The Shrewsbury and Telford Hospital NHS Trust

Paper 6

Recommendation ☐ **DECISION** ☑ **NOTE**	**For information only** n/a
Reporting to:	**SaTH Trust Board**
Date	29 November 2018
Paper Title	STP Directors Update
Brief Description	This is a monthly update detailing progress from all key areas of STP and system partners. Full detail available in Information Pack For further information on any aspect, please contact jo.harding1@nhs.net
Sponsoring Director	Phil Evans
Author(s)	STP PMO Office and system partners
Recommended / escalated by	n/a
Previously considered by	**n/a**
Link to strategic objectives	5 year forward view STP programme plan stragetic objectives
Link to Board Assurance Framework	n/a
Outline of public/patient involvement	Patients are involved through existing organisational frameworks as required
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

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

Region:
Shropshire and Telford & Wrekin

STP Directors Update

Oct 2018 Final

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.

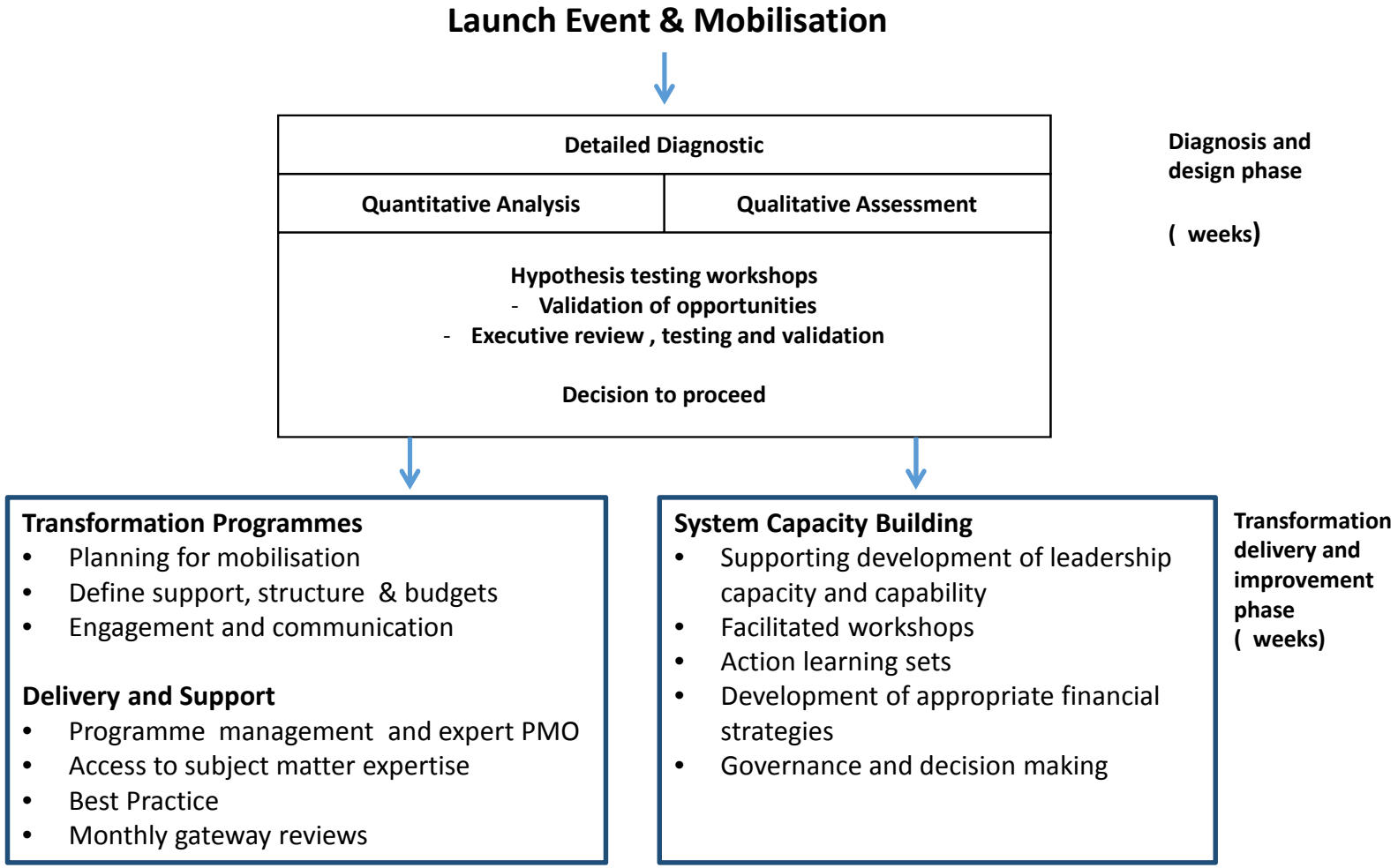
STP Development Programme

Overall Approach

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



Quantitative Diagnostic

- 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.

Qualitative Self Assessment

- NHSE will co ordinate 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

Methodology 2/2

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

JH4

Timeline of key STP activities June 17 – Dec 17

Pre -June 17

- STP Submission April 2017
- System OD Diagnostic undertaken
- 4 previous Interim STP Programme Directors

June - July 17

- STP Partners agreement to fund System PMO Resource
- Initial Governance structure published
- Programme Director appointed 1.0wte
- Head of PMO appointed 1.0 wte

Oct 17

- STP PMO Team approved
- First Directors Report published
- Kings Fund OD Phase 1 commences with system leaders
- Substantive PMO appointed 4.0 wte

Nov 17

- STP Delivery Group workshop with Kings Fund
- Review of Delivery & Enablement Groups
- Each work Programme offered STP Resource
- System UEC Director appointed 0.8wte

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

Slide 13

JH4 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

- Plan on a page reporting commenced Reducing duplication
- STP Clinical Strategy Group Evolved
- STP System Leaders Group established
- Office 365 deployed across PMO Team

April - May 18

- Successful Individual Placement Scheme Bid Wave 1 - £294,500 Wave 2 - £289,000
- Estates workbook system wide working
- Future Fit consultation commences May 18
- AHSN Innovation Implementation Lead funding £70k
- STP leadership agree system priorities

