will achieve consistent access of all cancer treatment standards. • Earlier recognition and faster diagnosis of cancers and other life threatening conditions,. • Faster treatments times and improved survival rates. • Reduced diagnosis through emergency admission or unplanned care provision. • Better patient experience of cancer care received

Nine Must Dos for 2017-18 and 2018

9 Must Dos		Delivery Programme
7. Mental Health	• Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages; Additional psychological therapies, more high quality Children and Young people services, treatment within 2 weeks for first episode of psychosis, increased access to individual placement support, community eating disorder teams and a reduction in suicides. • Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. • Increase baseline spend on mental health to deliver the Mental Health Investment Standard. • Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. • Eliminate out of area placements for non-specialist acute care by 2020/21.	• The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be embedded across our footprint – including crisis care, Mental Health liaison, transforming perinatal care and access standards . • Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 • The services in place will be responding to the health and wellbeing gaps and health inequalities identified.. • People who require more tertiary care/specialist support will have their care planned for via managed clinical networks.
8. Learning disabilities	• Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. • Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population. • Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check. • Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.	• Addressing Health Inequalities for people with LD – This is a priority for LD services its aim is to reduce barriers , promote inclusion and therefore increase access to health and social care services. • Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support. • Collaborating across Counties to provide Specialist services more efficiently/effectively
9. Improving quality	• All organisations should implement plans to improve quality of care, particularly for organisations in special measures. • Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services. • Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.	• The STP footprint currently has two acute Trusts in special measures. A key component of our STP is to ensure care is delivered of a standard and quality which is acceptable for our population and to the CQC and is on a trajectory to GOOD and aspires to be OUTSTANDING. • An impact of achieving this will be delivering safe, sustainable and productive services through transformation in general practice, primary care, urgent, non-elective and elective care as described in the annexes of this plan.

4

Next steps

There are a number of immediate next steps we need to take :

