Trust Board is asked to note contents of STP Directors report and direct any questions / follow up to:

Phil Evans – STP Programme Director  phil.evans1@nhs.net  
Jo Harding – STP Head of PMO  jo.harding1@nhs.net

### Items of Note

- Shropshire, Telford & Wrekin STP will be undertaking an ICS 12 week Development Programme with all system partners (slides 2-12)
- Please note system Performance & Transformation overview (slides 18-19)
- Please note people and programmes (slides 20 – 22)
- Please note Transformation Delivery & Transformation Enablement Programme updates (slides 26 onwards). These updates are continuously being updated by system colleagues and are up to date at time of report publication only

Slides available in full STP Update in supplementary Information Pack

### Link to CQC domain

- Safe  
- Effective  
- Caring  
- Responsive  
- Well-led

### Link to strategic objectives

This report is provided to give wider communication of STP Transformation & enabling activities to meet STP priorities as below:

- 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.

<table>
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<tr>
<th>Link to Board Assurance Framework</th>
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<tr>
<td>Outline of public/patient involvement</td>
<td>Public &amp; Patient involvement is through existing programme structures pertaining to individual organisations. The STP strives to involve public and patients in all aspects of transformation, continuous improvement and review of services.</td>
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| Equality Impact Assessment | ☐ Stage 1 only (no negative impacts identified)  
☐ Stage 2 recommended (negative impacts identified)  
☒ EIA must be attached for Board Approval  
☐ negative impacts have been mitigated  
☐ negative impacts balanced against overall positive impacts |
| Freedom of Information Act (2000) status | ☐ This document is for full publication  
☐ This document includes FOIA exempt information  
☒ This whole document is exempt under the FOIA |
Shropshire, Telford & Wrekin STP

**Sustainability and Transformation Plan**

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

**Region:**
Shropshire and Telford & Wrekin
Our vision for health and care services in Shropshire, Telford & 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.
STP Development Programme
Facilitated offers delivered over a condensed time period:

- System Opportunity Diagnostic programme
  - Hypothesis testing, Validation and priority setting
  - Identification of transformation programmes and priorities
  - Qualitative self assessment

- System support (Facilitated learning events)
  - Leadership
  - Provider alliance
  - Structural architecture

- Development of ICS
  - ICS roadmap
  - Meeting the requirement of the ICS MOU
High Level Critical Path

Launch Event & Mobilisation

Detailed Diagnostic

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<th>Quantitative Analysis</th>
<th>Qualitative Assessment</th>
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- Hypothesis testing workshops
  - Validation of opportunities
  - Executive review, testing and validation

Decision to proceed

Diagnosis and design phase

( weeks)

Transformation Programmes
- Planning for mobilisation
- Define support, structure & budgets
- Engagement and communication

Delivery and Support
- Programme management and expert PMO
- Access to subject matter expertise
- Best Practice
- Monthly gateway reviews

System Capacity Building
- Supporting development of leadership capacity and capability
- Facilitated workshops
- Action learning sets
- Development of appropriate financial strategies
- Governance and decision making

Transformation delivery and improvement phase

( weeks)
• NHSE has coordinated the production of a quantitative deep dive of all key analytical data and matrix:
  • Right Care (2017/18)
  • Model Hospital Programme
  • Getting it Right First Time (GIRFT)
  • Benchmarking from Social Care
  • Benchmarking from CHC
• It is acknowledged that for Shropshire CCG some of this analysis is available in its Optimity Report.
• Co-produced with NHSI, the information will be collated into a Hypothesis pack for Shropshire - mid September 2018

• Ambition is to support the identify any quick wins and to fully inform the production of an agreed set of transformation priorities.
• NHSE will coordinate a qualitative self assessment exercise, the scope of which will be informed by the STP.
• Assessment will utilise the key concepts of the Integrated Care System (ICS) maturity index designed to provide a self assessment and anonymised baseline for the health system
• Approach:
  • Structured interviews around the core capabilities of: leadership and governance, readiness and commitment to operate as a single system, financial management, current performance, delivery and impact across the system.
  • Understanding the barriers to system development
• Output to shape the system capacity support programme
Diagnostic Review:
• Designed to support the system to identify opportunities available to the system
• Undertaken through both quantitate and qualitative analysis
• Quantitative data and information analysis output a report that seeks to quantify the identified opportunities.
• Qualitative diagnostic – self assessment to shape development programme

Facilitated Workshops – delivered over a number of sessions:
• To discuss data, information and evidence base
• Generate and test hypothesis
• Focused output on quantification of opportunities and next steps.
• Planning for delivery and system support
• Gateway signoff
Facilitated Programme Support / Action Learning Sets
• Support to executive leadership across the system
• Readiness and commitment to operate as a system across all partners
• Financial strategy and programme delivery
• Progressing the ICS – roadmap
• Meeting the requirements of the ICS MOU

Transformation priority programmes
• Intensive review and detailed shaping of selected priority programmes
• Gateway signoff
The offer:

- North Midland DCO have agreement with National Team to access:
  - External support and subject matter exercise
  - Length of high impact delivery 3-6 months
  - Expert facilitation of programme and workshops

- Transitional support to move to sustainable business as usual at approximately 3 months

- Delivery team shared across multiple high impact areas

- ICS programme facilitation (Jointly funded)
Project oversight

- NHSE/I project team to meet weekly
  - Facilitator/alliance
  - Project manager
  - Locality Director/leads

- Steering group to meet 2 weekly
  - STP leads
  - Alliance lead
  - Project manager
  - Expert advisors/regional support
Next Steps for Shropshire, Telford & Wrekin STP

• Work through the ICS 12 week Development Programme (start date to coincide with new STP Chair appointment)

• Develop Shropshire, Telford & Wrekin ICS Roadmap
  • Clear system Governance and programme management support
    • Aligned to system priorities
  • Further develop System Strategic Commissioning
  • Identify System Redesign Requirements
    • Clinically Led, building on the work of the STP Clinical Strategy Group
    • Understand WHAT enablement requirements are needed and HOW they will be delivered and by WHEN
    • Financial alignment
    • Estates
    • Digital
    • Workforce
    • Back Office functions
  • Be clear how as a system we will continually improve and sustain those improvements
Timeline of key STP activities June 17 – Dec 17

