The Shrewsbury and Telford Hospital NHS Trust

Paper 16

Recommendation ☐ **DECISION** ☐ **NOTE**	**For information only**
Reporting to:	**SaTH Trust Board**
Date	29 March 2018
Paper Title	STP Directors Report
Brief Description	This is a monthly update detailing progress from all key areas of STP and system partners
Sponsoring Director	Phil Evans
Author(s)	STP PMO Office and system partners
Recommended / escalated by	n/a
Previously considered by	n/a
Link to strategic objectives	5 year forward view STP programme plan stragetic objectives
Link to Board Assurance Framework	n/a
Outline of public/patient involvement	Patients are involved through existing organisational frameworks as required
Equality Impact Assessment	○ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin

STP Directors Monthly Report
March 2018

Integrated System Working, the transition from STP to ICS

In 2018/19, all STPs are expected to take an increasingly prominent role in planning and managing system-wide efforts to improve services.

Integrated Care Systems

- *System working will be reinforced in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems.*
- *Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility*
- *The term 'Integrated Care System' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population.*
- Integrated Care Systems are seen as key to sustainable improvements in health and care
- *Integrated Care Systems will be supported by new financial arrangements*
- *It is anticipated that additional systems will wish to join Integrated Care System development programme during 2018/19 as they demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes. It is envisaged that over time Integrated Care Systems will replace STPs*
- *As systems make shifts towards more integrated care, they are expected to involve and engage with patients and the public, their democratic representatives and other community partners.*
- *Engagement plans should reflect the five principles for public engagement identified by HealthWatch and highlighted in the Next Steps on the Five Year Forward View.*

Further Information:

https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

Our vision for health and care services in Shropshire, Telford & Wrekin

https://www.england.nhs.uk/systemchange/view-stps/shropshire-and-telford-and-wrekin/

Our ambition is simple:

We want everyone in Shropshire, Telford and Wrekin to have a great start in life, supporting them to stay healthy and live longer with a better quality of life.

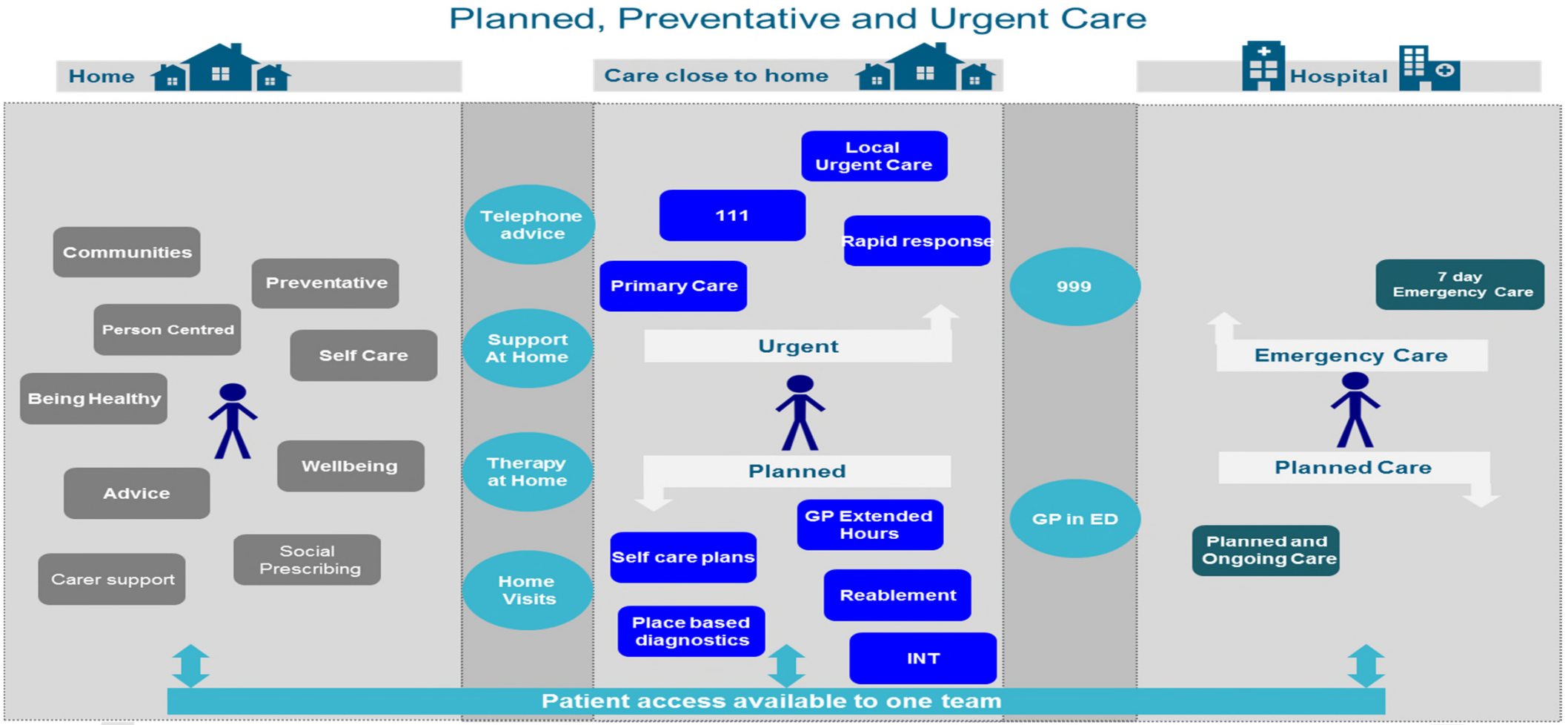
Our STP is the culmination of a wide range of local organisations, patient representatives and care professionals coming together to look at how we collectively shape our future care and services.
This strong community of stakeholders is passionate, committed and realistic about the aspirations set out in this document.

Our thinking starts with where people live, in their neighbourhoods, focusing on people staying well.
We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we improve access when its needed.

We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

Prevention will be at the heart of everything we do –
from in the home to hospital care. In line with the GP Five Year Forward View priorities, we plan to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible.

Its all about integration



Commissioner Led System Improvements Plan on a page

Out of Hospital Programme - Shropshire
Delivery of Integrated Care in the community

NHS England

NHS Improvement

Improvement in Community Care & Admission Avoidance

The Golden thread

Admission avoidance
Case Management
Crisis Resolution

Programme needs to:

- Using all available resources to commission integrated health and care services that are clinically effective and cost effective and as close as possible to where people live with the greatest needs

System needs to:

1. Collaborate and co-produce
2. Agree alliance working across providers
3. Agree pathways to support admission avoidance
4. Reduce occupied bed days by impact of F1&2 and F3 & 4

The progress:

- Stakeholder workshops held
- Patient and engagement workshops held
- Task & Finish groups formed to co-produce
- Governance in place
- Admission avoidance modelling complete
- Engagement strategy in development

Interventions and process changes

- Primary Care Development including risk profiling, case management, enhanced service delivery
- Development of a Hospital at Home service to support admission avoidance
- Development of a Rapid Response and Resolution team to manage patients prior to and during crisis
- Development of DAART and Community Bed Provision
- Enhancement of the Frailty Front Door/Community Pull Team

Risks to delivery

Risks

1. Culture of 'bed based' care persists, and risk aversion preventing people being managed at home
2. Needs assessment to inform future design (JSNA)
3. Workforce limitations and reluctance to develop one team approach
4. Contract negotiations and reluctance to risk share
5. Sustainability of current services

Data

The work completed by Optimity (2017) and Deloitte (2016) illustrates Shropshire's over dependency on in-patient resources secondary to historically commissioned services which have grown organically and failed to take into account key factors such as demographic changes. Optimity (2017) suggest that through shifting secondary service utilisation by a 5 year age band will reduce emergency usage of secondary services by 385 cases per 5,000 head of population within the 65+ age band equating to 4586 admission avoidances.

Out of Hospital Programme – Telford & Wrekin
Delivery of Integrated Care in the community

NHS England

NHS Improvement

The Golden thread

Improvement in

Programme needs to:

1. Improve access to activities that will prevent the development of poor health
2. Improve early identification of illness to stop further deterioration
3. Promote self-care/self-management
4. Demonstrably increase effective community support available
5. Strengthen Primary care
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation

System needs to:

1. Services and activities to be available closer to home
2. Prevention to be promoted throughout all work
3. Optimal use of technology
4. Introduction of new roles and ways of working
5. Well connected services and communities
6. Robust information accessible for communities and the professionals working with them
7. Empowerment for people and professionals
8. Consideration of mental health embedded

The progress:

- Community resilience and prevention
- Social prescribing within Newport and Central East Telford
- Healthy Lifestyle service
- Neighbourhood Teams
- Diabetes – improvement in patient outcomes has been achieved
- Hypertension – An increase in the number of individuals being screened has resulted in more diagnosis of hypertension and people referred for further support to manage this.
- Branches – feedback is demonstrating that a number of Section 136 are being avoided.
- Citizens Advice - outcomes achieved include an estimated £15,200 in welfare benefit gains
- Cancer Detection – 2 pilots have taken places with practices, both achieved an increase in screening for bowel cancer.
- Reduction in demand on social care

Interventions and process changes

Encouraging healthy lifestyles

Promoting community resilience

Direct care in the community

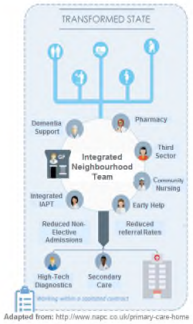
Speciality review

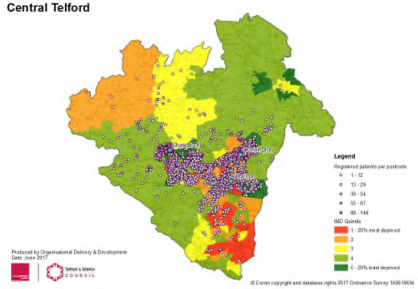
Risks to delivery

Risks

Actions:
Develop enablers as detailed below
Community Information Portal which holds information on services and groups in the area
Robust and practical communication and engagement plan
Strong, well represented working groups to progress development
Strong leadership within the organisations involved
Proactive working relationships between stakeholder