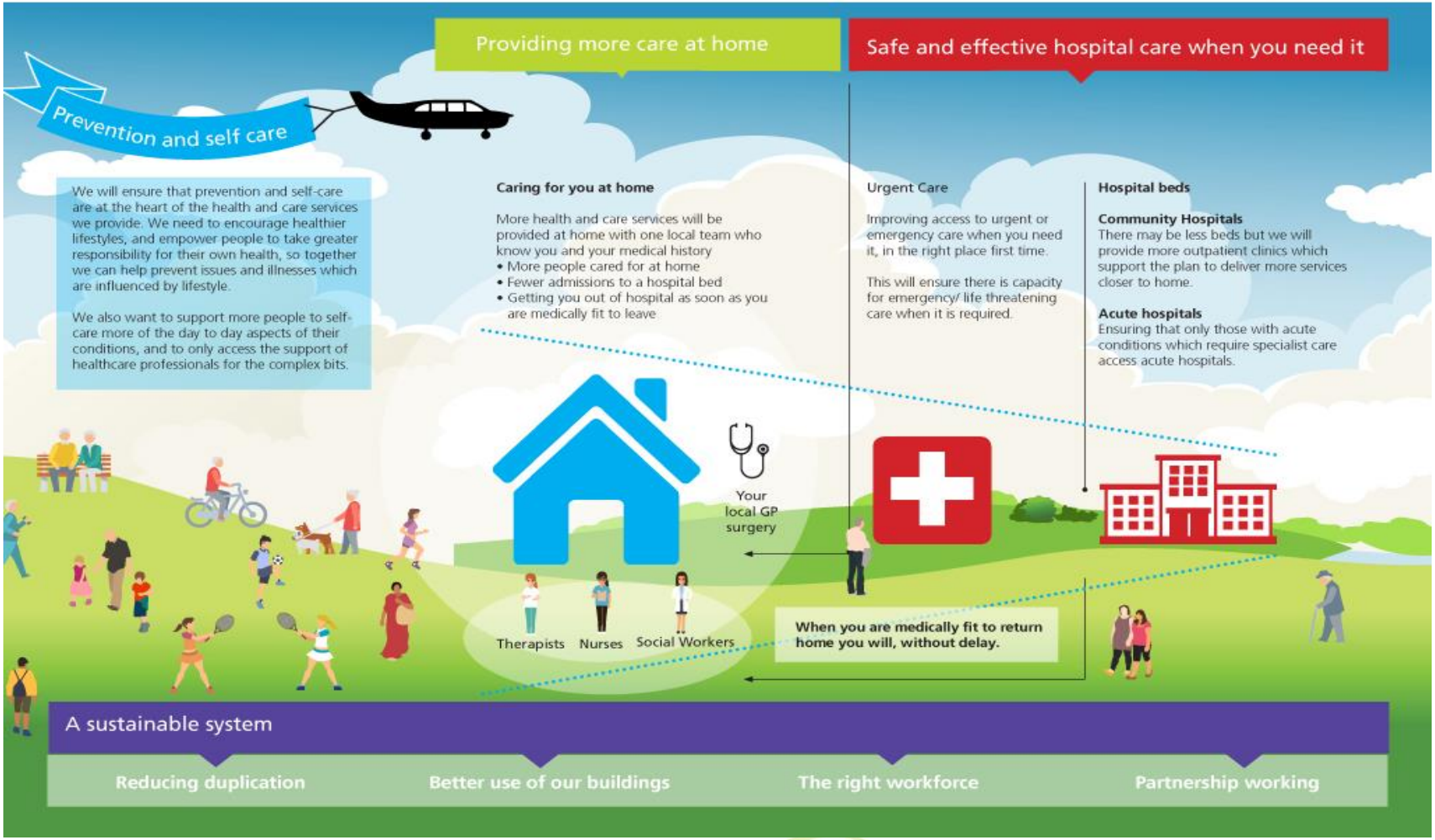
- Refine the planning assumptions based on the new control totals and STF funding, with a particular focus on year 1 and 2
- Implement our engagement plan for scaling up clinical, stakeholder and public engagement in the development of solutions to address the challenges set out in this document.
- Take immediate action and further development of the 4 key, at scale prevention programmes.
- Take immediate action on the primary care sustainability workstream to increase resilience in core general practice and prepare for delivery of Primary Care at Scale.
- Continue to develop the new out of hospital integrated care models in each county
- Participate in the West Midlands clinical review of the implementation of transforming urgent and emergency care services in the West Midlands
- Seek NHSE support to review specific services and test proposals to address them which have a potential solution beyond the STP footprint– eg. Stroke, mental health and cancer.
- Establish the benefits and delivery plan for those benefits of being a rural pathfinder for new ways of commissioning specialised services.
- Explore how we can unlock the benefits of the STP through different contracting models to incentivise delivery and develop partner risk share arrangements.
- Agree the revised governance structure to enable us to complete the planning process and transition into operational planning and contracting
- Commission an external partner to support the refinements of specific emerging proposals to include :
    - An assessment of the underlying cost of providing an acute service in Herefordshire reflecting the challenges of rurality
    - Complete a cost benefit analysis of the urgent care proposals
    - Undertake further analysis of the bed modelling work and the potential phasing
    - Develop a detailed financial and activity model for an increased care at home and closer to home offer which informs the proposals around bed configuration including modelled impact on social care

Communications and Engagement Plan

Herefordshire Council | worcestershire county council

DRAFT

NHS



#YOURCONVERSATION

Your Health & Wellbeing #YourConversation

Communications and Engagement Plan

Our STP priorities are not new; they have been central to our engagement for a number of years and include extensive engagement around our strategies for Urgent Care, the reconfiguration of acute hospitals services, increasing out of hospital delivery and the promotion of self care and prevention. The collaborative focus of the STP process has enabled us to bring the learning from these activities together to develop a consistent approach to our future work, namely to effectively scale up the engagement and interaction with our local communities, clinicians and staff from 17th October.