Pre-June 17
- System OD Diagnostic undertaken
- 4 previous Interim STP Programme Directors

June - July 17
- Programme Director appointed 1.0wte
- STP Submission April 2017
- STP Partners agreement to fund System PMO Resource
- Initial Governance structure published

Oct 17
- Head of PMO appointed 1.0 wte
- STP Team approved
- STP Delivery Group workshop with Kings Fund
- First Directors Report published
- Kings Fund OD Phase 1 commences with system leaders

Nov 17
- Substantive PMO appointed 4.0 wte
- Each work Programme offered STP Resource
- System UEC Director appointed 0.8wte
- Review of Delivery & Enablement Groups

Dec 17
- STP PMO aligned to Delivery or Enablement
- STP Governance structure refreshed
- Awaiting outcome of Future Fit Capital investment
- System Finance PMO appointed 1.0wte

Key appointments to enable System Development / Improvement
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

Jan-Mar 18
- Office 365 deployed across PMO Team
- STP Clinical Strategy Group Evolved
- STP System Leaders Group established
- Future Fit consultation commences May 18

April - May 18
- Successful Individual Placement Scheme Bid
  Wave 1 - £294,500
  Wave 2 - £289,000
- Estates workbook system wide working
- STP Clinical Strategy Group to agree system priorities
- AHSN Innovation Implementation Lead funding £70k
- STP leadership agree system priorities

May - June 18
- System wide Mental Health Group Development
- NHSE STP Governance Framework commenced
- STP Dashboard to inform conversation and system developments
- STP System Transformation Programme Marketplace

July - Aug 18
- Estates workbook submitted
- Elective Care Transformation Plan 1st Draft submitted
- Future Fit consultation on-going
- Business Intelligence capability & capacity Development
- Digital Roadmap refresh
Timeline of key STP activities July 18 – Aug 18

- **July-August 18**
  - SharePoint established for Shropshire Care Closer to Home Programme
  - System wide Mental Health Programme initiated
  - Future Fit Consultation concludes

- **August – Sept 18**
  - System Wide Elective Care Transformation Programme commences
  - Community Services Review Programme ongoing
  - Community Services Review concludes

- **Sept - Oct 18**
  - Future Fit Consultation analysis commences
  - System Pharmacia Programme to commence
  - STP Dashboard to inform conversation and system developments

- **Oct – Nov 18**
  - System Winter Planning
  - SharePoint established for Clinical Strategy Group
  - SharePoint established for Urgent Care Tracker
  - System Winter Planning
  - Future Fit Consultation analysis commences
  - System Pharmacia Programme to commence
• STP Review meetings with NHSE & I
  • Last review meeting was 6th Sept, we continue to be “Level 3” – making progress

• System wide working gaining momentum – next slide shows system wide groups
  • STP Leadership Group – Integrated Care System / Partnership developments
  • Clinical Strategy Group – meeting bi-monthly and work programme developing around STP Priority areas
  • Mental Health Group – just being establish
  • Elective Care Transformation – established and work programme drafted
  • Digital Enablement – Roadmap and work programme being reviewed
  • Population Health & Prevention – being established, system leads identified
  • Urgent Care, Frailty, Winter Planning – established and work programme underway
  • System wide Estates – submission completed
  • System Wide Pharmacia – draft formed and work programme being developed
  • Strategic Workforce Partnership working for our system transformation
    • Strategic planning
    • Organisational development
    • Education & training
  • Secondary Care reconfiguration (Future Fit) – consultation ongoing
  • Shropshire Community Services Review – work programme with GE Finnemore / Neil McKay
  • Out of Hospital Programmes
    • Shropshire Care Closer to Home
    • Telford & Wrekin Neighbourhood working
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<td>System wide consultation and feedback through existing mechanisms</td>
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Performance & Transformation Reporting Requirements

• 132 Deliverables categorised as:

  • 47 Operational deliverables
    • Established indicators
    • Automated Data Collection through Statutory reporting (previously UNIFY)

  • 85 Transformation deliverables
    • Mix of quantitative and qualitative standards
    • Data sources not established for all quantitative standards
    • Non statutory/local reporting required for some
    • Being built into FYFV Dashboard as data sources are identified
    • Monthly reporting on ALL 85

Note:
These requests come through a variety of routes and land in different parts of the system, all with different deadlines and requirements using a mix of templates that are continually being revised
## Shropshire, Telford & Wrekin STP Performance & Transformation Overview

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## Delivery Programmes – Key Contacts

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<th>STP PMO Link to Programme Enablement</th>
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<tr>
<td>Telford &amp; Wrekin Neighbourhoods</td>
<td>Fran Beck</td>
<td>Anna Hammond</td>
<td>Ruth Emery</td>
<td>Dr Jo Leahy</td>
<td>Andrea Webster</td>
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<tr>
<td>Shropshire Care Closer to Home</td>
<td>Julie Davies</td>
<td>Lisa Wicks</td>
<td>Barrie Reiss-Seymour</td>
<td>Dr Jess Sokolov</td>
<td>Andrea Webster</td>
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</tbody>
</table>
| Delivery Programmes | SRO / Exec Lead  
Clinical Lead  
Programme Director (where applicable) | Programme Key People | Clinical Lead  
Where applicable | STP PMO Link to Programme Enablement |
|---------------------|------------------------------------|-------------------|-------------------|-----------------------------------|
| **Comms & Engagement** | | Pam Schreier  
Sophie Powers | n/a | Maggie Durrant |
| **Workforce** | Jan Ditheridge  
Victoria Maher | Heather Pitchford  
Nichola Bradford | Nursing – Dawn Clarke  
Medical – Dr Julian Povey  
AHP’s – Rachael McKeown | Sara Edwards |
| **Estates** | Clive Wright  
Tim Smith | Becky Jones | n/a | Maggie Durrant |
| **Back Office** | Dave Evans  
Ros Preen | | n/a | Maggie Durrant |
| **Digital** | Mark Brandreth  
Gail Fortes-Myers  
Andrew Boxall | Andrew Crooks  
Simon Adams | Andrew Roberts | Rob Gray |
| **Finance** | Claire Skidmore | | n/a | Paul Gilmore |
| **Population Health management** | Kevin Lewis  
Helen Onions | Emma Sandbach | Kevin Lewis | Penny Bason |
| **Medicines Optimisation** | Gail Fortes-Myers  
Mani Hussain  
Liz Walker | Lynne Deavin  
Jacqui Seaton | Jo Harding |
| **End of Life** | Derek Willis | Heather Palin | Derek Willis | Jo Harding |
| **Clinical Strategy Group** | Julian Povey | | STP - Julian Povey  
Rachel McKeown – AHP’s | Jo Harding |
STP PMO currently support the following submissions to NHSE