What next – using data to drive change





Urgent & Emergency Care Programme
Frailty Programme

NHS England

NHS Improvement

Improvement in the A&E Quality Standard

The Golden thread

a) MDT at front door
b) Reduce Care Home admissions
c) Reduce bed days

Programme needs to:

1. **F1** Implement the MDT Frailty Team at RSH ED front door in line with AFN model
2. Adopt comprehensive Frailty Assessment Tool for use by MDT and wider hospital
3. Avoid all avoidable admissions by MDT assessment/rapid care plan for ongoing care in community
4. If admitted ensure frail patients have a clear time limited care/treatment plan with an EDD to minimise Length
5. **F2** Replicate at PRH
6. **Keep patients mobile** at all times to reduce de-compensation and rehabilitation needs
7. Discharge frail patients home on the agreed EDD

System needs to:

1. Implement the following schemes::-
2. F3 Reduce admissions/re-admission from Care Homes by a) focus on high admitters; b) Care Home team (T&W)
3. F4 Reduce admissions/re-admission from Care Homes by a) focus on high admitters;) b Trusted Assessors (Shrops) to reduce Los
4. Reduce occupied bed days by impact of F1&2 and F3 & 4

The progress:

- Frailty MDT in RSH piloted since Sept
- Model redesign following support from AFN
- £333K invested in new Care Home Team (T&W)
- 3 Trusted Assessors appointed by SPIC to work with Shropshire Care Homes
- Both CCGs to work with SPIC to focus on high admitting homes
- CHAS being reviewed as part of 'Out of Hospital' service design
- Care Home Pharmacists appointed in both SC and T&W
- Practices using Frailty Index to identify/risk stratify patients – next steps will be ensuring all Care Home residents have advanced care plans/CHAS; and then all >75s

Interventions and process changes

F1 Move Frailty Team to the front door PDSA February 2018 to ensure earlier decisions

F2 Replicate model at PRH with Community Matron/Rapid Response

Resolve payment for Frailty Teams from 1.4.18

F3 Agree actions with 10 Care Homes and SPIC
F4 Agree metrics for Care Home Team

F5 Agree actions with Primary Care clinicians across both Shrops and T&W for practices to prepare care plans for all patients on Frailty Index

Risks to delivery

1. F1 & 2 ED teams will not support the AFN model and allow Frailty MDT to make early decisions at front door before the ED Clinicians – this will waste time and opportunities for turn around on same day/avoid admissions
2. Insufficient awareness of the harm admissions can cause/understanding that de-compensation adds to delays/failure to embed rapid care/treatment/discharge to reduce LoS and discharge needs
3. Culture of 'bed based' care persists, and risk aversion to sending patients home first
4. Lack of ownership of all hospital staff to keep patients mobile – risk aversion re Falls
5. F 3 & 4 risk of insufficient engagement from Care Home managers/proprietors, and risk of hospital staff 'over-prescribing on going care needs on discharge.

Data

75+ admissions account for 25% of emergency admissions, and c75% of OBDs. Average LoS = 9.5 days

F1 & F2 will reduce admissions of Frail patients >75 by 7% (half the Frailty modelling number) **i.e.2205 f**ewer admissions (1483 SCCG 722 T&W) equivalent to 6/day. After 90 days the target will be revised and will rise to 9/day – **3,285**/year.

F1 & F2 will also result in corresponding reduction in OBDs of 20,897 (14,261 SCCG/6626 T&W), rising to 31,345

Impact of F1 & F2 on breaches will be X% from 1.3.18 rising to y% after 90 days

F3 & F4 will reduce admissions and LoS of Care Home residents – 2 fewer per day = 14/week = 728/year, with corresponding OBD reducing bed occupancy by 6,899. This will increase to 3 fewer admissions /day; 21/week; 1092/year after 90 days with corresponding OBDs reducing by 10,374.
Impact of F3 & F4 on breaches will be X% from 1.3.18 rising to y% after 90 days

Cancer

NHS England

NHS Improvement

The Golden thread

Improving Cancer survivorship

Programme needs to:

- Deliver all Cancer Waiting Times (CWT) standards consistently, including the forthcoming 28 days from referral to diagnosis standards
- Monitor and scrutinise performance for individual tumour sites and challenge the system where needed
- Pilot innovative ideas to improve cancer service and patient outcomes, such as Telford and Wrekin pilots to trial vague symptoms and FIT testing

System needs to:

- Make sure that processes and pathways are in place to deliver Cancer Waiting Times standards consistently
- Implement remaining parts of the NICE NG12 suspected cancer guidance – for upper GI, vague symptoms and FIT testing for lower GI
- Benchmark against optimal pathways produced by NHSE ACE programme to identify areas where improvements could be made
- Implement remaining areas of the national cancer strategy 'Achieving World Class Cancer Outcomes', such as the new CWT standards for confirmed diagnosis within 28 days of referral
- Improve 1 year survival for all cancer patients to achieve the overall target of 75%

The progress:

- Cancer Waiting Times standards generally met and performance good for SaTH as the main cancer centre
- Majority of NG12 pathways in place, with those outstanding in advanced stages of development
- Replacement of SaTH LINACs
- Representation at tertiary centre contracting meetings to make sure that our issues are addressed
- Recovery package implementation for all cancer patients - SaTH funded by Macmillan Cancer Support 2018 for 2 posts over 3 years
- The Local Health Economy established an STP local cancer group which continues to focus on objectives linked to STP:
  - Preventing cancer
  - Diagnosing more cancers early
  - Improving cancer treatment and care.

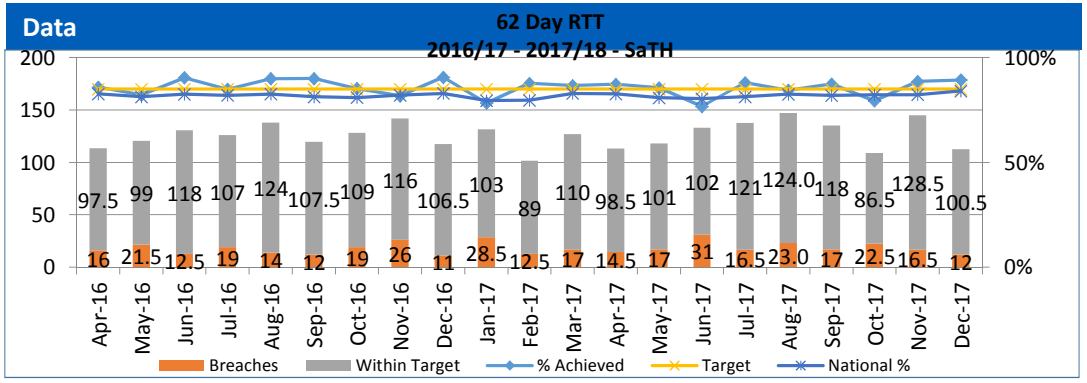
Interventions and process changes

- Develop health economy wide cancer strategy based on National Cancer Taskforce priorities in the national strategy
- Use of Digital Health solution to develop new whole population models of care
- Investment from NHSE to support tertiary centres to improve performance against cancer waiting times
- Plan capacity needs to implement GP direct to test aspects of NG12 guidance
- Development of a whole health economy cancer strategy and action plan linked to STP priorities

Risks to delivery

- Diagnostic capacity needed to deliver NG12 and optimal pathways
- Poor performance at tertiary centres
- Workforce development needed to meet future demand
- Lack of funding to further develop and roll out Cancer app and digital technologies to all cancer patients (particularly for treatment and recovery stages)
- Insufficient focus and capacity locally to drive and support earlier patient presentation and diagnosis through public awareness and community engagement

Data



End of Life

NHS England

NHS Improvement

Improvement in Quality of Care

The Golden thread

Improved communication & coordination to provide best end of life care possible.

Programme needs to:

- Develop a whole systems direction of travel for EOL care that all partners and organisations are working towards together. This direction of travel is to shift care further upstream from the last few weeks and days of life to at least the last 12 months.
- Consider EOL /palliative care for children and young people and where this fits into the STP

System needs to:

1. Shift approach to eol care further 'upstream'. This means recognising earlier when a person is in at least the last 12 months of life.
2. Reduce demand on acute trust by enhancing anticipatory care and planning ahead; reducing the amount of inappropriate and non beneficial treatments/interventions of for some patients.
3. Recognising that 'planning ahead' (Advance care planning) is a positive intervention . Including preferences and options and should be included in all care interventions/pathways.
4. Develop new models of working to support neighbourhoods- use of voluntary sector and communities to support eol care.

The progress:

- Development and agreement by all partners on the strategic direction of travel for eol care across the whole system.

Interventions and process changes

- Facilitate effective personalised care planning and planning ahead and support those important to the dying person
- Ensure equal access to palliative and end of life care. Develop systems to identify when a person is in the last year if life
- Establish concept of 'living well' supporting advanced and anticipatory planning and access to services
- Ensure skilled and compassionate workforce. Identify education needs across the county
- Work in partnership to ensure that care is co-ordinated between systems.

Risks to delivery

Risks

Capacity and demand- a growing elderly population, impacts on workforce
Multimorbidity including frailty.
Rural and urban models affecting care access and support.
Social care provision inconsistent across the county, worse in rural areas.

Inconsistent understanding of the term end of life- has different meanings for different organisations and professionals.

A shift in culture for many aspects: upstream working, stopping treatments that aren't beneficial, introducing the concept of planning ahead. This will be for all organisations

Data

Data is required to quantify this for example:
Those attending AE and the nature of emergency admissions and interventions
The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.

- Those attending AE and the nature of emergency admissions and interventions used.
- Those being admitted 3 times a year or more(particularly those patients with severe frailty).
- Those attending AE and the nature of emergency admissions and intervention used inappropriately;
- The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.
- Those being admitted 3 times a year or more(particularly those patients with severe frailty).

Referral to Treatment

NHS England

NHS Improvement

The Golden thread

Improvement in Quality of Care

Improvement in referral to Treatment, access & Waiting Times

Programme needs to:

1. Maintain progress made to date in achievement of standard
2. Mange transition at SaTH back to opening challenged services to referrals.
3. Manage the transformation of pathways (MSK) to improve RTT performance

System needs to:

1. Manage impact of winter capacity limitations and protect capacity where appropriate
2. Address pathway issues around diagnostics and reporting
3. Manage out of county provision
4. The STP/Ffit plan requires a reduction of 28,000 out patient appointments as part of the transformational change programme.
5. In 2016/17 there were almost 38,000 first appointments and almost 65,000 follow up appointments in the local acute provider. Work is being developed to reduce this by approximately 2,500 first appointments and 5,000 follow up appointments during 2018/19.

