Sustainability and Transformation Partnership (STP) – summary of areas for potential community pharmacy involvement

https://www.england.nhs.uk/systemchange/view-stps/

This document summarises the areas that PSNC has identified in STP plans which have the potential for community pharmacy involvement. LPCs that have additional information to add, should contact Zainab Al-Kharsan, Service Development Pharmacist.

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North

STP footprint	Priorities/key challenges outlined in the STP	Potential opportunities for community pharmacy involvement identified by PSNC	Website/further info
Cheshire & Merseyside	1. Improve the health of the population (physical and mental care in the community). 2. Improve the quality of care in hospital settings. 3. Optimise direct patient care.	Alcohol prevention and high blood pressure plans: • Targeted Brief Advice – facilitate local agreements with GPs, pharmacy and midwifery to screen pts with staff offering brief advice and referring to local specialist services as required. Antimicrobial resistance: • Ensure consistent messages on AMR are given by all prescribers and pharmacists. • Ensure pharmacies support the AMR strategy. Cheshire & Wirral - Collaborate productivity: • Explore the integration of services across C&W with exact form and localities to be determined.	http://www.liverpoolcommunityhealth.nhs.uk/downloads/news/Cheshire%20Merseyside%20STP.pdf
Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby	1. Preventing ill health and increasing self-care. 2. Health and care in communities and neighbourhoods. 3. Quality of care in hospitals – 'Better Health Programme'. 4. Use of technology in health care	• Focused input to identify, and work with, hard to reach groups and deprived communities. • Develop holistic alcohol brief intervention and treatment pathways with improved community support services. • Develop 4-year comprehensive prevention programme for Long Term Conditions, e.g. Cardiovascular disease prevention programme and COPD pathways (using PHE Programme). • Implement Smoke Free NHS (Acute and MH) with holistic smoke free pathway and access to smoking cessation services. • Increased capacity in cancer support services (including diagnostics, welfare advice, screening etc.) delivered through improved working practice and innovations such as pooling clinical capacity across the system. This will be undertaken in partnership with NHS, Independent Sector and Voluntary Community Sector providers. • Primary care records shared across the local health economy, including community pharmacy, with the introduction of common standards, paperless transfer of notes and digital summary care records. • Urgent and emergency care network – Redirection of patients to pharmacies for minor ailments. • Investment in the primary care workforce inc. increasing the number of staff working in primary care in substantive posts and training schemes, by a range of recruitment, retention and education initiatives. This includes developing the entire primary care workforce inc. practice nurses, pharmacists, health care assistants and practice management staff.	https://nhsbetterhealth.org.uk/

Greater Manchester	1. Radical upgrade in population health prevention. 2. Transforming community based care & support. 3. Standardising acute & specialist care. 4. Standardising clinical support and back office services.	Shared Clinical Services • Revised pharmacy arrangements through the improvement of drug procurement, logistics and medicines optimisation. Health prevention: • Large scale social marketing programmes, using behavioural insights, to support lifestyle change and engage the population to be more active in promoting their own and others' health. • Developing a GM framework for 'patient activation', motivating people to take control and supporting work to tackle health inequalities. • Increasing the range and profile of self-care support programmes and train the workforce to deliver them. • Working with HEE to upskill public sector workforce in key areas of practice such as self-management education, shared decision making, health coaching and patient activation. • Bringing together screening and immunisation commissioning and public health people to form an integrated commissioning team. • Implementing the evidence base for early detection of disease through screening and case finding to find the missing thousands who have a condition but have not yet been diagnosed. This will be supported by better information on a range of conditions including online advice, discussion forums and self-management programmes to empower people to look after themselves. • Proactively reaching out to people registered on a GP list who do not attend GP practices, to engage with the community and create a cultural movement for health awareness and improvement. Transforming community based care & support • Build on work in localities to introduce a standardised, streamlined discharge service and aim to develop an agreed GM discharge framework, which is focused on the standards that the people of GM expect to be delivered when patients are discharged and help them return home safely with a co-ordinated discharge plan.	http://www.gmhsc.org.uk/delivering-the-plan/
Humber, Coast and Vale	1. Helping people stay well. 2. Place-based care. 3. Creating the best hospital care. 4. Supporting people with mental health problems. 5. Helping people through cancer. 6. Strategic commissioning.	• Tobacco control. • Take steps to identify and act early on cancer. • Preventing cardiovascular disease and diabetes. • Implementing prevention activities at scale. • Changing how people access primary and community care. • Increase the number of people making health related visits to a pharmacist as an alternative to A&E. • Integrating the different services that provide care to patients. • Will look to use current staff differently for example creating multi -disciplinary roles for receptionists, pharmacist and mental health practitioners.	http://humbercoastandvale.org.uk/
Lancashire and	1. Introduce population health	• Population health system development will focus on prevention of ill health and enhanced	http://www.healt