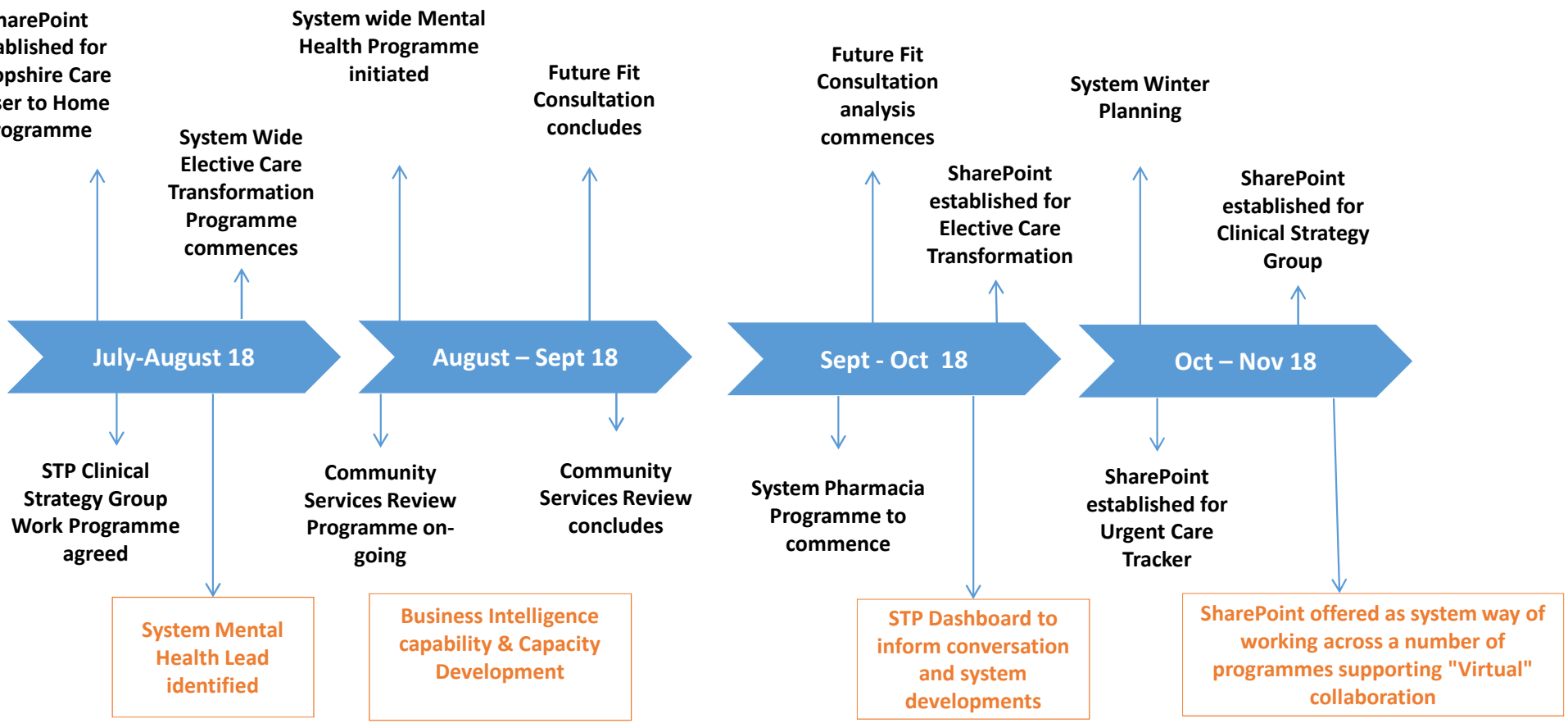
May - June 18

- System wide Mental Health Group Development
- STP Clinical Strategy Group to agree system priorities
- NHSE STP Governance Framework commenced
- STP System Transformation Programme Marketplace
- STP Dashboard to inform conversation and system developments

July- Aug 18

- Estates workbook submitted
- Digital Roadmap refresh
- Elective Care Transformation Plan 1st Draft submitted
- Future Fit consultation on-going
- Business Intelligence capability & capacity Development

Timeline of key STP activities July 18 – Aug 18



Shaping STP System Thinking

- 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

System Wide Working

Strategic Development & Leadership

Recruitment of independent STP Chair

STP System Leaders Group

Local Workforce Action Board (LWAB)

STP Clinical Strategy Group

Health & Well-being Boards

Community Services review work programme

System Communication & Engagement

System wide consultation and feedback through existing mechanisms

Strategic Enablement

Strategic Estates Group

Strategic Back Office

Digital Enablement Group

Strategic Workforce Planning

Strategic System Finances

System population health & prevention (new)

System End of Life (new)

System Business Intelligence (Gap)

Strategic Delivery of change

Hospital reconfiguration (Future Fit)

Urgent & Emergency Care

- Winter Planning
- High Impact Changes
- Frailty
- IUC / 111

Out of Hospital Care Delivery

- Shropshire Care Closer to Home
- Telford & Wrekin Neighbourhoods

Primary Care Transformation

Mental Health Transformation

Cancer & End of Life

Elective Care Transformation – 8 workstreams identified

1.Procedures of Limited Clin Value 2. MSK
3. Ophthalmology 4. Diabetes 5. MRI
6. Out-Patients 7. Neurology 8. Dermatology

Pharmacia Programme

Local Maternity Services

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

FYFV Programme	Constitutional Standards 18/19	RAG
Urgent and emergency Care	A&E 4 hour standard	
	DTOC	
	Ambulance	
	NHS 111	
Elective Care	RTT 18 week	
	52 week waits	
	Diagnostics	
	Wheelchair access	
Cancer	Cancer Waits	
Mental Health	IAPT Access	
	IAPT Recovery	
	Dementia Diagnosis	

FYFV Programme	85 Assurance Statements 18/19	RAG
Urgent and emergency Care	NHS 111 x 3	
	Ambulance x 3	
	Hospital to Home x 2	
	Hospitals x5	
	Technology x 8	
Elective Care	Avoidable demand x 4	
	Ophthalmology x 3	
Cancer	National Priorities x 10	
Mental Health	CYP x 2	
	CRHT x 2	
	OAP x 1	
	Liaison x 3	
	SMI x 1	
	Perinatal x 1	
	Suicide prevention x 2	
	IPS x 1	
	DQ x 1	
	Parity of esteem x 1	
	IAPT expansion x 1	
	EIP x 1	
	Dementia x 1	
	Workforce x 4	

85 Assurance Statements 18/19	RAG
CHC x 3	
Maternity x 5	
Primary Care x 14	
7 day services x 1	
Transforming Care x 2	

Updated Version 5.0
Oct 2018

Shropshire, Telford and Wrekin
Sustainability & Transformation Programme Governance Structure

Draft – tba - changes

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
- MPFT
- 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)

Vulnerable Services Review
Clinical Strategy Improvement

STP Transformation Programme Delivery Group

System Enablement

- Communication & Engagement
- Strategic Workforce
- Strategic Estates
- Back Office
- Digital Enablement
- System Finance
- Population Health Management & Prevention
- Medicines Optimisation
- End of Life Programme

System Delivery

Telford & Wrekin

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

- Urgent & Emergency Care
  High Impact Changes
  Frailty
- Acute Hospital Reconfiguration
  Future Fit
  Sustainable Services Programme
- Local Maternity Services
- Development of Primary Care
- System Mental Health Programme
- Elective Care Transformation Programme
- System Cancer

Shropshire

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

Wider Stakeholder involvement across all work programmes

- 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

STP PMO Team

Name	Role & capacity available	Key area's of responsibility / support
Phil Evans	Programme Director 1.0 wte	STP Leadership Group, system board meetings, external stakeholders, ICS development Oversight of Programme, escalation to STP System Leadership, strategic system developments
Joanne Harding	Head of PMO 1.0 wte	Clinical Strategy Group, End of Life Group, System Medicine Optimisation, workload allocation, system collaboration, system papers and overview, STP Dashboard development, SharePoint Admin Links to National STP/ICS Development, Transformation Programme Delivery Group
Jayne Knott	Senior Project Admin 1.0 wte	Support to STP Programme Director, UEC Programme Director, system meetings, point of contact for the PMO
Andrea Webster	Programme Manager 1.0 wte	Future Fit, Care Closer to Home, Telford Neighbourhoods Travel & Transport, support for Future Fit Consultation working with FF Programme Director
Rob Gray	Programme Manager 1.0 wte	Digital Enabling Group and sub-groups, link to all delivery workstreams from a digital perspective. HSLI and Local Digital Roadmap, system digital developments, SharePoint Admin
Penny Bason	Programme Manager 1.0 wte	Population Health, Better Care Fund
Paul Gilmore	Programme Manager 1.0 wte	STP Strategic Finance Group. Link to all delivery programmes from a finance perspective to support system financial understanding and modelling
Pam Schreier	Comms & Engagement 1.0 wte	STP comms and engagement, Future Fit consultation and wider STP Comms
Sara Edwards	Programme Manager 0.8 wte	Strategic Workforce Group, Primary Care Training Hub, link to delivery programmes from a workforce enabling perspective, inc Cancer & Mental Health, working alongside HEE
Maggie Durrant	Programme Manager 0.6 wte	Urgent Emergency Care - working with UEC Programme Director, system NHSE UEC Submissions Estates & Back office enabling groups
Jill Barker	Programme Manager 0.6 wte	Elective Care Transformation Programme, linking with CCG leads, preparing system readiness for NHSE Submissions and sign off IV Therapies & Therapy Services