1. Urgent & Emergency Care Tracker
   • System Coordination of response by Prog Director Claire Old & Maggie Durrant
   • Oversight and Exec sign off by Julie Davies on behalf of both CCGs

2. Elective Care Transformation Tracker
   • System Coordination of response by CCGs & STP PMO Jill Barker
   • Oversight & Exec sign off by Julie Davies on behalf of both CCGs

3. Mental Health Transformation – Tracker not yet available / required
   • System Coordination of system Plan by STP Mental Health Strategy Group (co-chaired by Tony Elliot & Steve Trenchard (on behalf of both CCGs
   • Oversight & Exec Sign off by Fran Beck on behalf of both CCGs

4. Clinical Vulnerable Services Stocktake
   • Stocktake to establish vulnerable services across STP Footprint, support by Joanne Harding (STP PMO)
   • Response coordinated through the Clinical Strategy Group on behalf of the system
   • Sign off of final stocktake by STP Clinical Lead Julian Povey on behalf of the system

• All other submissions / reporting is unchanged and goes through existing Provider / Commissioner Governance processes
• Note STP has NO authority for sign off and existing governance arrangements MUST be met using Lead Execs as above
Appendixes

Following slides provide additional level of detail
These slides are “Live” and are continually updated as work programmes progressed, they are published bi-monthly
Commissioner Led Transformation Programmes
Shropshire – Care Closer to Home

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.

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.

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.
Phase 1 - update

- This remains operationally functional, it is the Frailty Intervention Team (FIT) based within our local general hospital.
- FIT requirements in SaTH should taper off and reduce in time with the implementation of Phase 2. Positive impact reported with plans being developed to expand and rollout to PRH.

Phase 2 - update

- Scoping and design work on Phase 2, risk stratification and case management has been completed
- Final preferred model for risk stratification and case management has been agreed. Being presented to the CCC for consideration in August.

Phase 3 - update

- Scoping and design of possible model options for Phase 3 (Crisis intervention, Rapid Response and Hospital at Home) has commenced.
Telford & Wrekin Neighbourhood Programme

Exec Lead – Anna Hammond
Project Lead – Ruth Emery

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) and 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

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

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.

Diabetes outcomes need to be improved

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

NHS RightCare

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

Key Projects

Neighbourhood "Yes" at Newport Cottage Care
To include: Volunteer organisations, Early Help and Modernisation, Older People’s Services
Commissioning, Public Health

Development of integrated Team
To include: Social Services, Community Services, District Nurses, Public Health

Wound Healing
Promote evidence based wound healing service, dealing with complications such as diabetes.

Neighbourhood Vision

To support the frail elderly population of Newport to stay well in their own homes
To improve wound healing rates

Programme Links

1. Encouraging Healthy Lifestyles
   Targeting obesity, smoking and alcohol

2. Community Resilience
   To support strong communities, including those in areas of mental health risks, support for care, the development of wellbeing hubs

3. Direct Care to the Community
   To include the introduction of a dedicated care homes team, development of integrated services, and review of intermediate care beds

4. Specialty Review
   To include diabetes and respiratory

Success Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>Outcome 1</th>
<th>Outcome 2</th>
<th>Outcome 3</th>
<th>Outcome 4</th>
<th>Outcome 5</th>
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<tr>
<td><strong>Neighbourhood</strong></td>
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<td>Population increase</td>
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<td>Dementia diagnosis rate</td>
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<tr>
<td>Diabetes outcomes</td>
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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

Governance established
Engagement & Leadership in place

4 Neighbourhoods Formed

Telford Neighbourhood Programme

Co-Produced solutions to meet local need
Designed together
Delivered together

Working with CSU Strategy Unit re: Logic Model and robust evaluation

Plan on a page for each Neighbourhood in place

Strong engagement with all sector partners, alliance agreement drafted to support new ways of working

Newport
South East Telford
Central Telford
Telwell

Case Study Examples:

- Diabetes Management
- Hypertension Management
- Mental Health Hub – Branches
- Citizens Advice – Virtual Team
- Wound Healing project
- Community Information Portal
- Health Champions
The GPFV programme has five main elements:

New models of care
- Developing an approach to "working at scale" among practices using the guidance from NHS England to define and establish local "primary care networks."
- Linking practices working at scale to wider new models of care – i.e. Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG).

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) by Oct 1st 2018.

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.

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 Care Closer to Home and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation.

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.

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An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets.

The CCGs are working with the STP workforce group to explore the possibility of developing banks for GPs and other clinicians.

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 is being implemented.
- 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.

The progress:

New models of care
- Practices in both CCGs are increasingly working in groups/localities – further work is being planned with NHS England, including attending a conference on Primary Care Networks in September.
- Primary Care is inputting into the development of both Care Closer to Home (SCCG) and Neighbourhood Working (TWCCG).

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.