South Cumbria	model at scale across the footprint, with prevention strategies, comprehensive health promotion & well being programme, community resilience & mobilisation and support to people to co-produce health gains. 2. Population based care delivery model will need to maximise the learning from our Vanguards in developing comprehensive wraparound aligned mental health and physical health services for urgent Care, integrated primary & community services, prevention, self-help & education and regulated care. 3. A one service approach to our acute physical and mental health services. 4. Optimise population based care delivery model to understand the impact and roadmap for implementation of technology, workforce, partnerships and estates.	support for self care, thereby moderating demand for primary community and ultimately hospitals care. • Learning from the rapid evaluation of the vanguards will be shared to inform development of models across the footprint. • As collective workstreams are mobilised, clinical priorities will be identified for early action in line with local need and national expectations. • Digital health strategy will support the delivery of the triple aim through electronic sharing of health records to support safe, effective care and implement digital tools to support self care. • Workforce strategy will enable and ensure the workforce and requirements of new models of care are effectively planned for and delivered. • GPs will work with colleagues in community pharmacy to promote best access for those with minor self limiting conditions, those on multiple medications and those needing medicines management support.	hierlsc.co.uk/about/stp
Northumberland, Tyne and Wear and North Durham	1. Scale up prevention, health and wellbeing. 2. Out of hospital collaboration. 3. Optimal use of the acute sector.	• Reduce the prevalence of smoking and obesity, and reduce the impact of alcohol. • Radical upgrade in the approach to ill health prevention and secondary prevention. • Increase flu immunisation rates across the STP, particularly ensuring high uptake in frontline health and care staff, pregnant women and high risk groups. • Create a network approach to support community asset-based approaches, including social prescribing. • Enhance people's ability to self-care, increase their independence, self-esteem and self-efficacy.	http://www.northumberlandccg.nhs.uk/get-involved/stp/

		• Roll out MECC as an integral part of workforce strategy. • Redirection of patients to pharmacies for minor ailments.	
South Yorkshire and Bassetlaw	1. Healthy lives, living well and prevention. 2. Primary and community care. 3. Mental health and learning disabilities. 4. Urgent and emergency care. 5. Elective and diagnostic services. 6. Children's and maternity services. 7. Cancer. 8. Spreading best practice and collaborating on support services.	• Primary Care being represented at the Collaborative Partnership Board and Executive Partnership Board and through the newly formed Primary Care Advisory Group made up of representatives from dentistry, general practice, pharmacy and optometry. • Current health and social care services are not meeting our population's health needs, delivering prevention, or reducing health inequalities. • There is a need to commit to a radical upgrade in preventing ill health by increasing the size of shared resource on prevention. • There is a need to transform health and care through the development of new organisational forms such as ACOs and MCPs to shift focus to improve population health by encouraging the delivery of outcomes rather than activity. • Improving neighbourhood and primary care services so that they enable people to better manage their own health and stay well in their communities. This will include a range of professionals supporting patients and the wider population appropriately and seamlessly and an extensive range of services that have only previously been accessible in hospitals. • Bringing GPs, community pharmacists, social workers, hospital doctors and community nursing teams together around neighbourhoods to help make the connections between social and medical support and strengthen communities. • Increase telehealth monitoring, personal and GP planning to proactively help people who have long term conditions, such as diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.	https://smybndccgs.nhs.uk/what-we-do/stp
West, North and East Cumbria	1. Tackle population health issues where WNE Cumbria is performing poorly. 2. Tackle health inequalities. 3. Improve the quality of health and care provision. 4. Create a health and wellbeing system fit for the future.	• Main focus is to reduce social isolation, prevent illness and disease and enable people to live healthy and independent lives. Commitment to include creating a health and wellbeing system which will support and empower the population to stay healthy. • The development of universal and targeted prevention services, enabled through 'health and well-being coaches'. • Better targeting of lifestyle services towards those who will benefit the most from them. • Mechanism for connecting socially isolated people to local communities and opportunities. • Redesigning the re-ablement and intermediate care pathway and technology and equipment to remain living independently at home. • Extending the role of community pharmacies to provide a wider range of enhanced services.	http://www.northcumbriaccg.nhs.uk/index.aspx
West Yorkshire and Harrogate	1. Prevention. 2. Primary and community services. 3. Mental health. 4. Stroke. 5. Cancer.	• Every place will be a healthy place, focusing on prevention, early intervention and inequalities. • People will be supported to self-care, with peer support and technology supporting people in their communities. • Programmes focused on locally relevant challenges with most areas prioritising areas such as obesity, smoking, cardiology, respiratory, mental wellbeing and frail elderly. • Evidence based, person-centred approaches, which support people to take greater control and	http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-

	6. Urgent and emergency care. 7. Specialised services. 8. Hospitals working together. 9. Standardisation of commissioning policies.	management of long-term health conditions. Training of the workforce to facilitate this elevated level of independence. • Increasing access to primary care in hours and out of hours through primary care at scale and new models of care in the community. • A variety of models and options for integrating services to make them more efficient and better aligned to the delivery of people's health and wellbeing outcomes and person-centred care.	transformation-plan/

Midlands and East

STP footprint	Priorities/key challenges outlined in the STP	Potential opportunities for community pharmacy involvement identified by PSNC	Website/further info
Bedfordshire, Luton and Milton Keynes	1. Illness prevention and health promotion. 2. Primary, community and social care. 3. Secondary care. 4. Digital programme. 5. Demand management and commissioning.	• To radically upgrade prevention, early intervention and self-management of care by formulating system-wide prevention plans. • To secure systematic high-level support and intervention, at scale, across the footprint. • To embed ownership of prevention principles, and the practicalities of transformation in this area, with STP partners, with individuals and with communities at large. • Increased appetite by, and capability of citizens (and their family carers) to self-care and to "partner" the GP and other members of the primary care team (such as pharmacists) in the delivery of their care. • To shift activity away from acute services to community settings, closer to home. • To ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions. • Medicines optimisation – to support efficient and effective prescribing and use of medicines across the continuum of care (including hospitals) by establishing a system-focussed team that supports innovation, effective and efficient use of medications and safety. Involves developing pharmacy link to MDTs to ensure effective use of medicines in physical and mental health care management.	http://www.blmkstp.co.uk/
Birmingham and Solihull	1. Creating efficient organisations and infrastructure. 2. Transformed primary, social and community care. 3. Fit for the future: secondary and tertiary services.	• Organisations will work collectively to address the growing demand for hospital care. This includes moving activity that is currently provided in a hospital setting into more local settings of care, ideally at home. This will be achieved through the prevention and self care agenda to improve health and wellbeing and through integrated and enhanced primary, social and community care, developing community resilience, and improved use of technology keeping people independent and reducing acute crises.	http://www.solihull.gov.uk/stp
Cambridgeshire and Peterborough	1. At home is best. 2. People powered health and wellbeing. 3. Neighbourhood care hubs.	• Aim to deliver a truly integrate health and social care and capture savings opportunities through reducing demand growth and pathway changes including supported self-care and community-based care. • In the future, lifestyle interventions for those with diagnosed hypertension and at risk of	https://www.fitforfuture.org.uk/