STP – People & Programmes

Delivery Programmes – Key Contacts

Delivery Programmes	Exec Lead Clinical Lead Programme Director (where applicable)	Programme Key People	Clinical Lead Where appropriate	STP PMO Link to Programme Enablement
Urgent & Emergency Care	Julie Davies Claire Old	Emma Pyrah	Dr Kevin Eardley	Maggie Durrant
Frailty	Fran Beck	Emma Pyrah Michael Bennett	Dr Jo Leahy	Penny Bason
Future Fit	Debbie Vogler	Pam Schreier	Dr Mark Cheetham	Andrea Webster
Local Maternity Services	Chris Morris	Fiona Ellis Helen White	Sarah Jamieson	Jo Harding
Primary Care	Nicky Wilde Rebecca Thornley	Phil Morgan	Dr Jo Leahy Dr Julian Povey	Jo Harding
Mental Health	Fran Beck	Frances Sutherland Steve Trenchard	Prof Tony Elliot	Sara Edwards
Elective Care	Julie Davies	Bethan Emberton Angie Parkes	Opthalmology – Claire Roberts MSK -	Jill Barker
System Cancer	Gail Fortes-Myers	Sharon Clennell David Whiting	Dr Andy Inglis	Sara Edwards
Telford & Wrekin Neighbourhoods	Fran Beck	Anna Hammond Ruth Emery	Dr Jo Leahy	Andrea Webster
Shropshire Care Closer to Home	Julie Davies	Lisa Wicks Barrie Reiss-Seymour	Dr Jess Sokolov	Andrea Webster

STP – People & Programmes

Enablement Programmes – Key Contacts

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	Lynne Deavin Mani Hussain	Jacqui Seaton Liz Walker	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

System Submissions to NHSE Governance

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

Exec Lead – Julie Davies Clinical Lead Dr Jess Sokolov Programme Lead – Barrie Reis-Seymour

Phase 1

- Phase 1 is operationally functional as the Frailty Intervention Team (FIT) based within the A&E department of Royal Shrewsbury Hospital.
- The FIT works with frail patients to ensure that they experience as efficient an in-patient service as is possible; providing a bespoke assessment and evaluation in order to get the patient to the appropriate care setting rather than unnecessarily admitted into the acute bed base.
- 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 proactive & preventative Case Management into the community and primary care.
- This will enable risk-stratification of our patients for earlier identification of needs.
- This will enable those most in need to be pro-actively managed with an integrated holistic health and social care plan, provided by a community based Case Management Team.
- This service is underpinned by the principles of keeping people as well as possible, for as long as possible, and in their own home or community.
- This will enable a clear understanding of what the requirements of the models in phase 3 are for the patients with a more acute/intense level of need.
- This will enable effective, fit for purpose strategic workforce and estate planning.
- This will improve patient & family experience, improve outcomes, and reduce admissions into the general hospitals.

Phase 3

- Phase 3 will introduce a range of higher intensity care settings & services into the community including:
- Hospital at Home,
- A Rapid Response Team
- 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, providing other care settings into which patients can be transferred.
- Phase 3 will provide for significant market-place development.
- Phase 3 with Phase 2 provides layers of multiple care services that will keep people as well as possible and in the community or own home, reducing emergency hospital admissions to a critical minimum.
- 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.

NHS
Shropshire
Clinical Commissioning Group

Shropshire – Care Closer to Home - Progress

Phase 1 - update

- This remains operationally functional, it is the Frailty Intervention Team (FIT) based within Royal Shrewsbury Hospital A&E Department. Planning underway to implement at PRH A&E.
- FIT requirements in SaTH should taper off and reduce in time with the implementation of Phase 2 as a result of earlier intervention and proactive preventative care & support in the community.

Phase 2 - update

- Collaborative design of models and possibilities completed in July 2018.
- Final preferred model for risk stratification and case management approved by the Clinical Commissioning Committee on 15th August 2018.
- An Alliance Agreement being progressed that will enable the integrated working that will underpin the development of pilot demonstrator sites. This will involve finessing the model with the more detailed operational service delivery and workforce modelling.
- Monitoring and evaluation of pilots that will inform wider rollout across the county.
- Dedicated IT Task & Finish Group established to address need for shared data, and development of an electronic shared Care Plan.

Phase 3 - update

- Following 2 failed attempts at collaborative co-design (poor uptake from stakeholders, increasing system pressures and limited availability) the decision has been made for the in-house programme team to develop a range of Phase 3 model options by end of December 2018.
- In the new year, model options will be taken to GP, provider, and public & patient stakeholder workshops to provide critique, feedback and input that will further define a long list of possible model options.
- Phase 3 timeline being refreshed to reflect this necessary change in approach.
- It is likely that formal consultation will be required in elements of Phase 3, and this will be determine by the nature of the models that emerge in the design and option appraisal process.

NHS
Shropshire
Clinical Commissioning Group

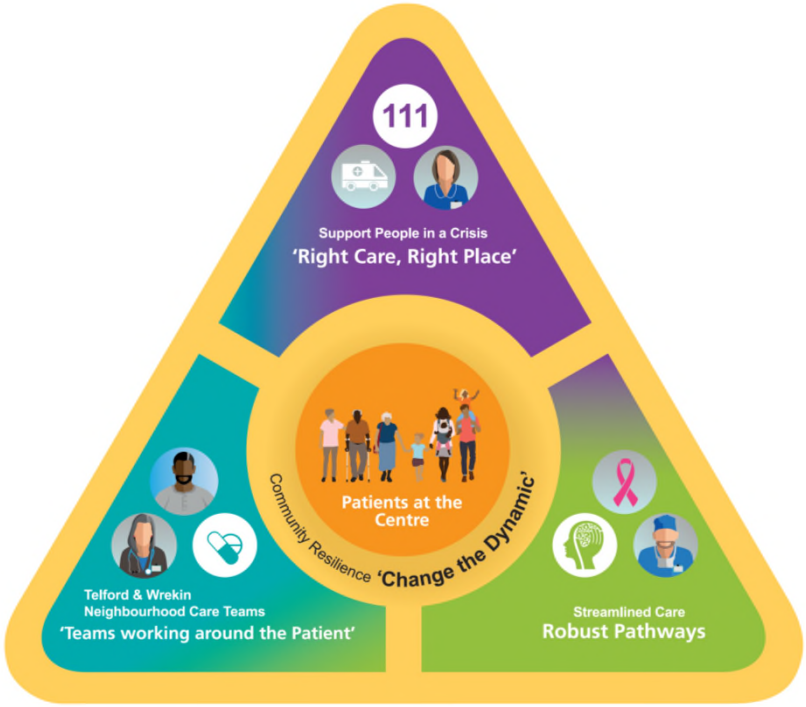
Telford & Wrekin Neighbourhood Programme