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### Milestones

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<thead>
<tr>
<th>Ref</th>
<th>Critical Milestones (Rolling)</th>
<th>Due Date</th>
<th>Current Assessment</th>
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<tbody>
<tr>
<td>1</td>
<td>Safety - LMS Trust level representative engaged with and actively participating in safety collaborative</td>
<td>30/08/18</td>
<td>On Track</td>
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<tr>
<td>2</td>
<td>Continuity of Carer - Roll out plan (may include plan to pilot as req.) in place which factors in both workforce and financial implications</td>
<td>07/09/18</td>
<td>At Risk</td>
</tr>
<tr>
<td>3</td>
<td>Safety - Saving Babies Lives Care Bundle survey 9 results shared across LMSs</td>
<td>30/09/18</td>
<td>On Track</td>
</tr>
<tr>
<td>4</td>
<td>Continuity of Carer - Through MVP Engagement plan in place for ensuring local woman have voice in the development of the continuity of carer pathway</td>
<td>30/09/18</td>
<td>On Track</td>
</tr>
<tr>
<td>5</td>
<td>Continuity of Carer - Mechanism in place for being able to capture how women feel and think about their continuity of carer pathway</td>
<td>30/09/18</td>
<td>On Track</td>
</tr>
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### Key

- **Complete**: The Deliverable or Milestone has been completed within specified timeframe
- **On Track**: The Deliverable or Milestone is currently on track to completed within specified timeframe
- **At Risk**: The Deliverable or Milestone is currently at risk of not being completed within specified timeframe
- **Will not be met**: The Deliverable or Milestone will currently not be completed within specified timeframe
Existing pressures in maternity services mean that the pace and scale of transformation may not be in line with national requirements.

Funding of £251,467 confirmed for Specialist Perinatal Mental Health service for 2018/19 (joint with Staffordshire LMS).

Health and Wellbeing Initiatives through LMS funding launched. Public Health and smoking cessation midwifery support increased from 1st September.
<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Type</th>
<th>Deliverable</th>
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<tbody>
<tr>
<td>1.</td>
<td>X097</td>
<td>Next Steps</td>
<td>Deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019.</td>
</tr>
<tr>
<td>2.</td>
<td>X098</td>
<td>Next Steps</td>
<td>Deliver full implementation of the Saving Babies Lives Care Bundle by 31 March 2019.</td>
</tr>
<tr>
<td>3.</td>
<td>X099</td>
<td>Next Steps</td>
<td>Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.</td>
</tr>
<tr>
<td>4.</td>
<td>X100</td>
<td>Next Steps</td>
<td>Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2019, 20% of women booking receive continuity.</td>
</tr>
<tr>
<td>5.</td>
<td>X101</td>
<td>Next Steps</td>
<td>Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women are able to give birth in midwifery settings.</td>
</tr>
<tr>
<td>6.</td>
<td>MTP1</td>
<td>System Ask</td>
<td>All services are investigating and learning from incidents, and share this learning through their LMS and with others by March 2021.</td>
</tr>
<tr>
<td>7.</td>
<td>MTP2</td>
<td>System Ask</td>
<td>All services are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme by March 2021.</td>
</tr>
<tr>
<td>8.</td>
<td>MTP3</td>
<td>System Ask</td>
<td>All women are able to make choices about their maternity care, during pregnancy, birth and postnatally by March 2021.</td>
</tr>
<tr>
<td>9.</td>
<td>MTP4</td>
<td>Oversight</td>
<td>The LMS is engaging with Operational Delivery Networks to deliver safe and sustainable models of neonatal care across England by March 2021.</td>
</tr>
<tr>
<td>10.</td>
<td>MTP5</td>
<td>Oversight</td>
<td>The LMS has a credible plan for how its financial allocation (Transformation funding) will be spent, and is it on track to spend in year.</td>
</tr>
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<td>11.</td>
<td>MTP6</td>
<td>Oversight</td>
<td>The LMS has sufficient core staffing, and clear governance and reporting processes in place by March 2021.</td>
</tr>
</tbody>
</table>
Mental Health 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

Risks to delivery
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. NHS 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
**Programme needs to:**

- 8 workstreams identified
  - Work Stream 1 – PLCV Policies
  - Work Stream 2 – MSK
  - Work Stream 3 – Ophthalmology
  - Work Stream 4 – Diabetes
  - Work Stream 5 – Outpatients
  - Work Stream 6 – MRI
  - Work Stream 7 – Neurology
  - Work Stream 8 – Dermatology

**System Partners / Enablers need to:**

**The progress:**

- Initial draft submission to NHSE

**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**
Acute Reconfiguration - Future Fit

Executive Lead – Debbie Vogler          Programme Manager – Andrea Webster

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 an 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 deliver 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 11th September having been extended by one week to support additional requested engagement events.
• Public exhibition and Pop-up events have been held across Shropshire, Telford and Powys engaging with the public and raising awareness of the consultation.
• A mid point review took place in July to determine progress
• All key priorities and leads to support development of the DMBC have been identified and working with the Programme Director to evidence plans and progress is being made.
• Ambulance modelling work being completed by ORH with all providers fully engaged supporting delivery of the work.
• Formal post consultation process is being formalised with advice from NHSE

Risks to delivery
Risks
FF Team capacity and resource needs to be maintained to support delivery of the programme – current capacity is at acceptable level. 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 to ensure factual and correct information and responses are readily in the public domain
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.

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)

Data
Urgent and Emergency Care

System Improvements

Plan on a Page

Mixed formats of plan on a page to reduce duplication
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 maggie.durrant@nhs.net
Stranded Patient Flash Report

Project Overview

| Project Title: | Stranded patient | Deadline: | 02/07/2018 |
| Exec Lead:     | Edwin Borman     | Project Lead: | Gemma McIver |
| Clinical Lead: |                  | Project Group: | Improving patient flow |
| Date of Report: | 21/08/2018 | % improvement in admitted performance target 4% |

Overall Project Status: AMBER

Progress, Issues/Risks, and Decisions Key Items completed this week/since the last report

Current Position
- Monday 20/08/2018 – 233 lowest ‘Monday’ figure since the improvement work commenced on average same period as last year was 275 – August tends to be historically the lowest point we have decreased this to date however seasonal trend indicates that by September the stranded patient number does increase
- Weekend figures fell below 200 for the third consecutive week
- COP Friday 17/08/2018 – number was 188
- Super Stranded 30/31st the Super Stranded went up to 66 however this has now reduced to 51 this week maintaining the 39% improvement against the NHSE 23% improvement target – this is in Summer so we need to continue to sustain efforts in order to still meet the target set for April.
- Model Hospital have released data up to May 2018 for patients with LOS over 6 days performance nationally shows that SaTH are in the first Quartile (this is positive) 4th against our ‘peers’
- For Super Stranded performance in Model Hospital- SaTH are again in the First Quartile showing over a 25% improvement and as such are ranked number 14 in the country.
- Model Hospital data reflects that LOS for >75’s is also below national average at 8 days across RSH and PRH this places SaTH as the best performers against our peers and ranked number 13 nationally.