	4. Responsive urgent and expert emergency care. 5. Systematic and standardised care.	diabetes will be increased along with malnutrition screening and access to stop-smoking services. • Increasing the proportion of people accessing information about alcohol, and improve diagnosis and treatment for cardiovascular diseases, such as heart failure and hypertension. • Aim to increase the numbers of people with COPD on self-assessment programmes and work with people who are obese by maximising opportunities for lifestyle interventions identified through health checks. • Preventing falls. • Approach to prevention also includes implementation of interventions designed to deliver health and wellbeing to staff including investment in mental health, physical health and smoking cessation programmes. • GPs, consultants, and nurses will make it easier for people with long-term conditions to manage their own care needs by adopting best practice for supporting self-care. This will include systematic use of 'activation measures', care planning, expert patient programmes, health coaching, targeted psychological intervention, personal budgets, and increasingly exploiting technology-based platforms. • Secure access to patient records to all frontline staff providing direct care, be they the person's usual team or an out-of-hours or urgent response team, and by building stronger relationships between GPs, hospitals, domiciliary care workers, and care homes to speed up discharges. • Neighbourhood teams, staffed by district nurses, matrons, social workers, therapists, and pharmacists already provide integrated care for populations of 30,000- 50,000, based around the GP registered list. The teams proactively care for those with long-term conditions, the dying, care home residents, and mental health service users. • STP is implementing an expanded 'integrated urgent care service (IUC) with clinical hub' which replaces the current separate NHS 111 and GP out of hours services. Within the hub there is access to mental health practitioners, GPs, nurses, and pharmacists, significantly strengthening current services. • Developing rural urgent primary care hubs – will being together GPs, nurses. Pharmacists, therapists and others.	
Coventry and Warwickshire	1. Proactive & preventative care. 2. Urgent & emergency care. 3. Planned care. 4. Maternity & paediatrics. 5. Productivity & efficiency.	• Preventing illness and self-care: Focus will be on areas identified as having a significant impact on the health of people, such as obesity, smoking (especially in pregnancy), falls prevention and building community capacity and resilience, so people are better able to look after their own health and stay in good health and enjoy life. • Integrated teams or communities (approximately 15-20 across the footprint covering 50k population) bringing together services that meet the needs of the population they cover. • Maximisation of the capacity and strengths that the person and their family bring and what is already available within the community. • Proactive in-reach into the acute by integrated teams, pulling people out of acute care and	https://www.uhcw.nhs.uk/about-us/stp

		support recovery and rehabilitation.	
Derbyshire	1. Prevention and self-care. 2. Place-based care. 3. Urgent care. 4. System efficiency. 5. System management.	• The establishment of a coordinated 'Wellness System' is proposed which will have nine Wellness Hubs/ Localities delivering a range of provision in a holistic way, including not only a focus on an individual's lifestyle and behaviour but also on their social networks, housing and wider socio-economic factors which we know have an impact on health. • Work with partners across the wider system to enable a 'whole-pathway' approach to prevention, particularly recognising the role and impact of wider determinants on morbidity, premature mortality, health inequalities and service utilisation. • Re-procure some commissioned services to enable more appropriate services to be available to individuals. Delivering at greater scale should be able to offer efficiencies. • Support primary and secondary care in the development of pathways that include referral to healthy lifestyle services and community initiatives. • Work with PHE to promote healthy lifestyles through a range of media on a national scale. • We need to embed prevention opportunities in all pathways and work streams, develop high-value pathways that are clinically cost effective, and develop place-based services where appropriate and feasible. • Support 2,500 health and social care staff to focus care out in communities, where it is needed, in GP practices, pharmacies, social care, mental health, opticians, and other providers. • Medicines management initiative – transform workforce to increase the number of independent prescribing patient facing pharmacists to work as part of community MDTs (including polypharmacy). • Urgent care – develop a Clinical Assessment, Advice and Treatment Hub as part of a network to include dentists, pharmacists and paramedics to support NHS 111, 000, OOH calls from the public and all HCPs. • Increase the number of Advanced Clinical Practitioners, drawing this workforce from not only nursing but AHP, Paramedic and Pharmacy workforce.	https://joinedupcarederbyshire.co.uk/
Herefordshire and Worcestershire	1. Sustainable general practice. 2. Primary & community services. 3. Prevention & self-care. 4. Mental health & learning disabilities. 5. Urgent Care. 6. Maternity. 7. Elective Care. 8. Infrastructure.	• 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 and care services. • Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness. • Embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change. • Put long term life outcomes for children, young people and their families' needs at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future. • Support people to manage their own health, linking them with social support systems in their communities and identify when a non-clinical intervention will produce the best experience and	http://www.hacw.nhs.uk/yourconversation/