Exec Lead – Tracey Jones 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

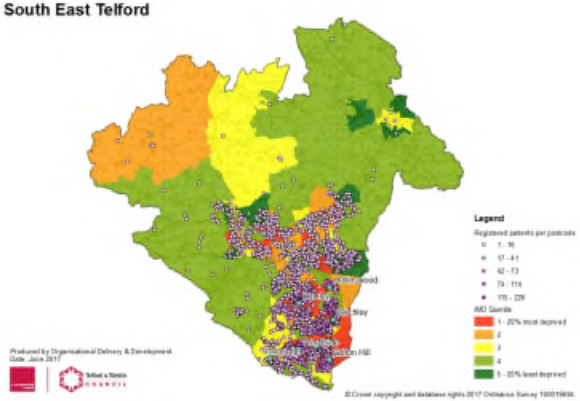
futurefit
Shaping healthcare together

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

NHS RightCare → *Diabetes outcomes need to be improved*

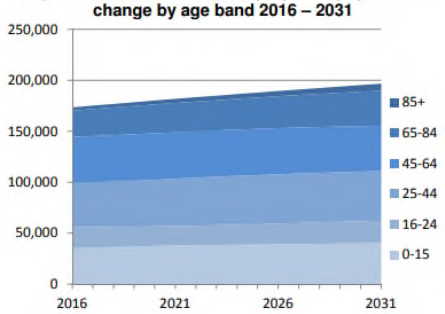
Between 2016 & 2031 the T&W population is expected to increase by 23,300 (13.4%). Over half of these are 65 and over, with the 85+ ages more than *doubling* (117.6%) and the 65-84 ages increasing by 33.1%. All England is expected to grow 10.2%, a slower growth than T&W(13.2%). The largest difference 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 Aug 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

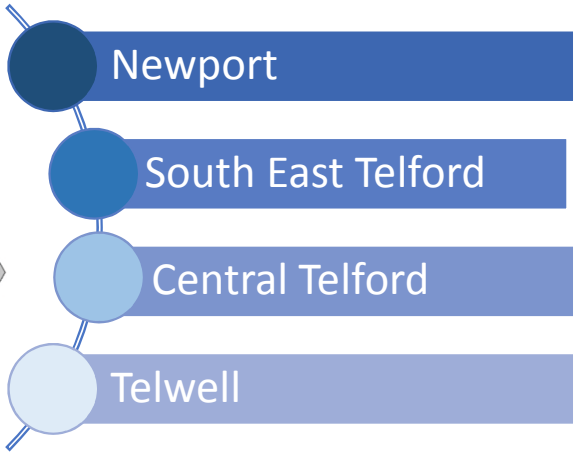
Quality:

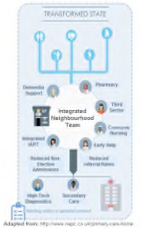
Please see individual projects for specific quality indicators

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





Primary Care Programme – GPFV

Updated Aug 2018
Next update– Oct 18

Exec Lead – Nicky Wilde & Rebecca Thornley

Project Leads – Phil Morgan

Programme needs to:

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.

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 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

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

Workforce
- 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

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 Care Closer to Home /neighbourhood plans
2. Continued uncertainty around continuation of funding for extended access pilots and the post-October 1st scheme(s)
3. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
4. Pressure on revenue budgets from ETTF-funded capital estates projects
5. A change in historical culture is required to enable transformation and collaborative change in Primary Care which will take time to embed
6. Difficulty in accessing up to date and meaningful data to identify unsustainable practices who need support with resilience funding

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 – both CCGs are confident of achieving 100% access by 1st October 2018

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 – T&W - 16 sites now live for VOiP and Wi-Fi; SCCG – 16 sites now live for VOiP and Wi-Fi

Local Maternity System

Exec Lead – Chris Morris Programme Lead – Fiona Ellis

NHS England NHS Improvement

Maternity Core Deliverables Overall RAG

X097	X098	X099	X100	X101	MTP1	MTP2	MTP3	MTP4	MTP5	MTP6
On Track	On Track	On Track	At Risk	On Track	On Track	On Track	On Track	On Track	On Track	On Track

Milestones

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

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**

Local Maternity System

Exec Lead – Chris Morris Programme Lead – Fiona Ellis

NHS England NHS Improvement

Risks

Ref	Top Risks & Issues	Rating (Pre)	Mitigation	Rating (Post)
	The target of 20% women on a continuity of carer pathway by March 2019 is not met.	Medium risk	Clear project plan in place. Engagement work with staff planned.	Medium risk
	Effect of existing instability in maternity services on staff morale hinders continuity of carer pilot and roll out. (Publicity, change exhaustion and poor estate and working environments)	High risk	Supporting staff with resilience and health and wellbeing. Robust staff engagement and increasing understanding of models of continuity of carer. Ensuring that staff feel listened to.	Medium risk
	Capacity of front line staff to absorb additional activity generated by achieving safe CofC ratios.	High risk	Supporting staff with resilience and health and wellbeing. Robust staff engagement and increasing understanding of models of continuity of carer. Ensuring that staff feel listened to.	High risk
	Capacity of Senior management team to lead and deliver changes required to implement continuity of carer pathway.	High risk	Transformation Midwife in place until April 2019 to undertake scoping and planning activities and to support implementation.	High risk

Activities

Key activities this reporting period	Key activities next reporting period
1. LMS Transformation Midwife is in post to support delivery of transformation projects, including continuity of carer. 2. Continuity of carer project launched. 3. Co-production workshop took place to agree approach to working in co-production. 4. Additional scanning resource in place.	1. Commence Continuity of Carer Pilot. 2. Recruit transformation champions (front line staff with protected hours for LMS activities). 3. Complete implementation of projects funded through additional £150k non recurrent funding. 4. Implement AMU pilot (bringing it closer to consultant unit) 5. Deliver implementation plan for Specialist Perinatal Mental Health service. 6. Launch initiatives to increase midwife led births (Shrewsbury MLU refurbishment, emergency situation training for midwives, AMU pilot)

Challenges; learning; & good news

Further issues & challenges / learning / good news	Comments
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.	

Local Maternity System

Exec Lead – Chris Morris Programme Lead – Fiona Ellis

NHS England NHS Improvement

Core Deliverables

No.	Ref	Type	Deliverable
1.	X097	Next Steps	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.
2.	X098	Next Steps	Deliver full implementation of the Saving Babies Lives Care Bundle by 31 March 2019.
3.	X099	Next Steps	Deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.
4.	X100	Next Steps	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.
5.	X101	Next Steps	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.
6.	MTP1	System Ask	All services are investigating and learning from incidents, and share this learning through their LMS and with others by March 2021
7.	MTP2	System ask	All services are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme by March 2021
8.	MTP3	System ask	All women are able to make choices about their maternity care, during pregnancy, birth and postnatally by March 2021
9.	MTP4	Oversight	The LMS is engaging with Operational Delivery Networks to deliver safe and sustainable models of neonatal care across England by March 2021
10.	MTP5	Oversight	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.
11.	MTP6	Oversight	The LMS has sufficient core staffing, and clear governance and reporting processes in place by March 2021

Mental Health

Programme Director – Steve Trenchard Clinical Lead - Professor Tony Elliott Programme Manager – Sara Edwards

Programme needs to:

1. Deliver the **implementation plan** for the Mental Health Forward View, ensure delivery of the mental health access and quality standards and increase baseline spend on mental health
2. Work to eliminate **out of area placements** and reduce PICU spend
3. Deliver a sustainable system-wide **IAPT service**
4. Progress against **CYP LTP**
5. Realise **Five Year Forward View targets** for STW STP footprint.
6. Ensure there is wider **stakeholder engagement** in setting the priorities for transforming MH services across STW.

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. Improve provision and support for out of area Looked After Children
6. 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
7. 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 underway to reduce PICU bed use out of area and improve quality, QIPP benchmarking in progress
3. Delivery issues in CAMHS being addressed via a Remedial Action Plan with clear milestones and objectives. Operational Group in place monitoring progress
4. Dementia diagnosis rate for Shropshire is presently at 69.9% against the national benchmark of 66.7%.
5. CCGs meeting entry, recovery and waiting times targets for Access to Psychological services
6. **STP MH Strategic Group** formulating with ToR being developed. Joint Chairing of the Group by STP MH Clinical Lead and STP MH Programme Director.
7. **A joint strategic needs assessment** undertaken to Identify service priority areas against 5YFV Plan. Presented to the STP Clinical Strategy Group. To form basis of the STP MH Strategy.
8. **MH Workforce Plan** for STW completed. Workforce Delivery Plan response being worked up with next steps to align service delivery, workforce and financial plans.