Progress
- Production boards now in place across all USC wards
- Drive to reduce days to hours has now commenced to support pre 12 discharges
- Continued to lower the threshold for case management from 21 to 18 days for USC
- Value stream aligned to this work on-going focus on board round and afternoon huddle
- Consistent support from Shropshire council and CCG at Super Stranded however due to commitments across the system attendance at these meetings is continuing to dwindle which will put a risk on maintaining the NHSE improvement target
- Stroke Therapist now reporting 3 longest lengths of stay at Super Stranded
- Ward 21 evaluation progressed with plan to present at execs for planning/ sign off
- Dr Eardley has supported with drive for Clinical Criteria for Discharge across medicine going into the weekend
Key Issues/Risks

- Medical capacity to engage and support to challenge/explore medical decisions is an area that is needed to fully achieve a reduction and sustained improvement
- Challenges with joint care arrangements peer-to-peer planning - speciality referrals – IT solution required
- Inconsistent use of PSAG on board rounds – delay in patients declared MFFD in medical notes being flagged on PSAG
- Therapy cover/vacancies across all wards impacting on discharge planning and goal setting
- Discharge to Assess culture not supported for pathway 3 patients requiring EMI environment
- FFA completion and ownership remains a challenge
- Frequent discharge pathway changes due to gaps in community provision (example: patient waiting 5 days for rehab bed improving and then needing pw1)
- Powys engagement and support is limited
- Criteria for accessing Pathways is different across local authorities impacting on decision making and trusted assessor model
- CHC at Telford and Shrewsbury have built in a brokerage model to source care that adds multiple days to LOS for fast tracks and PW1 patients (mitigated by S2H)
- Lack of community IV pathways
- No pathway 2 bed forward view for Telford to plan weekend discharges
- Pathway 1, 2 and 3 delays continue for Telford patients impacting on LOS and flow
- Challenges for Frailty Team and nursing staff when referring to community hospitals from ED
- Frailty funding decision pending for workforce recruitment

Key Items for next week

- Progressing phase 2 of stranded patient plan – invite case managers to the Super Stranded hubs
- PDSA stranded at RSH now standing and takes place around the PSAG – roll out to PRH on going
- Share ward 21 evaluation
- COE and Cardiology continue with AEP audit – Cardiology scheduled for next week
taskforce- steering group report

project overview

<table>
<thead>
<tr>
<th>project title:</th>
<th>improving ed processes</th>
<th>deadline:</th>
<th>06.04.18</th>
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<tbody>
<tr>
<td>exec lead:</td>
<td>nigel lee</td>
<td>project lead:</td>
<td>rebecca houlston</td>
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<tr>
<td>clinical lead:</td>
<td>dr kumaran subramanian</td>
<td>project group:</td>
<td>urgent care improvement programme</td>
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<td>date of report:</td>
<td>22nd august 2018</td>
<td>% improvement in admitted performance target</td>
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overall project status

amber

3b. progress, issues/risks, and decisions

key items completed this week/since the last report

- daily cross site huddles continue – circulated to execs daily
- external exec level huddles with external attendance
- ed summit internal clinical summit group and external risk summit group
- ed recovery document developed – inclusive of action plans (also revised to include recent nhsi visit)
- weekly ed performance meeting to review further actions
- weekly report describing minors performance for w/c 13/08/18
- acute medicine workforce review
- review of medical staffing deep dive with katy molland – job plan/dcc review of middle grade doctors and consultants
- paediatric review of attendances
- audit of patients that leave without being seen

key issues / risks

- ed middle grade overnight gaps continue to be a significant issue – next gap from 27th august at rsh continuing through the rest of august/early september on both sites, solution to cover prh with sho’s only overnight is not supported by paeds, anaesthetics or radiology. gaps during the day are occurring more often with some days left without any cover.
- since april 2018 there have been 44 night shifts where there has been no overnight middle grade
- external reporting minors vs non admitted
- data quality including ecds acuity issues – ongoing risk due to lack of changes on sema
- data quality – ambulance breaches
- ed workforce status – impact upon ability to deliver required process changes
- operational team capacity to deliver required process changes
- constant changes to medical rota to cover key shifts resulting in gaps ‘within hours’ is resulting in significant delays to be seen
- financial impact of highly escalated salaries for overseas doctors and locums
- additional physio clinics following the ed clinics no longer being in place – increased attendances under review and now added to the risk register
- admin backlogs in both ed – quality and financial risk
- nursing gaps – average of 44% agency used per week
- await confirmation from exec meeting as to funding for streaming nurse and if the service can continue

all risks mitigated where possible.
Taskforce- Steering Group Report

<table>
<thead>
<tr>
<th>Project Overview</th>
<th>Overall Project Status</th>
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<tbody>
<tr>
<td>Project Title:</td>
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</tr>
<tr>
<td>Exec Lead:</td>
<td>Nigel Lee</td>
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<tr>
<td>Clinical Lead:</td>
<td>Dr Kumaran Subramanian</td>
</tr>
<tr>
<td>Date of Report:</td>
<td>22nd August 2018</td>
</tr>
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</table>

Cont.