		outcomes for patients. • Significantly enhanced role for community pharmacies, including a review of dispensing practices in light of local population access and the most recent guidance and legislation. • Communities will be able to access more convenient alternatives to hospital based urgent care services, such as community pharmacies which are closer to home.	
Hertfordshire and West Essex	1. Prevention. 2. Integrated primary and community services. 3. Acute hospital services.	• People having the advice and support which will enable them to make lifestyle choices to improve their health and wellbeing and prevent ill health, with the opportunity to engage in activities designed to improve their health. • People at risk of developing avoidable long term conditions will be supported to make changes to their lifestyles, to reduce those risks and stay well. • Where someone has developed a long term condition, they will be supported to successfully manage that condition as far as they are able to, using information, advice and technology. • Care will be provided whenever possible in people's own homes and community settings, based on a single care plan delivered by an integrated, multidisciplinary team. Mental health and learning disability services will be part of the integrated teams, ensuring that an individual's all-round health and care needs are met. • There are three enabling approaches to prevention that the STP has recognised as having the potential to change culture and help deliver the desired approach - social prescribing, personalisation and self-management. • Develop a culture of supporting self-management amongst the Hertfordshire & West Essex population and all who work with patients with long term conditions, which is led by effective and strong clinical leadership. • A variety of interventions will be launched in year one, from working with employers to increase awareness of smoking cessation services and working with specific workplaces to introduce Smoke Free Toolkits, to increasing the role of community pharmacies and working more closely with key risk groups. • Reduce stroke through reducing blood pressure from above 140/90 in 10% of hypertensive patients. Improved management of atrial fibrillation will also play a significant contributory factor in efficiencies derived from this scheme. • Other areas to focus on: diabetes, weight management, alcohol management.	https://www.healthierfuture.org.uk/
Leicester, Leicestershire and Rutland	1. New models of care focused on prevention, moderating demand growth. 2. Service configuration to ensure clinical and financial sustainability. 3. Redesign pathways to deliver improved outcomes	• Patients will have the skills and confidence to take responsibility for their own health and wellbeing. • More people will be encouraged to lead healthy lifestyles to prevent the onset of long term conditions. • Screening and early detection programmes will enable more people to be diagnosed early to enable improved management of disease and to reduce burden. • Professionals will have access to a shared record to improve the quality and outcome of patient care.	http://www.bettercareleicester.nhs.uk/

	for patients and deliver core access and quality. 4. Operational efficiencies. 5. Getting the enablers right.	• General Practitioners will increasingly use their skills to support the most complex patients and routine care will be delivered by other professionals. • Identify roles and competencies currently that sit outside of primary care that will be required to support the demand. Such roles include primary care paramedical staff, community pharmacists, emergency care practitioners, and specialist roles such as geriatricians. • Actively support undergraduate medical, nursing and pharmacy training and GP training at a federated level to promote our practices as positive places to work to aid recruitment and retention. • Maximise the use of the pharmacy workforce to support clinical services and staff and also increase the use of non-medical prescribers. • Maximise the use of prescribing analysis support tools to reduce polypharmacy which leads to preventable hospital admissions.	
Lincolnshire	1. Promote prevention and early intervention and implement primary care strategy. 2. Deliver a smaller but more resilient acute hospital sector. 3. Clinical and financial sustainability secured.	• Residents will take more responsibility for their own health, both in managing long term conditions and in making healthy lifestyle choices to keep fit and well. • They will be able to access their records via the Care Portal to assist them with caring for themselves if they have self-limiting or long-term conditions. • Focus resources on keeping people well and healthy; providing tools and support for people and communities to make healthy choices and take more control. • Change the relationship between individuals and the care system, with a move to greater personal responsibility for health. • Move care from acute hospitals to neighbourhood teams in the community, closer to home; join up physical and mental health, health and social care; remove barriers between professionals, communities and patients so that people live well. • Increase the number of primary care, community pharmacy and secondary care engagement with smoking cessation. • New models of care: Neighbourhood teams: the initial building block providing services to a geographically based population of between 30,000 and 50,000 people and linking a GP Federation with other primary care professionals: a Lincolnshire-wide estimate of 26 whole time equivalent community pharmacists and others.	https://lincolnshirehealthandcare.org/
Mid and South Essex	1. Build stronger health and care localities, with reconfigured primary care delivering a broader range of integrated services. 2. Ease pressure on the non-elective pathway and reduce inappropriate admissions into the acutes.	• Deliver local public health priorities for example mental health, obesity. • Ensure face-to-face services are maintained, for example, for sexual health and substance misuse services.	http://www.nhsmidandsouthessex.co.uk/

