Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

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

Region:
Shropshire and Telford & Wrekin

STP Directors Update

June 2018

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

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

Priorities

•Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.

•Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.

•Ensuring all community services are safe, accessible and provide the most appropriate care.

•Redesigning urgent and emergency care, creating two vibrant ‘centres of excellence’ to meet the needs of local people, including integrated working and primary care models.

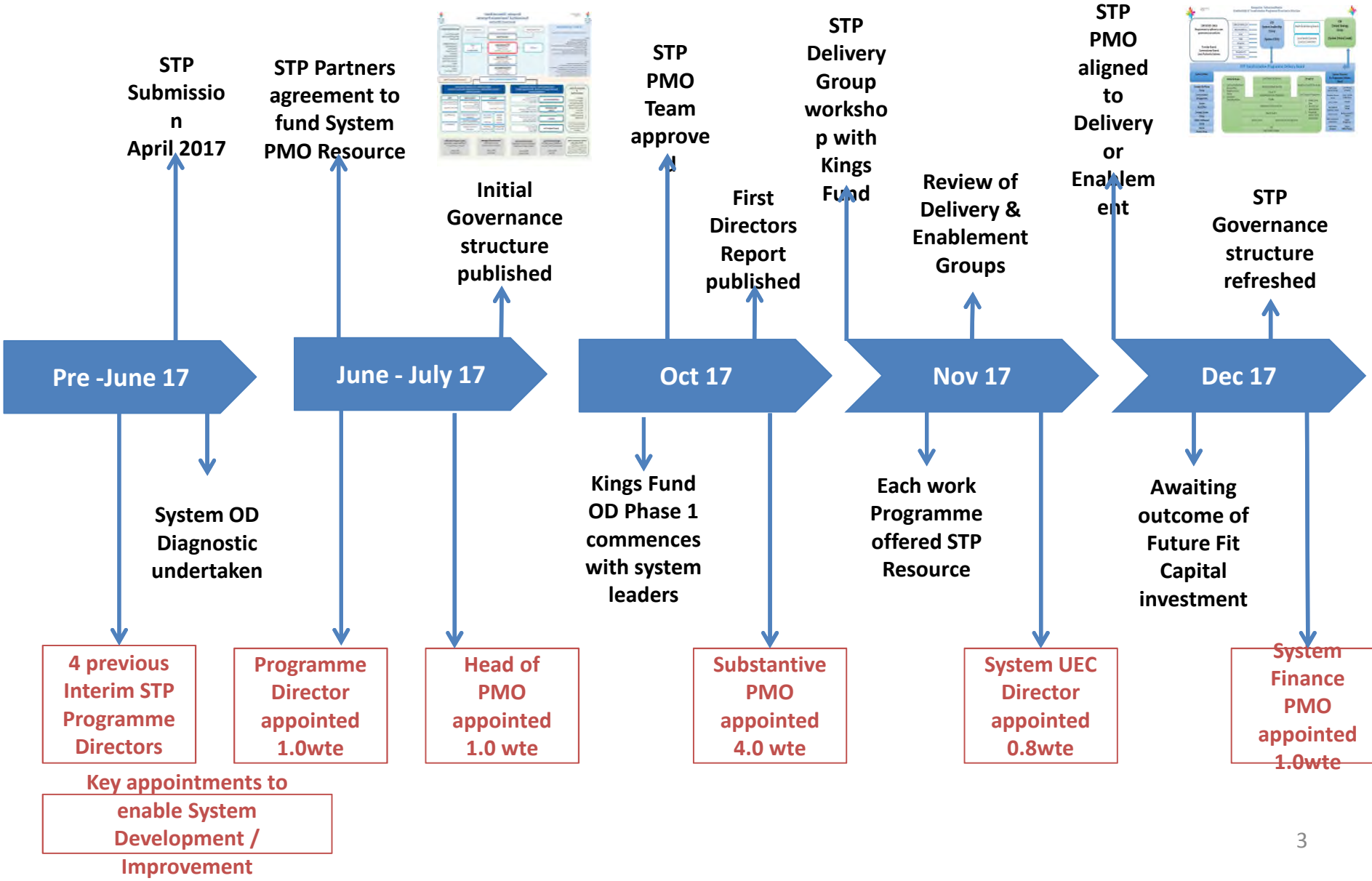
•Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.

•Involving local people in shaping their health and care services for the future.

•Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

JH1

Timeline of key STP activities June 17 – Dec 17

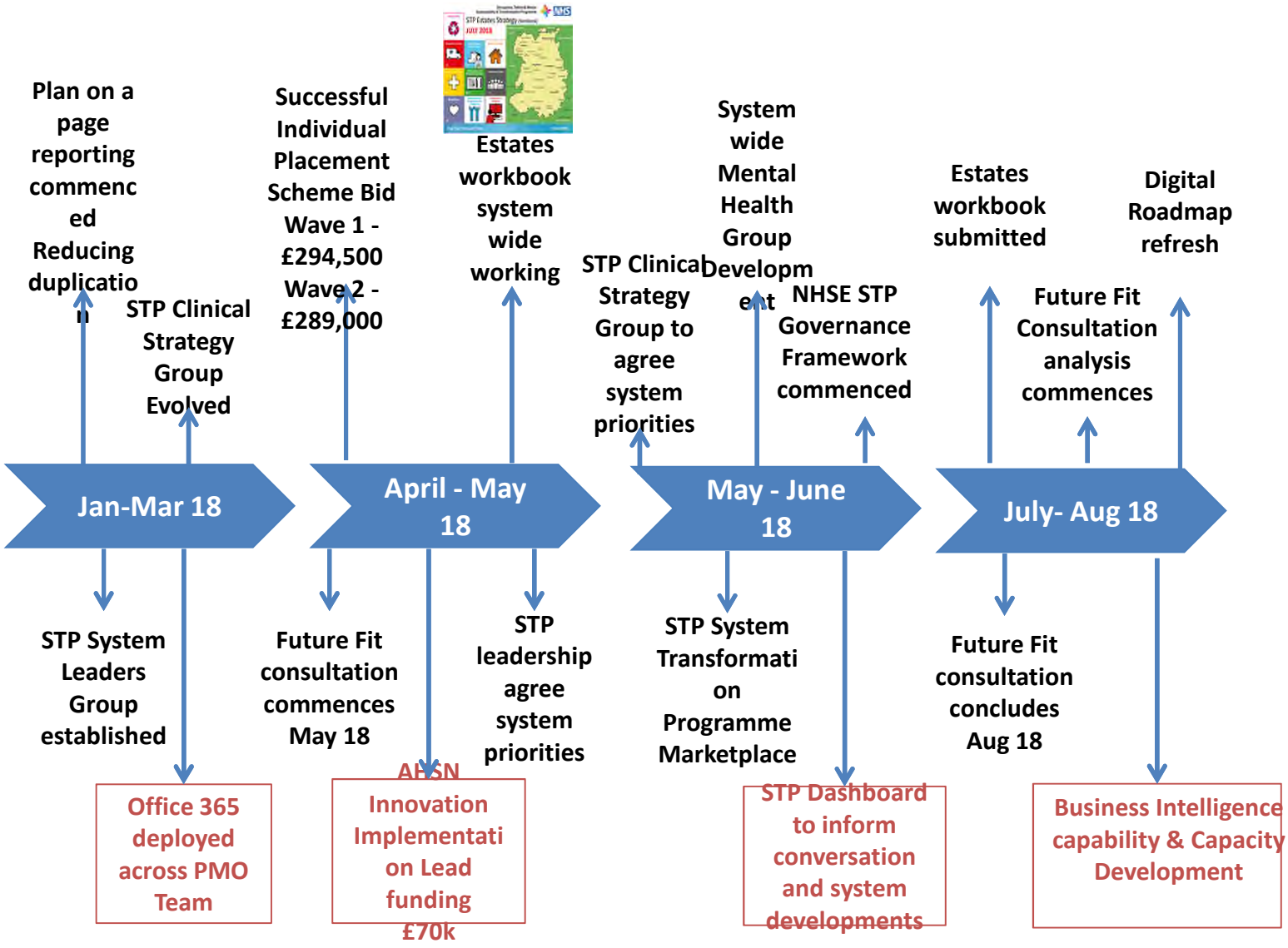


Slide 3

JH1 This is a new slide I have added in to capture some of the key things we have undertaken at a very high level, mostly those that are affecting system development

Jo Harding, 04/05/2018

Timeline of key STP activities Jan 18 – Aug 18

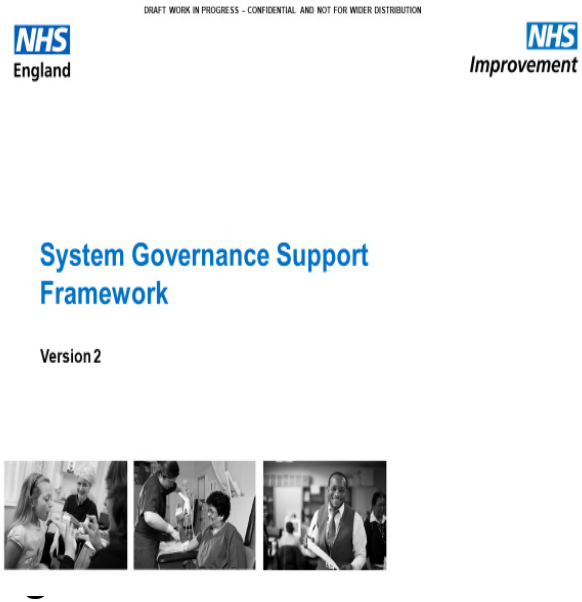


Shaping STP System Thinking

- STP PMO National Leads engagement
  - Shared intelligence, leadership thinking and peer s
- STP Governance developments
  - Use of NHSE System Governance Framework
- CQC style system health check being developed
- Better use of data – STP Dashboard, Model Hospital, Ri

Partnership working for our system transformation

- Clinical Strategy Group relaunch May 23rd
- System Estates – bringing all partners together thro
- System Delivery & Enablement Groups
- MSK
- ICS/ICP progression
- Reducing secondary care admissions
- ShropCom process
- Out of Hospital offer
- Future Fit

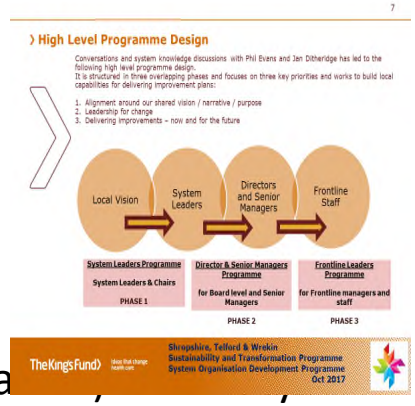


Key Progress since our last review meeting

- STP National Governance Framework – Working through NHSE Governance Fr
- Estates Workbook – Significant system input
- CQC style system health check – exploration discussions
- OD developments – Kings Fund, Transforming Care System Leadership, Yale pr
- Future Fit - £312m, commencing consultation 30th May
- Funding via HEE, AHSN, Individual Placement Scheme (
- System wide working –
  - Clinical Strategy
  - Mental Health (workforce plan submitted with no further update's requi
  - Estates
  - Future Fit
  - Out of Hospital
  - Cancer & End of Life
  - System Finances
  - Local Maternity System
- Independent system chair process and timeline
- Progressing system dashboard, exploration and development in process

System Organisational Development & Leadership

1. Kings Fund OD Programme
   - Phase 1 – System Leaders (All STP Partne
   - Phase 2 – Programme Delivery Transform
   - Phase 3 – Front line engagement in impr



2. Transformational Change through System Lead
   - Delivered through the ACT (Advancing Ch a
   - 10 system participants

3. Yale programme
   - 2 system Exec participants
   - Focusing on system change and leadership

4. Establishment of System Clinical Strategy Group

5. Plan to establish System mental Health Group – June/ July 18

6. Work with Health Education England through Strategic workforce Gr process to identify Education & Training requirements

Strategic
System Leadership
Programme for STP Footprints
2017

Performance & Risk

The following slides are Shropshire, Telford & Wrekin's latest Dashboard (April 2018)
This is being used to drive our key Delivery & Enablement Programmes
Some of which are updated below to indicate progress

- Shropshire Care Closer to home
- Telford Neighbourhoods
- Urgent & Emergency Care Programme
- System Finances

* Full data pack available in Information Pack

Shropshire and Telford and Wrekin

ACS: No

NHSE Dashboard development
April 18 Data

Providers with a type 1 A&E site within the STP footprint

Finance	%	Value (£m)	Rank (x/44)	Provider /commissioner
Q2 2017/18 CCG difference to operating plan	-	-	-	Commissioner
Q2 2017/18 NHS provider difference to operating plan	-	-	-	Provider
Q2 2017/18 STP difference to operating plan	-	-	-	Both
The distance from target funding (%)	-2.51%	N/A	39	Commissioner
Estates: cost to eradicate backlog	N/A	£61.0	19	Provider