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
- Programme plan to be produced for delivery of associated workforce transformation projects against **£100k STP/LWAB MH funding.**
- Costings against workforce expansion being developed for completion of **Workforce Delivery Plan** with submission to HEE by end of 2018.
- 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.
5. Required workforce growth will not be achieved if there is no additional financial investment from CCGs/NHSE.

Data

- Mental health MDS (MHMDS) - difficult to manipulate
- IaPTUS- IAPT service only
- **STP Mental Health Workforce Plan** submitted to HEE included expansion trajectory showing funded workforce growth against future targets. April 2016 baseline position of **528** to the current workforce baseline position (January 2018) of **597** showing an achieved growth of **78** of the original **134** target leaving a required growth of **56** to achieve a target of **662** by 2021.

Elective Care Transformation Programme

This Programme of work consists of the following workstreams:

- Workstream 1 – PLCV Policies
- Workstream 2 – MSK
- Workstream 3 – Ophthalmology
- Workstream 4 – Diabetes
- Workstream 5 – Outpatients
- Workstream 6 – MRI
- Workstream 7 – Neurology
- Workstream 8 - Dermatology

All workstreams are currently in draft and are being worked up as part of the Elective Care Transformation Programme

1. Procedures of Limited Value

Exec Lead – Julie Davies Programme Lead Project Lead –

Programme needs to:

The programme is clearly setting out procedures determined to be of limited clinical value and each CCGs policy in relation to these interventions. The programme intends to manage unnecessary demand on acute hospitals and ensure unnecessary procedures are not carried out on patients.

System Partners / Enablers need to:

1. Ensure they adhere to the CCGs policies (Values Based Commissioning for SCCG / Excluded and Restricted Interventions Policy for TWCCG)
2. Implement any changes to the policies quickly and efficiently

The progress:

- VBC policy in place for SCCG and ERIP in place for TWCCG
- Prior approval process implemented for VBC and ERIP
- Quarterly review of VBC completed
- CSU completed review of ERIP for TWCCG
- Task and finish group completed review of recommendations for ERIP and identified that further clinical input is required

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

- Clinical leads to discuss recommendations for ERIP in October
- VBC policy to CCC for approval in October
- Proposal for changes to ERIP in November
- Publish changes to VBC in xxx
- Publish changes to ERIP in January

Expected Benefits

- Improved control over procedures carried out on patients
- Patients not subjected to clinically inappropriate procedures
- Greater financial control for CCGs
- Improved utilisation of finite resources

Risks to delivery

Top 5 Risks

1. Providers do not follow the policies for the CCGs
2.
3.
4.
5.

Mitigating Actions:

1. Engage with providers to implement the policies

Data

- Number and cost of identified procedures carried out
- Number and cost of identified procedures rejected

2. MSK

Exec Lead – Clinical Lead - Programme Lead –

Programme needs to:

The programme is implementing the high impact interventions within MSK in the short term and exploring new models of care across the STP footprint in the long term.

(High impact interventions for MSK are triage for all routine referrals and implementation of a First Contact Practitioner pilot site)

System Partners / Enablers need to:

- Support implementation of VBC and ERIP in relation to MSK conditions across the pathways
- Ensure full utilisation of MSK triage for all routine MSK referrals
- Agree implementation of a pilot FCP service using existing resource
- Support development of new models of care for MSK
- Provide information to feed into the new models of care work
- Provide resource to deliver the project
- Potential pump prime funding may be required to gain the appropriate transformation of services required

The progress:

- Community MSK in place for TWCCG since 2015
- MSK triage in place for TWCCG since 2015
- MSK triage implemented in line with project plan for SCCG
- Prior approval for VBC and ERIP implemented
- MSK physiotherapy specification developed and implementation commenced for SCCG
- Self-management project commenced in SCCG
- FCP pilot site identified and agreed
- FCP pilot site planning undertaken
- Review of community MSK service in TWCCG in progress

Key Interventions / Milestones

- All SOOS staff in place by October
- Final community MSK report for TWCCG by November
- FCP pilot implementation to commence by first week in November
- FCP evaluation by March 2019
- Task and finish group established for new models of care during Q4

Expected Benefits

- Reduced demand on secondary care
- Reduced demand on primary care
- Alternative community based solutions
- Financial benefits for the CCG
- Improved access for patients

Risks to delivery

Risks

1. Availability of resource to complete required work
2. Differing models across the footprint
3. Lack of engagement from partners
4. High impact interventions do not deliver savings
5. Unmet need uses FCP slots resulting in no improvements and creating cost pressures

Data

- **TBC**

3. Ophthalmology

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is implementing the High Impact Interventions for ophthalmology and improving pathways to eye care services.

The High impact interventions are:

1. Secondary care providers to develop failsafe prioritisation processes and policies
2. Secondary care providers to undertake a clinical risk audit of patients
3. Complete eye health capacity reviews to understand demand

System Partners / Enablers need to:

- Complete the High Impact Interventions assigned to them
- Share the output of the work in relation to High Impact Interventions with partners
- Work together to develop alternative pathways through the Local Eye Health Steering Group

The progress:

- Secondary care providers have developed failsafe prioritisation process and policies (are we sure?)
- Secondary care providers have undertaken a clinical risk audit of patients
- Procurement of optometry scheme provider commenced to deadline
- Tenders received and evaluation taking place

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

- Award of new optometry scheme contract by January
- Review of corneal pathway
- Explore feasibility of virtual clinics
- Optometry provider service mobilisation by April 2019
-

Expected Benefits

- A sustainable model of care for our population
- Plans in place to provide required capacity
- Patient pathways that provide more out of hospital care
- Reduction in acute attendances
- Improved quality of care

Risks to delivery

Risks

1. Capacity to meet demand cannot be sourced
2. No bidders meet the required standard for the optometry scheme contract
3. Acute workforce continues to be fragile

Mitigating Actions:

Data

TBC

4. Diabetes

Exec Lead – Programme Lead Project Lead –

Programme needs to:

- Describe what the programme is setting out to do

System Partners / Enablers need to:

1. What's needed from STP System partners to make this programme a success
2. What do system enablers need to consider,
   - Finance
   - Comms
   - Workforce
   - estates

The progress:

- Insert bullet points to describe what's been achieved so far

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

You add additional milestone boxes if useful or delete if not needed

Expected Benefits

Patients / service users

Staff

Organisational

Financial

Risks to delivery

Top 5 Risks

1.
2.
3.
4.
5.

Mitigating Actions:

Describe the risks and mitigating actions

Data

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

5. Outpatients Redesign

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is looking to reduce demand for outpatient appointments, both first and follow up, in secondary care and looking to develop alternatives to traditional outpatient appointments.