The progress:

- SaTH achieving RTT standard
- RJAH expect to be close to standard at year end
- 52 week waits reduced in year
- The 'Incomplete' target was not met for 16/17 but performance improved by the third quarter of 2017/18 and the target was met. This has been achieved by:
- Continued outsourcing of services which including ophthalmology, gynaecology and Orthopaedic for both outpatient and elective activity.
- Demand management plans aimed at reducing referrals by working with primary care services.
- Agreed recovery plans with existing providers moving forward.
- TRAQS continuing to offer patient choice while enabling accurate monitoring of referral and trends.

Interventions and process changes

- MSK Pathway being redesigned
- MRI Direct Access pathway being reviewed
- Service provision being augmented in challenged specialties e.g Neurology

Risks to delivery

Risk Mitigation

Performance of out of county providers is main risk to overall CCG achievement of RTT standard

MSK pathway redesign may increase pressure at RJAH for RTT achievement

Reducing the number of follow up appointments to benchmarked levels for key specialties

- Increased use of advice and guidance as an alternative
- Increased use of telephone clinics
- Increased use of telemedicine and technology to enable patients to self care
- Managing levels of consultant to consultant referrals
- Managing PLCV policies application through the contract

Data

Month 9 RTT performance

Shropshire CCG	91.2%
SaTH	94%
RJAH	88.8%

52 Week waiters - 3 (Worcester Acute and Wye Valley)

Primary Care Programme – GPFV - Workforce

Programme needs to:

The Shropshire Primary Care Workforce Plan has 15 Projects:

1. GP Recruitment
2. GP International recruitment
3. GP Retention/Career Plus
4. GP Fellowships
5. Tier 2 Visas
6. Impact of Workflow Optimisation Training
7. Targeted Enhanced Recruitment Scheme (TERS)
8. Clinical Pharmacists
9. Physician Associates
10. Nurses
11. Upskilling HCAs
12. Other clinical groups – e.g. Urgent Care Practitioners, Mental Health Therapists, Physiotherapists, Occupational Therapists and Psychologists
13. Organisational Development – Training and Education
14. Engagement
15. Marketing and Communications

System needs to:

1. Focused Prevention
2. Enhanced Primary & Community Care
3. Effective & Efficient Planned Care
4. Simplify Urgent & Emergency Care
5. Reduce cost of services
6. Improve Cancer & End of Life Services

Improvement in Capacity & Capability of Primary Care Workforce

The Golden thread

Practice engagement to develop a diversified workforce.

The progress:

The key progress made to date is as follows:

- Data on GP and other clinicians (current numbers, anticipated numbers, trajectories) has been submitted to NHS England
- The Primary Care Workforce Plan has been refreshed and re-submitted to NHS England.
- The first 12 of the projects are aimed at recruiting and retaining GPs and non-doctor clinicians – the final three projects are cross-cutting enablers.
- An STP footprint Workforce working group has been set up with STP PMO membership
- Plans have been agreed, with both CCGs, to work with practices/groups of practices over the coming three months to develop local versions of the Plan – i.e. plans which will indicate which of the projects are a priority for the practices/groups of practices and what actions will be taken to deliver a more diverse workforce. These plans involve working with the NHS England Staffordshire and Shropshire workforce project manager.

Interventions and process changes

- Milestone 1: Interest in/appetite for GP International Recruitment identified and linked to the STP GP IR bid (May 2018)
- Milestone 2: Locality/Practice Group workforce plans produced (June 2018)
- Milestone 3: STP-wide workforce event held to identify emerging themes from the Locality/Practice Group workforce plans and plan next steps (June 2018)
- Milestone 4: At-scale bids for Clinical Pharmacists submitted (where identified by the localities/practice groups) - ongoing
- Milestone 5: Primary Care Workforce Plan reviewed in the light of the Locality/Practice Group workforce plans (October 2018)

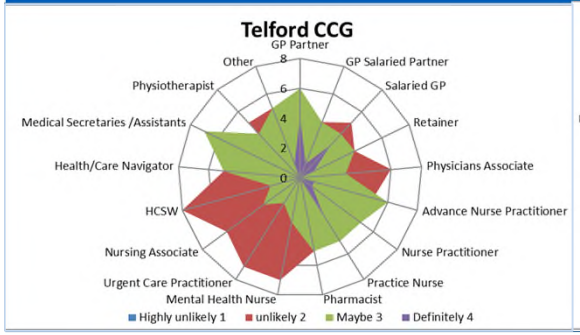
Risks to delivery

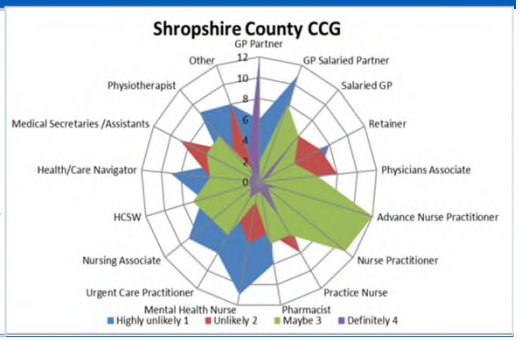
Risks

1. The lack of engagement by practices with the CCGs when developing bids for the national Clinical Pharmacists scheme may adversely affect the quality of the bids
Mitigation: Information to be provided to practices about the importance of engagement with the CCG over potential CP bids

2. IR application is not approved and cannot be used to mitigate requirement to recruit additional GPs by 2020
Mitigation: Application shared with NHSE prior to submission for comment.
Increased engagement with GPs planned to gain buy in to scheme

Data





Mental Health

NHS England

NHS Improvement

The Golden thread

Parity of Esteem

Programme needs to:

1. Deliver the implementation plan for the Mental Health Forward View, ensure delivery of the mental health access and quality standards, increase baseline spend on mental health;
2. work to eliminate out of area placements and reduce PICU spend
3. Improve access to psychological therapies and ensure at least 16.8% of the population access IAPT in 2018/19 rising to 19% in 19/20 and 25% by 20/21 a key milestone under 5YFV
4. Eradicate legacy issues in CAMHS around access, backlogs and reduce waiting lists whilst also providing specialist help to Looked After Children placed in the area and overall improve delivery and efficiency
5. Provide one stop coordinated service for Adult Autism and stepdown beds for Learning Disability patients from Tier 4

System needs to:

1. Work across all systems to consider mental health needs of individuals
2. Ensure services all are trauma aware
3. Focus on prevention and early intervention
4. System has a clear understanding of reasonable adjustments for individuals with mental health or learning disabilities issues
5. Close gaps in provision of Autism services for adults as there is no commissioned pathway in Shropshire
6. Improve provision and support for out of area Looked After Children
7. Eliminate inappropriate access arrangements ,improving multi-agency working and enhance understanding amongst other agencies of role of core CAMHS team and lead overall improvement of service
8. reduce treatment time in Early Intervention In Psychosis, reduce inequity in LD services
9. Have provision of both acute and PICU MH beds locally to avoid spot purchasing out of area based on competitive tariffs

The progress:

1. Extra Funding has been extended to current Provider to enable increase of Mental Health patients receiving employment support (IPS) under 5YFV
2. Scoping is now complete for the Commissioning of a clear integrated pathway for Adult Autism Disorder Spectrum, next stage will be moving into procurement process (April 2018)
3. Equity access to LD respite agreed with Local Authority
4. Scoping underway to reduce PICU bed use out of area and improve quality, QIPP benchmarking in progress
5. Delivery issues in CAMHS being addressed via a Remedial Action Plan with clear milestones and objectives. Operational Group in place monitoring progress
6. Dementia diagnosis rate for Shropshire is presently at 69.9% against the national benchmark of 66.7%.
7. CCGs meeting entry, recovery and waiting times targets for Access to Psychological services

Interventions

- Contractual talks pencilled for March 18 with aim to increase IAPT access
- Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete
- Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete
- Development and delivery of new models of integrated care for MH and LD services
- Benchmark and scope likelihood of having local PICU beds to reduce OOA placements

Risks to delivery

Risks

1. Legacy issues and backlogs in CAMHS require more resource in terms of workforce to eradicate. Provider currently running extensive recruitment process, Risks of serious incidents, safeguarding issues as a result of service problems with recruitment.
2. NHSE requirement that IAPT interventions be clustered and each treatment be tariff based will likely push contract prices up based on national reference costs which means there is a financial risk to the CCG to meet the required IAPT access targets mandated under the Five Year Forward View
3. Burden on financial resources due to spot purchasing of beds for female PICU
4. Gaps in provision, adult ASD (no LD), some patients might not receive required support.

Data

Mental health MDS (MHMDS) - difficult to manipulate
IaPTUS- IAPT service only

Mental health will be integral to our ambitions around improving population wellbeing. We will put services in place to support individual needs and in the most appropriate settings by transforming services and focusing on early education and prevention.

At the same time, we agree that everyone should have improved access to high quality specialist care in hospitals – and that no matter where people live they get the same standards, experience and outcomes for their care and treatment.

Key to this success will be developing innovative, integrated models of care, this will ensure care is provided in the right place, at the right time and by the most appropriate staff.

Developing a ”part of a system” networked approach to services across Shropshire, Telford and Wrekin, will improve the quality and efficiency of services for our patients, in areas such as Frailty and will simplify the urgent and emergency care system so that it is more accessible.