Source: NHS Improvement and NHS England

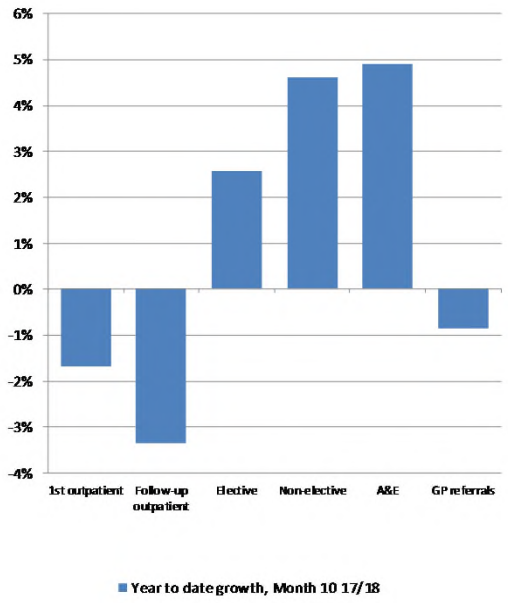
Performance ◆ STP value

Domain		Indicator (NT = national target, EV = England Value, UQ = upper quartile)	Value	Box plot	Date	Derivation	Provider /commissioner
Hospital performance		A&E (NT=95%)	79%		Mar-18 YTD	Proportion	Provider to comissioner, then to STP
		RTT (NT=92%)	90%		Feb-18		Comissioner
Patient-focused change	Primary care	Extended access to GP appointments (EV = 51.6%; UQ = 72.3%)	50%		Oct-17		
		Overall satisfaction (EV = 84.8%; UQ = 86.7%)	86%		2017		
	Mental health	IAPT recovery rate (NT=50%)	56%		Oct-17 to Dec-17		
		Early intervention for psychosis (NT=50%)	36%		Mar-17 to Feb-18		
	Cancer	Early diagnosis (EV = 52.6%; UQ = 54.6%)	50%		2016		
		Seen within 2 weeks (NT=93%)	93%		17-18 Q3 YTD		
		Treatment within 62 days (NT=85%)	84%		17-18 Q3 YTD		
Transformation (source for emergency admissions is SUS data)		A&E attendances per 100,000 (EV = 36245; UQ = 36734)	26,628		Mar-17 to Feb-18	Rate standardised by deprivation, age and sex	
		Emergency admissions per 100,000 (EV = 99; UQ = 107)	92		Mar-17 to Feb-18	Rate standardised by age and sex	
		Emergency bed days per 100,000 (EV = 491; UQ = 536)	414		Mar-17 to Feb-18		
		GP referrals per 100,000 (EV = 21421; UQ = 22462)	17,069		Mar-17 to Feb-18	Rate standardised by deprivation, age and sex	
		DTOC per 100,000 population (EV = 0; UQ = 193)	96		Mar-17 to Feb-18	Unstandardised rate	

Providers in special measures (source: NHS Improvement)	No		Apr-18	Number in special measures	Providers attributed to lead commissioner

Source: CCG Improvement and Assessment Framework unless otherwise stated. Indicators with * are benchmarked vs. national standards

Activity



Source: NHS England (SUS and CCG operational plans)

STP Dashboard – Midlands & East only

STP Progress Dashboard
April 2018 update

Key:

- Highest performing
-
-
- Lowest performing

			Hospital Performance						Patient Focused Change								Transformation				
			Emergency	Elective	Safety				General practice		Mental health		Cancer				Prevention			Leadership	Finance
			A&E waiting time performance	Referral to Treatment waiting time performance	Providers in special measures	CQC hospital performance	Healthcare associated infections - MRSA	Healthcare associated infections - c. difficile	Extended access	Patient satisfaction	Improving Access to Psychological Therapies recovery rate	Early Intervention in Psychosis 2-week waits	% of cancers diagnosed at stage 1 or 2	Cancer one-year survival	62-day waits	Cancer patient experience score	Emergency admissions rate	Emergency bed days rate	Delayed Transfers of Care rate	System-wide leadership	CCG/Trust performance vs. financial operating plan
STP	Region	July 2017 baseline assessment	Mar-18 YTD	Feb-18	Apr-18	Q2 1718	Q4 16 - Q3 17	Q4 16 - Q3 17	Oct-17	2017	Oct-17 to Dec-17	Mar-17 to Feb-18	2016	2015	17-18 Q3 YTD	2016	Mar-17 to Feb-18	Mar-17 to Feb-18	Mar-17 to Feb-18	Jun-17	16/17
Derbyshire	M&E	Category 2 - advanced	91.1%	91.8%	No	58	0.3	15.9	30.7%	86.3%	54.4%	88.9%	48.7%	71.5%	78.2%	8.8	102	490	82	2 - Established	0.9%
Shropshire and Telford and Wrekin	M&E	Category 3 - making progress	78.7%	90.3%	No	60	0.0	10.5	49.6%	85.9%	55.7%	35.9%	50.0%	71.7%	83.7%	8.7	92	414	96	2 - Established	-1.2%
Leicester, Leicestershire and Rutland	M&E	Category 2 - advanced	84.5%	88.1%	No	50	0.6	13.2	65.2%	81.8%	51.2%	72.7%	50.3%	71.3%	79.9%	8.6	97	501	112	1 - Advanced	0.5%
Mid and South Essex	M&E	Category 2 - advanced	86.2%	85.3%	No	60	2.6	14.1	21.8%	81.1%	50.6%	77.1%	54.2%	71.8%	72.6%	8.8	95	440	113	2 - Established	0.2%
Nottinghamshire	M&E	Category 2 - advanced	86.6%	92.4%	No	58	0.6	17.2	26.1%	85.7%	54.0%	73.0%	50.0%	71.5%	83.2%	8.6	93	492	124	1 - Advanced	0.8%
Milton Keynes, Bedfordshire and Luton	M&E	Category 1 - outstanding	94.3%	90.2%	No	66	0.9	4.5	27.2%	81.2%	48.7%	89.4%	55.0%	71.4%	85.5%	8.6	109	521	127	1 - Advanced	0.6%
The Black Country	M&E	Category 3 - making progress	87.2%	90.6%	Yes	59	0.3	10.7	61.2%	80.9%	55.4%	81.3%	52.1%	70.0%	82.3%	8.7	110	538	133	2 - Established	-0.1%
Norfolk and Waveney	M&E	Category 2 - advanced	87.8%	84.9%	Yes	52	0.0	15.7	1.6%	86.7%	34.3%	65.3%	53.9%	72.3%	84.6%	8.8	88	380	143	3 - Developing	-0.2%
Lincolnshire	M&E	Category 3 - making progress	87.2%	86.7%	Yes	58	1.1	19.2	0.0%	83.9%	52.4%	72.4%	48.2%	71.4%	71.4%	8.5	88	434	152	2 - Established	0.0%
Suffolk and North East Essex	M&E	Category 2 - advanced	90.8%	88.2%	No	51	1.0	15.7	65.3%	85.9%	50.0%	76.1%	55.5%	72.0%	80.0%	8.8	91	411	152	2 - Established	1.4%
Hertfordshire and West Essex	M&E	Category 3 - making progress	80.4%	88.1%	No	57	0.9	14.4	34.5%	84.7%	51.6%	72.5%	54.8%	72.8%	82.5%	8.6	88	448	171	2 - Established	-0.7%
Coventry and Warwickshire	M&E	Category 2 - advanced	86.5%	86.5%	No	53	0.2	7.6	39.6%	85.6%	50.1%	56.0%	47.6%	71.5%	84.6%	8.8	99	520	187	2 - Established	1.1%
Herefordshire and Worcestershire	M&E	Category 2 - advanced	79.8%	83.5%	Yes	53	0.6	13.1	62.9%	88.3%	51.9%	80.0%	53.4%	72.5%	74.3%	8.7	83	385	190	1 - Advanced	-0.4%
Cambridgeshire and Peterborough	M&E	Category 2 - advanced	85.1%	89.7%	No	63	0.8	17.4	28.0%	85.9%	52.3%	78.4%	56.1%	74.0%	85.1%	8.8	89	444	192	1 - Advanced	-1.2%
Birmingham and Solihull	M&E	Category 2 - advanced	88.6%	91.0%	No	56	0.5	14.1	19.6%	82.4%	53.2%	71.6%	55.5%	70.7%	83.0%	8.77	126	566	209	2 - Established	1.1%
Staffordshire	M&E	Category 4 - needs most improvement	81.9%	82.5%	No	59	0.7	16.0	18.2%	84.6%	56.1%	66.1%	53.3%	70.9%	78.6%	8.7	111	515	227	3 - Developing	-4.1%
Northamptonshire	M&E	Category 4 - needs most improvement	87.2%	86.7%	Yes	58	0.0	10.1	0.0%	82.6%	43.4%	91.7%	46.3%	71.7%	81.8%	8.6	110	663	301	4 - Early	-0.3%