System Partners / Enablers need to:

- Engage in outpatients task and finish group
- Identify improved ways of working
- Implement changes agreed as part of the task and finish group

The progress:

- Analysis of outpatients activity completed
- Task and finish group set up
- Initial focus of group agreed to be Cardiology and Paediatric Ophthalmology due to opportunities identified in these areas
- Gastro workbook released by NHSE
- Gastro group set up to look at potential for improvements in this area

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

- Deep dive into cardiology during October
- Deep dive into paediatric ophthalmology during November
- Implement identified quick wins during December and January
- Review new consultant to consultant policy (when received) and identify changes to local policy
- Explore use of apps and Telehealth by January

Expected Benefits

- Reduction in outpatient activity at SaTH
- Reduction in consultant led outpatient activity in SaTH
- More care delivered out of hospital
- Reduction in demand for outpatient appointments
- Reduction in avoidable attendance at outpatient appointments
- Improved use of finite resources
- Improved use of skill mix for delivering outpatient activity
- Opportunities for innovation and alternative delivery
- Financial benefits for partners

Risks to delivery

Risks
1.Partners don't engage in task and finish groups
2. Partners don't implement changes agreed
3. Released resource is filled with other patients so RTT improves for SaTH but savings are not made

Mitigating Actions:
Senior buy-in and support from partners

Data

TBC

6. MRI

Exec Lead – Programme Lead Project Lead –

Programme needs to:

- Describe what the programme is setting out to do

System Partners / Enablers need to:

1. What's needed from STP System partners to make this programme a success
2. What do system enablers need to consider,
   - Finance
   - Comms
   - Workforce
   - estates

The progress:

- Insert bullet points to describe what's been achieved so far

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

You add additional milestone boxes if useful or delete if not needed

Expected Benefits

Patients / service users

Staff

Oragnisational

Financial

Risks to delivery

Top 5 Risks

1.
2.
3.
4.
5.

Mitigating Actions:

Describe the risks and mitigating actions

Data

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

7. Neurology Redesign

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is looking to develop a sustainable neurology service across the STP footprint.

System Partners / Enablers need to:

1. Support the CCGs in the development of a sustainable model
2. Engage in any required groups
3. Provide information as required
4. Work with any new providers moving onto the patch as part of the new models of care

The progress:

- Met with neighbouring CCGs to explore the option of joining forces
- Published Prior Information Notice (PIN) to test the market
- Held market engagement event
- Virtual meeting with neighbouring trust to begin discussions in relation to the support available

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

- Virtual meeting with further neighbouring trust in October
- Virtual meetings with potential providers to gauge interest in November
- Procurement decision made (go out or work with individual provider or group of providers)
- Further actions to be determined
-

Expected Benefits

- Sustainable neurology service
- Neurology service delivered in county
- Improved use of skill mix for delivering outpatient activity

Risks to delivery

Risks
1. No provider is able to deliver a sustainable service
2. Providers are not able to deliver services in county
3. Increased cost as specialist service with no national tariff

Mitigating Actions:

Data

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

8. Dermatology

Exec Lead – Programme Lead Project Lead –

Programme needs to:

The programme is to procure a community dermatology service across the STP footprint

System Partners / Enablers need to:

Partners to work with any new service provider

The progress:

- Task and finish group established
- Workshop held to map processes
- Service specification developed
- Finance and activity modelling completed

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

- ITT published in October
- Evaluation completed in November and December
- Contract award by February 2019
- Service implemented by April 2019
-

Expected Benefits

- Support for the fragile acute service
- Sustainable dermatology services across the STP footprint
- Increased care closer to home
- Improved use of skill mix for delivering outpatient activity
- Improved likelihood of bidders due to increased activity levels

Risks to delivery

Risks
1. No bids are received for the service
2. Bidders set prices higher than current provision creating a cost pressure
3. Short implementation time impacts on ability of provider to mobilise

Mitigating Actions:

Data

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

Acute Reconfiguration - Future Fit

Executive Lead – Debbie Vogler Programme Manager – Andrea Webster

Programme needs to:

- Ensure delivery of the required Decision Making Business Case
- Evidence conscientious consideration in relation to process
- Prepare and deliver a structured and agreed timeline and process of drafting, submission and approval of the DMBC
- Work with all key stakeholders to ensure DMBC accurately reflects all identified priorities, interdependencies, NHSE/NHSI approvals and engagement as well as taking into consideration the Participate Report to identify recommendations and any mitigations

System Partners / Enablers need to:

- Support the effective delivery of the Decision Making Business Case with relevant clinical and managerial support to key events
- Contribute to the development of the DMBC
- Provide required expertise to confirm and challenge assumptions and mitigations from Participate Report, consultation themes feedbacks, IIA Priorities and other relevant interdependencies
- Ensure alignment and engagement with NHSE/NHSI , Specialised Commissioning approvals process as required
- 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 next phase of the Future Fit Programme is the development of the Decision Making Business Case. (DMBC)
- Joint Committee Terms of Reference has been prepared and submitted to the FF Programme Board on 24th October.
- An initial timeline has been developed in conjunction with SaTH and the FF Programme Team to outine development from SOC through to FBC and implementation
- Receipt of Participate Consultation Report will commence a high level implementation timeline for the drafting, approval and submission of the DMBC
- Support from tcl and NHSE continues to support the Programme

Key Interventions / Milestones

- Formal Public consultation ends 11th September 2018
- Analysis of surveys and feedback from the Consultation process collated into a Report by Participate Ltd by 9th November
- To Draft, develop and obtain fof the DMBC in line with agreed timescales and approval process
- Submit Final DMBC with recommendations submitted
- Joint Committee make recommendation

Risks to delivery

Risks

- FF Team capacity and resource needs to be maintained to support delivery of the DMBC
- High level timeline will require significant engagement and approvals process within a short timescale to meet proposed DMBC development and submission
- Telford and Wrekin local council elections could impact on timeline if PURDAH is actioned

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

Improving ED Systems & Processes

Project Summary

Project Overview				Overall Project Status
Project Title:	ED implementation	Deadline:	5.10.2018	AMBER
Exec Lead:	Nigel Lee	Project Lead:	Karen Barnett	
Clinical Lead:	Edwin Borman/Deirdre Fowler	Project Group:		
Date of Report:	12th October 2018	% improvement in admitted performance target		TBC

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- All working groups have conducted at least one meeting and actions are in place
- Modelling refined and agreed numbers are now in place for SaTH, WMAS and worked through with CCG colleagues
- Project plan updated
- Risk log updated
- Issues log updated
- Responses to external agencies continued – CQC, NHSI, elected members, media
- Continued to work with New Cross to review and agree repatriation policy
- Calls undertaken with WMAS, RWT, and UHNM to agree numbers of conveyance patients post go live

- Care pathway group – met and care pathways are being created for review on Monday 8th October.
- Regional Flows – met and list of concerns/issues identified from each partner organisation
- Operational delivery group – met and list of actions discussed
- Finance and data –1st met on Friday 12th
- Comms and engagement – group met and version 1 of Comms plan created and added to SharePoint
- Meeting set up with Telford CCG re extended GP hours
- The project team has gained lessons learnt from similar projects in Lincoln such Lincoln (recent Paediatrics and ED service changes)
- Provided an extensive set of evidence sent for Clinical Senate (next Weds)

Improving ED Systems & Processes

Key Issues/Risks

1. Regulators requiring significant assurance regarding process
2. Capacity to complete pieces of work within the timescale required with the operational pressures currently being experienced particularly regarding clinical input to pathways and clinicians have full clinical commitments
3. Go / No Go (GONG) tracker under development to ensure transparent decision making and project governance
4. Mental Health organisations to be included / briefed ie Police and local MH organisation

Key items for next week

- Call with Dudley Group to agree numbers of conveyance patients post go live
- Sign off, agree and publish each Care pathway (sign off deadline agreed at 12.00 noon Monday 15th October)
- All working groups to progress individual work at pace
- To discuss with wider partners – Police for attending ED with patients, Local council for road signs
- Agree STP support into the programme of work
- Agree and sign off Go / No Go (GONG) tracker
- Establish closer working with NEDs to inform Q&S next week
- Provision of further evidence for Clinical Senate (next Weds)

Stranded Patient Flash Report

Project Overview				Overall Project Status
Project Title:	Stranded patient	Deadline:	02/07/2018	AMBER
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%		

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 de creased 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**

Stranded Patient Flash Report

Project Overview				Overall Project Status
Project Title:	Stranded patient	Deadline:	02/07/2018	AMBER
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%		

Cont.