Acute & Specialist Programmes
Musculoskeletal Services

NHS England

NHS Improvement

Improvement in

The Golden thread

Workforce Capacity
Workforce Capability
Culture & Leadership to deliver Transformation

Programme needs to:

- Implement the national high impact MSK triage intervention
- Improve patient outcomes through improved access to conservative management
- Reduce surgical interventions to normalised rates
- Deliver a vertically integrated local care model

System needs to:

Support implementation of evidence based Value Based Commissioning (VBC) policy across the full pathway from referral to treatment
Ensure the MSK triage service is the single point of access to secondary care for all routine MSK referrals
Support the implementation of the single MSK physiotherapy specification and treatment pathways for Hips, knees, shoulders , spines and ankles.
Collaborate to maximise the effective utilisation of local physiotherapy, conservative management and secondary care capacity and capability
Better interface tier T3 and T4 health services with T1 and T2 social care physical activity services and maximise the opportunities for supported self management through shared decision making
Supporting Primary Care to implement evidence based care of osteo arthritis, providing early advice, education and management prior to any onward referral

The progress:

- Specialist MSK triage assessment and treatment service (SOOS) live in North and Shrewsbury localities, expansion into the South 10 th March 2018
- Appointment of SEM consultant to lead SOOS 1 April 2018
- Working with PHE to introduce effective local physical activity interventions
- Implemented prior approval for the VBC policy, with agreed schedule for future updates
- Signed up to the Shared decision making collaborative, with patient participation Jan 2018
- Improvement reported in the NJR PROMs
- CQUIN for MSK –health questionnaire outcome measure developed and currently being piloted
- MSK Physiotherapy specification developed and with local providers for implementation
- 2017/18 QIPP FOT of £3m from reduced secondary care intervention rates

Interventions and process changes

- Timely direct access to MSK therapies operating under a single specification (April 2018) and central booking (Sept 2018)
- Shropshire Patients have access to services compliant with NICE OA Quality Standards , in Primary Care from September 2018
- SOOS established as Countywide community based specialist MSK assessment and treatment service from March 2018 & providing MSK triage by April 2018
- All routine MSK direct access to be coordinated through SOOS, the specialist access route April 2018
- Aligned incentives contract in place with RJAH from 1st April 2018

Risks to delivery

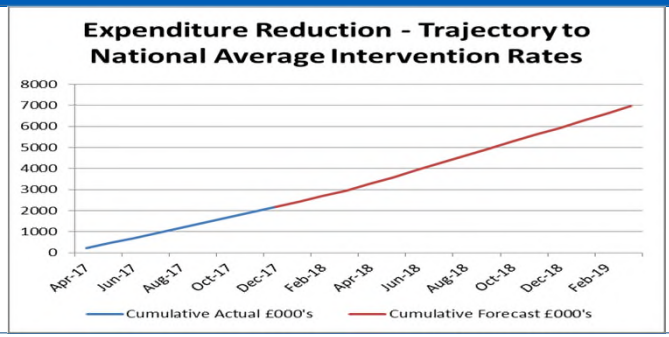
Risks

1. Lack of GP/provider engagement and support for the agreed pathways and associated compliance issues
2. Availability of conservative management
3. Patient expectation /acceptance of non surgical interventions

Actions:

1. Communication and engagement plan and targeted practice visits
2. Mapping of demand and capacity . Action plan to maximise utilisation and MSK business case to increase capacity
3. Patient and public involvement. Active engagement with and support from Health Watch and Shropshire Patient Group. Implementation of Shared decision making and partnership working with PHE .

Data



Acute & Specialist Programmes
Future Fit

NHS England

NHS Improvement

The Golden thread

Improvement in

Programme needs to:

- Ensure safe progress towards a formal public consultation, including developing effective relationships with scrutiny bodies
- Once approval received, deliver a formal public consultation, analysis of data, final report and decision making process
- Ensure implementation of the action plans arising from the Clinical Senate Review and NHSE Assurance Panel feedback
- Co-ordinate the development and delivery of a robust IIA Mitigation Plan before the end of the consultation period
- Ensure the completion of a ambulance and patient transport impact modelling exercise prior to the end of the consultation period
- At the end of the consultation period, ensure robust analysis and full report to inform next phase of decision making

System needs to:

- Support the effective delivery of the consultation with relevant clinical and managerial support to key events
- Contribute to the development of the IIA Mitigation Plan
- Ensure delivery of actions to timescale arising from external review exercises where individual stakeholder organisations are nominated as lead officers
- Develop and implement robust out of hospital/neighbourhood models which will support the required reduction in demand on acute hospital services in line with the Future Fit Activity and Capacity modelling and which also delivery effective and seamless integrated pathways between acute and community

The progress:

- NHSE assurance process undertaken
- Consultation materials developed and approved
- IIA Workstream established and held first meeting, next meeting scheduled for 5.3.18, chaired by RJAH Director of Nursing
- Ongoing monitoring of progress in implementation of the action plans from external reviews

Interventions and process changes

- Approval to proceed to formal consultation by NHSE (date tbc)
- Consultation exercise completed and results analysed and report available to inform DMBC (date tbc)
- IIA Mitigation Plan and Ambulance Impact Modelling completed prior to the end of the consultation period in order to inform DMBC
- All key actions arising from external reviews of the programme completed
- Development of DMBC (date tbc)

Risks to delivery

Risks

Lack of resource to effectively deliver a public consultation, including programme management, patient and public involvement and communications, impacting on ability to receive QA from external assessor

Insufficient non-pay budget to deliver a public consultation of this scale

Significant political and campaign opposition to the proposals, impacting on programme reputation in the media

Uncommissioned activity, including travel and transport analysis, therefore impacting on planning public involvement in the process

Continuing delay in progess ing to formal consultation risks damaging the reputation of the programme and the increasing workforce challenges in SATH with recruitment and retention of ED clinicians risks decision to close PRH A&E overnight to maintain safe services has to be taken which could be viewed as predetermination ahead of completion of the consultation exercise

Actions:

Data

Urgent & Emergency Care

System Improvements

Plan on a Page

Shrewsbury and Telford Hospitals NHS Trust
Urgent & Emergency Care Programme - overview

NHS England

NHS Improvement

The Golden thread

Improvement in the A&E Quality Standard

Reduction in the stranded patient metric

SATH needs to:

1. Fully implement the SAFER patient flow bundle and Red2Green days. This incorporates the Alex Knight work by 31st March 2018 -(Slide 1)
2. Improve ED Systems and processes as plan by 31st march 2018 (Slide 2)
3. Decrease the stranded patient metric from 360 to 180 by March 31st 2108 (Slide 3)

System needs to:

1. Implement the frailty model of care as per plan with acute frailty network (Slide 4)
2. Support the Capacity and Demand project and discuss the recommendations when received at the end of March 2018-(Slide5)
3. Develop towards an integrated discharge team using the guidance on the High Impact Change Model, Jan2018 (Slide 6)

The progress:

- Ian Surgess has been in three times now and has trained five of the SATH members of staff to perform AEP. Check, Chase and Challenge is happening daily. Stranded patient review in place from Mid December and taking place every week.
- Length of stay review commences on the 15th of February
- Plans for Perfect Week commenced 9th February- assisted by STP
- Plans to implement Ben Owen's recommendations being led by COO, Medical Director and Nurse Director(more detail on slides)
- Plans to join 'End PJ Paralysis 70 day challenge' commenced- start 28th April.

Interventions and process changes

- Complete LOS reviews on all bedded environments by the end of February 2018
- Complete the Appropriateness Evaluation Protocol on every inpatient ward by 31st March 2018
- Perfect Week/Stop the line to address stranded patient metric to be completed end March 18
- Support to SAFER start week 1st March 2018
- Move Frailty Team to the front door PDSA February 2018

Risks to delivery

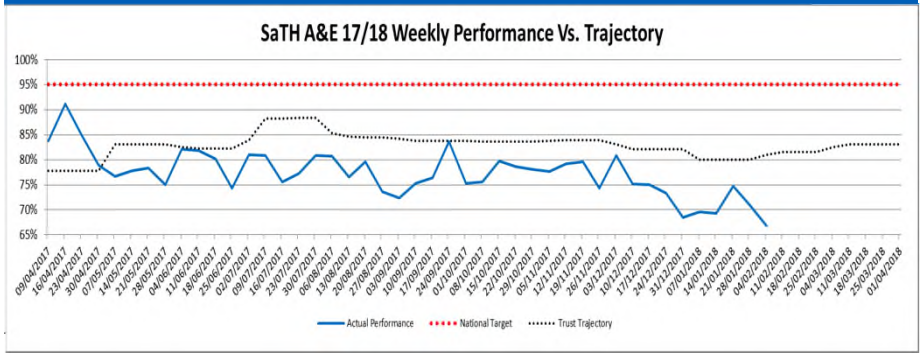
Risk

The medical workforce challenge including the number of junior doctors is the biggest risk in this environment

Actions:

- The chief executive officer has met with and negotiated with HEE for an expanded cohort by Feb 2018- this has been declined
- The emergency department is recruiting to fill vacant posts.
- The clinical lead and workforce lead are attempting to mitigate the risk through the appointment of long term agency staff ahead of the recruitment plan delivering any substantive appointments. The trust recognises the financial risk associated with this decision.

Data



Pathway Over View

Delivering 90% by September 2018

The Golden thread

System overview

Avoiding Admission

1. Optimity
2. Care Homes
3. Frailty
4. Readmissions
5. WMAS

AED Process

1. ECIP recommendations
2. Workforce
3. Control/Leadership
4. ED Value Stream (transformation)
5. WMAS:
   Reduction in conveyance
   Handover delay
   reduction plan

In-Hospital Process

1. Stranded patients
2. Ambulatory pathways
3. Pride & Joy constraints programme
4. SAFER

Discharge

1. Hospital discharge
2. Complex discharge
3. Pathway 1, 2, & 3 beds
4. Powys delays/capacity
5. Pre 12 discharge
6. Mental health pathways

The System

- Capacity and Demand review for the system
- External supporters: Dr Sturgess, Gary Swann, Emergency Care Improvement Programme (ECIP)
- KPO for urgent care pathway