Transformation Delivery Programmes

The next set of slides show key programmes through a simple set of slides that captures high level programmes plans. Progress & risks

Commissioner Led Transformation Programmes

Phase 1

- Phase 1 is operationally functional, it is the Frailty Intervention Team (FIT) based within our local general hospital.
- The FIT works with frail patients to ensure that they experience as efficient an in-patient service as is possible.
- The FIT helps us to understand the scale of the problem we need to address as a health economy, and the potential impact that can be achieved through getting things right in the community for our population.

NHS
Shropshire
Clinical Commissioning Group

Phase 2

- Phase 2 is about introducing Case Management to primary care.
- This will enable risk-stratification of our patients.
- This will enable those most at risk of acute admission to be pro-actively managed.
- This will enable a clear understanding of what the requirements of the models in phase 3 are.
- This will enable effective, fit for purpose strategic workforce planning.

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Clinical Commissioning Group

Phase 3

- Phase 3 will introduce a Hospital at Home Model, a Crisis Response Team and the provision of Step-up beds capable of managing high levels of need acuity.
- Phase 3 will enable the full benefits of case management to emerge.
- Phase 3 will provide for significant market-place development.
- Most importantly Phase 3 will enable us to serve our populations in a far more patient centred way than we can possibly achieve at this time.

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Clinical Commissioning Group

Progress

- Phase 1 is operational.
- 2 public engagement events have taken place with the next event scheduled for July.
- 3 GP locality scoping events have been delivered.
- 1 county-wide GP task and finish event has taken place with 3 further locality level task and finish groups scheduled for June.
- The design stage of Phase 2 is expected to be completed by early July.
- Our fortnightly working groups and monthly project board meetings are well attended.

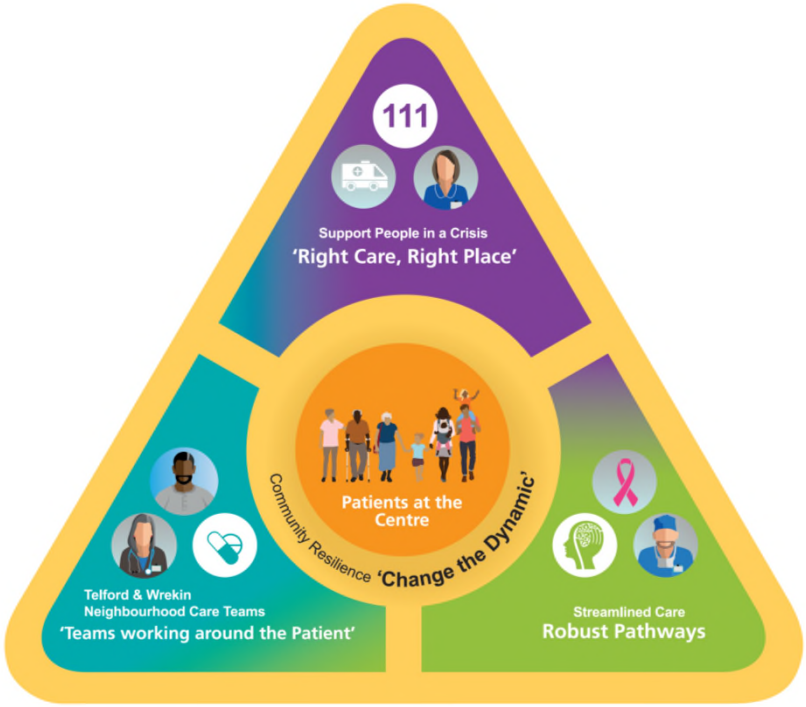
Telford & Wrekin Neighbourhood Programme

Exec Lead – Anna Hammond Project Lead – Ruth Emery

NHS England NHS Improvement

Programme needs to:

1. Improve availability and 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 to support out of hospital care
5. Enable Primary Care Resilience (feeds into Primary Care local strategy)
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation
9. Empowerment for people and professionals
10. Introduce new roles and ways of working
11. Ensure robust information accessible for communities and the professionals working with them
12. Ensure there are services and activities available closer to home
13. Develop well connected services and communities



System Partners / Enablers need to:

All stakeholders in the Telford and Wrekin area need to be open to change and new ways of working

Estates
- Support to ensure suitable estates to enable delivery, maximising to use of current resources available in addition to the development of new facilities

Communications
- Support with health literacy including mental health awareness

Digital
- Solution needed for shared patient records in particular those patients at risk
- Expertise/input regarding optimal use of assistive technology and how this can support the programme, and how IT can be utilised to work more effectively
- Develop data sharing agreement required across organisations

Workforce
- Supporting teams to develop a shared vision – neighbourhood working requires "virtual" teams and expertise on how this can work optimally is needed

Prevention
- Prevention is embedded throughout the programme, ensure awareness of programme and link where required

Out of Hospital
- Support with delivery of projects within programme – practical support needed

Mental Health

Development of STP wide strategy and governance .