Key Items for next week
- Progress actions in recovery plan
- Review key actions from medical deep dive
- Deliver any changes to pathways following decision around business continuity
- All patients to be managed against professional SOP’s/ professional standards – circulation of SOP required to all clinicians
- On-going recruitment drive and review of potential locums and nurses
- Continue to push internal ED actions to improve non admitted and minors performance
- Review next steps for business continuity
### Project Overview – IMPROVING FLOW STEERING GROUP

<table>
<thead>
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<th>Project Title:</th>
<th>Objective 3 - Red 2 Green/SAFER</th>
<th>Deadline:</th>
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<tr>
<td>Exec Lead:</td>
<td>Deidre Fowler</td>
<td>Project Lead: Rachael Brown</td>
</tr>
<tr>
<td>Clinical Lead:</td>
<td>To be agreed for each site</td>
<td>Project Group: Improving patient flow</td>
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</tbody>
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### Overall Project Status

| Date of Report: | 22nd August 2018 | % improvement in admitted performance target 4% |

### 3B. Progress, Issues/Risks, and Decisions

#### Key Items completed this week/since the last report
- Project / kaizen in place which incorporates SAFER principles under standard work. Task and finish group meeting fortnightly. First set of re-measures show improvements in some areas.
- Corporate nursing Nightingale project to be developed as part of standard work plan regarding safety huddles.
- Weekly data shows a slight dip against trajectory for this week. Currently at 14% against a trajectory of 16.4%
- As part of Kaizen plan board rounds and huddles established as priority areas, ward plans in place.
- Baseline metrics recorded for USC wards and in progress of collection SC wards.
- Buddy system of support in place and meetings held.
- SC engagement event held 15.8.18. Good engagement from ward areas.
- Further masterclasses held this week for production boards / people link boards.
- Further Kaizen events identified / scheduled for September to address some issues that need further exploration e.g. FFA
- Super - stranded patient reviews continue to take place on a weekly basis for both care groups across both sites. LOS threshold reduced to 18 days
- Red2Green function and clinical reasoning for changes to EDD live on psag. Developing tolerance reporting in line professional standards, to be in place end of September
- Check, chase, challenge process in place across both sites, all care groups. Production board developed to provide visibility of daily metrics.

#### Key Issues / Risks
- Discharge planning process and med fit category, changing of pathways, and ability to ‘flag’ complex patients earlier in the patient journey.
- Internal blocks: doctor review / specialty referrals and FFA completion still highlighted as areas of concern
- Lack of red2green completion leading to insufficient and potentially misleading data on some wards. Weekend completion remains poor. About half of all wards consistently submit data.
- Dip in performance against baseline measure / trajectory
- Pace of change
- Medical engagement

#### Key Items for Next Week
- Continue to work with the identified wards to understand processes, key issues and effectiveness with a view to making further improvements
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process.
- Ward manager meetings
**Integrated Discharge Team**

**Exec Lead – Claire Old**  
**Programme Leads – Sara Dillon & Tanya Miles**  
**01 October 2018**

### SaTH needs to:

1. Increase the number of FFAs received by the discharging organisation before midday – target 80% before midday.
2. Increase the number of FFAs received per week to enable the LAs to meet their discharge trajectories (target: Shropshire 64 per week, Telford 42) Through the demand and capacity work we will review the original figures for discharge to ensure that they are accurate as these have never been reached.
3. Nurse led discharge criteria embedded to improve earlier discharges
4. DLN’s to be part of the discharge team- the case management approach to be embedded across both sites to ensure the correct approach toward discharges.
5. SaTH therapists to goal set for minimum 72 hours post discharge – this needs to be across all wards.
6. Transfer by relative/Red Cross should be default unless otherwise indicated
7. Anticipatory equipment planning and prescribed meds with person day before discharge
8. Need access to Senior Medical advice and diagnostics from SaTH for Admission Avoidance – to be considered at A and E group – Frailty at Front Door on both sites – decision needed re future funding needed.

### System needs to:

1. System-wide Choice Policy in line with national guidance approved by all partners and implemented – need to ensure consistent application.
2. Trusted assessors for care homes in place to be extended in Telford.
3. Support the current demand and capacity modelling across the system.
4. Further develop the system wide assistive technology offer.
5. Continue to support the admission avoidance pathway provided by Rapid Response nursing and social care teams.

### The progress:

1. ECST review of IDT process and develop the SOP 15/16/10/18
2. RPIW event re FFA’s 5/11/18

### 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

1. Insufficient patients ready for discharge to achieve the required FFA numbers per week for the LA to hit their discharge trajectories
2. Provider failure dom/bed based care. Mitigation plan in place
3. BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.
4. PRH decision re closure and divert to other hospitals will have a huge impact upon the performance around DToC as patients are spread across the region.
5. Medication protocols for discharge are stretched with both in house and external providers being challenged by CQC on their processes around discharges.

### Data

**Shropshire A&E Dashboard**

*SaTH A&E 17/18 & 18/19 Weekly Performance Vs. Trajectory*
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 (e.g., 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

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.
Programme needs to:

- Implement Frailty Front Door at RSH in line with the AFN model
- Develop and implement Frailty Front Door at PRH by October at the latest
- Develop Inter-Disciplinary Teams to have robust MDT approach to complex discharge and achieve target of 136 complex discharges a week
- Support home First and achieving 60:30:10 for pathways 1/2/3
- IDTs support and wider ICS/ICT support SATH Red2Green/ SAFER through in-reach support
- Reduce admissions from Care Homes through specific dedicated Teams or focus
- Provide overview and scrutiny of the DTOC High Impact Changes progress across the economy in achieving Mature RAG rating by end of Quarter 4 reporting.
- Reduce and maintain DTOC target levels and reduce length of time of patients on the work list

System Partners / Enablers need to:

- Clinical and managerial support from all organisations to ensure prioritising programme of work
- Collaborate to maximise the effective utilisation of learning from PDSAs, and audit in order to create behaviour and system change
- Clearly define objectives, activity, resource, milestones within each program work stream to enable accurate assessment of progress
- Accessibility of clinical expertise to support programme development including ECIST and AFN

The progress:

- Frailty Front Door at RSH Evaluation Action Plan in place; monitored through the Frailty Task and Finish Group
- 6 As Audit completed highlighting potential for reduced admissions, reduced length of stay, improvements in clinical and care pathways
- PDSA for Frailty at Front Door at PRH completed 25-27th July to develop model and improve existing pathways. Evaluation highlighted need for additional medical and therapy capacity – within Winter Plan
- Inter-Disciplinary Teams (Clinical Hub) in place on both sites seeking to achieve target of 136 complex discharges/ week. IDTs engaged in weekly Stranded Patient reviews
- Trusted Assessors in place facilitating early discharge to care homes
- Care Home MDT in place in T&W. Commenced piloting Emergency Passports in six care homes in conjunction with WMAS. Preparing to launch Red Bag Scheme
- Shropshire Deep Dive of Care Homes including review of CHAS and potential for piloting Miralife
- Relaunch of NHS 111*6 clinical advice line for care homes
- Developed DTOC High Impact Changes Action Plan to achieve Mature by end of Quarter 4 RAG rating

Risks to delivery:

- Current funding for Frailty at Front Door at RSH is based on local tariff Agreement. Risk that not agreed putting funding from April 2019 into question
- Current RSH infrastructure does not support working more upstream in ED to prevent admissions which limits to Service’s impact on admission avoidance and potentially duplicates clinical input
- Additional capacity for Frailty at Front Door at PRH identified through PDSA. Needs approval through Winter Plan. Evaluation is needed to develop a Business Case for funding post April 2019
- Additional Domiciliary care capacity in both Boroughs to maximise complex discharges home for Pathway 1 and long term care at home supporting Home First and reduce length of time on the work list and recordable DTOCs

Data:

- SATH reporting on Frailty at RSH highlighting impact on admissions and length of stay of Frail patient
- Need to develop methodology for monitoring impact at PRH
- Weekly reporting to A&E Delivery Group on performance related to complex discharge
- A Frailty dashboard is in place to monitor performance across both CCGs. This is being updated
Transformation Enablers

System Improvements
Plan on a Page
Digital Enabling Programme

Programme needs to:

- developing the Local Digital Roadmap (LDR) - draft for NHS Digital Review October.
- Improve Connectivity: Provide seamless access networks and efficient procurement of new connections / wifi access for staff and citizens at all locations—close of financial year.
- 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.
- Improve Collaboration - Licensing future proof and cost efficient route for Microsoft and Office upgrades (towards O365 and CloudFirst)
- Identify & support digital requirements for all other programme groups.
- Improve Digital Maturity Assessment scores to support programme success.
- Establish business cases as appropriate for possible future funding availability.
- Analyse options for an Integrated care record across health and social care settings.
- Ensure and assist organisations within the STP to capture information electronically at point of care.
- Identify the capability for Interoperability across the STP area.

System Partners / Enablers need to:

1. Ensure “Right Information available to the right person in the right time and location” enabling better outcomes for citizens.
2. Clarify the end vision and the level of commitment required from organisations.
3. Act as One! Agree the objectives of the enabling group with in the strategic governance process at exec level.
4. Standardise on clinical coding (SNOMED-CT) for all organisations.
5. Provide resource (inc funding, project management etc) to define and plan programmes and projects.
6. Encourage digital solutions in all workstreams. Promote the modernisation and efficiency of paperless processes to increase efficiency through a digital programme.
7. Conform to cyber-security requirements – and resource specialist support.
8. 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:

- New DEG chair, SRO and Exec Lead to meet to agree LDR direction.
- LDR refresh process nearing completion.
- HSLI bid completed phase 1 – refinement to be completed.
- HSLI bid for 8/19 funding accepted by NHSE. £885k awarded.
- • Business cases to be created.
- • Project started - Enhance SCR for all active patients.

Key Interventions / Milestones

- Oct-18. LDR refreshed and new Digital Programme defined. HSLI bid created and applied for.
- Nov-18. Summary Care Record enhancement initiative started, and visible in secondary care, starting with A&E.
- Dec-18. Network - shared procurement in place. Corporate Wifi access for all orgs planned for all sites.
- Jan-19. Draw down funds for HSLI projects.
- Jan-19. Defined Procurement process started for Electronic Patient Record systems for SaTH and RJAH to support shared access to Integrated care records.

Risks to delivery

- Resources – (lack of revenue funding 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 is unclear.
- 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.)

Actions:
- DEG SRO, Exec Lead and co-chairs appointed.

Data

Outline programme plan.
Programme needs to:

- Use data in geographic layers at a very local level as evidence of emerging community need, and 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:

- Estates Workbook/Strategy completed and submitted on time and now a living document.
- Capital bid for Shawbirch submitted.
- Project pipeline in early stages of development.
- Joint OPE/STP Programme Delivery board established.
- Whitchurch Project Board up and running and Shropshire Council Cabinet report approved. Continuing on road to delivery.
- Asset Mapping & data layering work with Shropshire Council going well, producing evidence base & assisting to inform opportunities with regular meetings taking place to ensure co-ordination between Council and health future planning needs.
- Early stages of planning for OPE 7 projects.
- Engagement with Telford and Wrekin Council and aiming to continue engagement with Council and CCG to deliver joined up working 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:

- 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.
- 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.

Updated August 2018
Next update—October 2018
The STP Estates Strategy 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.

This strategy 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....
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 (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).

IT foundations to ensure the groundwork is most effectively procured to support the STP digital agenda.

System Partners / Enablers need to:

1. Support a level of ambition proposed by the programme – i.e. 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 group, on behalf of the STP health partners have commissioned a piece of ‘value added’ work via Midlands and Lancs CSU to appraise the options for rationalising the ‘back office’ in health organisations. Time scales are now firmer and are outlined below. With a project plan developed to underpin the work.
- Back Office work stream meetings suspended until the initial reporting of the CSU diagnostic has reached a point where it is appropriate to review progress (meeting scheduled for 24th Sept).
- 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, with the most recent national submission for corporate benchmarking (Model Hospital) due to be submitted by STP health providers by the 17th July.