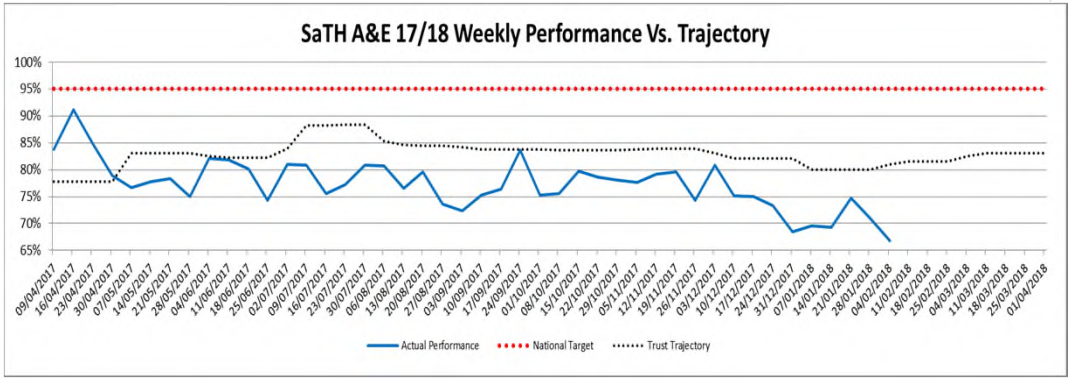
Interventions and process changes

- Complete LOS reviews on all bedded environments by the end of February 2018
- Complete review of percentages of simple and complex discharges by 7th March 2018 and compare with national average
- Review findings of the Appropriateness Evaluation tool to add intelligence
- Complete Length of Stay review in the acute Trust- end March 2018
- Dennis Holmes to complete interviews with identified system leaders and staff – end March 18

Risks to delivery

Risk

1. **Operational pressures prevent full engagement and involvement in review and development of an action plan and implementation.**
2. **Financial pressures prevent implementation of the review recommendations.**
3. **Workforce gaps and affordability**



Urgent & Emergency Care Programme
Stranded Patients

NHS England

NHS Improvement

Programme needs to:

Reduce the number of stranded patients with a length of stay of
- Daily / weekly review process in recording and reporting
- Management of 7 day patients
- Escalation and management of 21 day patients
- Use of AEP audit to identify baseline data – repeat bi-annually
- Identify top 5 reasons for patient delay and develop action plan to address

System needs to:

- System support for super stranded patient work including attendance at weekly escalation meeting and delivery of agreed actions
- System plan to address external reasons for delays identified via AEP audit

The progress:

- Established daily check, chase, challenge process across both sites
- Established super stranded patient (over 21 days) escalation process including executive triumvirate
- AEP audit completed for USCG and top 5 reasons for delay identified : Pathway plans, doctor reviews, pathway 2 beds, POCs, Pathway 3 beds
- Action plans to address SATH's identified areas (pathway decision and Doctor review) developed .

Interventions and process changes

- Establish daily check, chase challenge process
- Establish super stranded patient escalation process
- Complete AEP audit for USCG and identify top 5 reasons for delay
- Development and implementation of action plan to address internal delays
- Support system to address external delays identified via audit

Risks to delivery

Risks

1 Medical workforce constraints
2. Medical ownership of AEP audit outputs
3. Engagement of therapy department in required changes to working practices
4. Achievement of SP plan requires change in custom and practice for clinical staff – over prescription of social input noted
5. Engagement with local authority and Community Trust

Data

reduce LoS per pt	No of pts LoS greater than 6 days	Av LoS for stranded pts	beddays	beds at 100% occupancy	% Delivery of 180 target	reduction in beds required	OR	If beds maintained % occupancy	
0	5334	15	81213	295	0%	0		100%	current beds used by stranded patients based on 17.18 data
0.5	5334	15	78546	286	8%	9		97%	
1	5334	14	75879	276	17%	19		94%	
1.5	5334	14	73212	266	25%	29		90%	
2	5334	13	70545	257	34%	38		87%	
2.5	5334	13	67878	247	42%	48		84%	best practice occupancy rate
3	5334	12	65211	237	51%	58		80%	
3.5	5334	12	62544	227	59%	68		77%	
4	5334	11	59877	218	67%	77		74%	
4.5	5334	11	57210	208	76%	87		71%	
5	5334	10	54543	198	84%	97		67%	
5.5	5334	10	51876	189	93%	106		64%	
5.95	5334	9	49476	180	100%	115		61%	Target 180 beds for stranded patients

Urgent & Emergency Care Programme ED Systems & Processes

Programme needs to:

Improve ED Systems and processes as plan by 31 March 2018 by:

- Implement recommendations from internal and external reviews to improve non-admitted pathway
- Open CDU at PRH
- Review and revise operating plan CDU's across both sites
- Rapid Process Improvement Week (RPIW) for AEC unit at RSH 12-16 March
- Improve data quality issues associated with ECDS
- ED specific Value Stream – 16 March (Sponsor day), with RPIW 23-27 April
- Re-launch internal governance forum

System needs to:

- Review ambulance conveyance rates including:
  - Care homes via GP referrals
  - Batching of ambulance arrivals
  - Use of alternative pathways
- Ensure effective out of hours service provision to avoid unnecessary acute referrals
- 10 areas of focus – national priorities (cross-reference)
- Improve and embed escalation processes

The progress:

- Detailed action plan that incorporates outputs from both internal and external reviews developed and in place
- 2 DQC's appointed and commenced in post
- ED Patient Flow Co-ordinators appointed – in post from March
- CDU build on PRH site completed
- Planning underway for ED RPIW
- Planning underway for AEC RPIW

Interventions and process changes

- Change in working practices within ED departments
- Revise operational plan for CDU and implement
- Undertake RPIW for AEC and embed improved processes following the Kaizen event
- Undertake RPIW for ED value stream and embed improvements at 30/60/90 days
- Revise and re-launch internal SaTH governance to oversee improvements

Risks to delivery

Risks:

1. Clinical ED workforce constraints – failure to appoint to doctor and nursing workforce gaps associated with ED business continuity
2. Financial affordability associated with ED workforce plan
3. Volume of external assurance visits impacting upon staff morale
4. Pace of change required to deliver improvement
5. Capability of teams to implement required changes
6. Engagement of WMAS
7. Impact of 111 and Shropdoc service changes

Data

Potential improvement on ED performance 4.6%

Urgent & Emergency Care Programme SAFER - Red to Green

Programme needs to:

Fully implement the SAFER patient flow bundle and Red2Green days. This incorporates the Alex Knight work by 31 March 2018

- Board rounds & EDD
- R2G
- Criteria led discharge
- Pre 10 am/1600 ward huddle
- Pre 10am and 12pm discharges
- Average LOS

System needs to:

- SATH governance process for major work streams
- ED workforce improvement plan
- 10 areas of focus – national priorities (cross-reference)
- Escalation
- Whole Trust clinical communication
- Medical leadership
- Job planning
- Data and reporting
- Clinical pathways
- Pride and Joy

The progress:

- Patient journey facilitators now on 14 wards across both sites
- Completed various promotional events and have a regular slot on the trust's corporate induction
- Highlighted key delays and areas for improvement
- Work underway to integrate Red2Green on the PSAG board

Interventions and process changes

- Complete the Strategic Workforce Baseline data gathering
- Develop a consistent and streamlined FFA completion process
- Gain visibility around LOS and changes to EDD
- Develop consistent electronic process for Dr to Dr referrals
- Gain assurance that Board Rounds are adding value and are action orientated

Risks to delivery

Risks

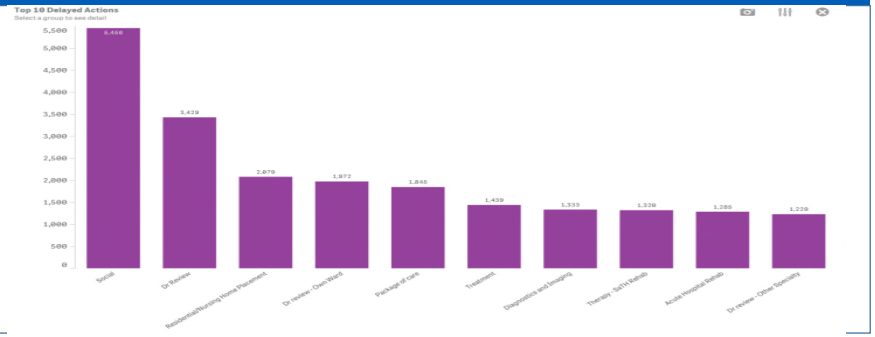
1. Ward staff engagement and capacity to support
2. Lack of engagement from medical staff
3. Ineffective board rounds and lack of standardisation
4. Duplication with other initiatives
5. Capacity of patient journey facilitators

Data

27.03.17 – 27.02.18

Top 3 delays

1) Social/therapy delays
2) Dr Review
3) Residential/ Nursing Home



Shrewsbury and Telford Hospitals NHS Trust
Integrated Discharge Team

NHS England

NHS Improvement

Improvement discharge practice

The Golden thread

Improved integrated discharge practice in Telford

Health and social care system needs to:

1. Ensure an integrated team discharge team approach continues to develop.
2. Continue to support the admission avoidance pathway provided by Rapid Response nursing and social care teams.
3. Review current team scope to further improve performance.
4. Improve flow through discharge process to maintain performance by improving the level of rigour particularly in the intermediate care bed process.
5. Haver a single narrative in the form of a system wide operational framework for intermediate care in Telford.

System needs to:

1. Increase membership and increase input to the current integrated discharge processes particularly enabling SaTH therapy directed transition planning for discharge.
2. Further develop towards an integrated discharge team using the guidance on the High Impact Change Model, Jan2018 (Slide 6)
3. Support the current demand and capacity modelling across the system.
4. Implement the aspiration target of 21 days length of stay inn the intermediate care beds to improve flow and access.
5. Further develop the system wide assistive technology offer.