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**

Red2Green/Safer

3A. Project Summary

Project Overview				Overall Project Status
Project Title:	**Objective 3 - Red 2 Green/SAFER**	**Deadline:**		**AMBER**
Exec Lead:	**Deidre Fowler**	**Project Lead:**	**Rachael Brown**	
Clinical Lead:	**To be agreed for each site**	**Project Group:**	**Improving patient flow**	
Date of Report:	**17th October 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 pm huddles, attendance at board rounds and nurse accompanying ward rounds. In the process of collecting next set of measures.
- Corporate nursing Nightingale project to be developed as part of standard work plan regarding safety huddles.
- Weekly data shows an increase in pre12pm discharges, although still below trajectory. Currently remains at 16% against a trajectory of 20%. This data set includes transfers to discharge lounge which are now open on both sites.
- 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 by October
- Check, chase, challenge process in place across both sites, all care groups. Production board developed to provide visibility of daily metrics
- Working with the community trust to share good practice around red2green, and check, chase, challenge.

Red2Green/Safer

• Lack of red2green completion leading to insufficient and potentially misleading data on some wards. About half of all wards consistently submit data. • Performance still below 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. • Collection of metrics

Taskforce- Steering Group Report

Project Summary

Project Overview				Overall Project Status
Project Title:	Workforce			RED
Exec Lead:	Victoria Maher	Project Lead:	Simon Balderstone	
Clinical Lead:		Project Group:	TBC	
Date of Report:	10 October 2018	% improvement in admitted performance target 4%		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

Consultant

- Re-advertised ED Consultant post – interviewed on 6 September. Candidate has been offered position and has accepted (confirmed on 4 October).
- We currently have 4 substantive Consultants with an additional 3 commencing over the next 5 months.
- Re-advertising Consultant post in BMJ in October.

Middle Grade

- From last round of interviews 3 Specialty Doctors have been offered position (1 has accepted 2 have declined)
- Adverts for Specialty Doctors closed 25 September. 1 application received plus 5 applications put forward from agencies. Interviewing 10 October.
- Re-advertised Specialty Doctor which now closes on 15 October 2018.
- Advertised for Simulation Fellow which now closes on 15 October.

In summary

- We have 12 middle grades in post. Including 1 appointment that started in July and 1 in September.
- Appointed 1 middle grade from last round of interviews commencement date to be confirmed.
- We have 2 ST2 level doctors that are progressing to middle grade but will not be ready for at least 6 months.
- We are continuously advertising and interviewing middle grade doctors via internal process and agencies but require 7 more substantive to reach a total of 20.

ACP

Advanced Clinical Practitioner (ACP) - Candidate has been offered position – commenced 28 August.

Nursing

- ED Recruitment Day (Nursing) on 5 September. Only 1 applicant appointed.
- New recruitment event being organised likely to be in October / early November.
- 8 newly qualified /qualified nurses recruited and joining from September and October.
- Looking at how we are using social media to attract candidates given the poor response we have had recently to ED recruitment.
- Continue to engage the following agencies for substantive recruitment Medacs Healthcare, ID Medical, Remedium.

Key Issues/Risks

- Failure to secure locum cover for ED will lead to enacting contingency plan.
- Risk to overall agency work.
- Patient and staff wellbeing

Key Items for next week

- Interview arrangements in place for Speciality Doctors and Simulation Fellow.

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 Wrekin 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. ECIST review of IDT process and develop the SOP 15/16/10/18
2. RPIW event re FFA's 5/11/18

Overall status

Amber

Improvement in the A&E Quality Standard/Improvement discharge practice

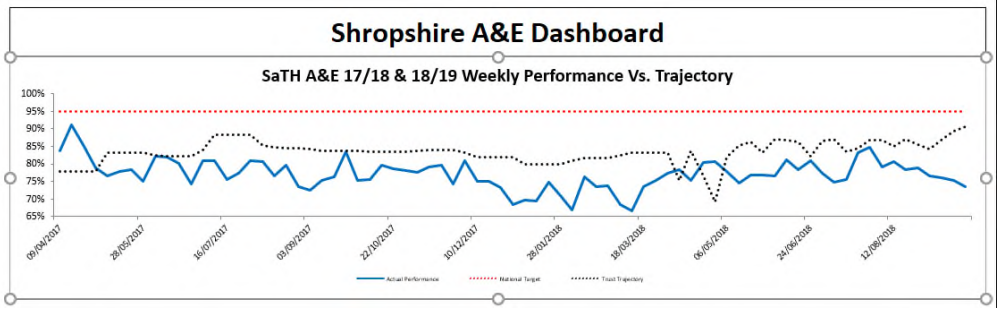
Interventions and process changes

- 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



IV Antibiotic Therapy – Community Based Delivery

Updated: 29/10/18
Next Update: November 2018

Exec Lead – Steve Gregory

Programme Lead – Yvonne Gough

Reasons for change

Why is the change indicated?

Give 4 reasons

- Admission avoidance
- Point prevalence data suggests 70 patients in acute beds suitable for community ambulatory delivery
- Reduce LOS
- Reduce number of stranded patients

Which Strategic Priority does this support?

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

Evidence to support change required

- National Priority
- ECIP – LOS projects and external support received suggests opportunity for delivery outside of acute bed base
- Admission avoidance; low admission avoidance attainment
- Volume of patient treatments within SATH for IV antibiotic therapy

Expected Benefits

Patients / service users
- Less stay in hospital, reduced dependency on acute hospital stay
- Understanding of alternative treatment options
- Encouragement for maintained independence

Staff
- Improve morale
- Improve MD Team working

Organisational
- Opportunity to challenge cultural working practices and to consider community options
- Improved communications between all the different organisations

Financial
- Reduced occupancy for IV antibiotic therapy

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

- Development of pathways and governance for community 'chair based' antibiotic IV therapy
- Identify capacity within the MIU/DAART to deliver treatment
- Financial modelling for costs of drugs, consumables and pathway delivery and initial funding for equipment
- Agreement for pilot to commence October 2018 –April 2019, with funding stream approved
- Collection of data to validate efficacy of project

The progress:

Describe progress to date;

- Project live from 1st October 2018 delivering a chaired based service from Ludlow and Bridgnorth MIU plus DAART Shrewsbury (OD/BD Ivs)
- Capacity to deliver within current staff resource for 12 additional appointments per day across the 3 sites using an inclusion and exclusion criteria
- Governance and medical responsibility agreed
- Staff matrix and competencies completed and relevant staff trained
- All medication to be stocked in the community
- All activity to be invoiced to SaTH direct
- All current referrals continue to be triaged through Phil Atkins MIU Lead in order to accept the maximum activity as many patients identified fall outside of the inclusion criteria.
- Shropcom have developed bespoke care for the current referrals to ensure the project is successful
- Rachel Brown (SaTH) engaging in-house to increase referrals

Risks to delivery

Top Risks
1. Lack of engagement from all partners
2. Reluctance to change prescribing behaviours
3. Insufficient patients identified for community delivery
4. Governance – maintaining medical responsibility within SATH
5. Finance – redirection of funding for pathway delivery
6. High re-admission rate
7. De-skilling of staff due to lack of referrals

Mitigating Actions:
- Full liaison and involvement of all partners including engagement workshops
- Robust capacity model; therefore financial redirection only required for those patients who attend this community provision
- Patient inclusion criteria with on-going virtual MDT until discharge
- Monitor all staff training and rotate through rapid response IV service if de-skilling

Data

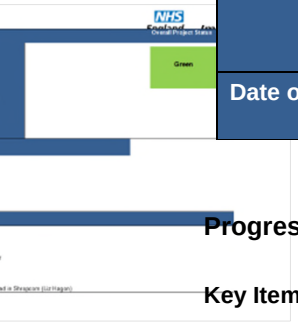
Data set has been developed by Shropcom for community delivery. Manual calculation in place to ensure all activity recorded accurately during initial stages.