- Our collective experience from previous engagement around "the left shift" in the delivery of care is that the majority of stakeholders understand and support both the need for change, as well as the necessity for improvement, especially for older/ more vulnerable people. From April 2016, as STP partners we have been using all our existing engagement events to talk to members of the public and stakeholders about this system wide strategic case for change; providing us with over 100 engagement opportunities across the 2 counties to outline the Triple Aim challenge, our local gaps and gain feedback on some of emerging issues . These early discussions reflected the position above, namely that the rationale for change is supported but there are specific themes that require more exploration and assurance, for example transport and capacity of our workforce to deliver much more care at home.
- The Communications and Engagement workstream is well established and has leads from all partner organisations that meet every fortnight to coordinate activities and feedback, both internally and externally. Each workstream also has an identified communications and engagement lead to ensure consistency of messages.
- From September our STP communication has been branded as #yourconversation and a dedicated website was launched in September. www.yourconversationhw.nhs.uk. The website includes some of the previous engagement activities and content, FAQs, details of our engagement events and a questionnaire. There is a weekly #yourconversation bulletin which is issued to all staff and stakeholders.
- Staff engagement in all partner organisations is being increased in preparation for the next phase of STP development. The 'Back Office' and 'Workforce and Organisational Development' workstreams have the potential to affect the working lives of many of our staff and we are engaging with them to help them devise solutions which will make the back office of all our organisations more efficient. Each partner organisation has taken responsibility for engaging with their staff and staffside organisations using agreed messages.

Communications and Engagement Plan

We have now reached a point on our STP journey where it is critical that we engage more fully on our emerging thinking, including the ways in which we might work differently to address our priorities if we are to realise onward success. Although we are formally consulting on Worcestershire's acute services from November 2016 the other areas being explored in our STP are still in formation and from 25th October we are wanting to facilitate early discussions around the likely direction of travel , the development of local solutions and co-design around more formal engagement going forward (as per the NHS publication on "Engaging Local People - a guide for local areas developing Sustainability and Transformation Plans" September 2016). This will approach will be cascaded into all formal meetings, stakeholder forums, staff events etc supplemented by roadshows, briefing, social media campaigns and proactive media coverage.

#yourconversation

The early engagement outlined above will start on 18th October with our staff and then external stakeholders on 19th October. This will also publically launch #yourconversation in the media as a mechanism to gain early views and wider engagement in further shaping of our STP. The content will build on previous cascades and specifically scale up our wider staff engagement to include written briefs, drop-in sessions and roadshows (#yourconversation mobile briefings via our training bus) as well as interactive #yourconversation webinars, blogs etc.

Clinical Engagement

There are two countywide clinical reference groups which provide advice to the Programme Board on all aspects of the STP. In addition there is a joint clinical engagement group which straddles both counties to come together to discuss specific items and concerns. In addition each workstream has clinical input and have plans to involve the wider community in the further development of their ideas and concepts. Clinical engagement also forms part of the staff engagement programmes in all partner organisations. Plans are underway for a series of workshops for clinicians from across the two counties at the beginning of December to discuss the STP and how clinicians can shape the current thinking and future plans.

Key stakeholder engagement

We are establishing a Stakeholder Advisory Group under the chairmanship of the. Voluntary and Community Sector. The group will consist of councillors, lay members from CCGs and Trusts and representatives from community and voluntary groups. Its role will be to advise on all STP communications and engagement with the public. A briefing is being arranged in London for the eight MPs who represent Herefordshire and Worcestershire. This is in addition to the individual briefs which they have received from partner organisations. All partner organisations receive updates at their Boards/Governing Bodies and support the STP direction of travel as well as specific briefings as required

Engagement with the public

As partners we will continue to use all our existing engagement events as opportunities to talk to members of the public and stakeholders about the case for change and the emerging thinking in our STP. #yourconversation will be scale up as our interactive tool to discuss the issues stakeholders have around STP priorities . This will be supported by awareness raising social media activity, proactive media campaigns and publicity through open events and forums.

Communications and Engagement Timeline