The progress:

1. Review day held 5/2/18 for all system partners in discharge and intermediate care planning including; SaTH/SSSFT/SCHT/TW CCG/TWC/third sector/independent sector.
2. System wide operational refresh intermediate care framework agreed by all partners.
3. Review of intermediate care beds provision and process carried out by CCG quality Lead Nurse and improvement action plan developed as a result.
4. Visit booked to Warwickshire to view best practice model.
5. From 26/2/18 British Red Cross will be seeing all PW 1 patients before discharge on the ward and once home if required.
6. Since Jan 18 specific OT to support patients being discharged from intermediate care to prevent re-admission.
7. Well-being sessions being offered to those on GP Frailty list following MDT to prevent urgent admissions to hospital.
8. NHS Digitial bid submitted to join up partner discharge planning

Interventions and process changes

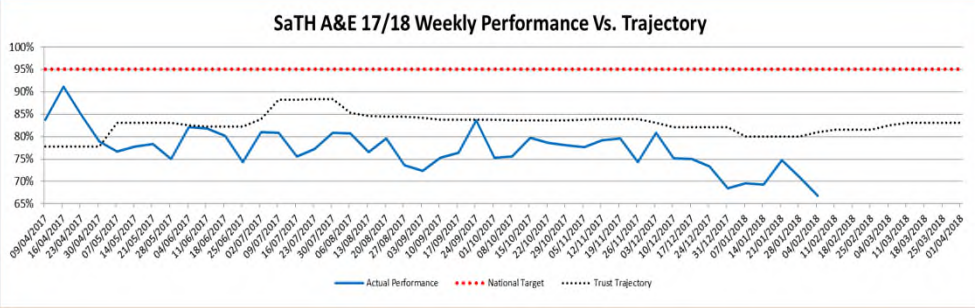
- Set criteria met nurse discharge especially at weekends
- Operational intermediate process and framework review and system wide agreement to new framework.
- Training across all partners regarding new intermediate care process.
- Red, amber, green process for all intermediate care pathways with twice weekly monitoring and MDT's. tracker post out to advert.
- Point prevalence/audit to review progress against new framework
- SaTH therapists to goal set for minimum 72 hours post discharge
- Transfer by relative/Red Cross should be default unless otherwise indicated
- Anticipatory equipment planning and prescribed meds with person day before discharge

Risks to delivery

Risk

- **Provider failure dom/bed based care. Mitigation plan in place**
- **Lack of collaboration between partners. Framework in place across all partners including trainng and routine consultation and collaboration.**
- **BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.**

Data



Urgent & Emergency Care
Demand and capacity review

NHS England

NHS Improvement

Improvement in the A&E Quality Standard

The Golden thread

Reduction in the stranded patient metric

SATH needs to:

1. Chris Green to visit the Trust to discuss acute modelling. Date to be confirmed (aim for before Mid- March)
2. Develop an acute plan using data and intelligence provided
3. Task and Finish Group to be set up to implement findings

System needs to:

1. System needs to support Dennis Holmes in the review of all out of hospital capacity by the end of March 2018
2. In April 2018, used the refreshed D2A group to develop the action plan based on report recommendations.
3. Julie Davies to ensure that Powys are informed and engaged with system review.
4. System lead to visit Wye Valley to discuss implementation of SOP with Powys.
5. Draft TOR to April A&E Delivery Board
6. Final plan to A&E Delivery Board in May

The progress:

- Initial acute modelling performed by Chris Green
- Review of P2 and P3 for Shropshire, Telford and Wrekin completed by 23rd February 2018.

Interventions and process changes

- Complete LOS reviews on all bedded environments by the end of February 2018
- Complete review of percentages of simple and complex discharges by 7th March 2018 and compare with national average
- Review findings of the Appropriateness Evaluation tool to add intelligence
- Complete Length of Stay review in the acute Trust- end March 2018
- Dennis Holmes to complete interviews with identified system leaders and staff – end March 18

Risks to delivery

Risk

1. Operational pressures prevent full engagement and involvement in review and development of an action plan and implementation.
2. Financial pressures prevent implementation of the review recommendations.

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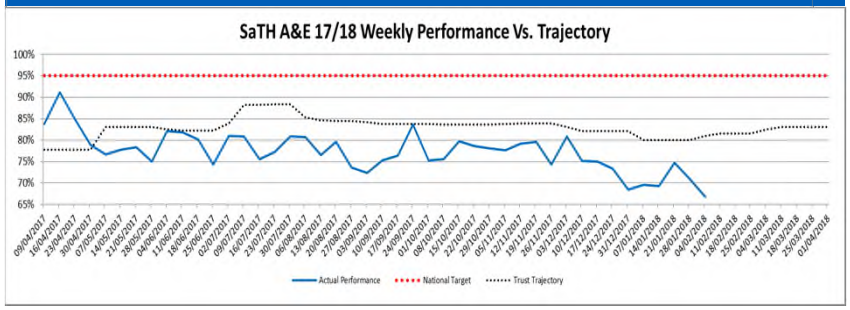


Transformation Enablers

System Improvements

Plan on a Page

Digital Enabling Programme

NHS England

NHS Improvement

Improvement in use of technology enabled care

The Golden thread

Appropriate information securely available to the appropriate person at the appropriate time.

Programme needs to:

- Connectivity :
  - Provide seamless access networks and efficient procurement of new connections
  - wifi access for staff and citizens at all locations.
- Populate Information sharing Gateway with agreements to allow sharing of information between organisations.
- Formulate an STP-wide plan for Cybersecurity: Ensure records and systems are secure.
- Licensing: future proof and cost efficient route for Microsoft and Office upgrades (towards O365 and CloudFirst)
- Support digital requirements for all other programme groups
- Improve Digital Maturity Assessment scores to support programme success.
- Develop funding bids for possible future funding availability
- Analyse options for an Integrated care record across health and social care settings.
- Identify the capability for Interoperability across the STP area.

System needs to:

1. Clarify the end vision and the level of commitment required from organisations.
2. Act as One! Agree the objectives of the enabling group with in the strategic governance process at exec level
3. Standardise on clinical coding (SNOMED-CT) for all organisations.
4. Provide resource (inc funding, project management etc) to define and plan programmes and projects
5. Involve digital solutions in all workstreams. Promote the modernisation and efficiency of paperless processes to increase efficiency through a digital programme
6. Conform to cyber-security requirements – and resource specialist support
7. Provide Strategic direction for an STP solution to enabling a system wide approach to an infrastructure that enables the use of all modern technologies to improve frontline patient care.

The progress:

- Universal Capabilities: most on target to be significantly delivered by March-18, with enhanced delivery going forward.
- Digital Maturity Assessment improved over previous year (except for medicines management, and where the requirement changed e.g. B.I.)
- Information Governance – ISG signed up to by all agencies, and becoming operational
- Funding Bids
  - ETTF for GP wi-fi and Voice over IP telephony - implementation in progress
  - LMS bid for user kit and software development - bid submitted
  - Electronic discharge to social care – bid submitted
  - Online consultations - part of GP5YFV - going to procurement
  - ETTF money secured for video consultations and telehealth

Interventions and process changes (milestones)

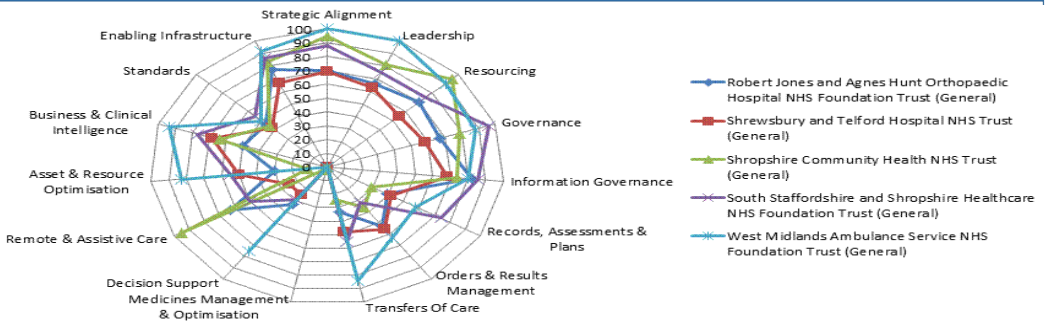
- Data Sharing Agreements on Electronic register across the LHE May 2018
- Universal Capabilities significantly delivered by end of March –2018 (on target)
- Electronic Patient Record systems need to be procured for SaTH and RJAH to support shared access to Integrated care records.
-
-

Risks to delivery

Risks

Resources – (lack of funding, governance and leadership to progress strategic planning, and availability. commitment from senior management to release or increase resources)
Lack of Technology standardisation - Action :Identify interoperable platforms and recommending their use across the STP
Licencing costs are set to increase with a requirement to migrate to a supported set of office applications with revenue costs instead of capital.
Executive Strategic Direction
Lack of clear co-ordinated approval processes for schemes with a cross-organisation impact.
Complex governance arrangement (STP is not an executive group with delegated authority.)
Lack of consistent engagement from social care and mental health trust.
Uncertain leadership of the DEG. No consistent CCIO appointment process and no DEG CCIO position defined.
Actions:
Creation of 3 supporting groups

Data



Strategic Estates Programme

Improvement in Systems Estates Planning

The Golden thread

Community Centric Approach.
People rather than building focused.
Partnership approach the norm.

Programme needs to:

- Use data in geographic layers at a very local level as evidence of emerging community need, & how or if they are being addressed
- Identify opportunities for developing community hubs, housing solutions or projects to support economic growth, where a local need is present.
- Inform the requirements for future service provision and ultimately guide the utilisation of the public estate
- Ensure estate is accessible, efficient and safe.
- Engage the expertise and knowledge of public sector delivery leads in developing community needs-based projects stemming from opportunities created by the One Public Estate work-stream.

System needs to:

- Provide an integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- Deliver a reduction in estate
- Reduce / plan removal of backlog maintenance
- Support Estate aligning with and utilising the One Public Estate agenda
- Utilisation aligned with Carter review
- Deliver a Reduction in annual revenue costs
- Provide flexible estate that will enhanced a dynamic healthcare economy
- Develop local solutions drawing on all the assets and resources of an area
- Build resilience of communities

The progress:

- SHAPE database validation undertaken by all partner organisations.
- Estates Workbook & Disposal produced, now a 'living' document
- Initial Community Needs workshop 27 Feb 18 to inform future Estates projects delivered with engagement from senior reps inc. Public Health England, CCG's Providers; VCSA, Adult & Social Care, DH, Early Help, Shropshire Council, Keele Uni, Housing, Economic Growth, Community Health FT, Nature Partnership, Data Analyst/Intelligence,
- Similar repeat workshop planned for Telford localities 17Apr18*
- Project Manager & Project Group in place for Whitchurch Project, following successful OPE bid. Now moving from strategic planning to delivery
- Asset Mapping & data layering work with Shropshire Council going well, producing evidence base & assisting to inform opportunities

Interventions and process changes

- Circulate workshop outcomes , feedback through STP/Council/OPE partners/Local Councillors. Market Town specific Workshops to inform next steps
- Run Telford & Wrekin Workshop, identify opportunities and then bring together all opportunities into one whole system approach
- Overarching and adopted estate strategy aligning with the estate outcomes and key STP outcomes
- Outline rationalisation plan, with better use of void space, shared/bookable space, joint utilisation, extended opening hours, energy efficient
- Evidence using Geographical Intelligence Systems applied in layers ; to include Voluntary Sector services

Risks to delivery

Risks

- Timelines for funding bids vary across different organisations; aligning for cross-organisational estate projects difficult to achieve.
- Aligning existing projects and agreement on potential future opportunities
- Engagement not fully embraced

Actions:

- Transparency and awareness of funding timelines between organisations
- Agreed approach to partnership working
- Identify and Plan for interim arrangements

Data

- Validation and updates of SHAPE database (Health Service Estates) by all relevant organisations; ongoing requirement to maintain accuracy
- Property and Estates (Shropshire and Telford), Freehold land, Leasehold land, Leased land;
- Transport , Shropshire and Telford Bus routes 2016, Car and Van ownership *(2011 Census);*
- Demographic (covers Telford and Shropshire) *(2016 MYE ONS)* ,
- Deprivation (2015 IMD, DCLG)
- Community Facilities (e.g. libraries/schools)
- Older People,
- Health, including long-term illness & disability; health deprivation
- Planning Themes (Planning and Land Use Monitoring
- systems, Planning Policy Team
- Economy
- Housing Affordability

Strategic Back Office

NHS England

NHS Improvement

The Golden thread

Improvement in shared resources & risks

STP Long Term Financial Sustainability

Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;

Corporate services savings in the health economy, using recent benchmarking data,
Shared recruitment processes (being developed by the Workforce Work stream
Procurement savings through model hospital and PPIB data
Estate rationalisation (developed by the STP Estates Work stream)

- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value (e.g. target set to drive costs to the national median).