	3. Reconfigure the acute footprint to address quality, financial and workforce challenges – in line with national guidance. 4. Optimise mental health care: integrated, joined up services across sectors.		
Norfolk and Waveney	1. People living with frailty and long term conditions. 2. Acute admissions from care homes. 3. End of life. 4. Frequent users of emergency services. 5. Prevention of unnecessary mental health admissions into acute care.	• Consolidate further Pharmacy across Norfolk & Waveney footprint • Support population and prevention approaches – e.g. Health Checks, identifying hypertension to ensure early treatment and improving the uptake of flu vaccination. • Improved management of Diabetes in working age adults through patient activation and education and better management in primary care. • Smoking – Reduce prevalence, targeting pregnant women and deprived areas. Reduce maternal smoking prevalence 10% year on year. • Reducing harmful drinking – identify those at risk from drinking and provide brief advice for 20,000 patients at next consultation and through the alcohol liaison team. • Improved management of children and young people with asthma, diabetes and epilepsy through patient and carer education and better management in primary care. • Reduce acute admissions for ear nose and throat conditions for children and young people by patient education and better use of primary and community care.	https://www.healthwatchnorfolk.co.uk/ingoodhealth/
Northampton-shire	1. Health and wellbeing 2. Care and quality. 3. Funding and efficiency.	• Same day access to an appropriate health or social care professional via a GP led multi-disciplinary service model which includes therapists, pharmacists, community physical and mental health nurses and social workers. Delivery will be through a network of practices and/or hubs within each Federation, with services available from early morning into the evening, 7 days a week. • Support for the prevention agenda through delivery of 'lifestyle' clinics to help patients stop smoking, lose weight and stop drinking. • Reduced health inequalities and an enhanced quality of life for people living with long term conditions. • Development of a wider integrated workforce i.e. Adult Nurse Practitioners, therapists, pharmacists and care navigators	http://www.northamptonshirestp.co.uk/
Nottinghamshire	1. Promote wellbeing, prevention, independence and self-care. 2. Strengthen primary, community, social care and carer services.	• Help those who are largely well today (most of the population) stay well through prevention and health education and manage minor issues themselves in so far as it is possible. • Help those with a complex or advanced long-term condition that needs professional expertise and support to be as enabled as possible to manage their own care, to have an identified system to escalate care quickly in the event of exacerbations, and to have regular monitoring to identify changes in their health and social care needs as early as possible.	http://www.stpnotts.org.uk/about-the-stp/stp-our-plan

	3. Simplify urgent and emergency care. 4. Deliver technology enabled care. 5. Ensure consistent and evidence based pathways in planned care.	• Help people remain independent through prevention programmes and offering proactive rather than reactive care, which will also reduce avoidable demand for health and care services. • Work in multi-disciplinary teams across organisational boundaries to deliver integrated care as simply and effectively as possible. • Decrease prevalence of smoking, particularly pregnant women. • Reduce levels of overweight and obesity, alcohol-related admissions and staff sickness absence rates. • A reduction in avoidable demand for health and care services by promoting independence and self-care, including through improved information and education and greater use of technology. • Reduced instances of waste and patient harm from poor medicines management. • Fewer people arriving at hospital as a result of improved access to urgent care in settings other than A&E, such as general practice or pharmacy. • Address capacity and capability in primary care to deliver the General Practice Forward View, Pharmacy Forward View and the ambitions of the STP.	
Shropshire and Telford & Wrekin	1. Supporting people to become more resilient, stay healthy. 2. Developing Neighbourhood Care Teams. 3. The community bed review. 4. To re-evaluate hospital services. 5. To continue to develop other services. 6. Maximise resources.	• Bringing about population level behaviour change through a suite of prevention activity that reduces the burden of ill health and disease. • Improve the presentation, detection, treatment & management of preventable cardiovascular disease. • Systematic delivery of lifestyle advice, signposting and referral – the NHS and the Community.	http://www.twbstaffsandstoke.org.uk/index.php
Staffordshire and Stoke on Trent	1. Focussed prevention. 2. Enhanced primary & community care. 3. Effective & efficiency planned care. 4. Simplify urgent & emergency care system. 5. Reduce cost of services.	• Focus investment and prevention activities on tackling the top 3 issues e.g. obesity, smoking and diabetes along with addressing health inequalities. • Identify the top three industrial prevention actions (e.g. secondary prevention of diabetes, reducing the harm caused by smoking in pregnancy, obesity prevention in high risk individuals). Identify where upstream investment in prevention and early intervention services will have a positive impact on both the health of the population of Staffordshire & Stoke-on-Trent in the short, medium and long term and will have an upstream positive impact on the population of Staffordshire & Stoke-on-Trent and reduce high cost care. • Enhance and integrate primary and community care to enable frail elderly and those with long term conditions (LTCs) to live independent lives and avoid emergency admissions. • Integrated Urgent Care model which incorporates minor injury, walk-in, GP Urgent appointment, Pharmacy, Dental, MH crisis and other urgent non-emergency functions into a single model.	http://www.twbstaffsandstoke.org.uk/index.php

Suffolk and North-East Essex	1. Self-care, independence and community based care. 2. Hospital reconfiguration and transformation. 3. Working together across the system.	• Concentrate on the top six risk factors for early death and reduced quality of life; smoking, high blood pressure, being overweight or obese, lack of physical activity, poor diet and excessive alcohol consumption. • Increase NHS health checks for high blood pressure. • Increase screening to identify people at risk of • developing diabetes. • Introduce alcohol screening. • Develop strategies for good health and wellbeing • for all communities. • Promote healthy lifestyle choices and behaviour change. • Encourage more people to look after themselves, to develop the role of community pharmacies and to look at how people access urgent and emergency care (through integrated 111/OOHs).	http://www.westsuffolkccg.nhs.uk/health-care-working-together-differently/
The Black Country	1. Local place-based models of care. 2. Extended collaboration between service providers. 3. Mental health and learning disability services. 4. Maternal and infant health.	• Support the promotion of prevention activities in all settings and facilitate patient activation and engagement. • Focus on clinical areas with particular challenge or opportunity such as Musculoskeletal conditions, Cardiovascular Disease and Frailty. • Those being supported to live with a health condition (especially LTCs), need improved continuity of care. They need more consistent and proactive services that support them to manage their conditions and achieve their goals. • Improved long-term conditions care pathways with emphasis on prevention and selfcare supported by Integrated Care Teams who are striving to achieve the same outcomes. • Established NHS111 as a single point of entry into urgent care services and are also developing central points where calls from patients can be taken by doctors and other health professionals including pharmacy, dentist and mental health services. • Around 34,500 patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and bloody pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.	https://sandwellandwestbhamccg.nhs.uk/news-a-events/1553-plans-published-for-better-health-and-care-in-the-black-country-and-west-birmingham