Practical project support for AC OOA framework for 0-25 mental health (must do quickly) amd OOA adult mental health placements (longer term QIPP)

Crisis pathway for 16-18 year old children (including children who don't meet tier 4 threshold, those who have challenging behaviour and setting up PARA registers)

Encouraging Healthy Lifestyles
Targeting obesity, smoking and alcohol

Community Resilience
To support strong communities and improving access to community resources, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs

Direct Care in the Community
To include the introduction of a dedicated care homes team, development of integrated neighbourhood teams, and review of intermediate care beds

Specialty Review
To include Diabetes and Respiratory

What the neighbourhood Programme Looks like for a single locality – an example

Using the data to drive the change

Description of Neighbourhood Working has fed into the Pre Consultation Business Case, including 5 year activity profiling for the acute

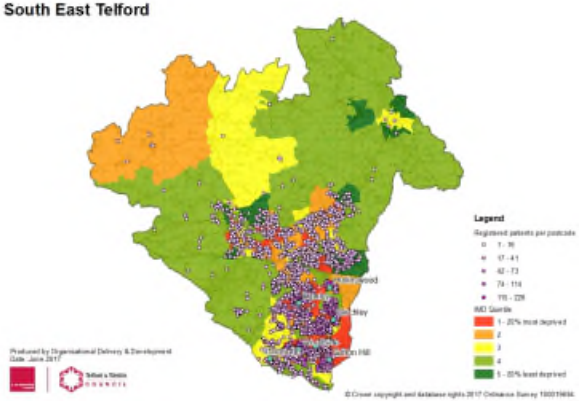
futurefit
Shaping healthcare together

Dementia diagnosis rate (add more context)
Rising hospital admissions (add more context)

NHS RightCare → *Diabetes outcomes need to be improved*

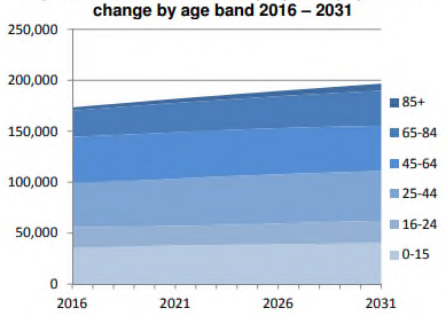
Between 2016 & 2031 the T&W population is expected to increase by 23,300 (13.4%). Over half of these are 65 and over, with the 85+ ages more than *doubling* (117.6%) and the 65-84 ages increasing by 33.1%. All England is expected to grow 10.2%, a slower growth than T&W(13.2%). The largest difference is seen in the T&W 25- 44 age group which expects 11.6% growth compared with just 3.2% for England.

South East Telford



Practices and deprivation by neighbourhood – one of these for each n'hood has been produced

Figure 6: Telford and Wrekin projected population change by age band 2016 – 2031



NEWPORT LOCALITY: NEIGHBOURHOOD WORKING PROGRAMME PLAN ON A PAGE 2018/19 DRAFT

Neighbourhood Priorities	Neighbourhood Vision
To support the frail elderly population of Newport to stay well in their own homes To improve wound healing rates	For Newport Cottage Care to be a neighbourhood hub, hosting integrated teams, wound healing clinics, early help and support, social groups and more; strengthening the community and reducing dependency on GP practices for non medical issues

Key Projects	Who?	When?	Programme Links
	Public Health		1 Encouraging Healthy Lifestyles – *Targeting obesity, smoking and alcohol*
Neighbourhood "Hub" at Newport Cottage Care – *To include: Voluntary organisations, Early Help and Support Workers, Assistive Technology, Sight and hearing impairment, Public Health*	Dr Aidan Egleston – Wellington Road Surgery Julie Smith T&W Council	Planned "go live" May 2018	2 Community Resilience – *To support strong communities, including drop in service for mental health crisis, support for carers, the development of wellbeing hubs*
Development of Integrated Team – *To include: Social Workers, Community Matrons, District Nurses, Therapy, Mental Health*	Dr Aidan Egleston Anna Hammond - CCG Ruth Emery - CCG Sarah Dillon / Victoria Worthington – T&W Council Yvonne Gough/Sam Townsend – ShropCom	Staff fully allocated to neighbourhood: April 18 Continuation of MDT working – 18/19 ongoing	3 Direct Care in the Community – *To include the introduction of a dedicated care homes team, development of integrated teams, and review of intermediate care beds*
Wound Healing – *Pilot neighbourhood for dedicated wound healing service taking on all complex wound care activity from practcies and dinstrict nurses*	Dr Aidan Egleston Anna Hammond - CCG Yvonne Gough - ShropCom Ruth Emery - CCG	Commence pilot service: April 2018 Review of outcomes: January 2018	4 Specialty Review – *To include Diabetes and Respiratory*

Success Measures

Neighbourhood	Start of phasing	Point at which they will be achieving 3 per week	April	May	June	July	August	September	October	November	December	January	February	March	Total	Savings based on Avg Cost NEL
Newport	April	Spells Avoided per Week	1	1	2	2	2	2	3	3	3	3	3	3	28	£
		spells avoided per month	4	5	8	8	8	8	12	12	12	13	12	12	116	£ 197,200

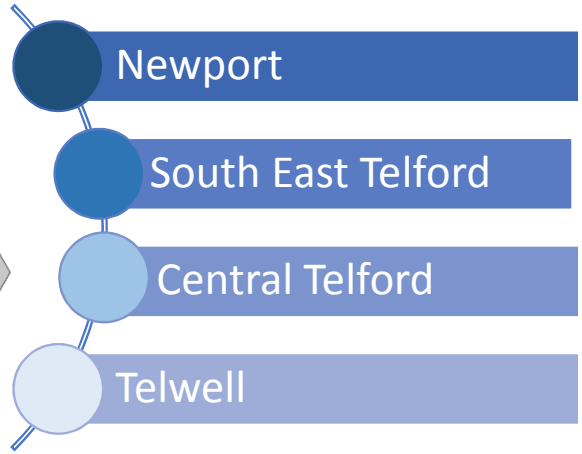
Quality:

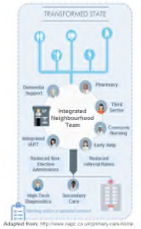
Please see individual projects for specific quality indicators

Telford Neighbourhoods – how it all fits together – delivering transformation

Case Study Examples to showcase progress

- Diabetes Management
- Hypertension Management
- Mental Health Hub – Branches
- Citizens Advice – Virtual Team
- Wound Healing project
- Community Information Portal
- Health Champions





Cancer

Exec Lead – Julie Davies Clinical Lead – Andy Inglis Project Le JH38

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 Partners / Enablers need 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.

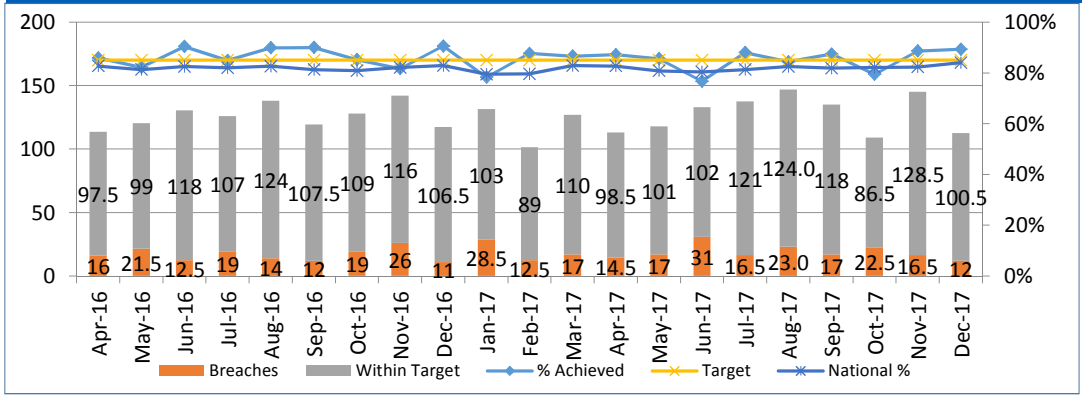
Key Interventions / Milestones

- 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



Slide 12

JH38 CCG Leads, Edith McCalister & David Whiting
Jo Harding, 30/05/2018

JH39

Primary Care Programme – GPFV

Updated April 2018
Next update– June 2018

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan/Berni Williams

Programme needs to:

The GPFV programme has five main elements:

New models of care
- Developing an approach to "working at scale" among practices
- Linking practices working at scale to wider new models of care – i.e. the Out of Hospital Model (SCCG) and Neighbourhood Working (TWCCG) – collaborating with other key stakeholders (eg social care, community care, voluntary sector)

Extended Access
- Ensuring that 100% of the population has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need

Workforce
- Meeting national targets for increases in the number of GPs and other clinicians
- Retaining existing GP and other clinical staff in practices
- Developing at-scale approaches to workforce

Resilience/Workload
- Using the Resilience Fund to deliver practical, local solutions to increase resilience
- Implementing the 10 High Impact Actions

Estates and Technology Transformation Fund
- Delivering against key physical and digital projects, funded through the ETTF

In addition, CCGs are required to **invest** £3 per head, over two years, to enable Primary Care transformation.

System Partners / Enablers need to:

There are a number of enablers that would assist in the successful implementation of the GPFV programme:

Workforce
- The CCGs need to work with other health stakeholders to increase and improve the integration of workforce across different providers.
- The OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation
- A robust OD programme needs to be commissioned to ensure outcomes are realised and measured.

Digital Information and Technology
- Key projects within the GPFV, particularly extended access and implementing the 10 High Impact Actions, are dependent on IT/digital solutions

Estates Investment
- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate which enables multidisciplinary team working.

The progress:

New models of care
- Practices in both CCGs are increasingly working in groups/localities – further work is being planned with NHS England to develop at-scale working
- Primary Care is inputting into the development of both the Out of Hospital Model (SCCG) and Neighbourhood working (TWCCG)
- Governance issues are being addressed to ensure resilience and sustainability of agreed models.

Extended Access
- Current provision of evening and weekend appointments covers over 90% of the population
- Local pilots are being developed to ensure that the 100% target is met by October 1st and 80% target by September 2018.

Workforce
- An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets – bids have also been submitted to secure GP resilience and retention funding
- The CCGs are working with the STP workforce group to enhance recruitment, HEE to secure transformational training opportunities and portfolio careers.

Resilience/Workload
- Successful bids to the Resilience Fund have helped to increase resilience
- The CCGs are working with the national Time for Care team around the 10 High Impact Actions

Estates and Technology Transformation Fund
- A programme to install VOiP, VDI and WiFi across practices has been agreed – now in place in T&W
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

Interventions and process change milestones

- Increased levels of working at scale between practices
- 100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need
- Targets for workforce recruitment and retention across primary care met
- Successful implementation of the GPFV 10 High Impact Actions
- Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks
1. Lack of alignment between the at-scale primary care plans and the out of hospital/left shift strategies
2. Continued uncertainty around recurrent funding for extended access post national scheme pilot
3. Insufficient interest from GP practices in providing the extended access service
4. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
5. Pressure on revenue budgets from ETTF-funded capital estates projects
6. A change in historical culture is required to enable transformation and collaborative change in Primary as per the GPFV
7. Difficulty in accessing up to date and meaningful data to identify unsustainable practices who need resilience funding
8. Completing investment priorities against CCG baselines
9. Developing gap in the nursing workforce – anticipated to be widening over the next three to give years.

Data

Extended Access
- Over 90% of the registered population currently has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at need

Workforce
- NHS England targets for Shropshire STP are for 101 GPs and 47 non-Doctor clinicians to be recruited/retained by September 2020

Resilience/Workload
- Each of the practices across the STP need to implement at least two of the 10 High Impact Actions during 2018/19

Estates and Technology Transformation Fund
- VOiP Telephony Project – 2 sites now live for VOiP and Wi-Fi

Slide 13

JH39 Updated 26/06/18
Jo Harding, 27/06/2018

Mental Health

Exec Lead – Clinical Lead - Professor Tony Elliot Project Lead –

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 Partners / Enablers need 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

Key Interventions / Milestones

- 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

Acute & Specialist Programmes – MSK Services

Exec Lead – Julie Davies Clinical Lead - Programme Lead –

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 Partners / Enablers need 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

Key Interventions / Milestones

- 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

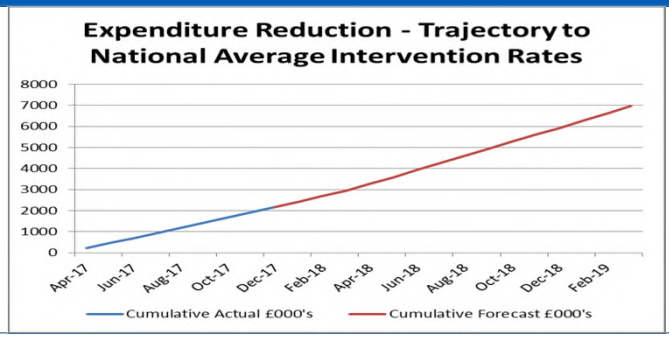
Risks

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 Reconfiguration - Future Fit

Executive Lead – Debbie Vogler Programme Manager – Andrea Webster

NHS England NHS Improvement

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 Partners / Enablers need 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 OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

The progress:

- The consultation process commenced on 30th May and will run until 4th September.
- 8 Public exhibition events have been planned with 3 completed by the end of June. These have been well supported by clinical staff and managerial staff
- 70+ Pop-up events raising awareness of the consultation process are taking place
- Additional engagement work has been commissioning to undertake a targeted piece of work around equality impact assessments with focus groups being undertaken to engage seldom heard groups/9 Protected characteristics
- In addition the FF team have been invited to present at a variety of internal and external stakeholder events.
- A mid point review will take place early July.
- TcI are providing guidance and support throughout the process
- Quality Assessor receiving assurance of progress
- IIA Priorities have now been formally agreed

Key Interventions / Milestones

- Approval to proceed to formal consultation by NHSE and commenced on 4th May
- Consultation exercise completed and results analysed and report available to inform DMBC (Consultation ends 4 September 2018). Date for analysis and report 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

FF Team capacity and resource remains challenging. However additional resources have been identified.
Significant political and campaign opposition to the proposals, impacting on programme reputation in the media with significant resource required to manage emails, letters and media responses – Additional resources have been identified and a media plan is in place
Formal post consultation and decision making process needs to be formalised to provide assurance of process at the end of the consultation process.
The Care Closer to Home and Neighbourhood working models and the Future Fit strategy need to formally report on progress of alignment to primary care strategic planning when considering workforce mobilisation and out of hospital activity modelling.