Key Interventions / Milestones

- Commence CSU diagnostic – Summer 18
- Data sharing to underpin the data analysis and diagnostic (Aug 18)
- Initiate director/senior team interviews (Sept 18)
- Evaluate CSU diagnostic conclusions and agree programme of change – Autumn/Winter 18
- Implement change programme – Winter 18 onwards

Risks to delivery

- The scale of opportunity will not be realised due to;
  1. Lack of collaboration beyond health on procurement.
  2. Willingness to share data to support the CSU review.
  3. Capacity and will to drive ideas forward across organisations at pace
  4. Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
  5. 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
  - Use 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)
**Programme needs to:**

1. Develop a system-wide Strategic Transformation Workforce Plan which supports Future Fit options linking acute and community models.
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 and support transformation.

**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 taking into account Future Fit options.
- 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.

**Key Interventions / Milestones**

- Complete the workforce profile data gathering and individual specialist workforce plans. Aligning with Future Fit Programme.
- Leadership and OD Programme with the King’s Fund completed. NHSI (ACT Academy) TCSL Programme change management tools being used.
- Development of Shared Recruitment project and Collaborative Bank – Project Briefs developed with partner engagement.
- Implementation of a pilot Rotational Apprenticeship Programme with September 2018 start.
- Delivery of 2018/19 STP/LWAB funded priority areas and development of a shared training/learning offer to meet system needs and promote integrated working.

**Risks to delivery**

- Planning without knowledge of future finances and service redesign/configuration. Future Fit Consultation ends in September 2018.
- 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.
- Collaborative Workforce Support and align programmes.
- Piloting areas of work to test outcomes.

**Data**

- **Shropshire Workforce Baseline:** STW system workforce baseline developed by HEE Workforce Intelligence Team utilising data from NHSI operational plans (workforce plan) for acute/community and mental health services, NHS Digital for primary care and NMDS for social care.
- **Mental Health Workforce Plan –** Submitted with no requirement to resubmit. MH Delivery Plan now being addressed.
- **STP OD Group** - now set up with priorities being planned.
- **Local Maternity Services (LMS) Transformation Plan developed. First draft of WFP taken to LMS Board and WFP sub group meetings in progress. Leadership & Cultural Development Plan to follow in Autumn 2018.
- **GP Forward View Workforce Plan** has identified projects to address recruitment and retention targets and bids have been submitted to support GP recruitment, retention and resilience programmes.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services being delivered.
- **2018/19 workforce investment** scoping exercise in progress.
- **STP/LWAB** relaunched with priorities refreshed.
- **Education & Development Group** – Identification of priorities and development of Multidisciplinary Preceptorship Framework, Shared Learning Assets and Shared Statutory and Mandatory training projects.
- **Training Hub** – Re-establishment of the Shropshire and T&W Training Hub provision within the STP PMO.
### National Ambitions

- **Individual care**
  - Facilitate effective personalised care planning and support of those important to the dying person
    - Documentation provides clarity to all regarding patients’ preferences/goals for living
    - Important conversations
    - Identify key worker
    - Patient and carer access to documentation
    - Shared electronic records

- **Fair access to care**
  - Ensure equal access to palliative and end of life care
    - Develop systems with prognostication to identify patients in last year of life
    - Co-ordinated processes for referral: clear Access criteria and Co-designed referral documents
    - Establish a needs based model that identifies phase of illness and a system for prioritization
    - Links with non-cancer specialists
    - All supported by GSF and Frailty registers
    - Support Transitional Care Initiatives

- **Comfort and Wellbeing**
  - Establish ‘Living Well’ concept: support advanced & anticipatory care planning & timely access to services
    - Culture of care is enablement
    - Programs for palliative rehabilitation are established
    - Expand homecare models to support a preference to die at home; further develop H@H service
    - Provide necessary medication and associated documented administration authority

- **Coordinated care**
  - Work in partnership to ensure that care is coordinated between services
    - Facilitated by Local Health Economy End of Life Group supported by CCGs
    - Services compliment not replicate each other
    - There is shared accessible documentation where possible (RESPECT, EOL care plan, PPC) and Flagging
    - Integration of H@H with the Hospice Outreach Service

- **All staff care**
  - Ensure a competent workforce
    - Identify education needs across services; Establish education programmes
    - Robust systems for appraisal and CPD across groups; System learning from Significant Adverse Events

- **Caring Community**
  - Recognise compassionate communities voluntary support as an extension to services
    - Severn Hospice continued roll out of coco
    - Volunteering is seen as an arm to wider services
    - Clinical services refer to established volunteer support
    - Expand competencies in verification of death to facilitate this promptly and confidently

### National Foundations

- **Personalised care planning**
- **Shared records**
- **Evidence and information**
- **Those important to the dying person**
- **Education and training**
- **24/7 access**
- **Co-design**
- **Leadership**
The programme needs to:
1. Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC+, PHE’s One You, including for:
   - Stop Smoking Support
   - Weight management
   - Physical activity programmes
   - Immunisation opportunities, e.g. flu
2. Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension
3. Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services
4. Deliver prevention expectations of the national Cancer Strategy
5. To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support
6. Work together to make best use of resource and expertise
7. Develop our wider workforce to ‘make every contact count’ (MECC+)
8. Improve communication between organisations

Key Interventions / Milestones
- Developing local Health & Wellbeing Intelligence
- Population health management
- Deliver and Deliver System CVD, Diabetes and Obesity Strategy
- Deliver the prevention expectations of cancer strategy
- Develop system social prescribing infrastructure
- Development of a system plan to reduce harm related to alcohol
- Develop the system MECC Plus proactive approach, including training and delivery plan

System Partners / Enablers need 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 by connecting with the national and regional population health management support mechanisms
6. Support and embrace the role of the VCSE and communities to drive forward prevention activity
7. Focus on developing a good understanding of need – continual information provision for the JSNA
8. Improve communication between organisations

The progress:
- 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
- Development and Deliver of MECC Plus for NHS providers, VCS, housing

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

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