London

STP footprint	Priorities/key challenges outlined in the STP	Potential opportunities for community pharmacy involvement identified by PSNC	Website/further info
North Central London	1. Prevention. 2. Service transformation. 3. Productivity & efficiencies. 4. Enablers: digital, workforce, estates, new commissioning and delivery models.	• Supporting residents to look after their health: by smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing. • Diagnosing residents with clinical risk factors and long term conditions much earlier to increase life expectancy. Once diagnosed, giving people the tools and resources to better manage their	http://www.candi.nhs.uk/about-us/north-central-london-sustainability-and-

		own condition(s) alongside proactive management by health professionals to prevent the development of further conditions and complications. • Specific interventions: increasing awareness and case finding (including national cancer screening and HIV testing) and appropriate medications to control conditions for people with high blood pressure, diabetes, atrial fibrillation; self-care and structured self-management for long term conditions; reablement offers in social care and care navigation. • Scaling up smoking cessation activities and alcohol screening. • Supporting patients through social prescribing and patient education. • For orthopaedics: Better use of non-medical support and education: promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.	transformation-plan

East London	1. The right services in the right place.
	2. Encourage self-care and care closer to home.
	3. Secure the future of health and social care providers.
	4. Improve specialised care.
	5. A system-wide decision making model to enable place-based care.
	6. Using infrastructure better.
		• People will be well informed regarding the resources and services that are available to them, empowering them to choose the most appropriate pathway for their care, reducing the number of unnecessary admissions and A&E attendances.
		• Promote better self-care, not only by providing better information and resources, and easy access to advice (for example pharmacy) but also through the millions of encounters with health and social services in NEL every year.
		• Self-care schemes to further develop and scale up:
		  ○ Peer support on a one-to-one group basis (online or in-person).
		  ○ Providing alternative care or services that facilitate self-care.
		  ○ Proactive management and planning for those with complex needs.
		• Widen the implementation of healthy living programmes such as the National Diabetes Prevention Programme to achieve obesity and diabetes targets.
		• Integrate smoking cessation services with mental health programmes to deliver a 10% decrease in the number of smokers.
		• Implement a 24/7 integrated 111 urgent care service that connects to clinical hubs at all levels, including dental and pharmacy hubs and CAMHS.
		• Medicines optimisation – central to this is the role of pharmacists and their teams (in primary and secondary care) in improving patient care through pathway redesign, promoting patient empowerment and self-care and efficient use of NHS resources through procurement and reducing waste.
			http://eastlondonhcp.nhs.uk/progress-to-date/

North West London	1. Support people who are mainly healthy to stay health and self-care. 2. Improve children's mental and physical health and wellbeing.	• Improve health and wellbeing of local diabetic population. • Delivery of Patient Activation Measure Year 1 targets as part of the self care framework. • Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17. • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery.	https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps

	3. Reduce health inequalities and disparity in outcomes for the top three killers (cancer, heart & respiratory diseases). 4. Reduce social isolation. 5. Reducing unwanted variation in the management of LTCs. 6. Right care in the right place at the right time. 7. Improve end of life care quality. 8. Reduce gap in life expectancy between adults with serious mental health needs vs rest of population. 9. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.	• Introducing measures to reduce alcohol consumption and associated health risks as well as learn from and implement the output from prevention devolution pilots across London. • Patient Activation Measures embedded across health and social care supporting tailoring of care for all people with LTC. • Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be offered access to expert patient programmes.	
South East London	1. Developing consistent and high quality community based care and prevention. 2. Improving quality and reducing variation across physical and mental health. 3. Developing sustainable specialised services.	• Support a whole system approach for issues such as obesity, mental health, diabetes and alcohol. • Investing in innovative ways to empower self-management of LTCs. • The Health Innovation Network will support the roll out Alcohol Intervention & Brief Advice across health settings, social care and the criminal justice system, along with minimum standards which set out how staff can deliver. • Promote prevention, self-care, prevention and self-management by expanding accessible, proactive, preventative and self-management care for mental and physical health problems outside of hospital. • Under the STP, the stroke prevention pathways will be shared across the borough and increasing use of self-management and pharmacists to monitor hypertension to reduce demand for primary and secondary services. • Re-commissioning of GUM/Contraception and Sexual Health Clinics: will include a shift of basic services to primary care/pharmacy. • Establishing an integrated urgent care system, which includes promoting the use of alternative services (community pharmacy).	http://www.ourhealthiersel.nhs.uk/news-events/news.htm?postid=25496

		• Leverage existing pharmacy medicines optimisation work to drive work on consolidation clinical support services forward.	
South West London	1. Use money and staff differently to build services around patients' needs. 2. Invest in more and better services in local communities. 3. Invest in estates. 4. Bring all services up to the best standards.	• Identify people most at risk of developing long term conditions and use modern technology and a modern local workforce to develop proactive care and better support them at home and in the community. • Implementing the recommendations of the national NHS Urgent and Emergency Care (UEC) review through the south west London UEC Network, which found that acute hospital admissions and attendances could be tackled by integrating primary care, 111, community and acute hospital services, and greater use of community pharmacy. • Aligning priorities and improving efficiencies relating to medicines optimisation and the "Hospital Pharmacy Transformation Programme". • In addition to the provider schemes, pharmacy teams across the six south west London CCGs have worked together to identify opportunities for medicines related saving that go beyond the usual quality, innovation, productivity and prevention (QIPP) savings through collaborative approaches. • Opportunities to reduce medicines wastage (particularly through changes in doctor, pharmacist and patient behaviours around ordering, dispensing, and repeat prescriptions.	https://www.swlondon.nhs.uk/