System needs to:

1. Support a level of ambition proposed by the programme – ie. drive costs to the national median (where there is one or other agreed benchmark where there isn't),
2. Sponsor and support the collaboration on key priorities, initially by sponsoring the CSU's diagnostic and option appraisal process.
3. Have an 'open book' approach to data and information to enable opportunity assessment,
4. Develop the relationship with other STP stakeholders to assess the opportunity for wider public sector benefits,
5. Agree a change programme in due course.

The progress:

- The work stream has demonstrated good practice in collaborating and sharing information between NHS providers.
- Underpinning case for change still holds true.
- Individual STP work streams are working on discrete aspects of rationalisation or collaboration (estates and workforce)
- All providers are using benchmarking data to support decision making

Interventions and process changes

- Initial exploration of the Model Hospital opportunities for Providers, including corporate services and ambition set – February 18
- Initial discussion with Midlands and Lancashire CSU Value Add proposal to pump prime further review and option appraisal – March 18
- Commence CSU diagnostic – April 18
- Evaluate CSU diagnostic conclusions and agree programme of change – Summer 18
- Implement change programme – Autumn 18 onwards

Risks to delivery

Risks
The scale of opportunity will not be realised due to;

1. Lack of collaboration beyond health on procurement.
2. Capacity to drive ideas forward across organisations at pace
3. Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
4. A Shropshire centric preference not accessing the opportunity where it is at its greatest on a wider footprint (ie out of STP boundaries)

.....
Actions:
A review of the effectiveness of the existing county wide Procurement Group
Using the CSU diagnostic and option appraisal process to increase pace, draw conclusions and propose a change programme which will require tangible agreement.

Data

Model hospital (Carter)
Corporate services data (Model Hospital)
NHS Efficiency Map
Procurement data (PPIB)

Strategic Workforce Programme

NHS England

NHS Improvement

The Golden thread

Improvement in strategic workforce development

Workforce Capacity
Workforce Capability
Culture & Leadership to deliver Transformation

Programme needs to:

1. Develop a system-wide **Strategic Transformation Workforce Plan.**
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change.

System needs to:

- **Work closely to share workforce intelligence**, undertake workforce modelling and strengthen system ownership of workforce strategies.
- **Work collaboratively** to attract, recruit and retain the current and future health and care workforce.
- **Agree system-wide requirements** in order to maximise the education, development and training opportunities for our workforce.
- Lead a **system programme** that delivers transformation and sustainability.
- Lead **cultural change** through health and care that supports **integrated working** which prioritises patients resulting in improved population health and wellbeing.
- Deliver **system-wide workforce solutions** and improvements in response to the system workforce challenges.

The progress:

- Agreement between STP partners on **priority areas.**
- **System-wide Workforce Strategy** initial stages begun .
- **Mental Health Workforce Plan** March submission on schedule
- **OD plans and Workshops** with King's Fund underway.
- **Local Maternity Services (LMS) Transformation Plan** developed with workforce analysis being undertaken.
- **GP Forward View Workforce Plan** and delivery of GPFV primary care workforce projects underway.
- West Midlands agreement for **consistent /shared statutory and mandatory training** across NHS organisations.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services.

Interventions and process changes

Complete the **workforce profile data** gathering and individual specialist workforce plans.

Leadership and OD Programme with the King's Fund ongoing. STP Partner attendance on **TCSL Programme .**

Development of **Shared Recruitment** project and **Collaborative Bank.**

Implementation of a pilot **Rotational Apprenticeship Programme.**

Delivery of **STP/LWAB funded priority areas** and development of a **shared training/learning** offer to meet system needs and promote integrated working.

Risks to delivery

Risks:

- Planning without knowledge of future finances and service redesign/configuration.
- Varying levels of stakeholder engagement driven by different approaches to Workforce and access to data.
- Ability to fund workforce development activities both in terms of finance and time.
- Risk to quality of STP submissions due to a lack of clarity around requirements .
- Timely decisions in respect of funding which affects education, development and recruitment.

Actions:

- Ensure strong workforce links with STP clinical /service priorities reporting into the Strategic Workforce Group.
- Continue to build relations through working together on identified projects/ task & finish groups.
- Identify priority development areas and align through STP PMO processes.
- Collaborating with HEE to access support and align programmes.
- Piloting areas of work to test outcomes.

Data

Shropshire Workforce Baseline: HEE are developing an STP dashboard for workforce data which will use NHS organisations workforce data submitted to NHSI as part of the operating plan submission on 8th March along with social care data from the NMDS. There is also the potential for Skills for Health to undertake some analysis on behalf of the STP.

Individual areas of workforce:

- Mental Health Workforce data included in the submission of the MH Workforce Plan in March.
- Maternity workforce data being developed as part of the LMS Plan
- Primary Care workforce data has been collated as part of the GPFV Workforce Plan
- Future plans to include Cancer Workforce.

Strategic Communication & Engagement Programme

Improvement in Communication & Engagement

The Golden thread

A single message and understanding of the STP Programme of work

Programme needs to:

- Create a comprehensive communications and engagement strategy, building on the wider vision and values OD activity, to encompass all workstreams of the developing STP, ensuring co-production with all stakeholders
- Provide communications and engagement support to STP priorities
- Develop channels for communication of STP activity
- Provide advice, support and guidance to individual workstreams, facilitating two-way communication and identifying content for communicating across the STP partners and beyond

System needs to:

1. Work together to utilise each organisations' limited resource for patient involvement and communications
2. Ensure synergy across core delivery partners - such as providing additional assurance that the delivery of the plans is embedded within the sponsoring organisations' own activities, but also provide insights on how to best deliver across the wider community that the programme impacts
3. Develop and embed a cohesive vision and values for the STP footprint that each organisation and their staff recognise and understand, thereby facilitating the production of a meaningful communications and engagement strategy

The progress:

- Communications and engagement workstream meets monthly and includes representation from all partner organisations, including Healthwatch
- Communications and engagement leads aligned to each of the workstreams, to offer support and advice and gather progress articles

Interventions and process changes

- Gain a clear understanding of the vision and values of the STP that have been signed up to by all partners
- Map activity across workstreams to understand timing of potential service changes
- Develop a comprehensive communications and engagement strategy
- Develop and deliver channels for communication of STP priorities
- Support service reconfiguration activity

Risks to delivery

Risks

Lack of building blocks in place to effectively resource (pay and non-pay) the activity required lead to an inability to develop and maintain external, internal communications

Lack of understanding of the proposed overall plan for the STP leads to public objections.

Limited system wide resource may lead to failure of workstreams to adhere to required processes leading to assurance test issues going forward.

Inadequate patient, citizen, stakeholder involvement in proposed service transformations, leads to public opposition and a potential failure to meet assurance tests moving forward.

Lack of coordination or necessary timings lead to service reviews and potentially consultations taking place at the same time, leading to public confusion and opposition.

Negative presence in the media undermines confidence in the programme which may lead to distraction, unnecessary excess utilisation of resources and finances.

Data

Plan is to use Comms & Engagement data to inform

1. Public perception of service changes
2. Confidence levels in strategies and plans
3. How well we are including stakeholders in our redesign and service changes
4. Measure responses from websites and surveys

Population Health & Prevention

NHS England

NHS Improvement

Improving population health

The Golden thread

Embedding prevention through all the work we do

The programme needs to:

1. Develop our wider workforce to 'make every contact count' (MECC+) / proactive identification of people at risk of ill health and behaviour change conversations, brief interventions
2. Prevent harm due to alcohol, obesity and CVD
3. Support culture change and new working practices that help people at the earliest opportunity
4. Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
5. Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities
6. Support and embrace the role of the VCSE and communities to drive forward prevention activity
7. Focus on developing a good understanding of need – continual information provision for the JSNA
8. Improve communication between organisations

The system needs to:

1. Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC +, PHE's One You, including for:
   - Stop Smoking Support
   - Weight management
   - Physical activity programmes
   - Immunisation opportunities, e.g. flu
2. Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension
3. Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services
4. Deliver prevention expectations of the national Cancer Strategy
5. To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support
6. **Work together to make best use of resource and expertise**

The progress:

STP

Mobilisation of the National Diabetes Prevention Programme March-May
Neighbourhood working to build community capacity- focus on Healthy places, Active and Creative communities
Delivery of Social Prescribing initiatives and infrastructure
Supporting Carers through all age strategies and Dementia Companions
Delivery of Fire Safe and Well Visits (since July 17)
Develop and deliver a system prevention framework for all pathways
Developing very positive joint working across health and care
Individual Placement Support Service for those in secondary MH services

Telford & Wrekin – Healthy Telford

Borough-wide lifestyle offer
Twitter and blog – using social media to inspire behaviour change
Developing and nurturing our community health champions
Public Health Midwife, stop smoking support and maternal health advice