A system wide data will assess scale of opportunity and to validate efficacy of project (including but not limited to the following);

- Numbers of patients with reason for admission as IV antibiotic therapy in acute hospital
- Number of patients suitable for OD /BD regimes
- LOS for patients receiving IV antibiotics
- Patient feedback and experience
- Number of avoidable admissions

Summary

Overview				Overall Project Status
Title:	**AHP collaborative**	**Deadline:**		**Green**
Lead:	**Amanda Taylor**	**Key contacts:**		
Date of Report:	**September 2018**			



Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Project plan in place and reviewed as part of integration work stream in STP
- Driver diagram in place and reviewed as part of integration work stream

Storyboard_v01_SaTH_Shropcom.pptx

- Attended all AHP collaborative events and presented poster
- Currently in data capture continuing and being refined
- Networking between therapy teams in progress
- Continued development of good conversations and relationships with AHP lead in Shropcom (Liz Hagon)

Key Issues/Risks

• Timeline is tight to demonstrate significant changes though processes will be clear going forward. • Community hospital (Whitchurch) about to lose its physio leaving one full time OT for the whole bed base • Commitment from Orthopaedic surgeons to test the new system – discussions happening • Data sharing across organisations to identify total time person away from home – Liz Hagon now has data and is merging from 2 systems

Key Items for next week / next period of work

• Complete phase 2 • Complete simple actions from project plan • Continue changes in PDSA model

Measures of success

• Overall time a person is away from home is reduced by a day • Pathway decisions are correct for 60% of the time • Patients and relatives expectations are aligned to service provision • Patients are informed of their choices following orthopaedic surgery or admission to Whitchurch hospital • Therapy staff across the system are clear on the services on offer in order to support patient decision making • Transfer of care is more streamlined and effective

Frailty Programme

Exec Lead – Fran Beck Programme Lead – Michael Bennett / Emma Pyrah

NHS England NHS Improvement

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

Key Interventions / Milestones

- Further develop Frailty at Front Door to maximise avoidable admissions and reduce length of stay on RSH site
- Develop and implement Frailty at Front Door at PRH to maximise avoidable admissions and reduce length of stay on PRH
- Implement DTOC High Impact Changes Action Plan to ensure achieving a Mature RAG rating by Q4
- Care Homes actively utilising the NHS111 * 6 line for telephone clinical advice from the NHS111
- Funding for Frailty team at Front Door at PRH to enable implementation and evaluation

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 Care 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

Exec Lead – Clinical Lead - Programme Lead – Rob Gray

NHS England NHS Improvement

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.
- Develop 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 in line with 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. Involve 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:

- Continue direct engagement with NHS England, and NHS Digital for strategic direction.
- New DEG chair, SRO and Exec Lead to meet to agree LDR direction.
- LDR refresh process nearing completion.
- HSLI bid for 8/19 funding accepted by NHSE. £885k awarded.
  - Business cases now to be created and locally approved.
  - Benefits expectation to be refined
- Project started - Enhance SCR for all active patients.
- Data Analytics forum to be defined as centre for data-driven decision making.
- Evaluating options for interim digital system in A&E to increase time-critical processes, reduce data-entry delays, and increase access to existing patient information.

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. HSLI refinement and planning
- Dec-18. Network - Corporate Wifi access for all orgs planned for all sites. Business cases in progress for HSLI funding
- 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

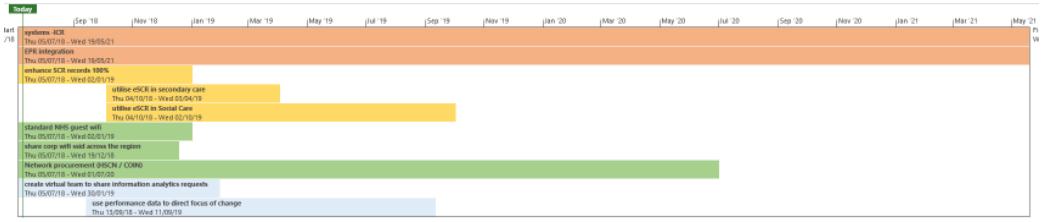
Risks to delivery

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.



Strategic Estates Programme

Updated October 2018
Next update– December 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:

- Estates Workbook/Strategy completed and submitted on time and now a living document
- Capital bid for Shawbirch submitted and support being provided to CCG
- Project pipeline in early stages of development
- Joint OPE/STP Programme Delivery board established and functioning well
- 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 progressing. Potential opportunities identified and looking to further identify and expand
- Planning workshop for estate strategy requirements

Key Interventions / Milestones

- Awaiting feedback on Estate Workbook/Strategy then progress against recommendations in line with requirements of system and Wave 3 bid caveats
- Build on engagement with T&W Council to identify possible project opportunities through joint working
- Identify systemwide requirements of an estate strategy and work with colleagues to develop
- Improve disposal information and data and develop a disposals pipeline in conjunction with the project opportunities
- Real national focus on delivery of Wave 1 – 3 capital bids – need to ensure the joined up approach between all elements of Future Fit/SSP, and the out of hospital offer is there

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
- Huge national focus on delivery of Wave 1 – 3 capital bids, need to ensure linkages are there and supported
-

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

Strategic Estates Progress so far

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….

Strategic Back Office

Updated August 2018 Next update– October 18

Exec Lead – Ros Preen Programme Lead – Maggie Durrant

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 – 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 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 wok 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

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

1. Lack of collaboration beyond health on procurement.
2. Willing ness 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)

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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 August 2018 Next update - October 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** 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.

The progress:

- Agreement between STP partners on **priority areas** through the Strategic Workforce Group **.**
- **System-wide Workforce Strategy** – Baseline data being worked up via HEE.
- **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 WF 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.

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

Risks:

- 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.
- Collaborating with HEE to access 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.
Data presented at July meeting of Strategic Workforce Group and LWAB. The data provides demographic information, nurse to bed ratio and a comparison with the 17 LWABs across Midlands and East. A focused session with workforce planners to review the data and provide a response to HEE is currently being arranged.

Individual areas of workforce:

- **Mental Health Workforce** data included in the submission of the MH Workforce Plan in March.
- **Local Maternity Transformation Plan (LMS)** developed with workforce analysis being undertaken to inform WFP. Financial analysis underway with STP Finance Lead for LMS. WF risk register updated to include financial risks.
- **Primary Care workforce data** has been collated as part of the GPFV Workforce Plan.
- Cancer Alliance now linked into Collaborative Cancer Group to progress Cancer Workforce Plan.

Local *H*ealth Economy *E*nd of *L*ife and *P*alliative Care *S*trategy

Caring, Responsive, Effective, Well-Led, Safe: A positive experience for patients, carers and families

The Shrewsbury and Telford Hospital NHS Trust

Severn Hospice

Shropshire Community Health NHS Trust

National Ambitions

- Individual care
- Fair access to care
- Comfort and Wellbeing
- Coordinated care
- All staff care
- Caring Community

Living Well HELPS ---> Dying Better

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

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

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

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

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

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

Population Health & Prevention

System Leads –Kevin Lewis / Helen Onions

Programme Lead – Penny Bason

Updated October 2018

Next update– November 2018

NHS England

NHS Improvement

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 by connecting with the national and regional population health management support mechansims
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:

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

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

- Developing local Health & Wellbeing Intelligence Population health management
- Develop 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

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