South

STP footprint	Priorities/key challenges outlined in the STP	Potential opportunities for community pharmacy involvement identified by PSNC	Website/further info
Bath and North East Somerset, Swindon and Wiltshire	1. Transforming primary care. 2. Focus on prevention and proactive care. 3. Making best use of technology and public estates. 4. Modernising the workforce. 5. Improved collaboration across hospital trusts.	• Engage with local people and provide the necessary information and resources that will help them to stay healthy and well for longer, reducing the need for traditional healthcare treatment. • Embrace technology and more efficient ways of working across the footprint, improving access to health advice, services and patient information where necessary and avoiding duplication of work. • The goal is to provide a wider range of health and social care services in the community, coordinated around the needs of individual patients. • The integration of key professionals within Primary Care hubs including community pharmacists. • Embed prevention and self-management along identified LTC pathways, including diabetes, recognising the needs of people with multi-morbidities, and drawing on the support of 'expert' peers within the voluntary sector. • Collective campaigns for flu and pneumococcal vaccinations using social marketing to achieve behaviour change. • Trial of pharmacies receiving direct calls from NHS 111 in B&NES.	http://www.bathandnortheastsomersetccg.nhs.uk/bnes-swindon-wiltshire-sustainability-transformation-plan-published

		• Scope opportunities for closer working in clinical support services for out of hours provision where practicable to do so e.g. Labs, Pharmacy. • Mental health: adjust skill mix towards non-medical health professionals (including pharmacists) to create efficiencies.	
Bristol, North Somerset and South Gloucestershire	1. Preventing illness and injury. 2. Providing care closer to home. 3. Personalised care.	• Initial priorities: MECC, infection prevention and control, self-care and social prescribing, supported self-care (digital) and alcohol harm reduction. • Repeat prescriptions management service pilot. • Shift of care from an acute setting to primary and community care making best use of available resources.	https://www.bristolccg.nhs.uk/about-us/sustainability-and-transformation-plan/
Buckinghamshire, Oxfordshire & Berkshire West	1. Preventing ill health. 2. Improving access to primary, community and urgent care services. 3. Collaboration across acute trusts. 4. Improving mental health outcomes. 5. Improving alternatives to specialised services such as cancer. 6. Supporting people in their own homes and avoiding hospital.	• Specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists will offer treatment and care in teams who work together in local neighbourhoods around the needs of patients. • Prevention priorities: mobility, obesity, physical activity, diabetes and tobacco. • Oxfordshire: 'Primary Care Plus' to enable more out-patient consultants and non-consultant clinics in the community, supported by a local diagnostic service. • Properly resources integrated care in the community can be tested, adapted and scaled to provide enhanced services to the population for a variety of LTCs. • Primary care practitioners (including community pharmacists) need to actively work with patients to prevent them from developing serious illnesses through immunisations, smoking cessation and managing their long term mental and physical conditions.	http://www.oxonhealthcaretransformation.nhs.uk/about-us/buckinghamshire-oxfordshire-berkshire-sustainability-and-transformation-plan
Cornwall and the Isles of Scilly	1. Prevention and primary care. 2. Community care and support. 3. Urgent and emergency care. 4. Designing pathways of care. 5. Productivity and efficiency.	• Enhance our targeted prevention and intervention activity to address harmful lifestyle behaviours and help to manage demand on the overall system. • Specifically address the stark inequality for those in our most deprived areas through more rigorous and focused prevention work in these areas. • Provide a greater focus on health education, health and wellbeing improvement and prevention to keep people fit and healthy without needing to access other services where possible. • Early identification and management of key conditions such as diabetes and frailty. • Enhanced role and promotion of community pharmacist in other primary care practitioners (e.g. paramedics) to release GP capacity, with greater streaming of people directly to the person who can deliver the care they need. • GPs, community pharmacists and other primary care practitioners will play a key role in ensuring appropriate signposting, advice and access to relevant programmes to support prevention and self-care which enables greater independence and reduces demand elsewhere in the system.	http://www.cornwall.gov.uk/health-and-social-care/shaping-the-future-of-health-and-social-care-services/