Shropshire – Healthy Lives

Development of an Integrated Care Navigation Programme
Delivery of Healthy Lives Programme and prevention services

Opportunities

- Smoke free hospital and brief interventions in hospital
- Connecting to workforce (and funding) to support development of staff (link to MECC plus)
- Mental health hubs, MH support in Local Maternity hubs, Early help for children and young people, link to Estates
- Healthy hubs and social care support/ advice and guidance in hospital
- Risky behaviour CQUIN - link to MECC Plus

Interventions and process changes

- Improve access and use of population health and wellbeing data from across the system to support decision making
- Develop and Deliver System CVD & Diabetes Strategy
- Deliver the prevention expectations of cancer strategy
- Develop system social prescribing infrastructure
- Develop and Deliver System Obesity Strategy
- Development of a system plan to reduce harm related to alcohol
- Develop the system MECC Plus proactive approach, including training and delivery plan

Risks to delivery

1. Lack of buy in by partner organisations
   - Risk to strategy delivery
   - Risk to culture change needed
2. Investment in prevention programmes (national and local)
   - Local Authority Public Health Grant challenges
   - Lack of NHS investment in prevention
3. Medical and nursing capacity
   - NHS Trusts (SaTH, SSSFT, ShropCom, RJAH)
   - Primary Care

Outcomes – how do we know it's working? DRAFT

Public Health Outcomes Framework
- Healthy life expectancy
- Health Equity
  - Smoking rates
  - Obesity – children and adults
  - Physical activity
  - Wellbeing measures – Social Prescribing
  - Reduction in GP attendances
  - Reduction in unplanned hospital admissions
  - Cancer rates
  - Harm due to alcohol – alcohol admission rates

Connecting to other programmes

- Health and Wellbeing Boards Strategic Planning (both T&W and Shropshire)
- Better Care Fund (T&W and Shropshire)
- Rightcare
- STP Neighbourhoods and Out of Hospital Programmes – community development,
- GP 5 Year Forward View –
- Mental Health 5 Year Forward View – preventing
- Maternity Services Transformation
- Workforce – developing our
- Estates Partnership
- Musculoskeletal and Falls System Planning

System Strategic Finance Programme

NHS England

NHS Improvement

Improvement in System Financial Position

The Golden thread

Provide improved financial support and probity through impartial, transparent, accurate, timely, complete and relevant financial information across the Integrated Care System.

Programme needs to:

- Provide clear, timely, accurate and relevant financial information and reporting to internal and external stakeholders including NHSE/NHSI, member organisations, Executive groups and individual work stream programmes and enabling work streams
- Support individual and collective work stream program managers, provider and commissioner finance teams to provide financial guidance to achieve defined outcomes and benefits including specific programme targets and timelines
- Support identify the optimum decisions with pertinent financial information.
- Increase the financial profile and raise financial understanding amongst non-financial management
- Better understand the objectives and congruence with each work stream to advise most appropriate action/outcome.
- Provide clear financial overview of each work stream, timing and planned gap to achieve overall financial control total.

System needs to:

- Clearly define objectives, activity, resource, milestones within each program work stream to enable accurate assessment of financial impact and timings of each work stream quantifying target financial benefit / cost.
- Clearly define current financial position for each work stream
- Share all pertinent current financial information.
- Organisations needs to appoint and advise of financial resource (personnel) for each project.
- Greater financial transparency; Organisation needs to share financial information sufficient to be able to identify potential double counts for QIPP/CIPS and identify any performance / activity / demand / income / expenditure gaps.
- Identify additional cost savings to recover adverse in year FOT performance
- Include a suitable provision (target over-performance) to cover performance slippage and help protect control total target attainment

The progress:

- Identifying current financial gaps in STP outturn group performance
- Started to work with LMS projects to understand project objectives, milestones and financial impact with timings (process needs to be completed for all work streams)
- Supporting Estates work stream improving financial transparency and congruence with the members' strategic capital investment plan Establishing a credible portfolio of executive reporting tools for financial transparency to aid control and improve relevant response
- Developing a risk register that includes valuations of risk, pre and post mitigation potential
- Building strong links with CCG and provider finance teams to aid transparency and consistency to help provide a congruent financial footing for effective decision making

Interventions and process changes

Understand and report control gap
Support work streams, providing financial management, help define and achieve financial and quality goals

Work with the Integrated Care System and work streams to:
1. attain / retain identified financial and quality benefits
2. Identify additional opportunities to recover the reported control deficit

3. Establish a work plan provision for a robust trading position (aim for over delivery)

Develop and deliver channels for communication of STP priorities

Identify capital requirements and ensure full disclosure (link with estates strategy

Risks to delivery

- **Risks**
- '17/18 FOT negative variance from control totals; achieving underlying financial performance targets. Additional plans required to recover this forecast deficit.
- Future CIP, QIPP and STP double counts between commissioners / providers
- Co-operation and necessary disclosure between all member organisations.
- Triangulation and accuracy of contract activity and income assumptions between CCG and provider.
- Availability and timing of capital for strategic change e.g. Future Fit requirements.
- Resource; STP finance support available throughout project life .
- Extended double running; timings of inter-connected and enabling work streams essential to ensure efficient transformation and full financial benefit attainment.

Data

1. System Data in relation to finances will be shared via the following routes
   - Strategic Leadership Group
   - Organisational Board Meetings
   - System Finance Group

All data in relation to system finance will need to be consolidated and checked for accuracy

STP PMO Resource

STP PMO Support

- STP PMO are a flexible system resource allocated across a number of Transformation Enabling & Delivery programmes
- Their key role is to support existing system staff: Programme Management, including project set up, engagement, reporting, risk mitigation, benefits realisation.
- STP PMO can provide standard templates and methodologies where those don't already exist and support the system as required.
- They hold a system wide view and can help identify interdependencies and risks across system programmes of work
- STP PMO are NOT leaders for programme delivery, they support coordination and facilitation to drive change. The leaders come from within the system itself.
- The PMO will hold the System Project register

Current Support Provided

- The next slide shows the STP Team Resource and allocated area of work
- Where STP Partners have existing resource, the ethos is to work in a matrix approach to avoid duplication and to ensure added value
- Collaborative working will be facilitated through SharePoint shared files and virtual working practices using Skype and Microsoft teams

STP Governance

- STP has no authority and is bound by current governance arrangements, it relies on partnership and trust between STP Partner Organisations through the STP Strategic Leadership Group (System CEO's)
- STP Priorities are driven nationally & locally and are influenced by System Leadership and STP Clinical Strategy Group
- Patient & Public involved is required in Every Delivery & Enablement Group, it's a requirement of individual workstreams to ensure this occurs as required.
- STP Programme Board is where system Programme Delivery and Enabling Workstreams come together to share progress and mitigate / escalate risk as required (this Group is due to be reconvened in April 18)

To contact a member of the team or ask any questions please contact:

STP Programme Director	Phil.Evans1@nhs.net	Programme Leadership
STP Urgent Care Director	Claire.Old1@nhs.net	System Urgent & Emergency Care
STP Head of PMO	Jo.Harding1@nhs.net	PMO Transformation & Enablement
STP Communication & Engagement Lead	pam.schreier1@nhs.net	System Communication & Engagement
STP Senior Project Administrator	J.Knott@nhs.net	STP Diaries, Meetings, Requests,
STP Programme Manager	Andrea.Webster5@nhs.net	Transport, Telford Neighbourhoods
STP Programme Manager	Penny.Bason@nhs.net	Future Fit, Population Health, Prevention,
STP Programme manager	Robgray@nhs.net	Digital Enablement
STP Programme Manager	sara.edwards3@nhs.net	Strategic Workforce
STP Programme Manager	Maggie.durrant@nhs.net	Estates, Back Office
STP Programme Manager	Paul.gilmore1@nhs.net	System Finances
STP Programme Manager	Jill.barker4@nhs.net	Urgent Care, MSK
Future Fit Programme Support	haley.barton1@nhs.net	Future Fit Programme Project Support
Future Fit Senior Communication & Engagement	niki.mcgrath@nhs.net	Future Fit Programme
Future Fit Communication & Engagement	kathryn.smith37@nhs.net	Future Fit Programme

All Resource is coordinated through STP Programme Leadership and PMO and area's of responsibility may change according to STP priorities.
The team work across all sites and are a combination of full and part time staff.

If you have a programme of work not already identified in this slide pack that you would like to see developed across our system that has clear **SYSTEM** benefits:
Please contact jo.harding1@nhs.net
Existing governance arrangements will still apply to all programmes of work in terms of approvals

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Shropshire, Telford and Wrekin
Sustainability & Transformation Programme Governance Structure

STATUTORY ORGS
Requirement to adhere to own governance procedures

Provider Boards
Commissioner Boards
Local Authority Cabinets

- Telford & Wrekin CCG
- Telford & Wrekin LA
- SaTH
- RJAH
- ShropCom
- SSSFT
- Shropshire CCG
- Shropshire LA

STP System Leadership Group

(System CEOs)

Health & Wellbeing Boards

Joint Health Overview Scrutiny Committee

STP Clinical Strategy Group

(System Clinical Leads)

STP Transformation Programme Delivery Board

System Enablers

- Strategic Workforce Group
- Communication & Engagement
- System Back Office
- Strategic Estates Group
- Digital Enablement Group
- System Finance Group

Telford & Wrekin

1. Community Resilience & prevention
2. Neighbourhood Teams
3. Systematic Speciality Review

- Local Maternity Services
- Muscular Skeletal Services
- Future Fit Sustainable Services Programme
- Frailty
- Development of Primary Care
- Mental Health
- System Cancer
- System End of Life programme
- UEC High Impact Changes

Shropshire

- Neighbourhoods & Prevention
- Out of Hospital Programme
  1. Frailty Front Door
  2. Primary Care Development
  3. Hospital at Home / Crisis intervention

System Partners On Programme Delivery Board

- Health Watch Telford & Wrekin
- Local Pharmacy Committee
- Shropshire Partners in Care
- Powys Teaching Health Board
- Severn Hospice
- ShropDoc
- West Midlands Ambulance Service
- Patient Groups
- Voluntary Sector
- Welsh Ambulance Service
- Wider independent organisations
- System Neighbours
- Health Watch Shropshire
- Subject Matter Experts