Data

Urgent & Emergency Care – Transformation Programme

Implementation of UEC High Impact Changes

- Demand & Capacity Review
- Stranded Patients
- ED Systems & Processes
- Red2Green / SAFER
- Integrated Discharge Team
- IV Therapies in the Community
- Frailty
  - Frailty Team at ED front door
  - Reduce admissions / readmissions from care homes
  - Trusted Assessors

- Further details around the Urgent & Emergency Care work programme are available by contacting jill.barker3@nhs.net

Frailty

Exec Lead – Fran Beck

Programme Leads – Emma Pyrah & Michael Bennett

NHS England

NHS Improvement

SATH 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 and make it a mandatory field in the electronic patient clerking system in ED
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 LoS
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. F1: Shropcom to work with SATH to explore the potential for Shrewsbury DAART to function as the frailty assessment area
3. F3 Reduce admissions/re-admission from Care Homes by a) focus on high admitters; b) Care Home team (T&W)
4. F4 Reduce admissions/re-admission from Care Homes by a) focus on high admitters;) b Trusted Assessors (Shrops) to reduce Los
5. Reduce occupied bed days by impact of F1&2 and F3 & 4

The progress: 5.4.18

- Frailty MDT in RSH piloted since Sept – scheme continuing post end of non-recurrent NHSE funding at the end of March 2018.
- Evaluation report drafted and out with stakeholder partners for comment. Final report will be submitted to A&E Group 17.4.18.
- Mapping of existing services and pathways underway to inform the PRH model.
- Meeting being scheduled with SATH/Shropcom to explore the potential of DAART as the frailty assessment area
- £333K invested in new Care Home Team (T&W). 3 Trusted Assessors appointed by SPIC to work with Shropshire Care Homes – start in post w/c 9.4.18
- Both CCGs to work with SPIC to focus on high admitting homes. Shropshire have commenced a deep dive to identify homes to target.
- System focus on 3 areas:-Prevention, Admission Avoidance and End of Life.
- 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

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- risk that 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. Workforce gaps to allow staffing Frailty MDTs
3. 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
4. Culture of 'bed based' care persists, and risk aversion to sending patients home first, or to prescribe bed based rehabilitation instead of home
5. Lack of ownership of all hospital staff to keep patients mobile – risk aversion re Falls
6. 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

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.

Integrated Discharge Team

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 Digital bid submitted to join up partner discharge planning

Interventions and process changes

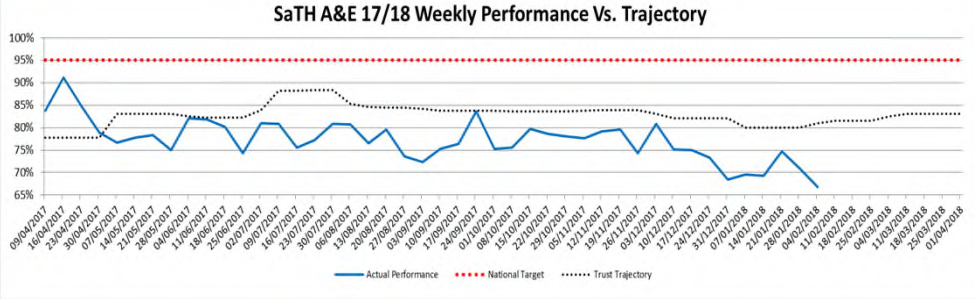
- Set criteria met nurse discharge especially at weekends
- Operational intermediate process and framework review and system wide agreement to new framework.
- Training across all partners regarding new intermediate care process.
- Red, amber, green process for all intermediate care pathways with twice 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 training and routine consultation and collaboration.**
- **BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.**

Data



UEC - IV Therapies

Updated May 2018

Exec Lead – Steve Gregory Project Board Chair – Yvonne Gough Project Lead – Mandee Worrell

Programme needs to:

- Develop a plan for delivery of IV therapy in community settings, with 4 phases;
- IV antibiotic therapy in MIU/DAART/Community Hospitals for patients on pathways for bronchiectasis, diabetic foot, UTI, cellulitis
- Patients on pathways as per phase 1 but requiring domiciliary delivery
- Non antibiotic IV therapy within community settings (eg iron)
- Self administration of IV antibiotics via pump therapy

System Partners / Enablers need to:

- Understand the potential need for funding to expand community capacity
- Support workforce development and competency
- Commit to review and consider commissioning additional service hours for DAART and MIU in key locations
- Support governance and accountability arrangements for medication and medical responsibility

The progress:

- Initial meeting held 30/4/18 to define scope of project and themes
- Good representation from SaTH and Shropcom
- Leadership and reporting arrangements defined
- High level output dates agreed

Key Interventions / Milestones

- Phase 1; Business case and plan to be presented July 2018
- Phase 1; Commence delivery October 2018
- Phases 2,3,4 Dates to be determined

Risks to delivery

- Workforce – skills, competency and capacity
- Governance – medical responsibility, accountability, licencing
- Finance – redirection of resource to expand community provision, cost of medication
- Cultural change – to transfer patients to the community
- Limitations of currently commissioned opening hours of DAART and MIU centres

Data

Data is being collected to inform phase 1 of the delivery by Shropcom and SaTH and identify the following from April 2017-April 2018;

1. How many bed days occupancy in SaTH for patients only for antibiotic therapy for each of the 4 identified conditions
2. How many patients does this represent and their demographic
3. How many patients seen by Shropcom in DAART for antibiotic therapy for each of the 4 identified conditions and their demographic
4. How many patients seen by Shropcom in domiciliary settings for antibiotic therapy
5. Project group members are collating existing pathway information for the 4 initial therapies, for discussion and review of potential relevance or need for change.

UEC Integrated Therapeutic Discharge

Exec Lead – Steve Gregory Programme Lead Jill Barker Project Lead TBA –

Reasons for change

Why is the change indicated?

Give 4 reasons

- To prevent delay in discharge
- To prevent further deterioration/decompensation on discharge from hospital
- To prevent re admission to hospital
- Person owns their recovery

Which Strategic Priority does this support?

- **Admission Avoidance** ☐
- **Length of Stay** ☐
- **Effective Discharge** ☐

Evidence to support change required

- Benchmarking
- National Priority
- ECIP

- ECIP supported work as seamless transition from hospital to community/home

Expected Benefits

Patients / service users seamless transfer, continued rehabilitation plans, ownership in their recovery, sets own goals for recovery. Safer transfer and best use of all resource. Maximise improvement in post-discharge outcomes.

Staff Seamless working between acute and community – including community hospitals

Reduced Length of Stay

Financials shorter recovery period as no 'stand still' 'fall back' of recovery. Better outcomes for 91 day remainder at home. Less readmissions as better recovery. Reduced reliance upon/reduced length of stay on paid domiciliary services on discharge. **These need to be quantified**

Key Interventions / Milestones (Describe key milestones (Blue dots achieved, grey dots still to do)

- Choice of ward
- Training of staff on holistic person centred goal /outcome setting
- Training of acute staff on what is available in the community
- Training of provider staff on assisting person to achieve their goals/outcomes
-

The progress:

Describe progress to date

Risks to delivery

Top 5 Risks

1. Lack of engagement from key partners
2. Risk adverse staff
3. High level of Therapy vacancies across the system
4. Potentially different issues across 2 sites and 2 LAS
5.