Devon	1. Ill health prevention and early intervention. 2. Integrated care model. 3. Primary care. 4. Mental health and learning disabilities. 5. Acute hospital and specialist services. 6. Increasing service productivity. 7. Children and young people.	• Increasing focus on prevention or avoidance of ill-health. • Focus on long-term conditions prevention and early intervention with a focus on co-morbidities in particular mental health and diabetes and hypertension. • Priorities for prevention: smoking, alcohol misuse, falls prevention and a few others. • Better integration of other primary care providers especially pharmacy and optometry.	
Dorset	1. Support people to better manage their own health. 2. Provide care that is based on the needs of our local population. 3. Enable more people to receive care at home and in the community and to self-manage LTCs. 4. Ensure community services support frail older people. 5. Personalised care. 6. Adapt new technologies. 7. Create integrated teams of professionals – skill mix. 8. Maximising estates.	• Priorities for prevention: heart disease, diabetes, musculoskeletal, mental health and alcohol. • Developing roles across community and primary care services including community pharmacy and pharmacists in a range of settings. • Ensure health and care practitioners provide timely and high quality support to help people to consistently control their blood sugar, blood pressure and cholesterol, especially for people with diabetes.	https://www.dorsetsvision.nhs.uk/#vision
Frimley Health	1. Prevention, self-care & early detection. 2. Improve LTCs include greater self-management. 3. Frailty management. 4. Redesigning urgent and emergency care. 5. Reducing variation and health inequalities across pathways.	• Support self-care through identification and use of digital platforms such as patient portal, patient facing technology and shared care record across the STP footprint to develop comprehensive care and support planning. • Programme implemented across STP to detect higher than normal blood pressure within primary care and the community. • Learn from the Vanguard self-care initiatives, for example, healthy living pharmacies and safe haven model for mental health and replicating effective interventions across the STP footprint. • Empowering patients, citizens and communities: volunteering and social action as key enablers, including Healthy Living Pharmacies. • Investing in new roles including care navigators, mental health leads, pharmacists and extensivists.	http://www.surreyheathccg.nhs.uk/about/frimley-health-care-stp

		• At weekends, specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists will offer treatment at the 14 new 'health hubs'.	
Gloucestershire	1. Enabling active communities (self-care and prevention). 2. Place based commissioning & urgent care design. 3. Clinical programme approach. 4. Reducing clinical variation. 5. System enablers (primary care, joint IT strategy, joint estates strategy, workforce).	• Promote healthy lifestyles and self-care: a new conversation with the public through a 'social movement' approach focussed on personal responsibility for health and wellbeing. • Targeted approaches for vulnerable population groups. • Ensure a strategic approach to the commissioning of self-management support. • By 2017 will have rolled out AF diagnosis treatment programme with AHSN to 60 practices. • By 2017 will have worked to develop a new integrated healthy lifestyle service to target the top four modifiable lifestyle causes of chronic disease and support self-care. • Ensure that advice and treatment is available from a network of community pharmacies across the county.	http://www.gloucestershireccg.nhs.uk/gloucestershire-stp/
Hampshire and the Isle of Wight	1. Investing in prevention and self-care. 2. Strengthening primary and community care. 3. Simplifying the urgent and emergency care system. 4. Improving the quality of hospital services. 5. Improving mental health services. 6. Creating a financially sustainable health system for the future.	• Supporting more people to be in good health for longer (improving healthy life expectancy) and reducing variations in outcomes (improving equality). • Targeting interventions to improve self-management for people with key long term conditions (Diabetes, Respiratory, Cancer, Mental Health) to improve outcomes and reduce variation. • More people supported to give up smoking, achieve a healthy weight and drink sensibly (reducing lifestyle related diseases). • Develop a highly skilled integrated primary care workforce with a greater range of healthcare professionals including qualified nurses, allied health professionals and pharmacists, who are equipped with the skills and experience to work in integrated teams.	https://www.westhampshireccg.nhs.uk/stp
Kent & Medway	1. Preventing ill health, intervening earlier and bringing excellent care closer to home. 2. Maximising synergies and efficiencies in shared services, procurement and prescribing. 3. Investing in estates, digital infrastructure and the workforce needed to underpin a high-performing system.	• Concentrating prevention activities in four key areas: obesity and physical activity, smoking cessation and prevention, workplace health and alcohol harm. • Facilitate clear signposting to the most relevant service that is driven by a 'community first' philosophy. • Utilise coordinated statutory, voluntary and where appropriate the independent sector services including: primary, community, secondary, social care, mental health and voluntary services that are wrapped around defined GP populations. • Facilitation of transitions of care incl. discharge planning. • Increase supply and develop specific roles proactively e.g. paramedic practitioners; dementia care workforce; pharmacy in community and primary care, physicians assistants.	https://www.kmpt.nhs.uk/information-and-advice/stp.htm

	4. Developing the commissioner and provider structures which will unlock greater scale and impact.		
Somerset	1. Driving improvement in the system-wide financial and performance position. 2. Focus on prevention to develop a sustainable system. 3. Redesign out of hospital services. 4. Address clinical and financial unsustainability. 5. Create Accountable Care Systems by April 2-19.	• Ensure joined up/collaboration between GP practices and pharmacies. • Widen the primary care team to include health coaches, pharmacy, mental health professionals, MSK, and physician assistants. • Agree plan to align community staff around practices to include optometry, dentists and pharmacy. LPC Lead for Somerset already engaged with STP. • Develop, in collaboration with education providers, a local training package to support clinicians to de-prescribe / reduce poly-pharmacy. The key outcomes associated with this are improved patient safety, reductions in avoidable emergency admissions and reduced costs. This would involve working with NHSE as the current commissioner of pharmacy and local LPC to support this education.	http://www.tsft.nhs.uk/about-your-hospital/somerset-sustainability-and-transformation-plan/
Surrey Heartlands		• Developing innovative outreach methods and increasing case finding in primary care to identify at risk populations for high blood pressure and type 2 diabetes.	http://surreyheartlands.uk/about-surrey-heartlands/our-plan/
Sussex and East Surrey	1. Focus on prevention and self-care.	• Management of long term conditions (e.g., respiratory): prevention and support. • Particular focus on tobacco and diet and exercise. • Primary care-led implementation of actions to improve the detection and appropriate management of atrial fibrillation. • Improve the detection and management of hypertension.	http://www.hastingsandrotherccg.nhs.uk/news/sussex-and-east-surrey-sustainability-and-transformation-plan/#.WlZHTahl-Ul