Mitigating Actions:

Multiagency Task and Finish group

Therapy workshop with good attendance from frontline staff across all agencies

One task and finish group across both sites involving both LAs

Data

Use data to describe progress

If no data available, describe what will be used to measure benefits

Length of stay of current stranded patients

System Pharmacia – draft outline

Exec Lead – tbc Project Board Chair – tbc Project Lead – tbc

Shropshire / Telford and Wrekin Sustainability and Transformation Plan - Pharmacy

Priorities to deliver: The Right Care in the Right place at the Right time

Accessing care at the appropriate level - reducing demand on urgent and emergency care	Communication - Seamless transfer of care/information	Ensure medicines use is as safe as possible	Promoting self-care/self help	Admissions avoidance	Upskill pharmacy workforce to support transformational change	Reduce medicines related waste	Break down barriers between physical and mental health
Enablers							
Supporting care closer to home (e.g. parenteral community pathways, support for LTCs)	Supporting patients/carers to make informed decisions about medicines	Sharing learning relating to medicines safety incidents	Primary intervention – healthy living pharmacies / make every contact count	Improve adherence to medication	Embedding clinical pharmacists in the healthcare team	Review polypharmacy in LTC	Ensure all community pharmacies have staff trained as dementia friends
Clear pathways signposting patients to ensure optimum use of medicines	Integration within the digital road map - Implement digital solutions which would allow seamless electronic transfer of medicines related information across care settings	Review all HARMs	Public health campaigns - raising awareness to support lifestyle change	Promoting self-care (improving patients understanding of their LTC)	Increase number of pharmacist prescribers to improve access to medicines.	Support patients to improve their understanding of their medication	Integrate pharmacy into mental health care pathways
Improving access to medicines (e.g. emergency supply services)	Improving adherence to prescribing medicines	Medicines optimisation	Improve patient education about their LTC and their prescribed treatment	Clear pathways to access emergency medicines	Increase clinical pharmacists / technicians input in care homes. Support the wider care homes MDT	Develop health economy wide systems to reduce pharmaceutical waste related to prescribing and reordering of medication	Make every contact count - promote physical and mental health well-being.
Fully integrate 'pharmacy first' care pathways	Integrating medicine optimisation within social care	Provide medicines safeguarding support to care homes		Develop pathways to deliver care in the community	Opportunistic screening in pharmacy– AF, BP, diabetic screening		
		Develop a joint health economy wide formulary		Provide pharmaceutical care support to the wider care homes MDT			

Underpinning principles to enable transformational change

- Deliver care for our population seamlessly across health and social care providers .
- Develop communities so that people have the skills and confidence to take responsibility for their own health and care.
- Develop the workforce across our health and social care system so that it is able to deliver new models of care.
- Use technology to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.
- Redevelop our services to promote care closer to home.
- Ensure full integration of pharmacy with the wider health and social care team
- A focus on health promotion across all our communities
- Promote physical well-being for patients with mental health problems

Outcomes										
Improved access to healthcare services	Care closer to home ('home is best')	Improved patient experience	Reduction in medication related hospital admissions	Improved patient outcomes	Reduced hospital admissions from care homes	Reduced inequalities in access to medicines related services across our communities	A health and social care system that provides care for all with the patient as its central focus	A workforce skilled and motivated to deliver high quality care in the right place at the right time	A joint health economy wide formulary to reduce waste and improve safety and cost effective use of resources

Transformation Enablers

System Improvements

Plan on a Page

Digital Enabling Programme

Updated April 2018
Next update– June 2018

Exec Lead – Clinical Lead - Programme Lead – Rob Gray

Programme needs to:

- Refresh the Local Digital Roadmap (LDR) to focus on most beneficial changes.
- 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 Partners / Enablers need 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: target to significantly deliver by March-18 – successful. (9/10 see data below). New programme items to be decided in refreshed LDR.
- LDR refresh process started
  - Core team brainstorming
  - Full PB session with James Seaman - (worked on Manchester devolution) to help formulate.
  - Evaluation of some early infrastructure projects to enable future progress.
  - Owners nominated to define project scopes.
- Further meetings scheduled to refine vision, to support future plans.

Key Interventions / Milestones

- Data Sharing Agreements on Electronic register across the LHE — May 2018
- LDR refreshed and new Digital Programme defined. GP IT Forum also follows lead of LDR.
- Electronic Patient Record systems need to be procured for SaTH and RJAH to support shared access to Integrated care records.
- Network - shared procurement in place. Access for all orgs at all sites
-

Risks to delivery

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

Decisions on benefits from

JH12

Strategic Estates Programme

Updated April 2018
Next update– June 2018

Exec Lead – Clive Wright

Programme Lead – Becky Jones

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 Partners / Enablers need 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

Key Interventions / Milestones

- 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
- Rejection of future capital bids through omission of estate projects/concepts from STP Estates Strategy
-

Actions:

- Transparency and awareness of funding timelines between organisations
- Agreed approach to partnership working
- Identify and Plan for interim arrangements
- Comprehensive links across all STP workstreams/enablers to include their known and anticipated estate implications

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

Slide 25

JH12 Maggie & becky - please see next slide - intention is to invite Tim on the 23rd May
Jo Harding, 04/05/2018

Strategic Estates Progress so far

The Estates Workbook has been a key piece of working with:
“ALL SYSTEM PARTNERS”

Through facilitated workshops, shared conversations recognising system interdependencies, increasing knowledge and understanding of Estates requirements across the system both now and in the future.

The workbook is facilitating system change through encouraging work to be done once by involving all partners in initial discussions, thus looking at the bigger picture and understanding the wider implications of organisational decisions….

Strategic Back Office

Updated April 2018 Next update– June 2018

Exec Lead – Ros Preen Programme Lead – Maggie Durrant

NHS England NHS Improvement

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 Partners / Enablers need 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

Key Interventions / Milestones

- 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

Updated April 2018 Next update– June 2018

Exec Sponsor – Jan Ditheridge Exec Lead – Victoria Maher Programme Manager – Sara Edwards

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 Partners / Enablers need 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.

Key Interventions / Milestones

- 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

Updated April 2018

Next update– June 2018

Exec Lead –

Programme Lead – Pam Schreier

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 Partners / Enablers need 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

Key Interventions / Milestones

- 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

Exec Lead –Rod Thompson

Clinical Lead - Helen Onions / Emma Sandbach

Updated April 2018

Next update– June 2018

Programme Lead – Penny Bason

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

System Partners / Enablers need 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

Key Interventions / Milestones

- Health & Wellbeing Intelligence Population health management
- 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

Updated April 2018 Next update– June 2018

Exec Lead – Claire Skidmore Programme Lead – Paul Gilmore

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 Partners / Enablers need 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

Key Interventions / Milestones

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

Updated Version 3.0
May 2018

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
- Care Closer to Home
  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

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 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